Supporting Statement
Revised and New Procedural Requirements for the FY 2018 Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
CMS-10432, OMB 0938-1171

This package is associated with the August 14, 2017 Inpatient Prospective Payment System/ Long-Term Care Hospital Prospective Payment System (IPPS/LTCH PPS) final rule: CMS-1677-F, RIN-0938-AS98.

Background

Pursuant to section 1886(s)(4) of the Social Security Act, as amended by sections 3401 and 10322 of the Patient Protection and Affordable Care Act (ACA), starting in fiscal year (FY) 2014, and for subsequent FYs, Inpatient Psychiatric Facilities (IPF) shall submit pre-defined quality measures to the Centers for Medicare & Medicaid Services (CMS). IPFs that fail to report on the selected quality measures and comply with other administrative requirements will have their IPF prospective payment system (PPS) payment updates reduced by 2.0 percentage points. To comply with the statutory mandate, we are proposing to update the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program for FY 2020. This package addresses the changes to the IPFQR program in the FY 2018 IPPS/LTCH PPS final rule, including the decision not to adopt the Medication Continuation following Inpatient Psychiatric Discharge measure into the IPFQR Program.

A. Justification

1. Need and Legal Basis

Section 1886(s)(4)(C) of the Act requires that, for FY 2014 (October 1, 2013 through September 30, 2014) and each subsequent FY, each psychiatric hospital and psychiatric unit paid under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) shall submit to the Secretary data on quality measures as specified by the Secretary (42 CFR §412.404(b)). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary.

The following is a list of measures included in the IPFQR Program and a brief explanation of their inclusion in this program.

- The Hospital-Based Inpatient Psychiatric Services (HBIPS)-2, HBIPS-3, and HBIPS-5 measures collect information on hours of physical restraint use, hours of seclusion use, and patients discharged on multiple antipsychotic medications with appropriate justification respectively. These are NQF endorsed measures (NQF # 0640, NQF # 0641, and NQF #0560) that address the National Quality Strategy (NQS) priority of "making care safer by reducing harm caused in the delivery of care."[1] Documentation on the website of The Joint Commission (TJC), the measure steward, has more detail on the specification of these measures: http://www.jointcommission.org/assets/1/6/TJC_Annual_Report_2011_9_13_11_.pdf.

[1] Agency for Healthcare Research and Quality, National Quality Strategy. Accessed at: https://www.ahrq.gov/workingforquality/about.htm.

- The SUB-1, SUB-2 and SUB-2a, and SUB-3 and SUB-3a measures provide information on substance use screening, substance use brief intervention offered or provided, and substance use treatment or referral offered or provided at discharge, respectively. These are NQF endorsed measures (NQF #1661, NQF #1663, and NQF #1664) that address the NQS priority of "promot[ing] wide use of best practices to enable healthy living."[2] Documentation on the website of TJC, the measure steward, has more detail on the specification of these measures: http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx.

- The TOB-1, TOB-2 and TOB-2a, and TOB-3 and TOB-3a measures provide information on tobacco use screening, tobacco use brief intervention offered or provided, and tobacco use treatment or referral offered or provided at discharge, respectively. These are NQF endorsed measures (NQF #1651, NQF # 1654, and NQF #1656) that address the NQS priority of "promot[ing] wide use of best practices to enable healthy living."[3] Documentation on the website of TJC, the measure steward, has more detail on the specification of these measures: http://www.jointcommission.org/assets/1/6/HIQR_Jan2015_v4_4a_1_EXE.zip.

- The Follow-up After Hospitalization for Mental Illness (FUH) measure provides information on the percentage of discharges for which patients receive follow-up within 7 and 30 days of discharge. This is an NQF endorsed measure (NQF #0576) that addresses the NQS priority of "promoting effective communication and coordination of care." The measure steward for this measure is the National Committee for Quality Assurance (NCQA), and more detail on the specification is available on the NQF website: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70617

- The IMM-2 measure provides information on influenza vaccination among the patient population in IPFs. Similarly, the Influenza Vaccination Coverage Among Healthcare Personnel measure provides information on influenza vaccination among the healthcare personnel (HCP) in IPFs. These are NQF endorsed measures (NQF #1659 and NQF #0431) that address the NQS priority of "promot[ing] wide use of best practices to enable healthy living."[4] The measure steward for IMM-2 is CMS, and more detail on the specification is available in the specifications manual: https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890516476&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2.6.1_IMM_v5_1.pdf&blobcol=urldata&blobtable=MungoBlobs: The forms for the Influenza Vaccination Coverage Among Healthcare Personnel measure are maintained by the Centers for Disease Control and Prevention and can be found at http://www.cdc.gov/vaccines/hcp.htm.

- The Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) and the Timely Transmission of Transition Record (Discharges from an Inpatient Facility to

[2] *Ibid.*
[3] *Ibid.*
[4] *Ibid.*

Home/Self Care or Any Other Site of Care) measures provide information on the completeness and timeliness of the transition records provided to patients and transmitted to the next level care provider upon discharge. These are NQF endorsed measures (NQF #0647 and NQF #0648) that address the NQS priority of "promoting effective communication and coordination of care."[5] Documentation on the website of the American Medical Association (AMA) convened Physician Consortium for Performance Improvement (PCPI), the steward for these measures, has more detail on the specification of these measures: http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI.

- The Screening for Metabolic Disorders measure provides information on the percentage of patients on antipsychotic medications who are screened for metabolic disorders. While this measure is not NQF endorsed, it does address the NQS priority of "reducing harm caused in the delivery of care."[6] The measure steward for this measure is CMS, and more information regarding the specification of the measure can be found in the IPFQR Program Manual: https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890516476&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2.6.1_IMM_v5_1.pdf&blobcol=urldata&blobtable=MungoBlobs

- The Thirty-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF measure provides information regarding the number of patients who are readmitted to an inpatient care setting (either acute care or psychiatric) within thirty days of discharge. This is an NQF endorsed measure (NQF #2860) that addresses the NQS priority of "promoting effective communication and coordination of care."[7] The measure steward for this measure is CMS, and more information on the measure specifications can be found in the IPFQR Program Manual: https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890516476&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2.6.1_IMM_v5_1.pdf&blobcol=urldata&blobtable=MungoBlobs

- The Assessment of Patient Experience of Care measure provides information on which facilities use a standardized instrument to assess patient experience of care, and which instrument each facility uses. While this is not an NQF endorsed measure, it addresses the NQS priority of "ensuring that each person and family is engaged as partners in their care."[8] Additional detail about this measure can be found in the IPFQR Program Manual: https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890516476&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2.6.1_IMM_v5_1.pdf&blobcol=urldata&blobtable=MungoBlobs

- The Use of an Electronic Health Record (EHR) measure provides information about the technical capability of IPFs to use EHRs to exchange health information across care partners and during transitions of care. While this is not an NQF endorsed measure, it addresses the

[5] *Ibid.*
[6] *Ibid.*
[7] *Ibid.*
[8] *Ibid.*

NQS priority of "promoting effective communication and coordination of care."[9] Additional detail about this measure can be found in the IPFQR Program Manual: https://www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228890516476&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3D2.6.1_IMM_v5_1.pdf&blobcol=urldata&blobtable=MungoBlobs

Section 1886(s)(4)(E) of the Act requires the Secretary to establish procedures for making public the data submitted by IPFs under the IPFQR Program. For CMS to publish the measure rates, IPFs are required to submit the Notice of Participation (NOP) form. By such submission, IPFs indicate their agreement to participate in the IPFQR Program and submit the required data pertaining to the eighteen (18) quality measures for the FY 2020 payment determination. In addition, IPFs give their consent to publicly report their measure rates on a CMS website. CMS is mindful and respectful that IPFs may choose not to participate or may choose to withdraw from the IPFQR Program. To this end, our procedures include the necessary steps that IPFs must take to indicate their intent to participate or withdraw.

As part of our procedural requirements, we require that IPFs acknowledge the accuracy and completeness of submitted data. We seek to collect information on valid, reliable, and relevant measures of quality, and to share this information with the public; therefore, IPFs must submit the Data Accuracy and Completeness Acknowledgement (DACA) form. In our effort to foster alignment across quality reporting programs, we removed the Extraordinary Circumstances Exception form and the Reconsideration Request form and are now submitting these forms as part of the Hospital Inpatient Quality Reporting (HIQR) Program's PRA package (OMB control number 0938-1022; CMS-10210). While IPFs may also need to complete and submit these forms, the associated burden is addressed in the HIQR PRA package.

2. Information Users

- **IPFs**: The primary ways an IPF will use the information are: to examine individual IPFs' specific care domains and types of patients; to compare present performance to past performance and to national performance norms; to use quality measures to evaluate the effectiveness of care provided to specific types of patients; to monitor quality improvement outcomes over time; to assess their own strengths and weaknesses in the clinical services that they provide; to address care-related areas, activities, or behaviors that result in effective patient care; and to alert themselves to needed improvements. Such information is essential to IPFs in initiating quality improvement strategies. This information can also be used to improve an IPF's financial planning and marketing strategies.

- **State Agencies/CMS**: Agencies will use the data to compare an IPF's results with its peer performance. The availability of peer performance enables state agencies and CMS to identify opportunities for improvement in the IPF and to evaluate more effectively the IPF's own quality assessment and performance improvement program.

[9] *Ibid.*

- **Accrediting Bodies**: National accrediting organizations, such as TJC, or state accreditation agencies may wish to use the information to target potential or identified problems during the organization's accreditation review of that facility.

- **Beneficiaries/Consumers**: The IPFQR Program publicly reports data through a CMS website. This data provides information for consumers and their families on the quality of care provided by individual facilities, allowing them to compare patient outcomes between facilities and against the state and national average. The website provides information in consumer-friendly language and offers a tool to assist consumers with selecting a hospital.

3. Use of Information Technology

IPFs can utilize electronic means to submit/transmit their forms and data via a CMS- provided secure web-based tool, which is available on the QualityNet website. IPF users are required to open an account to set up secure logins and then will be able to complete all the necessary forms/applications as may be applicable to their circumstance (e.g., NOP, DACA, Request for Reconsideration). We have included copies of these forms within this package.

A web-based measure online tool is used for data entry through the QualityNet website. Data are stored to support retrieving reports for hospitals to view their measure rates/results. Facilities are sent a preview report via QualityNet Exchange prior to release of data on the CMS website for public viewing.

4. Duplication of Efforts

Facilities that currently collect and report data on TJC measures can use the same information to report to CMS, which avoids duplication of efforts and reduces burden to the IPFs. As for collection of the FUH and Thirty-day All-cause Readmission Following Hospitalization in an IPF, CMS will collect such data using Medicare Part A and Part B claims; therefore, these measures will pose no burden on IPFs.

5. Small Business

Information collection requirements are designed to allow maximum flexibility specifically to small IPF providers participating in the IPFQR Program. This effort assists small IPF providers in gathering information for their own quality improvement efforts. For example, we provide a help-desk hotline for troubleshooting purposes and 24/7 free information available on the QualityNet website through a Questions and Answers (Q&A) functionality.

6. Less Frequent Collection

We have designed the collection of quality of care data to be the minimum necessary for reporting of data on measures considered to be meaningful indicators of psychiatric patient care. To this end, we only require a single, annual report of measure data from facilities.

7. Special Circumstances

Although IPF participation is voluntary (i.e., not required by Medicare Conditions of Participation), all eligible IPFs must submit their data to receive the full market basket update for a given FY. If data are not submitted to CMS, the IPF receives a reduction of 2 percentage points from its Annual Payment Update (APU) unless CMS grants an exception.

8. Federal Register Notice/Outside Consultation

The FY 2018 IPPS/LTCH PPS final rule is serving as the 30-day Federal Register notice. The rule published August 14, 2017 (82 FR 37990).

The FY 2018 IPPS/LTCH PPS proposed rule was placed on file for inspection on April 14, 2017 at: https://www.federalregister.gov/documents/2017/04/28/2017-07800/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-long. Comments were due 60-days later on June 13, 2017. No PRA related comments were received.

CMS is supported in this initiative by TJC, the NQF, and the Agency for Healthcare Research and Quality (AHRQ). These organizations, in conjunction with CMS, will provide technical assistance in developing or identifying quality measures, and assist in making the information accessible, understandable, and relevant to the public.

9. Payment/Gift to Respondent

No other payments or gifts will be given to respondents for participation.

10. Confidentiality

All information collected under this initiative is maintained in strict accordance with statutes and regulations governing confidentiality requirements, which can be found at 42 CFR Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication and are Health Insurance Portability and Accountability Act (HIPAA)-compliant. Further, the program requires submission of aggregate data, thereby eliminating the need to transmit confidential or patient level information.

11. Sensitive Questions

Pursuant to 42 CFR Part 480, no case-specific clinical data will be collected or released to the public.

12. Burden Estimate (Total Hours and Wages)

In our burden calculation, we have included the time required for chart abstraction and for training personnel on collection of chart-abstracted data and aggregation of the data, as well as training for submitting aggregate-level data through QualityNet.

In the PRA package associated with the FY 2017 IPPS/LTCH PPS final rule, the burden estimates for data collection related to the measures for the IPFQR Program were calculated for the IPFs based on the following data:

- We estimated that there were approximately 1,684 facilities eligible to participate in the IPFQR Program. Because historical data indicates that almost all facilities participate, and because we wish to be conservative in our estimates, we estimated that all eligible facilities will participate in the IPFQR Program.
- We estimated that the average facility submits measure data on 848 cases per year for all the measures except the Influenza Vaccination Coverage Among Healthcare Personnel measure, the Assessment of Patient Experience of Care measure, and the Use of an Electronic Health Record measure. For the Influenza Vaccination Coverage Among Healthcare Personnel measure, consistent with previous years, we estimated 40 cases per year. For the Assessment of Patient Experience of Care measure and the Use of an Electronic Health Record measure, consistent with prior years, since facilities are only required to submit an attestation, we estimate 0 cases.
- 1,684 IPF facilities, with approximately 848 cases per facility, results in a total of 1,428,032 cases per year.
- We estimate that it takes an IPF approximately 15 minutes (0.25 hours) per case for chart abstraction of a measure for collection.
- We estimate an hourly labor cost of $32.84/hour, see Section 12a of this document, below, for an explanation of this estimate.

a. Estimated Wages

We estimated an hourly base salary of $16.42/hour which is based on the Bureau of Labor Statistics (BLS) wage for a Medical Records and Health Information Technician (29-2071). Additionally, per OMB Circular A-76, in calculating direct labor, agencies should not only include salaries and wages, but also "other entitlements" such as fringe benefits.[10] However, obtaining data on other overhead costs is challenging. Overhead costs vary greatly across industries and firm sizes. In addition, the precise cost elements assigned as "indirect" or "overhead" costs, as opposed to direct costs or employee wages, are subject to some interpretation at the firm level. Therefore, we have chosen to calculate the cost of overhead at 100 percent of the mean hourly wage. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative, and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method. In calculating the labor cost, we estimate an hourly labor cost of $32.84 ($16.42 base salary + $16.42 fringe).

b. FY 2020 Payment Determination and Subsequent Years

Measure Data Collection and Reporting

[10] http://www.whitehouse.gov/omb/circulars_a076_a76_incl_tech_correction.

In the PRA Package associated with FY 2017 IPPS/LTCH PPS final rule[11], for the FY 2019 payment determination and subsequent years, we had adopted eighteen (18) measures. The following table sets out our estimated annual burden for the eighteen (18) measures for FY 2019 and subsequent years as previously approved. As indicated below, the FUH measure and the Thirty-day all-cause unplanned readmission following Psychiatric hospitalization in an Inpatient Psychiatric Facility measures are calculated from Part A and Part D claims and therefore have no associated burden.

NQF Number	Measure ID	Measure Description	Estimated Cases (per facility)	Effort per Case (hours)	Annual Effort (per facility) (hours)
0640	HBIPS-2	Hours of Physical Restraint Use	848	0.25	212
0641	HBIPS-3	Hours of Seclusion Use	848	0.25	212
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	848	0.25	212
1661	SUB-1	Alcohol Use Screening	848	0.25	212
1663	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered	848	0.25	212
1664	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge	848	0.25	212
0576	FUH	Follow-up After Hospitalization for Mental Illness*	0	0	0*
1651	TOB-1	Tobacco Use Screening	848	0.25	212
1654	TOB-2 TOB-2a	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment	848	0.25	212
1656	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	848	0.25	212
1659	IMM-2	Influenza Immunization	848	0.25	212

[11] https://www.reginfo.gov/public/do/DownloadDocument?objectID=67679400

NQF Number	Measure ID	Measure Description	Estimated Cases (per facility)	Effort per Case (hours)	Annual Effort (per facility) (hours)
431	n/a	Influenza Vaccination Coverage Among Healthcare Personnel	40	0.25	10
n/a	n/a	Assessment of Patient Experience of Care	0	0	0
n/a	n/a	Use of an Electronic Health Record	0	0	0
647	n/a	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	848	0.25	212
648	n/a	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	848	0.25	212
n/a	n/a	Screening for Metabolic Disorders	848	0.25	212
2860	n/a	Thirty-day all-cause unplanned readmission following Psychiatric hospitalization in an Inpatient Psychiatric Facility*	0	0	0*
				Annual Total	**2,766**

*CMS will collect this data using Medicare Part A and Part B; therefore, these measures will not require facilities to submit data on any cases.

For the 1,684 IPF facilities, the aggregate burden is 4,657,944 hours and $152,966,881.

For the FY 2020 payment determination and subsequent years, we proposed to add one measure (Medication Continuation following Inpatient Psychiatric Discharge), which is calculated from Medicare Part A, Part B, and Part D claims and therefore has no associated burden for facilities. However, we did not finalize adoption of this measure.

Non-measure Data Collection and Reporting

Continuing for FY 2020 and subsequent payment determinations, IPFs must submit to CMS aggregate population counts for Medicare and non-Medicare discharges by age group, and diagnostic group, and sample size counts for measures for which sampling is performed. Since

there are no new measures we do not anticipate any change to previous estimates for this requirement.

We previously estimated that it will take each facility approximately 2.5 hours to comply with this requirement.

Tasks	Hours per IPF	Total Hours for All IPFs	Wage Rate	Cost per IPF	Total Cost for All IPFs
Non-measure Data Collection and Submission	2.5	4,210	$32.84/ hour	$82	$138,256

Notice of Participation, Data Accuracy Acknowledgement, and Vendor Authorization Form

The NOP must be completed once per facility and the DACA form must be filled out only once for each data submission period. The Vendor Authorization form is optional. While it is estimated that these forms should take less than 5 minutes to complete, the 15 minutes per measure estimated for chart abstraction also includes the time for completing and submitting any forms related to the measures.

Burden Summary for FY 2020 Payment Determination and Subsequent Years

Tasks	Hours per IPF	Total Hours for All IPFs	Wage Rate	Cost per IPF	Total Cost for All IPFs
Chart-Abstracted Measure Data Collection and Reporting* **(please note that these are average annual estimates)**	2,766	4,657,944	$32.84/hour	$90,835	$152,966,881
Non-measure Data Collection and Reporting	2.5	4,210	$32.84/hour	$82	$138,256
Totals	**2,768.5**	**4,662,154**	**$32.84/hour**	**$90,917**	**$153,105,137**

*Includes burden associated with the preparation and submission of the Notice of Participation, Data Accuracy Acknowledgement, and Vendor Authorization Form.

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs being placed on IPFs.

14. Cost to Federal Government

The data for the IPFQR Program measures will be reported directly to the QualityNet website utilizing existing system functionality. A support contractor will be utilized to provide help desk and Q&A assistance, as well as the monitoring and evaluation effort for the program. There will be minimal costs for development of the data entry tools because the development is part of an existing software development contract.

The labor cost for IPFQR Program oversight is estimated as follows:

- Current year 1.0 FTE (2,080 hours) at GS-13 salary = $106,839

- For subsequent years 1.0 FTE (2,080 hours) at GS-13 salary = $106,839

15. Program or Burden Changes

In the FY 2018 IPPS/LTCH PPS Proposed Rule published on April 14, 2017, for the FY 2020 IPFQR Program, CMS proposed to increase this to nineteen (19) measures from eighteen (18), where the newly added measure is calculated from Medicare Part A, Part B, and Part D claims and therefore has no associated burden for facilities. However, in the FY 2018 IPPS/LTCH PPS Final Rule published on August 14, 2017, CMS did not finalize adoption of this measure. Therefore, there is no change to the anticipated burden because of this rule.

16. Publication/Tabulation Dates

CMS will not be employing any sampling techniques or statistical methods. However, CMS will allow IPFs to report data for certain measure using sampling.

IPFs will submit their measures through a Web-based Measures Tool on the QualityNet website. After IPFs have previewed their data, CMS will publicly display the measure rates on the CMS website. The following is the planned schedule of activities to reach these objectives.

The following table shows the timeline for measures for the FY 2020 payment determination and subsequent years.

Date	Scheduled Activity
4/15/2017	Proposed Rule Published (approximate date)
8/1/2017	Final Rule Published (approximate date)
1/1/2018	Start of Reporting Period
12/31/2018	End of Reporting Period
7/1/2019	Begin Data Submission*
8/15/2019	End Submission Deadline*
8/15/2019	Deadline to Complete Data Accuracy and Completeness Acknowledgement (DACA) *
FY 2020	Public Display of data on *Hospital Compare**

*Specific dates to be announced via subregulatory guidance

17. Expiration Date

We will display the expiration date on associated forms.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

Not applicable to this collection.