

Supporting Statement A
Requirements for the
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
CMS-10432, OMB 0938-1171

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 updating the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program requirements.

This 2021 collection of information request finalizes changes to the IPFQR Program in association with our FY 2022 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) final rule (CMS-1750-F, RIN 0938-AU40) and burden adjustments based on the availability of more recent wage figures, facility estimates, and case estimates. The rule-related changes finalize proposals to adopt two measures and remove two other measures; the rule does not finalize our proposals to remove two additional measures. Overall, we project that the changes would reduce respondent burden by 287,924 hours and \$512,065. Details are provided in section 15, below.

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 previously finalized for inclusion 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). Documentation on the website of The Joint Commission (TJC), the measure steward, has more detail on the specification of these measures: <https://manual.jointcommission.org/>
- The SUB-2 and SUB-2a, and SUB-3 and SUB-3a measures provide information on substance use brief intervention offered or provided, and substance use treatment or referral offered or provided at discharge, respectively. (We did not finalize our proposal to remove SUB-2/2a in

the FY 2022 final rule). Documentation on the website of TJC, the measure steward, has more detail on the specification of these measures: <https://manual.jointcommission.org/>.

- The TOB-2 and TOB-2a, and TOB-3 and TOB-3a measures provide information on tobacco use brief intervention offered or provided, and tobacco use treatment or referral offered or provided at discharge, respectively. (We did not finalize our proposal to remove TOB-2/2a in the FY 2022 final rule). Documentation on the website of TJC, the measure steward, has more detail on the specification of these measures: <https://manual.jointcommission.org/>
- 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). (Removal of the FUH measure is being finalized in the FY 2022 final rule). CMS is the measure steward for this measure, and more detail on the specification is available through the Hospital Quality Reporting system: <https://qualitynet.cms.gov/ipf/ipfqr/resources#tab3>
- The IMM-2 measure provides information on influenza vaccination among the patient population in IPFs. This is an NQF-endorsed measure (NQF #1659). The measure steward for IMM-2 is CMS, and more detail on the specification is available on the NQF website: <https://www.qualityforum.org/QPS/1659>
- 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 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 measures were previously NQF-endorsed (NQF #0647 and NQF #0648). (Removal of the Timely Transmission of Transition Record measure is being finalized in the FY 2022 final rule). More information regarding the specification of the measure can be found in the IPFQR Program Manual: https://qualitynet.cms.gov/files/602d8a8b6bb42a002559574e?filename=AMA_PCPI_Care_Transitions_2016.pdf
- The Screening for Metabolic Disorders measure provides information on the percentage of patients on antipsychotic medications who are screened for metabolic disorders. This measure has never been submitted for NQF endorsement. 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/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772864255>
- 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). The measure steward for this measure is CMS, and more information on the measure specifications can be found through the Hospital Quality Reporting system: <https://qualitynet.cms.gov/ipf/ipfqr/resources#tab3>

In summary, the previously adopted fourteen (14) measures for the FY 2022 IPFQR Payment

Determination and subsequent years are:

- Hours of Physical Restraint Use (HBIPS-2, NQF #0640)
- Hours of Seclusion Use (HBIPS-3, NQF #0641)
- Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5, NQF #0560)
- Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB-2 and TOB-2a)
- Tobacco Use Treatment or Referral Offered or Provided at Discharge and Tobacco Use Treatment at Discharge (TOB-3 and TOB-3a)
- Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2 and SUB-2a)
- Alcohol Use and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge (SUB-3 and SUB-3a)
- Follow-up After Hospitalization for Mental Illness (FUH, NQF #0576)
- Influenza Immunization (IMM-2, NQF #1659)
- Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- Screening for Metabolic Disorders
- Thirty-day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF (NQF #2860)
- Medication Continuation Following Inpatient Psychiatric Discharge (Med Cont, NQF #3205)

For the FY 2023 Payment determination and subsequent years, we are finalizing our proposal to adopt one additional measure, the COVID-19 Vaccination Coverage Among Health Care Personnel (HCP) measure. This measure provides information on whether personnel at an IPF have received a complete course of a COVID-19 vaccine.

For the FY 2024 payment determination and subsequent years, we are finalizing our proposal to adopt one measure, the Follow-Up After Psychiatric Hospitalization (FAPH) measure. This measure expands the denominator of the Follow-Up After Hospitalization for Mental Illness (FUH) measure (NQF #576) that is currently in the IPFQR Program measure set to include patients with substance use disorders.

Additionally, we proposed to remove four measures from the IPFQR program for FY 2024 payment determination and subsequent years. These four measures are:

- Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a);
- Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB-2/2a);
- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care); and
- Follow-Up After Hospitalization for Mental Illness (FUH, NQF #0576).

We finalized removal of two of these measures:

- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care); and
- Follow-Up After Hospitalization for Mental Illness (FUH, NQF #0576).

We did not finalize removal of the other two of these measures:

- Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a); and
- Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment (TOB-2/2a).

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 applicable quality measures for the each fiscal year's 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 now include the Extraordinary Circumstances Exception form and the Reconsideration Request form as part of the Hospital Inpatient Quality Reporting (IQR) 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 Hospital IQR Program PRA package.

2. Information Users

- **IPFs:** The primary ways an IPF will use the information are: to examine the 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.

- **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. These data provide 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 through the secure portal in the Hospital Quality Reporting system. 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 or DACA). We have included copies of these forms within this package.

A web-based measure online tool is used for data entry in the secure portal in the Hospital Quality Reporting system. Data are stored to support retrieving reports for hospitals to view their measure rates/results. Facilities are sent a preview report via the secure portal within the Hospital Quality Reporting system 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 on TJC measures remaining in the IPFQR Program, which avoids duplication of efforts and reduces burden to the IPFs. As for collection of the FUH, Thirty-day All-cause Readmission Following Hospitalization in an IPF Medication Continuation following Discharge from an IPF, and the newly added FAPH measures, CMS will collect such data using Medicare Part A and Part B, and Part D claims; therefore, reporting these measures will pose no additional information collection 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 in the Hospital Quality Reporting system through a Questions and Answers (Q&A) functionality. Further we will support submission of patient-level data through the CMS Abstraction &

Reporting Tool (CART).

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 for data covered by this PRA package.

7. Special Circumstances

While the COVID-19 Vaccination Coverage Among Healthcare Personnel measure would require more frequent reporting to provide necessary health surveillance data during the ongoing COVID-19 public health emergency (PHE) this measure is accounted for by the CDC, currently under the National Childhood Vaccine Injury Act (NCVIA) waiver.

With respect to the information collection covered in this package, there are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register Notice/Outside Consultation

Federal Register Notice

Serving as the 60-day notice, the proposed rule (CMS-1750-P, RIN 0938-AU40) filed for public inspection of April 7, 2021, and published in the Federal Register on April 13, 2021 (86 FR 19480). Comments were due by June 7, 2021.

We received public comments on the burden associated with the COVID-19 Vaccination Among Healthcare Personnel (HCP) measure; however, this burden is accounted for by the CDC and is

not discussed here.

The final rule (CMS-1750-F, RIN 0938-AU40) published in the Federal Register on August 4, 2021 (86 FR 42608). The rule is effective on October 1, 2021.

Outside Consultation

CMS is supported in this initiative by TJC, the NQF and the Centers for Disease Control and Prevention (CDC). 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

Although participation in the IPFQR Program 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.

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.

11. Sensitive Questions

There are no sensitive questions included in the information request. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates

The following burden estimates include the time required for chart abstraction and for training personnel on collection of chart-abstracted data, training for submitting data through the Hospital Quality Reporting system, and the time required for submitting non-measure specific patient population data (e.g., population counts by payer).

We estimate that there are approximately 1,634 facilities eligible to participate in the IPFQR Program (based on the most recent eligibility data, submitted in CY 2020). 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 also estimate that the average facility would submit measure data on 609 cases per year for all measures that allow sampling, and measure data on 1,346 cases for measures that require data submission on all discharges. Furthermore, the Follow-up After Psychiatric Hospitalization, the Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF, and the Medication Continuation Following Discharge from an IPF measures will not require facilities to submit data on any cases since CMS will collect the data under Medicare Part A, Part B, and Part D claims.

We also note that data collected for the COVID-19 Vaccination Among HCP measure is being collected by the CDC under a PRA waiver under the National Childhood Vaccine Injury Act (NCVIA). We will continue to work with the CDC to ensure that the burden is appropriately accounted for.

We continue to estimate that it takes an IPF approximately 15 minutes (0.25 hours) per case for chart abstraction of a measure for collection.

The collection of quality of care data is designed 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 for the measures discussed in this PRA package from facilities.

Estimated Wages

In the FY 2020 IPF PPS final rule (84 FR 38468), which is the most recent rule in which we adopted updates to the IPFQR Program, we estimated that reporting measures for the IPFQR Program could be accomplished by a Medical Records and Health Information Technician (BLS Occupation Code: 29–2071) with a median hourly wage of \$18.83/hr (May 2017). Since then, BLS (the Bureau of Labor Statistics) has revised their wage data (May 2019) to \$20.50/hr. In response, we adjusted our cost estimates using the updated median wage figure of \$20.50/hr, an increase of \$1.67/hr.

Additionally, per OMB Circular A-76 (<https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A76/a076.pdf>), in calculating direct labor, agencies should not only include salaries and wages, but also “other entitlements” such as fringe benefits. 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 median 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. We believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method. Consequently, in calculating the labor costs, we are using an adjusted labor rate of \$41.00/hr as described in Table 1.

TABLE 1: Wage costs for Medical Records and Health Information Technician.

Occupation Title	Occupation Code	Median Hourly Wage (\$/hr)	Fringe Benefits and Overhead (\$/hr)	Adjusted Hourly Wage (\$/hr)
Medical Records and Health Information Technician	29-2071	20.50	20.50	41.00

Information Collection/Reporting Requirements and Associated Burden Estimates

Measure Data Collection and Reporting: In the FY 2020 IPF PPS final rule, for the FY 2020 payment determination and subsequent years, we had adopted fourteen (14) measures. The FY 2022 IPF PPS final rule adds two (2) additional measures, one of which will be calculated by CMS using Medicare claims data that facilities already submit and the second of which is accounted for by the CDC under a PRA waiver. Therefore, these measures do not impose additional information collection burden associated with the IPFQR Program.

We have also removed two measures: one chart-abstracted measure to which our sampling policies apply and one claims based measure that does not impose information collection burden. We did not finalize proposals to remove two other chart-abstracted measures to which our sampling policy applies.

The burden associated with the IPFQR Program measure set is summarized in Table 2.

TABLE 2: Burden Associated with IPFQR Program Measure Set

NQF #	Measure ID	Measure Description	Estimated Cases per facility	Effort per Case (hours)	Annual Effort per facility (hours)	IPFs	Total Annual Effort (hours)	Total Annual Cost (\$)
0640	HBIPS-2	Hours of Physical Restraint Use	1,346	0.25	336.50	1,634	549,841	22,543,481
0641	HBIPS-3	Hours of Seclusion Use	1,346	0.25	336.50	1,634	549,841	22,543,481
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	609	0.25	152.25	1,634	248,776.5	10,199,836.50
n/a (no longer NQF endorsed)	SUB-2 and SUB-2a	Alcohol Use Disorder Brief Intervention Provided or Offered and Alcohol Use Disorder Brief Intervention	609	0.25	152.25	1,634	248,776.5	10,199,836.50

NQF #	Measure ID	Measure Description	Estimated Cases per facility	Effort per Case (hours)	Annual Effort per facility (hours)	IPFs	Total Annual Effort (hours)	Total Annual Cost (\$)
n/a (no longer NQF endorsed)	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	609	0.25	152.25	1,634	248,776.5	10,199,836.50
n/a	FAPH	Follow-up After Psychiatric Hospitalization *	0	0	0	1,634	0	0
n/a (no longer NQF endorsed)	TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment	609	0.25	152.25	1,634	248,776.5	10,199,836.50
n/a (no longer NQF endorsed)	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	609	0.25	152.25	1,634	248,776.5	10,199,836.50
1659	IMM-2	Influenza Immunization	609	0.25	152.25	1,634	248,776.5	10,199,836.50
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)	609	0.25	152.25	1,634	248,776.5	10,199,836.50
n/a	n/a	Screening for Metabolic Disorders	609	0.25	152.25	1,634	248,776.5	10,199,836.50

NQF #	Measure ID	Measure Description	Estimated Cases per facility	Effort per Case (hours)	Annual Effort per facility (hours)	IPFs	Total Annual Effort (hours)	Total Annual Cost (\$)
2860	n/a	Thirty-day all-cause unplanned readmission following Psychiatric hospitalization in an Inpatient Psychiatric Facility*	0	0	0	1,634	0	0
3205	n/a	Medication Continuation Following Inpatient Psychiatric Discharge*	0	0	0	1,634	0	0
n/a	n/a	COVID-19 Vaccination Coverage Among Healthcare Personnel	n/a	n/a	n/a	1,634	n/s	n/a
TOTAL			7,564	Varies	1,891	1,634	3,089,894	126,685,654

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

Non-Measure Data Collection and Reporting: IPFs must submit to CMS aggregate population counts for Medicare and non-Medicare discharges by age group and diagnostic group. Our currently approved information collection request estimates that it will take each facility approximately 2.0 hours to comply with this requirement as shown in Table 3.

TABLE 3: Burden associated with non-measure data collection and submission.

Tasks	IPFs	Hours per IPF	Total Hours for All IPFs	Wage Rate (\$/hr)	Cost per IPF (\$)	Total Cost for All IPFs (\$)
Non-measure Data Collection and Submission	1,634	2.0	3,268	41.00	82.00	133,988

Notice of Participation, Data Accuracy and Correctness (DACA) 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 five (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.

Annual Burden Summary

Table 4 shows the total estimated burden associated with the IPFQR Program.

Table 4: Total IPFQR Program Burden.

Requirement	Respondents	Responses	Time (hours)	Cost (\$)
Measure Data Collection and Reporting	1,634	12,359,576 (7,564 responses per facility * 1,634 facilities)	3,089,894	126,685,654
Non-Measure Data Collection and Reporting	1,634	6,536 (4 responses per facility *1,634 facilities)	3,268	133,988
Notice of Participation, Data Accuracy Acknowledgement, and Vendor Authorization Form*	n/a	n/a	n/a	n/a
TOTAL	1,634	12,366,112	3,093,162	126,819,642

*The 15 minutes per measure estimate for chart abstraction under Measure Data Collection and Reporting also includes the time for completing and submitting any forms.

Information Collection Instruments and Instruction/Guidance Documents

The following documents are part of the IPFQR program:¹

- IPFQR web based submission screen shots_v3.pdf
 - Vendor Authorization Form (no changes)
 - Data Accuracy and Completeness (DACA) Form (no changes)
 - HBIPS-2 (NQF #0640) (no changes)
 - HBIPS-3 (NQF #0641) (no changes)
 - HBIPS-5 (NQF #0560) (no changes)
 - TOB-2 and -2a (NQF #1654) (no changes)
 - TOB-3 and -3a (NQF #0656) (no changes)
 - IMM-2 (NQF #0659) (no changes)
 - SUB-2 and -2a (NQF #0663) (no changes)
 - SUB-3 and -3a (NQF #0664) (no changes)
 - Screening for metabolic disorders (no changes)
 - Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0647) (no changes)
 - Non Measure Data Collection Tool (no changes)
 - Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (NQF #0648) (removed)
- Notice of Participation (paper form, no changes)

13. Capital Costs (Maintenance of Capital Costs)

¹ For All-Cause Unplanned Readmission (NQF #2860), Follow-up after Hospitalization (FUH, NQF #0576), and Medication Continuation Following Inpatient Psychiatric Discharge (NQF #3205) we collect this data using Medicare Part A, Part B, and Part D claims.

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 Hospital Quality Reporting system 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 (step 6) salary = \$120,972²
- For subsequent years 1.0 FTE (2,080 hours) at GS-13 (step 6) salary = \$120,972

15. Program and Burden Changes

This 2021 collection of information request finalizes changes to the IPFQR Program in association with our FY 2022 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) final rule (CMS-1750-F, RIN 0938-AU40) and burden adjustments based on the availability of more recent wage figures, facility estimates, and case estimates. The final rule-related changes finalize adoption of two measures and removal of two other measures.

Overall, we project that the changes would reduce respondent burden by 287,924 hours and \$512,065.

Changes Associated with IPF PPS Final Rule (CMS-1750-F)

(a) Measure Adoptions

In the FY 2022 IPF PPS final rule, we finalized adoption of the following two new measures:

- COVID-19 HCP Vaccination for FY 2023 Payment Determination and Subsequent Years; and
- Follow-Up After Psychiatric Hospitalization (FAPH) for FY 2024 Payment Determination and Subsequent Years.

We finalized our proposal to adopt the COVID-19 HCP Vaccination measure beginning with an initial reporting period from October 1 to December 31, 2021 affecting the FY 2023 payment determination followed by quarterly reporting beginning with the FY 2024 payment determination and subsequent years. IPFs will submit data through the CDC NHSN. The NHSN is a secure, Internet-based system maintained by the CDC and provided free. Currently the CDC does not estimate burden for COVID-19 vaccination reporting because the agency has been granted a waiver under Section 321 of the National Childhood Vaccine Injury Act (NCVIA).³

² <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2021/DCB.pdf>

Although the burden associated with the COVID-19 HCP Vaccination measure is not accounted for due to the NCVIA waiver, the cost and burden information will be included in a revised information collection request for 0920-1317. We are not setting out such burden under this collection of information request (OMB 0938-1171) since the burden will be accounted for by the CDC under the 0920-1317 control number.

We further note that we will calculate performance on the FAPH measure using Medicare Part A and Part B claims that facilities and other providers submit for payment. Since this is a claims-based measure, there is no additional burden outside of submitting the claim.

The claim submission is approved by OMB under control number 0938-0050 (CMS-2552-10). The rule does not adopt any changes under that control number.

(b) Update Wage Rate, Case Counts, and Facility Counts

In the FY 2022 IPF PPS final rule, we updated our estimated wage rate from \$37.66 per hour to \$41.00 per hour (an increase of \$3.34 per hour).

The previous estimate shows that the two (2) measures which do not allow sampling had 1,283 cases per measure and the nine (9) chart-abstracted measures which do allow sampling have 609 cases per measure per facility. We estimated that these measures would take 0.25 hours per case.

The effects of the updated wage rate are depicted in Table 5:

TABLE 5: Effects of updated wage rate on IPFQR Program Burden.

Data collection type	Number of measures	Number of estimated cases per measure per facility	Total number of cases per facility	Effort per case (hours)	Total effort per facility (hours)	Change in cost per facility (\$)
No-sampling measure	2	1,283	2,566	0.25	641.5	2,142.61
Sampling	9	609	5,481	0.25	1,370.25	4,576.64
Non-Measure Data	1	4	4	0.5	2	6.68
Total Change per Facility	N/A	N/A	N/A	N/A	N/A	6,725.93

³ Section 321 of the National Childhood Vaccine Injury Act (NCVIA) provides the PRA waiver for activities that come under the NCVIA, including those in the NCVIA at section 2102 of the Public Health Service Act (42 U.S.C. 300aa-2). Section 321 is not codified in the U.S. Code, but can be found in a note at 42 U.S.C. 300aa-1.

The remaining tables will use the updated wage rate to calculate the effects of other updates.

Estimated Number of Responses

In the FY 2020 IPF PPS final rule, for the FY 2021 payment determination and subsequent years, we had estimated 1,283 cases for measures which do not allow sampling, and 609 cases for measures which do. Based on more recent data, we are updating our estimate for measures that do not allow sampling to 1,346 cases per facility (a change of +63 cases for each of these 2 measures) which is equivalent to 211,554 cases across the 1,679 IPFs in our previous estimate. We are not changing our estimate for measures that allow sampling. We continue to assume an average of 0.25 hours of effort per case. This is a change in total annual effort of 31.5 hours per facility (2 measures * 63 cases per measure * 0.25 hours per case) at a cost of \$1,291.50 (31.5 hours * \$41.00/hour).

Estimated Number of Facilities

Our currently approved information collection request estimates 1,679 IPFs, as indicated above we now estimate 1,634 facilities, or a decrease of 45 IPFs. Table 6 shows the effects of this update on the 11 measures that require data submission and the non-measure data collection.

TABLE 6 Effects of updating case and facility count estimates.

NQF #	Measure ID	Measure Description	New Number of Estimated Cases (per facility)	Effort per case	Effort per facility	Change in Annual Effort for removing 45 facilities (hours)	Change in Annual Effort for removing 45 facilities (dollars)
0640	HBIPS-2	Hours of Physical Restraint Use	1,346	0.25	336.5	(15,142.5)	(620,842.5)
0641	HBIPS-3	Hours of Seclusion Use	1,346	0.25	336.5	(15,142.5)	(620,842.5)
0560	HBIPS-5	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	609	0.25	152.25	(6,851.25)	(280,901.25)
1663	SUB-2 and SUB-2a	Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention Provided	609	0.25	152.25	(6,851.25)	(280,901.25)

NQF #	Measure ID	Measure Description	New Number of Estimated Cases (per facility)	Effort per case	Effort per facility	Change in Annual Effort for removing 45 facilities (hours)	Change in Annual Effort for removing 45 facilities (dollars)
1664	SUB-3 and SUB-3a	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Treatment Provided at Discharge	609	0.25	152.25	(6,851.25)	(280,901.25)
1654	TOB-2 and TOB-2a	Tobacco Use Treatment Provided or Offered and Tobacco Use Treatment	609	0.25	152.25	(6,851.25)	(280,901.25)
1656	TOB-3 and TOB-3a	Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge	609	0.25	152.25	(6,851.25)	(280,901.25)
1659	IMM-2	Influenza Immunization	609	0.25	152.25	(6,851.25)	(280,901.25)
0647	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)	609	0.25	152.25	(6,851.25)	(280,901.25)
0648	N/A	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	609	0.25	152.25	(6,851.25)	(280,901.25)

NQF #	Measure ID	Measure Description	New Number of Estimated Cases (per facility)	Effort per case	Effort per facility	Change in Annual Effort for removing 45 facilities (hours)	Change in Annual Effort for removing 45 facilities (dollars)
N/A	N/A	Screening for Metabolic Disorders	609	0.25	152.25	(6,851.25)	(280,901.25)
N/A	N/A	Non-Measure Data Collection	4	0.5	2	(90)	(3,690)
TOTAL			8,177	Varies	6,417	(92,036.25)	(3,773,486.25)

We note that at 8,177 cases per facility, removing 45 facilities from our estimate removes a total of 367,965 cases.

(c) Measure Removals

We finalized our proposal to remove the following two measures for the FY 2024 payment determination and subsequent years:

- Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care); and
- FUH – Follow-Up After Hospitalization for Mental Illness (NQF #0576).

For the FY 2024 payment determination, data on CY 2022 performance would be reported during the summer of 2023. Therefore, we are applying the burden reduction that would occur to the FY 2023 burden calculation. One of these measures (the Timely Transmission measure) falls under our previously finalized “global sample” (80 FR 46717 through 46718) and, therefore, would require abstraction of 609 records. Therefore this measure under this PRA package would remove 609 cases per facility, which removes a total of 995,106 cases across the 1,634 facilities in our estimate (609 * 1,634). We estimate that removing this measure would result in a decrease in burden of 152.25 hours per facility, or 248,776.5 hours (152.25 hours x 1,634 facilities) across all IPFs. Therefore, the decrease in costs for this measure is approximately \$6,242.25 per IPF (\$41.00hr * 152.25 hours), or \$10,199,836.50 across all IPFs (\$6,242.25/facility * 1,634 facilities).

We have previously estimated that the FUH (NQF #0576) measure does not have any reporting burden because it is calculated from Medicare FFS claims. Therefore, we do not anticipate a reduction in facility burden associated with the removal of this measure. Table 7 describes our estimated reduction in burden associated with removing these two measures.

We note that we did not finalize our proposal to remove the following two measures:

- SUB-2 – Alcohol Use Brief Intervention Provided or Offered and the subset measure SUB-2a Alcohol Use Brief Intervention Provided; and
- TOB-2 – Tobacco Use Brief Intervention Provided or Offered and the subset measure TOB-2a Tobacco Use Brief Intervention.

(d) Reference to QualityNet System Administrator

We finalized our proposal to use the term “QualityNet security official” instead of “QualityNet system administrator.” Because this update does not change the individual’s responsibilities, we do not believe there would be any changes to the information collection burden as a result of this update. We also do not believe that removing the requirement for facilities to have an active QualityNet security official account to qualify for payment updates will affect burden because we continue to recommend that facilities maintain an active QualityNet security official account.

(e) Adoption of Patient-Level Reporting for Certain Chart Abstracted Measures

We finalized our proposal to adopt patient-level data submission for the eleven chart -abstracted measures currently in the IPFQR Program measure set. Because submission of aggregate data requires facilities to abstract patient-level data, then calculate measure performance prior to submitting data through the Hospital Quality Reporting system’s secure portal, facilities must already abstract patient-level data. Therefore, we do not believe that submitting data that facilities must already calculate through a tool that facilities already have experience using will change provider burden.

Summary of Burden Changes

We estimate that the policies in the FY 2022 IPF PPS final rule for the IPFQR Program result in a facility specific burden reduction as depicted in Table 7, and a total burden reduction as depicted in Table 8.

TABLE 7: Per facility effects of FY 2022 IPF PPS final rule changes on IPFQR Program burden.

	Case Counts Per IPF	Burden Per IPF (hr)	Cost per IPF (\$)
Update Wage Rate	No adjustment	No adjustment	6,725.93
Update Case Estimates	126	31.5	1,291.50
Update estimate of participating facilities	No adjustment	No adjustment	No adjustment
Removal of two measures	(609)	(152.25)	(6,242.25)
TOTAL	(483)	(120.75)	41,775.18

TABLE 8: Total effects of FY 2022 IPF PPS final rule changes on IPFQR Program burden.

	Affected IPFs	Total Case Counts	Total Burden (hr)	Total Cost (\$)
Update Wage Rate	1,679	No adjustment	No adjustment	11,292,828.08
Update Case Estimates	1,679	211,554	52,888.50	2,168,428.50
Update estimate of participating facilities	(45)	(367,965)	(92,036.25)	(3,773,486.25)
Removal of two measures	1,634	(995,106)	(248,776.5)	(10,199,836.50)
TOTAL		(1,151,517)	(287,924.25)	(512,066.17*)

* Numbers may not add exactly due to rounding.

16. Publication/Tabulation Dates

IPFs will submit their measures through the Hospital Quality Reporting system. 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.

Table 9 shows the timeline for measures for the FY 2023 payment determination and subsequent years.

TABLE 9: Timeline for FY 2023 payment determination.

Date	Scheduled Activity
4/13/2021	Proposed Rule Published
8/4/2021	Final Rule Published
10/1/2021	Start of Reporting Period
12/31/2021	End of Reporting Period
7/1/2022	Begin Data Submission (approximate)
8/15/2022	End Submission Deadline (approximate)
8/15/2022	Deadline to Complete Data Accuracy and Completeness Acknowledgement (DACA) *
FY 2023	Public Display of data on <i>Care Compare</i> *

*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

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

Because CMS is not employing any sampling techniques or statistical methods, this section is not applicable to this collection.