Supporting Statement – Part A

Submission of Information for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program: FY 2026 IPF PPS Proposed Rule (OMB# 0938-1171; CMS-10432)

A. Background

This is an update of the currently approved information collection request. The Centers for Medicare & Medicaid Services' (CMS') quality reporting programs promote higher quality, more efficient healthcare for Medicare beneficiaries by collecting and reporting on quality-of-care metrics. This information is made available to consumers, both to empower Medicare beneficiaries and inform decision-making, as well as to incentivize healthcare facilities to make continued improvements.

Specifically, CMS has implemented quality measure reporting programs for multiple settings, including for the Inpatient Psychiatric Facility (IPF) setting, to achieve its overarching priorities and initiatives, including the Meaningful Measures 2.0 Initiative[1]. In particular, Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality to better address health care priorities and measurement gaps, reduce burden, and increase efficiency by: (1) using only high-value quality measures impacting key quality domains, (2) aligning measures across value-based programs and across partners, including CMS, federal, and private entities, (3) prioritizing outcome and patient-reported measures, and (4) transforming measures to be fully digital and incorporating all-payer data.

The information collection requirements for the FY 2014 through FY 2029 program years (that is, data submitted from CY 2013 through CY 2027) are currently approved under OMB control number 0938-1171 (expiration date February 29, 2028).

B. Justification

1. Need and Legal Basis

Pursuant to section 1886(s)(4)(C) of the Social Security Act (the Act), starting in FY 2014 and for subsequent fiscal years, IPFs paid under the IPF Prospective Payment System (PPS) shall submit selected quality measures to CMS. Such data shall be submitted in a form and manner, and at a time specified by the Secretary. Section 1886(s)(4)(A) of the Act provides that IPFs that fail to submit data on the selected quality measures and comply with other administrative requirements will have their IPF PPS payment updates reduced by 2.0 percentage points.

a. IPFQR Program Quality Measures

The FY 2028 IPFQR payment determination will be based on IPFQR Program data reported and supporting forms submitted by IPFs on chart-abstracted measures and patient surveys for calendar year (CY) 2026 discharges. In an effort to reduce burden, a variety of data collection mechanisms

[1] https://www.cms.gov/medicare/quality/cms-national-quality-strategy/meaningful-measures-20-moving-measure-reduction-modernization

are employed, with every consideration taken to employ data and data collection systems already in place.

The IPFQR Program seeks to collect and publicly report data on quality-of-care metrics for the IPF setting. Measure data are submitted via one of four modes: (1) web-based, (2) claims-based, (3) survey-based, and (4) chart-abstracted, as seen in Table 1.

For web-based measures, measure data are submitted differently depending on the measure. For the measure data submitted via the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN), specifically, data for the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure, data are submitted under OMB control number 0920-1317 (expiration date January 31, 2028). For web-based structural and process measures, IPFs are required to submit measure data via CMS' Hospital Quality Reporting (HQR) system.

For measure data submitted as "claims-based," information is derived through analysis of administrative Medicare Fee-for-Service (FFS) claims and beneficiary enrollment data and therefore, do not require additional effort or burden from IPFs.

For measure data submitted as "survey-based," information is derived through analysis of patient responses to the Psychiatric Inpatient Experience (PIX) survey. Survey-based data involves manual data entry effort and requires some burden for IPFs.

For measure data submitted as "chart-abstracted," information is derived through analysis of a patient's medical record. Chart-abstracted data involves manual data entry effort and requires some burden for IPFs.

Table 1. Currently Approved IPFQR Program Measures for the CY 2026 Reporting Period/FY 2028 Payment Determination and Subsequent Years

Measure Data Submission Mode and Name
NHSN Measures (web-based)
COVID-19 Vaccination Coverage among Healthcare Personnel*
Structural Measures (web-based)
Facility Commitment to Health Equity
Process Measures (web-based)
Screening for Social Drivers of Health
Screen Positive Rate for Social Drivers of Health
Claims-Based Measures **
Follow-Up After Psychiatric Hospitalization
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge
Medication Continuation Following Inpatient Psychiatric Discharge
Survey-Based Measure
Psychiatric Inpatient Experience (PIX) Survey
Chart-Abstracted Measures
Hours of Physical Restraint Use

Measure Data Submission Mode and Name
Hours of Seclusion Use
Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge
Influenza Immunization
Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
Screening for Metabolic Disorders

* Burden for this measure is accounted for under OMB control number 0920-1317.

** Burden for these measures is accounted for under OMB control number 0938-0050.

In the FY 2026 IPF PPS proposed rule, we proposed to remove four web-based measures beginning with the FY 2026 payment determination: (1) the Facility Commitment to Health Equity measure; (2) the COVID-19 Vaccination Coverage among HCP measure; (3) the Screening for Social Drivers of Health measure; and (4) the Screen Positive Rate for Social Drivers of Health measure.

In the FY 2026 IPF PPS proposed rule we are also proposing to modify one claims-based measure which will not affect information collection burden under this OMB control number. We are proposing to begin use of the 30-Day Risk-Standardized All-Cause Emergency Department (ED) Visit Following an IPF Discharge measure (IPF ED Visit measure) with the FY 2029 payment determination instead of the FY 2027 payment determination, and to modify the reporting period for the IPF ED Visit measure to a two-year reporting period that runs from July 1st four years prior to the applicable fiscal year payment determination to June 30th two years prior to the applicable fiscal year payment. determination. Additionally, in the FY 2026 IPF PPS proposed rule, we are proposing to update the Extraordinary Circumstances Exception (ECE) policy and codify the process for requesting or granting an ECE. This proposed update would explicitly include *extensions* as a type of extraordinary circumstances relief option, in addition to exceptions. Because the process for requesting or granting an ECE would remain the same as the current ECE process, these updates would not affect burden associated with the submission of the ECE form, which is accounted for under OMB control number 0938-1022 (expiration date April 30, 2027).

b. IPFQR Program Administrative Forms

CMS has implemented procedural requirements that align the current quality reporting programs, including the Hospital Inpatient Quality Reporting (IQR) Program, the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, the Hospital Outpatient Quality Reporting (OQR) Program, and the IPFQR Program. These procedural requirements involve submission of forms to comply with the IPFQR Program requirements.

The IPFQR Program uses six administrative forms: (1) Notice of Participation Form; (2) Data Accuracy and Completeness Acknowledgement (DACA) Form; (3) Extraordinary

Circumstances Exception (ECE) Request Form; (4) Annual Payment Update (APU) Reconsideration Request Form; (5) Vendor Authorization Form; and (6) Request Form for Withholding/Footnoting for Public Reporting. None of these administrative forms are completed on an annual basis; all are on a need-to-use, exception basis and most IPFs will not need to complete any of these forms in any given year, with the exception of the DACA Form, which is completed annually. The burden for IPFs associated with forms is discussed in section B.12.k.

i. Notice of Participation Form

To begin participation in the IPFQR Program, IPFs paid under the IPF PPS must complete an IPFQR Notice of Participation. The Notice of Participation explains the participation and reporting requirements for the program. The form explains that in order to receive the full market basket update or APU, IPFs are agreeing to submit data on selected measures and allow CMS to publish their data for public viewing according to section 1886(s)(4)(E) of the Act. We note that the Notice of Participation has been previously approved under this OMB control number (that is, OMB control number 0938-1171). We recognize 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.

ii. DACA Form

As part of our procedural requirements, we require that IPFs acknowledge the accuracy and completeness of submitted data on an annual basis after the end of each reporting year. Requiring submission of the DACA form supports us in our aim to collect and report information on accurate, reliable, and relevant measures of quality. In our effort to foster alignment across quality reporting programs, the same DACA form can be used for multiple programs and is part of the Hospital IQR Program's PRA package (OMB control number 0938-1022) to reduce administrative burden and the potential for errors when updates are necessary.

iii. ECE Request Form

We offer a process for IPFs to request exceptions to the reporting of required quality data when an IPF experiences an extraordinary circumstance beyond the IPF's control. The CMS Quality Program ECE Request Form indicates that the request must be submitted within 90 calendar days of an extraordinary circumstance event for all programs. In our effort to foster alignment across quality reporting programs, the Extraordinary Circumstances Exception Request Form is part of the Hospital IQR Program's PRA package (OMB control number 0938-1022) to reduce administrative burden and the potential for errors when updates are necessary. While IPFs may also need to complete and submit this form, the associated burden is addressed in the Hospital IQR Program PRA package.

As noted in section B.1.a, in the FY 2026 IPF PPS proposed rule, we are proposing to update the Extraordinary Circumstances Exception (ECE) policy and codify the process for requesting or granting an ECE. This proposed update would explicitly include *extensions* as a type of extraordinary circumstances relief option, in addition to exceptions. Because the

process for requesting or granting an ECE would remain the same as the current ECE process, these updates would not affect burden associated with the submission of the ECE form, which is accounted for under OMB control number 0938-1022 (expiration date April 30, 2027).

iv. APU Reconsideration Request Form

When CMS determines that an IPF did not meet one or more of the IPFQR Program requirements, the IPF may submit a request for reconsideration to CMS using the CMS Quality Reporting Program APU Reconsideration Request Form, by the deadline identified on the IPFQR Program APU Notification Letter it received. In our effort to foster alignment across quality reporting programs, the APU Reconsideration Request form is part of the Hospital IQR Program's PRA package (OMB control number 0938-1022) to reduce administrative burden and the potential for errors when updates are necessary. While IPFs may also need to complete and submit this form, the associated burden is addressed in the Hospital IQR Program PRA package.

v. Vendor Authorization Form

We recognize that some IPFs may choose to have a vendor transmit quality data on the IPF's behalf. To ensure that the IPF has authorized the vendor, and the vendor has agreed that it will collect and transmit data in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements regarding security and privacy, we require IPFs to complete a vendor authorization form approving the vendor to transmit the facility's quality of care data.

vi. Request Form for Withholding/Footnoting Data for Public Reporting

We recognize that there are times when a facility identifies an error in claims-based measure calculations during the review and correction period. In these instances, we have developed a process for facilities to request a footnote be added to their publicly reported data on the *Compare* tool hosted by HHS, currently available at: https://www.medicare.gov/care-compare, or its successor website(s) to indicate that the facility has identified errors. The Request Form for Withholding/Footnoting Data for Public Reporting is part of the Hospital IQR Program's PRA package (OMB control number 0938-1022) to reduce administrative burden and the potential for errors when updates are necessary. While IPFs may also complete and submit this form, the associated burden is addressed in the Hospital IQR Program PRA Package.

2. Information Users

The IPFQR Program, as a pay-for-reporting program, strives to have a streamlined measure set that provides meaningful measurement that also serves to differentiate IPFs by quality of care while minimizing burden to the extent possible. We provide confidential feedback reports that IPFs may use to assess their performance and operationalize quality improvement activities. These reports include the data that we have collected from the IPF and the IPF's claims, and some also include information about how the IPF's data compared to the performance of other IPFs. For example, the Facility, State and National (FSN) Report allows

IPFs to compare their performance on a specific measure during a specific timeframe to the average performance of other IPFs at the state and national levels.

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. Additionally, Quality Improvement Organizations (QIOs) use Hospital OQR Program data to improve quality of care through education, outreach, and sharing best practices.

National accrediting organizations such as The Joint Commission 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.

The information from the IPFQR Program is also available to Medicare beneficiaries, as well as the general public, on the *Compare* tool and in the Provider Data Catalog to assist patients and their families in making decisions about their healthcare. We sometimes conduct focus groups or market testing prior to publicly reporting quality data on the Compare tool to get feedback on ways to make the website more user-friendly. Feedback from these focus groups has helped us understand how beneficiaries and consumers use the Compare tool.

Under section 1890A(a)(6) of the Act, CMS is required to evaluate the impact and efficiency of CMS measures in quality reporting programs and to post the report every three years. Following the compilation of data from the IPFQR Program and other CMS programs, CMS' findings were formally written into the latest triennial National Impact Assessment Report, which was released in CY 2024.[2]

3. Use of Information Technology

To assist IPFs in participating in standardized data collection initiatives across the industry, we continue to improve data collection tools with the goal of making data submission easier (e.g., the free CMS Abstraction and Reporting Tool (CART) for use in collecting data from paper or electronic medical records for chart-abstracted measures or the collection of data from federal registries like the NHSN), and to increase the utility of the data provided by IPFs. We also provide a secure data warehouse via the HQR system for storage and transmittal of data as well as data validation and aggregation services prior to the release of data to the CMS website. IPFs have the option of using vendors to transmit the data. We have engaged a national support contractor to provide technical assistance with the data collection tool as well as other program requirements, and to provide education to support program participants.

As reflected by the collection and reporting of claims-based quality measures and quality measures submitted via the HQR system, efforts are made to reduce burden by limiting the adoption of measures requiring the submission of patient-level information that must be acquired through chart-abstraction and to employ existing data and data collection systems.

[2] The latest 2024 Impact Assessment Report, as well as earlier reports from 2012, 2015, 2018, and 2021 may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/National-Impact-Assessment-of-the-Centers-for-Medicare-and-Medicaid-Services-CMS-Quality-Measures-Reports.

For the claims-based measures, this section is not applicable, because these measures can be calculated based on data that are already reported to the Medicare program for payment purposes. Therefore, no additional information technology will be required of IPFs to collect these data for these measures.

4. Duplication of Efforts

The information to be collected is not duplicative of similar information collected by CMS or other efforts to collect quality of care data for IPF care. We require IPFs to submit quality measure data for services provided. We prioritize efforts to reduce reporting burden for the collection of quality-of-care information by utilizing data that IPFs already report to The Joint Commission for accreditation, where possible.

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 IPFs in gathering information for their own quality improvement efforts. No special processes or procedures are available to small hospitals to make the information collection less burdensome. However, we provide a help-desk hotline for troubleshooting purposes and 24/7 free information available on the QualityNet website and through an online Questions and Answers (Q&A) functionality. Further, we will support submission of patient-level data through the publicly available 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. We require annual reporting of data for medical-record abstracted measures and attestation measures. Claims-based measures are calculated from Medicare FFS claims data; IPFs submit claims for reimbursement or payment per separately defined claims processing timeliness requirements.

7. Special Circumstances

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

a. Federal Register Notice

The 60-day Federal Register notice for this data collection published as part of the notice of proposed rulemaking (CMS-1831-P; RIN 0938-AV346) on March 30, 2025 (90 FR 18494)

b. Outside Consultation

Measures adopted for the IPFQR Program are required by statute to undergo a recognized consensus process. Section 1890A of the Act requires CMS to consider quality and efficiency measures from a multi-stakeholder group convened by the "consensus-based entity." To fulfill this requirement, the Partnership for Quality Measurement provides input on the Measures under Consideration list as part of the Pre-Rulemaking Measure Review (PRMR) process. We refer readers to https://p4qm.org/PRMR/About for more information on the PRMR process.

CMS is additionally supported in this program's efforts by The Joint Commission, CDC, Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ). These organizations consult with CMS on an ongoing basis, providing technical assistance in developing and/or identifying quality measures, and assisting in making collected information accessible, understandable, and relevant to the public. CMS also regularly engages interested parties (e.g. solicitation of comments).

9. Payment/Gift to Respondent

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 APU unless CMS grants an exception.

As noted in the FY 2024 IPF PPS final rule (88 FR 51143), we reimburse IPFs directly for expenses associated with submission of charts for measure data validation – we reimburse hospitals at a rate of $3.00 per record submitted.

10. Confidentiality

We pledge privacy to the extent provided by law. As a matter of policy, CMS will prevent the disclosure of personally identifiable information contained in the data submitted. All information collected under the IPFQR Program will be maintained in strict accordance with statutes and regulations governing confidentiality requirements for CMS data, including the

Privacy Act of 1974 (5 U.S.C. 552a), HIPAA, and the Quality Improvement Organizations confidentiality requirements at 42 C.F.R. Part 480. In addition, the tools used for transmission of data are considered confidential forms of communication, and there are safeguards in place in accordance with HIPAA Privacy and Security Rules to protect the submission of patient information, at 45 CFR Part 160 and 164, Subparts A, C and E. Only IPF-specific data will be made publicly available as mandated by statute.

Data related to the IPFQR Program is housed in the HQR application group. CMS' HQR is a General Support System (GSS) housing protected health information (PHI). Users who access CMS' HQR system are identity-managed to permit access to the system and have role-based restrictions (including log-in and password) to the data they can see. The System of Records Notice (SORN) in use for the quality programs including the IPFQR Program is MBD 09-70-0536.

11. Sensitive Questions

There are no questions of a sensitive nature associated with these forms. Case-specific clinical data elements will be collected and are necessary to calculate statistical measures. These statistical measures are the basis of all subsequent improvement initiatives derived from this collection and cannot be calculated without case-specific data. Case-specific data will not be released to the public and are not releasable by requests under the Freedom of Information Act. Only IPF-specific data will be released to the public after IPFs have had an opportunity to review the data that are to be made public with respect to the IPF, as mandated by statute. The patient-specific data remaining in the CMS clinical data warehouse after the data are aggregated for release for public reporting will continue to be subject to the strict confidentiality regulations in 42 CFR Part 480.

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

a. Background

In the FY 2026 IPF PPS proposed rule, we proposed to remove four measures beginning with the FY 2026 payment determination: (1) the Facility Commitment to Health Equity measure; (2) the COVID-19 Vaccination Coverage among HCP measure; (3) the Screening for Social Drivers of Health measure; and (4) the Screen Positive Rate for Social Drivers of Health measure. We discuss our proposed policies in the FY 2026 IPF PPS proposed rule which will not affect information collection burden in section B.1.a. of this document.

b. Updated Hourly Wage Rate

In the FY 2025 IPF PPS final rule (89 FR 64664), we estimated that the labor performed could be accomplished Medical Records Specialists based on a mean hourly wage in general medical and surgical hospitals of $26.06 per hour. More recent wage data reflect a mean hourly wage of $27.69 per hour.

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. 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 $55.38/hour as described in Table 2.

Because the IPFQR Program requires that IPFs collect data from patients using standardized instruments (specifically for the Screening for Social Drivers of Health (SDOH) measure and the PIX measure) we also estimate the costs for patients. To derive the costs for patients, we used a measurement of the median usual weekly earnings of wage and salary workers of $1,192, divided by 40 hours to calculate an hourly pre-tax wage rate of $29.80/hour. This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent, resulting in the post-tax hourly wage rate of $25.63/hour. This is an upwards adjustment from $24.04, which we adopted in the FY 2025 IPF PPS final rule (89 FR 64664). Unlike our State and private sector wage adjustments, we are not adjusting beneficiary wages for fringe benefits and other indirect costs since the individuals' activities, if any, would occur outside the scope of their employment.

Table 2: Wage Information

Role	Occupation Code, if applicable	Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Medical Records Specialist	29-2072	27.69	27.69	55.38
Patient	N/A	25.63	N/A	25.63

c. Chart-Abstracted Measure Reporting and Submission Burden

In calculating the total burden of the chart-abstracted measures in the IPFQR Program we have considered the number of cases that IPFs must report for each measure. We are not changing the number of cases that IPFs must submit for these measures. As previously finalized and approved two of our chart-abstracted measures require reporting data for all patients.[3] The remaining six chart-abstracted measures allow sampling under the global sample and therefore we estimate that each IPF will report data on an average of 609 cases.[4]

[3] These measures are the Hours of Physical Restraint Use measure and the Hours of Seclusion Use measure.

[4] These measures are the Alcohol Use Disorder Brief Intervention Provided or Offered and Alcohol Use Disorder Brief Intervention measure, the Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol and Other Drug Use Disorder Treatment at Discharge measure, the Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge measure, the Influenza Immunization measure, 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) measure, and the Screening for Metabolic Disorders measure.

d. Structural Measure Reporting and Submission Burden

The Facility Commitment to Health Equity structural measure requires each IPF to attest "yes" or "no" in response to five sets of questions one time per year. In the FY 2026 IPF PPS proposed rule, we proposed to remove the Facility Commitment to Health Equity measure beginning with the FY 2026 payment determination.

e. Process Measure Reporting and Submission Burden

For the Screening for Social Drivers of Health measure, IPFs are able to collect data from patients via multiple methods. Measure data aggregated at the IPF level must be submitted via the HQR System annually.

For the Screen Positive Rate for Social Drivers of Health measure, IPFs will be required to report on an annual basis the number of patients who screen positive for one or more of the five domains divided by the total number of patients screened (reported as five separate rates). For this measure, we estimated only the additional burden for an IPF reporting this measure via the HQR System since patients will not need to provide any additional information for this measure.

In the FY 2026 IPF PPS proposed rule, we proposed to remove the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures beginning with the FY 2026 payment determination.

f. Experience of Care Measure Reporting and Submission Burden

For the PIX measure, IPFs must calculate performance on several domains based on the input from patients to the PIX survey. To align with patient experience measures in other programs (specifically the Hospital Consumer Assessment of Healthcare Providers and Systems survey measure) we have adopted a different sampling requirement from that of our chart-abstracted measures and thus, we estimate that each IPF will report 300 cases annually. Note, we have removed the optional demographic questions from the PIX survey.

g. National Healthcare Safety Network (NHSN) Measure Reporting and Submission Burden

For the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure we require IPFs to submit data through the CDC's NHSN system. The burden estimates under OMB control number 0938-1171 exclude burden associated with this measure because the data are submitted under OMB control number 0920-1317. In the FY 2026 IPF PPS proposed rule, we proposed to remove the COVID-19 Vaccination Coverage Among HCP measure beginning with the FY 2026 payment determination.

h. Claims-Based Measure Reporting and Submission Burden

Claims-based measures are derived through analysis of administrative claims, which are submitted under OMB control number 0938-0050 (CMS-2552-10) and do not require additional effort or burden for IPFs. As a result, the IPFQR Program's claims-based measures

do not influence our burden calculations. We note that in the FY 2026 IPF PPS proposed rule, we proposed to begin use of the IPF ED Visit measure with the FY 2029 payment determination instead of the FY 2027 payment determination, and to modify the reporting period for the IPF ED Visit measure to a two-year reporting period that runs from July 1st four years prior to the applicable fiscal year payment determination to June 30th two years prior to the applicable fiscal year payment determination. These proposed changes would not impact burden.

i. Patient Data Collection Burden

Two of the measures in the IPFQR Program also require collecting data from patients. The Screening for Social Drivers of Health measure requires screening all patients and the PIX measure requires each IPF to collect data from a sample of 300 patients. Our estimates for how long patients will spend completing these screenings is based on estimates completed by programs with similar measures. As previously discussed, in the FY 2026 IPF PPS proposed rule, we proposed to remove the Screening for Social Drivers of Health measure beginning with the FY 2026 payment determination.

j. Non-Measure Data Reporting and Submission Burden

We have also considered requirements in addition to submitting measure data. These requirements include submission of non-measure data (specifically, aggregate population counts for Medicare and non-Medicare discharges by age group and diagnostic group), which we estimate takes 2.0 hours per IPF per year.

k. Information Collection Instruments and Instruction/Guidance Documents

As described in section B.1.b, the IPFQR Program uses six administrative forms. Other than the DACA Form, these forms would not be filled out by IPFs on a regular basis. The DACA Form is the only form being updated in association with the FY 2026 IPF PPS proposed rule, and it is included in the PRA package.

l. Information Collection/Reporting Requirements and Associated Burden Estimates

The total proposed burden associated with the IPFQR Program for the CY 2026 reporting period and subsequent years is summarized in Table 3; this total burden includes previously approved burden.

Table 3: Burden Associated with the IPFQR Program (OMB control no. 0938-1171)

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
All-Patient Measures (See B.12.c)	1,596	4,025,112 (1,596 IPFs x 1,261 discharges/IPF x 2 measures)	1,006,278 (4,025,112 responses x 0.25 hours/response)	55.38	52,447,209
Global Sample Measures (See B.12.c)	1,596	5,831,784 (1,596 IPFs x 609 cases/IPF x 6 measures)	1,457,946 (5,831,784 responses x 0.25 hours/response)	55.38	75,988,146
Submission of	1,596	478,800 (1,596 IPFs x	119,700 (478,800	55.38	6,238,764

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
PIX Measure (See B.12.f)		300 cases/IPF x 1 measure)	responses x 0.25 hours/response)		
Non-Measure Data (See B.12.j)	1,596	6,384 (1,596 IPFs x 4 responses/IPF)	3,192 (6,384 responses x 0.5 hours/response)	55.38	166,367
Patient Survey Completion – PIX (See B.12.i)	1,596	478,800 (1,596 IPFs x 300 cases/IPF x 1 measure)	57,935 (478,800 responses x 0.121 hours/response)	25.63	1,392,757
TOTAL	**1,596**	**10,820,880**	**2,645,051**	**Varies**	**144,759,358**

13. Capital Costs (Maintenance of Capital Costs)

We do not anticipate any capital costs associated with the policies in the FY 2026 IPF PPS proposed rule.

14. Cost to Federal Government

The cost to the Federal Government for maintaining program activities is for supporting data system architecture, data storage, maintenance and updating of information technology infrastructure on the HQR system secure portal, providing ongoing technical assistance to IPFs and their vendors, calculation of claims-based measures and validation, measure development and maintenance, the provision of IPFs with feedback and preview reports, as well as costs associated with public reporting. These costs are inclusive of the costs described in OMB control number 0938-1022, estimated at $10,050,000 annually for the validation and quality reporting contracts which support multiple quality programs. The IPFQR Program also requires one CMS staff at a GS-13 Step 5 level to operate. The approximate annual salary for GS-13 Step 5 is $136,658 plus benefits (30%) of $40,997 for a total compensation of $177,655.

For most of the claims-based measures, the cost to the Federal Government is minimal. We use data from the CMS National Claims History system that are already being collected for provider reimbursement; therefore, no additional data will need to be submitted by IPFs for claims-based measures.

15. Program and Burden Changes

This collection of information request describes changes to the IPFQR Program in association with the FY 2026 IPF PPS proposed rule (CMS-1831-P, RIN 0938-AV46) and burden adjustments based on the availability of more recent wage figures. The proposed rule-related change reflects removal of three measures (we reiterate that burden associated with the COVID-19 Vaccination Coverage Among HCP measure is accounted from under a separate OMB control number).

a. Effects Updates on Facility and Patient Burden

In the FY 2026 IPF PPS proposed rule, we proposed to remove four measures beginning with the FY 2026 payment determination: (1) the Facility Commitment to Health Equity measure;

(2) the COVID-19 Vaccination Coverage among HCP measure; (3) the Screening for Social Drivers of Health measure; and (4) the Screen Positive Rate for Social Drivers of Health measure. We note that the proposed removal of the COVID-19 Vaccination Coverage Among HCP measure would have no effect on information collection burden under OMB control number 0938-1171. Table 4 below reflects the reduction in burden associated with the proposed removal of these measures.

Table 4: Updates to Burden Associated with Proposed Measure Removals

Measure ID	# Respondents (Facilities)	Estimated Responses per Facility	Total Annual Responses	Time per Response (hours)	Time per Facility (hours)	Total Time (hours)	Total Cost ($)
Facility Commitment to Health Equity	1,596	(1)	(1,596)	0.167	(0.167)	(267)	(13,899)
Screening for Social Drivers of Health (Data Submission)	1,596	(1)	(1,596)	0.167	(0.167)	(267)	(13,899)
Screening for Social Drivers of Health (Patient Screening)	1,596	(1,261)	(2,012,556)	0.033	(41.6)	(66,414)	(1,596,593)
Screen Positive for Social Drivers of Health	1,596	(1)	(1,596)	0.167	(0.167)	(267)	(13,899)
TOTAL	**1,596**	**(1,264)**	**(2,017,344)**	**0.533**	**(42.1)**	**(67,214)***	**(1,638,289)***

*Totals do not reflect the sum of individual measure removals due to rounding

b. Effects of Updated Wage Rates

As described in Section 12, we have updated our estimated wage rate; the effects of this update are described here.

We previously estimated a wage rate of $52.12/hour; we are updating that estimate to $55.38/hour, a change of $3.26/hour. Furthermore, for requirements that require patients to engage in activities on their own time, we previously estimated a wage rate of $24.04/hour; we are updating that estimate to $25.63/hour, a change of $1.59/hour. The effects of these updates on the requirements associated with the IPFQR Program are shown in Table 5.

Table 5: Effects of Updated Wage Rates

Requirement	Respondents	Time (hours) (See Table 3)	Change in Applicable Wage Rate ($/hr)	Change in Cost ($)
All-Patient Measures	1,596	1,006,278	+3.26	3,280,466
Global Sample Measures	1,596	1,457,946	+3.26	4,752,904
PIX Measure	1,596	119,700	+3.26	390,222
Non-Measure Data	1,596	3,192	+3.26	10,406
Patient Survey - PIX	1,596	57,935	+1.59	92,117
TOTAL	**1,596**	**2,645,051**	**Varies**	**8,526,115**

In aggregate, we estimate a total decrease in burden hours of 67,214 and an increase of $6,887,826 due to proposed measure removals and updated wage rates.

16. Publication/Tabulation Dates

The goal of the data collection is to tabulate and publish IPF-specific data. We will continue to display IPF quality information for public viewing as required by Social Security Act section 1886(s)(4)(E). Data from the IPFQR Program are currently used to populate the *Compare* tool. Data are presented on the *Compare* tool in a format mainly aimed towards consumers, patients, and the general public, providing access to IPF-specific quality measure performance rates along with state and national performance rates. More detailed measure data, including the data used for the *Compare* tool, are also available to the public as downloadable files from the Provider Data Catalog available at https://data.cms.gov/provider-data/. IPF quality data associated with this PRA are currently updated on an annual basis on the *Compare* tool. One of the goals of the IPFQR Program is to publicly display data on all measures adopted for the Program. We note, however, that in certain circumstances we may decide to delay public display as we evaluate the accuracy of the measure data.

17. Expiration Date

We will display the approved expiration date on each of the forms included as appendices to this PRA, which would become available on the QualityNet website (https://qualitynet.cms.gov). We will also display the approved expiration date prominently on the QualityNet website's IPFQR Program pages used to document our measure specifications and reporting guidance.

18. Certification Statement

We are not claiming any exceptions to the Certification for Paperwork Reduction Act Submissions Statement.

B. Collection of Information Employing Statistical Methods

The PIX survey allows but does not require sampling and CMS will not employ any statistical methods or sampling in the calculation of survey results. However, IPFs can choose to use a valid sampling methodology for collecting survey data, though they are not required to do so.