Supporting Statement – Part A

Submission of Information for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program: FY 2025 IPF PPS Proposed Rule (OMB# 0938-1171; CMS-10432)

A. Background

This is a revision 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 National Quality Strategy and the Meaningful Measure 2.0 Framework. In particular, Meaningful Measures 2.0 promotes innovation and modernization of all aspects of quality to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives by supporting five interrelated goals: (1) empower consumers to make good health care choices through patient-directed quality measures and public transparency, (2) leverage quality measures to promote health equity and close gaps in care, (3) streamline quality measurement, (4) leverage measures to drive outcome improvement through public reporting and payment programs, and (5) improve quality measure efficiency by transitioning to digital measures and using advanced data analytics.

The information collection requirements for the FY 2014 through FY 2028 program years (that is, data submitted from CY 2013 through CY 2027) are currently approved under OMB control number 0938-1171 (expiration date January 31, 2027). This request covers updates to the data collection requirements beginning with the FY 2026 payment determination (that is data submitted in CY 2025) and subsequent years.

B. Justification

1. Need and Legal Basis

Pursuant to section 1886(s)(4)(C) of the Social Security Act as added and amended by sections 3401 and 10322 of the Patient Protection and Affordable Care Act (ACA) and further amended by section 4125(c) of the Consolidated Appropriations Act, 2023, starting in FY 2014 (that is, October 1, 2013 through September 30, 2014) and for subsequent fiscal years, IPFs paid under the IPF PPS shall submit pre-defined quality measures to the 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 prospective payment system (PPS) payment updates reduced by 2.0 percentage points.

a. IPFQR Program Quality Measures

The FY 2027 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) 2025 discharges. In an effort to reduce burden, a variety of data collection mechanisms 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 is 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), that is the 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, 2024). We note that the CDC currently has a PRA waiver for the collection and reporting of vaccination data under section 321 of the National Childhood Vaccine Injury Act of 1986 (enacted on November 14, 1986).[1] 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.

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 2025 Reporting Period/FY 2027 Program Year

Measure Data Submission Mode and Name	CBE No.
NHSN Measures (web-based)	
COVID-19 Healthcare Personnel (HCP) Vaccination*	N/A
Structural Measures (web-based)	
Facility Commitment to Health Equity	N/A
Process Measures (web-based)	
Screening for Social Drivers of Health	N/A
Screen Positive Rate for Social Drivers of Health	N/A
Claims-Based Measures **	
Follow-Up After Psychiatric Hospitalization	N/A

[1] Pub. L. 99-660.

Measure Data Submission Mode and Name	CBE No.
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	2860
Medication Continuation Following Inpatient Psychiatric Discharge	3205
Survey-Based Measure	
Psychiatric Inpatient Experience Survey (PIX)***	N/A
Chart-Abstracted Measures	
Hours of Physical Restraint Use	0640
Hours of Seclusion Use	0641
Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	N/A
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	N/A
Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge	N/A
Influenza Immunization	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)	N/A
Screening for Metabolic Disorders	N/A

* 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.
** The PIX measure is voluntary for FY 2027 payment determination and will be mandatory for subsequent years.

In the FY 2025 IPF PPS proposed rule, we have one proposal which would affect information collection burden under this OMB control number. We are proposing to increase reporting frequency for chart-abstracted measures from once per year to once per quarter (that is, an increase of three reporting periods per year).

We also have one proposal in the FY 2025 IPF PPS proposed rule which would not affect information collection burden under this OMB control number. We are proposing to adopt one claims-based measure, the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure.

b. IPFQR Program Administrative Forms

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

The IPFQR Program uses five administrative forms: (1) Notice of Participation Form; (2) Data Accuracy and Completeness Acknowledgement (DACA) Form; (3) Extraordinary Circumstances Exception (ECE) Request; (4) APU Reconsideration Request Form; and (5) Vendor Authorization Form. 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 valid, reliable, and relevant measures of quality.

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 form is part of the Hospital Inpatient Quality Reporting (IQR) Program's PRA package (OMB control number 0938-1022; expiration date January 31, 2026). While IPFs may also need to complete and submit this form, the associated burden is addressed in the Hospital IQR Program PRA package.

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 Inpatient Quality Reporting (IQR) Program's PRA package (OMB control number 0938-1022; expiration date January 31, 2026). 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 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.

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 throughout the quality reporting period. 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 compare 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.

National accrediting organizations such as The Joint Commission (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.

The information from the IPFQR Program is also available to Medicare beneficiaries, as well as the general public, on the *Care Compare* website and in the Provider Data Catalog (PDC) 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 hosted by HHS or its successor website(s) 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 hosted by HHS or its successor website(s).

Under section 3014 of the Patient Protection and Affordable Care Act of 2010 (ACA), 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

[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.

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, 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. The complete list of measures and data collection forms are organized by type of data collected and data collection mechanism in Table 1.

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 hospitals 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 a 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. While we have previously required annual reporting, we are now proposing to require quarterly reporting of patient-level, chart-abstracted data because of data storage and

transmission limitations for data covered by this PRA package. 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-1806-P; RIN 0938-AV32). The proposed rule published on April 3, 2024 (89 FR 23146).

b. Outside Consultation

Measures adopted for the IPFQR Program are required by statute to undergo a recognized consensus process. Section 3014 of the ACA modified section 1890(b) of the Act to require CMS to develop quality and efficiency measures through a "consensus-based entity." To fulfill this requirement, the Measure Applications Partnership (MAP) was formed to review measures consistent with this provision of the Act and renamed the Pre-Rulemaking Review (PRMR) in CY 2023. We refer readers to https://p4qm.org/PRMR-MSR 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

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.

As noted in the FY 2024 IPF PPS final rule (88 FR 51143), we reimburse hospitals 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), the Health Insurance Portability and Accountability Act (HIPAA), and the Quality Improvement Organizations confidentiality requirements, which can be found 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 consent has been received from the IPF for the release, 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 PIX survey, which is currently approved under this PRA package (that is, OMB# 0938-1171; CMS-10432) asks patients to respond to demographic questions, including their age, gender, sexual orientation, and others. The questions are optional and are provided to collect additional information to stratify the results of the survey at a population level, in order to determine whether patient experience at inpatient psychiatric facilities significantly differs by any of these patient factors.

Otherwise, 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

a. Background

In the FY 2025 IPF PPS proposed rule, we are proposing one policy which would affect the information collection burden. We are proposing to transition to quarterly data submission for measures which require patient-level data submission. We discuss our other proposal in the FY 2025 IPF PPS proposed rule which would not affect information collection burden in section B.1.a of this document.

b. Updated Hourly Wage Rate

In the FY 2024 IPF PPS final rule (88 FR 51145), we estimated that the labor performed could be accomplished Medical Records Specialists based on a median hourly wage in general medical and surgical hospitals of $22.43 per hour. More recent wage data reflect a median hourly wage of $26.06 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 $52.12/hour as described in Table 1.

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 beneficiaries. To derive the costs for beneficiaries, we used a measurement of the usual weekly earnings of wage and salary

workers of $1,118, divided by 40 hours to calculate an hourly pre-tax wage rate of $27.95/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 $24.04/hour. This is an upwards adjustment from $20.71, which we adopted in the FY 2024 IPF PPS final rule (88 FR 51150). 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 1: Wage Information

Role	Occupation Code, if applicable	Median Hourly Wage ($/hour)	Fringe Benefits and Overhead ($/hour)	Adjusted Hourly Wage ($/hour)
Medical Records Specialist	29-2072	26.06	26.06	52.12
Beneficiary	N/A	24.04	N/A	24.04

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 have not proposed any changes to 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 IPFs will report data on 609 cases.[4]

d. Structural Measure Reporting and Submission Burden

We are not proposing any changes to the reporting or submission requirements for the Facility Commitment to Health Equity structural measure in the FY 2025 IPF PPS proposed rule. Reporting on this measure requires each IPF being required to attest "yes" or "no" in response to as many as five questions one time per year.

e. Process Measure Reporting and Submission Burden

We are not proposing any changes to the reporting or submission requirements for the process measures in the FY 2025 IPF PPS proposed rule. For the screening for Social Drivers of Health measure, IPFs are able to collect data and report the measure via multiple methods. Measure data aggregated at the IPF level will be submitted via the HQR System annually.

For the Screen Positive Rate for Social Drivers of health measure, IPFs will be required to

[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.

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 estimate 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.

f. Experience of Care Measure Reporting and Submission Burden

We are not proposing any changes to the reporting or submission requirements for the patient experience of care measure in the FY 2025 IPF PPS proposed rule. For the patient experience of care measure (that is, the PIX measure) IPFs must calculate performance on several domains based on the input from patients to the Psychiatric Inpatient Experience (PIX) survey. To align with patient experience measures in other programs (specifically the Hospital Consumer Assessment of Healthcare Providers and Systems) we have adopted a different sampling requirement from that of our chart-abstracted measures and thus we estimate that IPFs will report 300 cases annually.

g. National Healthcare Surveillance 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. We reiterate that our estimates exclude burden associated with this measure because the data are submitted under OMB control number 0920-1317.

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 we are proposing one claims-based measure, the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure, in the FY 2025 IPF PPS proposed rule.

i. Patient Data Collection Burden

Two of the measures in the IPFQR Program also require collecting data from patients. One of those measures requires screening all patients and the other requires collecting 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.

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.

k. Information Collection Instruments and Instruction/Guidance Documents

We also require submission of certain forms[5] which we estimate to take less than five minutes per IPF and have included time for submitting measure related forms in the estimates of time for each measure. The following documents are part of the IPFQR program, none of these documents are being updated in association with these proposals:

- IPFQR Program Data Entry Screen Shots
- Notice of Participation
- Vendor Authorization
- Data Accuracy and Completeness Attestation (DACA)
- Psychiatric Inpatient Experience (PIX) survey

l. Increased Reporting Frequency

In the FY 2025 IPF PPS proposed rule we are proposing to require IPFs to submit patient-level data on a quarterly basis (increasing frequency from the current requirement of annual submission). We estimate that the increase in burden associated for each newly added data submission period (that is, a total of three per year) is approximately equal to the burden of reporting one attestation measure because both of these activities require logging into and interacting with user interfaces within CMS' HQR system.

m. Information Collection/Reporting Requirements and Associated Burden Estimates

The total burden associated with the IPFQR Program for CY 2027 data submission and subsequent years is summarized in Table 2, this total burden includes previously approved burden as well as burden associated with the requirements proposed in the FY 2025 IPF PPS proposed rule..

Table 2: Burden Associated with the IPFQR Program

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)	52.12	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)	52.12	75,988,146
Single Data Point Measures (See B.12.d and B.12.e)	1,596	4,788 (1,596 IPFs x 1 response/IPF x 3 measures)	800 (4,788 responses x 0.167 hours/response)	52.12	41,696
Measures Submitted	1,596	0	0	52.12	0

[5] The forms that are not covered under the Hospital Inpatient Quality Reporting (IQR) Program's PRA package (OMB control number 0938-1022; expiration date January 31, 2026) are the Notice of Participation, which is completed once per facility, the Data Accuracy and Completeness Acknowledgement, which is completed once per data submission period, and the Vendor Authorization Form, which is optional.

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
under Separate OMB Control Numbers (See B.12.g and B.12.h)					
Submission of Patient Experience Measure (See B.12.f)	1,596	478,800 (1,596 IPFs x 300 cases/IPF x 1 measure)	119,700 (478,800 responses x 0.25 hours/response)	52.12	6,238,764
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)	52.12	166,367
Patient Survey Completion– Screening for SDOH (See B.12.i)	1,596	2,012,556 (1,596 IPFs x 1,261 discharges/IPF)	66,414 (478,800 responses x 0.033 hours/response)	24.04	1,596,593
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)	24.04	1,392,757
Addition of 3 Data Reporting Periods (See B.12.l)	1,596	4,788 (1,596 IPFs x 1 response/ quarter x 3 additional quarters)	800 (4,788 responses x 0.167 hours/response)	52.12	41,696
TOTAL	**1,596**	**12,843,012**	**2,713,065**	**Varies**	**137,913,228**

13. Capital Costs (Maintenance of Capital Costs)

We do not anticipate any capital costs associated with the proposals in the FY 2025 IPF PPS proposed rule.

14. Cost to Federal Government

This program requires one CMS staff at a GS-13 Step 4 level to operate. The approximate salary for GS-13 Step 4 is $120,207 plus benefits (30%) of $36,062.10 for a total cost of $156,269.10.

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.

The data for the IPFQR Program measures will be reported directly to the HQR system using existing system functionality. A support contractor will 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.

15. Program and Burden Changes

This collection of information request describes changes to the IPFQR Program in

association with the FY 2025 IPF PPS proposed rule (CMS-1806-P, RIN 0938-AV32) and burden adjustments based on the availability of more recent wage figures. The proposed rule-related changes include proposed adoption of one claims-based measure and a proposal to shift from annual reporting of patient-level data to quarterly submission of these data. We do not anticipate any change in information collection burden associated with the claims-based measure because there will be no change to the content of the information IPFs are required to submit to CMS. For the purposes of calculating burden, we attribute the costs to the year in which the costs begin. For the proposed transition to quarterly reporting, these changes would occur CY 2025 and CY 2026. Overall, we project that the changes would increase information collection burden by approximately 800 hours annually resulting in a cost increase of $41,696.

a. 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 $44.86/hour; we are updating that estimate to $52.12/hour, a change of $7.26/hour. Furthermore, for requirements that require beneficiaries to engage in activities on their own time, we previously estimated a wage rate of $20.71/hour; we are updating that estimate to $24.04/hour, a change of $3.33/hour. The effects of these updates on the requirements associated with the IPFQR Program are shown in Table 3.

Table 3: Effects of Updated Wage Rates

Requirement	Respondents	Time (hours) (See Table 1)	Change in Applicable Wage Rate ($/hr)	Change in Cost ($)
All-Patient Measures	1,596	1,006,278	+7.26	7,305,578
Global Sample Measures	1,596	1,457,946	+7.26	10,584,688
Single Data Point Measures	1,596	800	+7.26	5,808
Separate OMB Control Measures	1,596	0	+7.26	0
Patient Experience Measure	1,596	119,700	+7.26	869,022
Non-Measure Data	1,596	3,192	+7.26	23,174
Patient Survey – Screening for SDOH	1,596	66,414	+3.33	221,159
Patient Survey - PIX	1,596	57,935	+3.33	192,924
TOTAL	**1,596**	**2,712,265**	**Varies**	**19,202,353**

b. Updates Affecting Burden Beginning with CY 2025

Our proposal to require IPFs to submit data on chart-abstracted measures quarterly would lead to a total increase of three data submission periods per year. This increase would be incremental, increasing from one data submission period in CY 2024 to two in CY 2025 (an increase of one data submission period) and then increasing to four in CY 2026 (an increase of two data submission periods versus CY 2025). We estimate that the increase in burden associated with the increase in data submission periods is approximately equal to the burden of reporting one attestation measure because both of these activities require logging into and

interacting with user interfaces within CMS' HQR system. The effects of this increase on the IPFQR Program for CY 2025 are set forth in Table 4.

Table 4: Burden Associated CY 2025 Quarterly Reporting

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
Addition of one data submission period (for a total of 2)	1,596	1,596 (1,596 IPFs x 1 additional quarter)	267 (1,596 responses x 0.167 hours/response)	52.12	13,892

c. Updates Affecting Burden Beginning with CY 2026

In CY 2026, under our proposal to shift to annual reporting, there would be an additional two data submission periods (for a total of four annually). The effects of this increase on the IPFQR Program for CY 2026 are set forth in Table 5.

Table 5: Burden Associated with CY 2026 Quarterly Reporting

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
Addition of two data submission periods (for a total of 4)	1,596	3,192 (1,596 IPFs x 2 additional quarters)	533 (3,192 responses x 0.167 hours/response)	52.12	27,783

The total change in requested burden associated with updating our wage estimates and switching to quarterly reporting are set forth in Table 6.

Table 6: Changes in Burden Associated with New Wage Estimates and Quarterly Reporting

Update	Respondents	Responses	Time (hours)	Cost ($)
Change in Wage Estimates	No Change	No Change	No Change	19,202,353
Addition of three data submission periods	No change	4,788 (1,596 IPFs x 3 additional quarters)	800 (4,788 responses x 0.167 hours/response)	41,696
Totals	**No Change**	**4,788**	**800**	**19,244,049**

16. Publication/Tabulation Dates

The goal of the data collection is to tabulate and publish hospital-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 hosted by HHS, available at: https://www.medicare.gov/care-compare/, or its successor website(s). Data are presented on the *Compare* tool hosted by HHS in a format mainly aimed towards consumers, patients, and the general public, providing access to hospital-specific quality measure performance rates along with state and national performance rates. More detailed measure data, including the data used for the *Compare* tool hosted by HHS, are also available to the public as downloadable files at https://data.medicare.gov. IPF quality data on the *Compare* tool hosted by HHS are currently updated on an annual basis. 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 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.