Supporting Statement – Part A

Submission of Information for the Inpatient Psychiatric Facility Quality Reporting Program: FY 2027 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's) quality reporting programs promote higher quality, more efficient healthcare for consumers, including Medicare beneficiaries by collecting and reporting quality-of-care metrics. This information informs consumer decision-making and incentivizes healthcare facilities to make continued improvements.

The information collection requirements for the FY 2028 payment determination and future years (that is, data submitted in calendar year (CY) 2026 and future years) 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 2029 IPF Quality Reporting payment determination will be based on IPF Quality Reporting Program data reported and supporting forms submitted by IPFs on chart-abstracted measures and patient surveys for CY 2027 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 IPF Quality Reporting Program seeks to collect and publicly report data on quality-of-care metrics for the IPF setting. Measure data are submitted via one of three modes: (1) claims-based, (2) survey-based, and (3) chart-abstracted, as seen in Table 1.

Claims-based measures use information derived through Medicare Fee-for-Service (FFS) claims and beneficiary enrollment data. Because these data are already submitted by IPFs for payment purposes, claims-based measures do not require additional reporting burden on IPFs.

Survey measures rely on patient responses to the Psychiatric Inpatient Experience (PIX) survey. Survey-based data involves manual data entry effort and requires some reporting burden on IPFs.

Chart-abstracted measures rely on information manually abstracted from patient medical records. Because chart abstraction requires manual data entry, these measures typically impose greater burden on IPFs than other reporting modes.

Table 1. Currently Approved IPF Quality Reporting Program Measures for the FY 2028 Payment Determination and Subsequent Years

Measure Data Submission Mode and Name
Claims-Based Measures*
Follow-Up After Psychiatric Hospitalization
Thirty-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility
Medication Continuation Following Inpatient Psychiatric Discharge
Survey-Based Measure
Psychiatric Inpatient Experience Survey
Chart-Abstracted Measures
Hours of Physical Restraint Use
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 these measures is accounted for under OMB control number 0938-0050.

† In the FY 2027 IPF PPS proposed rule, these measures were proposed for removal beginning with the FY 2028 payment determination.

We note that the 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure will be used in the IPF Quality Reporting Program beginning in FY 2029.

In the FY 2027 IPF PPS proposed rule, we proposed to remove two chart-abstracted measures beginning with the FY 2028 payment determination: (1) the Alcohol Use Brief Intervention Provided or Offered (SUB-2) and subset Alcohol Use Brief Intervention (SUB-2a) measure; and (2) the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) and subset Tobacco Use Treatment at Discharge (TOB-3a) measure.

Additionally, we proposed to implement the IPF Patient Assessment Instrument (IPF-PAI) beginning with Quarter 4 of the CY 2027 reporting period/FY 2029 payment determination. We have requested approval for the information collection burden associated with the IPF-PAI under a separate new OMB control number.

b. IPF Quality Reporting Program Administrative Forms

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

The IPF Quality Reporting 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. With the exception of the DACA Form, which is completed annually, these administrative forms are completed on a need-to-use, exception basis and most IPFs will not need to complete any of these forms in any given year. The burden for IPFs associated with administrative forms is discussed in section B.12.h.

i. Notice of Participation Form

To begin participation in the IPF Quality Reporting Program, IPFs paid under the IPF PPS must complete an IPF Quality Reporting 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 IPF Quality Reporting 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 Inpatient Quality Reporting 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 or extensions to the reporting of required quality data when an IPF experiences an extraordinary circumstance beyond the IPF's control, such as a cyberattack or natural disaster. The CMS Quality Program ECE Request Form indicates that the request must be submitted within 60 calendar days of an extraordinary circumstance event for all programs. In our effort to foster alignment across

quality reporting programs, the ECE Request Form is part of the Hospital Inpatient Quality Reporting 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 Inpatient Quality Reporting Program PRA package.

iv. APU Reconsideration Request Form

When CMS determines that an IPF did not meet one or more of the IPF Quality Reporting 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 IPF Quality Reporting 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 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 Inpatient Quality Reporting 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 to CMS.

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 Inpatient Quality Reporting 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 Inpatient Quality Reporting Program PRA Package.

IPFs may submit a request to add a footnote to claims-based measure data publicly reported on the Compare Tool or its successor website. If the request is approved, the footnote would be added to the data, indicating that the IPF has identified errors in its claims-based measure data during the program-specific preview period for the applicable reporting period. IPFs may request to footnote any or all claims-based measures. Forms must be received before the end of the preview period in order to be considered.

2. Information Users

The IPF Quality Reporting Program, as a pay-for-reporting program, strives to have a streamlined measure set that differentiates 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 of these reports also include information about how the IPF's data compared to the performance of other IPFs. For example, the Facility, State and National 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 information from the IPF Quality Reporting Program is also available to Medicare beneficiaries, as well as the general public, on the *Compare* tool and in the Provider Data Catalog, which helps the public make informed decisions about their care. CMS periodically conducts focus groups or market testing 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 IPF Quality Reporting Program and other CMS programs, CMS's findings were formally written into the latest triennial National Impact Assessment Report, which was released in CY 2024.[1]

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 dual goals 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), 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, including for the PIX survey. CMS has engaged a national support contractor to provide technical assistance with the data collection tools and other program requirements, and to provide education to support program participants.

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

[1] 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.

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 collect as part of their regular workflows.

5. Small Business

Information collection requirements are designed to allow maximum flexibility specifically to small IPF providers participating in the IPF Quality Reporting 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, and free information available on the QualityNet website and through an online Questions and Answers functionality. Further, we will support submission of patient-level data through the publicly available CART. These activities will assist small IPFs in gathering information for their quality improvement efforts and for meeting IPF Quality Reporting Program information collection requirements.

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. Claims-based measures use information derived through Medicare FFS claims; IPFs submit claims for reimbursement or payment per separately defined claims processing timeliness requirements.

7. Special Circumstances

There are no special circumstances.

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 (RIN 0938-AV77; CMS-1847-P) on April 7, 2026 (91 FR 17720).

b. Outside Consultation

Measures adopted for the IPF Quality Reporting 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, Centers for Disease Control and Prevention, Health Resources and Services Administration, and the Agency for Healthcare Research and Quality. 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 IPF Quality Reporting 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 CFR 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 IPF Quality Reporting Program is housed in the HQR application group. CMS's HQR is a General Support System housing protected health information. Users who access CMS's 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.

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 2027 IPF PPS proposed rule, we proposed to remove two measures beginning with the CY 2026 reporting period/FY 2028 payment determination: (1) the Alcohol Use Brief Intervention Provided or Offered (SUB-2) and subset Alcohol Use Brief Intervention (SUB-2a) measure; and (2) the Tobacco Use Treatment Provided or Offered at Discharge (TOB-3) and subset Tobacco Use Treatment at Discharge (TOB-3a) measure. We discuss other proposed policy changes in the FY 2027 IPF PPS proposed rule which would not affect information collection burden under OMB control number 0938-1171 in section B.1.a. of this document.

Our currently approved burden estimates assume that 1,596 IPFs would report data for 1,261 discharges, on average per facility, for the IPF Quality Reporting Program in CY 2026 and subsequent years. In the FY 2027 IPF PPS proposed rule, based on data from the FY 2027 payment determination, we updated our assumption and estimate that 1,564 IPFs will report data for an average of 1,342 discharges annually per facility for the IPF Quality Reporting Program in CY 2027 and subsequent years.

b. Updated Hourly Wage Rate

Our currently approved burden estimates assume that the labor to submit data for the IPF Quality Reporting Program could be accomplished by Medical Records Specialists based on a median hourly wage in general medical and surgical hospitals of $27.69 per hour. More recent wage data reflect a mean hourly wage of $27.53 per hour.[2]

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 $55.06/hour as described in Table 2.

Because the IPF Quality Reporting Program's PIX measure requires that IPFs collect data from patients using a standardized survey, we also estimate the costs for patients. To derive

[2] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics: General Medical and Surgical Hospitals, Medical Records Specialists. Accessed January 8, 2026. Available at: *https://data.bls.gov/oes/#/industry/622100*

the costs for patients, we used a measurement of the median usual weekly earnings of wage and salary workers of $1,204, divided by 40 hours to calculate an hourly pre-tax wage rate of $30.10/hour.[3] This rate is adjusted downwards by an estimate of the effective tax rate for median income households of about 14 percent,[4] resulting in the post-tax hourly wage rate of $25.89/hour. This is an upwards adjustment from our currently approved estimate of $25.63. 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	27.53	27.53	55.06
Patient	N/A	25.89	N/A	25.89

c. Chart-Abstracted Measure Reporting and Submission Burden

In calculating the total burden of the chart-abstracted measures in the IPF Quality Reporting 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.[5] In the FY 2027 IPF PPS proposed rule, we proposed to remove the SUB-2/SUB-2a and TOB-3/TOB-3a measures beginning with the CY 2026 reporting period/FY 2028 payment determination. The remaining four 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.[6]

d. 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.

e. Claims-Based Measure Reporting and Submission Burden

Claims-based measures use information derived through Medicare FFS claims, which are submitted under OMB control number 0938-0050 (CMS-2552-10) and do not require additional burden for IPFs. As a result, the IPF Quality Reporting Program's claims-based

[3] *https://www.bls.gov/news.release/pdf/wkyeng.pdf*. Accessed February 18, 2026.
[4] *https://www2.census.gov/library/publications/2025/demo/p60-286.pdf*. Accessed January 9, 2026
[5] These measures are the Hours of Physical Restraint Use measure and the Hours of Seclusion Use measure.
[6] These measures are 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 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.

measures do not influence our burden calculations.

f. Patient Data Collection Burden

The PIX survey requires each IPF to collect data from a sample of 300 patients. Our estimate for how long patients will spend completing these screenings is based on estimates completed by programs with similar measures. We continue to estimate each patient requires 7.25 minutes (0.121 hours) to complete the PIX survey.

g. 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.

h. Information Collection Instruments and Instruction/Guidance Documents

As described in section B.1.b, the IPF Quality Reporting 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 will be updated from last's version to reflect current project timelines. There are no changes to the other forms.

i. Information Collection/Reporting Requirements and Associated Burden Estimates

The total burden associated with the IPF Quality Reporting Program for the CY 2027 reporting period/FY 2028 payment determination and subsequent years is estimated to be 2,179,121 hours at a cost of $118,326,339, as summarized in Table 3. This total burden estimate includes previously approved burden.

Table 3: Burden Associated with the IPFQR Program for the CY 2027 Reporting Period (OMB control no. 0938-1171)

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
All-Patient Measures (See B.12.c)	1,564	4,197,776 (1,564 IPFs x 1,342 discharges/IPF x 2 measures)	1,049,444 (4,197,776 responses x 0.25 hours/response)	55.06	57,782,387
Global Sample Measures (See B.12.c)	1,564	3,809,904 (1,564 IPFs x 609 cases/IPF x 4 measures)	952,476 (3,809,904 responses x 0.25 hours/response)	55.06	52,443,329
Submission of PIX Measure (See B.12.d)	1,564	469,200 (1,564 IPFs x 300 cases/IPF x 1 measure)	117,300 (469,200 responses x 0.25 hours/response)	55.06	6,458,538
Non-Measure Data (See B.12.g)	1,564	6,256 (1,596 IPFs x 4 responses/IPF)	3,128 (6,256 responses x 0.5 hours/response)	55.06	172,228
Patient Survey Completion – PIX (See B.12.f)	1,564	469,200 (1,564 IPFs x 300 cases/IPF x 1 measure)	56,773 (469,200 responses x 0.121 hours/response)	25.89	1,469,858

Requirement	Respondents	Responses	Time (hours)	Applicable Wage Rate ($/hr)	Cost ($)
TOTAL	**1,564**	**8,952,336**	**2,179,121**	**Varies**	**118,326,339**

13. Capital Costs (Maintenance of Capital Costs)

We do not anticipate any capital costs associated with the proposed policies in the FY 2027 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 IPF Quality Reporting 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 $138,024 plus benefits (30%) of $41,407 for a total compensation of $179,431.

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 2027 IPF PPS proposed rule and burden adjustments based on the availability of more recent wage rates. The proposed rule-related change reflects removal of two measures (SUB-2/SUB-2a and TOB-3/TOB-3a).

a. Effects of Updates on Number of Facilities and Discharges

In the FY 2027 IPF PPS proposed rule, we updated our assumption of the number of IPFs from 1,596 to 1,564 (a decrease of 32) and annual discharges per IPF from 1,261 to 1,342 (an increase of 81). The effects of these updates on the requirements associated with the IPFQR Program are shown in Table 4.

Table 4: Updates to Number of IPFs and Annual Discharges per IPF

Measure ID	Change in # Respondents (Facilities)	Change in # Responses per Facility	Change in Total Annual Responses	Time per Response (hours)	Change in Time per Facility (hours)	Change in Total Time (hours)	Change in Total Cost ($)
All-Patient Measures (See B.12.c)	(32)	81	172,664	0.25	40.5	43,166	2,390,533
Global Sample Measures (See B.12.c)	(32)	0	(116,928)	0.25	0	(29,232)	(1,618,868)
Submission of PIX Measure (See B.12.f)	(32)	0	(9,600)	0.25	0	(2,400)	(132,912)
Non-Measure Data (See B.12.j)	(32)	0	(128)	0.5	0	(64)	(3,544)
Patient Survey Completion – PIX (See B.12.i)	(32)	0	(9,600)	0.121	0	(1,162)	(29,772)
TOTAL	**(32)**	**Varies**	**36,408**	**Varies**	**40.5**	**10,308***	**605,437***

*Totals may not reflect the sum of individual changes due to rounding

b. Effects of Updates on Facility and Patient Burden

In the FY 2027 IPF PPS proposed rule, we removed two measures beginning with the FY 2028 payment determination: (1) the SUB-2/SUB-2a and (2) TOB-3/TOB-3a measures. Table 6 below reflects the reduction in burden associated with the proposed removal of these measures.

Table 6: 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 ($)
SUB-2/SUB-2a	1,564	(609)	(952,476)	0.25	(152.25)	(238,119)	(13,110,832)
TOB-3/TOB-3a	1,564	(609)	(952,476)	0.25	(152.25)	(238,119)	(13,110,832)
TOTAL	**1,564**	**(1,218)**	**(1,904,952)**	**0.5**	**(304.5)**	**(476,238)**	**(26,221,664)**

c. 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 $55.38/hour; we are updating that estimate to $55.06/hour, a decrease of $0.32/hour. Furthermore, for requirements that require patients to engage in activities on their own time, we previously estimated a wage rate of $25.63/hour; we are updating that estimate to $25.89/hour, an increase of $0.26/hour. The effects of these updates on the requirements associated with the IPF Quality Reporting 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	1,564	1,049,444	(0.32)	(335,822)

Requirement	Respondents	Time (hours) (See Table 3)	Change in Applicable Wage Rate ($/hr)	Change in Cost ($)
Global Sample Measures	1,564	952,476	(0.32)	(304,792)
PIX Measure	1,564	117,300	(0.32)	(37,536)
Non-Measure Data	1,564	3,128	(0.32)	(1,001)
Patient Survey - PIX	1,564	56,773	+0.26	14,761
TOTAL	**1,564**	**2,179,121**	**Varies**	**(664,390)**

In aggregate, we estimate a total decrease in burden hours of 465,930 hours (+10,308 - 476,238) and decrease in cost of $26,280,617 (+$605,437 - $26,221,664 - $664,390) due to measure removals, updated number of IPFs and discharges, 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 quality measures in the IPF Quality Reporting 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 measure data associated with this PRA are currently updated on an annual basis on the *Compare* tool. One of the goals of the IPF Quality Reporting 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 IPF Quality Reporting 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.