# Children's Hospital Graduate Medical Education Payment Program

# SUPPORTING STATEMENT

A. Justification

1. Circumstances of Information Collection

This is a request for Office of Management and Budget (OMB) extension of approval of the information collection instruments associated with the annual reporting requirements, instructions, and guidance for the Children's Hospitals Graduate Medical Education Payment Program (CHGME Payment Program). The Children's Hospital GME Support Reauthorization Act of 2006 (Public Law 109-307) requires the annual report by participating children's hospitals and a special Report to Congress to be submitted by the Secretary. The legislation provides detail about the types of information to be provided by each children's hospital participating in the CHGME Payment Program.

The Healthcare Research and Quality Act of 1999 (Public Law 106-129) amended the Public Health Service (PHS) Act to establish a new program to support graduate medical education (GME) in children=s hospitals. The provision authorized payments in Federal Fiscal Year (FY) 2000 and FY 2001 for expenses associated with operating approved GME programs. The Children's Health Act of 2000 (Public Law 106-310) amended Public Law 106-129 with extension of Section 340E of the PHS Act authorizing the CHGME Payment Program through FY 2005. In December 2004, Section 340E of the Public Health Service Act was amended again (Public Law 108-490) to exclude beds or bassinets assigned to healthy newborn infants when calculating case mix (based on severity of illness) for CHGME Payment Program payments. The Children's Hospital GME Support Reauthorization Act of 2006 (Public Law 109-307) further amended the Public Health Service Act to reauthorize support for graduate medical education programs in children's hospitals for Federal fiscal years 2007 through 2011.

The reauthorizing statute established an annual reporting requirement for children's hospitals participating in the CHGME Payment Program. The legislation requires an annual report from participating children's hospitals that includes information for the residency training academic year completed immediately prior to each fiscal year for which the hospital applies for funds. The provision requires detailed reporting on several aspects of the pediatric graduate medical education programs supported by the CHGME Payment Program. Information to be reported includes: 1) types of resident training programs provided by the hospital; 2) the number of training positions for residents, the number of positions recruited to fill and the number of positions filled; 3) the types of training that the hospital provided residents related to the health care needs of different populations, such as children who are underserved for reasons of family income

or geographic location; 4) changes in residency training, including changes in curricula, training experiences, and types of training programs, including benefits that have resulted from the changes, and changes for purposes of training residents in the measurement and improvement of the quality and safety of patient care; and 5) the number of residents who have completed training in the academic year and who care for children within the borders of the service area of the hospital or within the borders of the State in which the hospital is located.

The reauthorization requires a *25 percent reduction in payment* under the CHGME Payment Program if a participating hospital fails to provide the annual report as an addendum to the hospital's application for each fiscal year. Procedures have been developed to give hospitals' time to submit or amend an annual report and to process a potential reduction in payment.

The reauthorizing statute also requires a *Report to Congress* to be submitted by the Secretary not later than the end of fiscal year 2011 that summarizes the information submitted in the annual reports, describes the results of the CHGME Payment Program and makes recommendations for improvement in the program.

The addendum to the application package includes an introductory letter, overview of the CHGME Payment Program reporting requirement, information on the application cycle and deadline requirements, the annual report forms, and guidance and instructions on how to complete the annual report forms. The annual report data collection forms are contained in three Excel workbooks with several pages (worksheets) each, an Annual Report Certification Form (HRSA 100-4) and an Annual Report Checklist (HRSA 100-5). Below is a description of the annual report forms.

A. <u>CHGME Payment Program Annual Report Screening Form (HRSA 100-1)</u>
The form is used to identify the hospital and the training program status and program change. Under program status, the form asks whether the hospital is a sponsoring institution, a major participating institution and/or a rotation site for specific primary care training programs, combined (pediatrics and another specialty) programs, or pediatric subspecialty programs. Under program change, the form asks whether the program has been added or dropped since the previous academic year. It requests information on the number of approved training positions for residents, the number of positions recruited to fill, the number of positions filled for each program and the number of residents in FTE training positions. Information provided in this form will be used to determine whether the hospital is required to complete the remainder of the annual report. Information about the training programs offered by the hospital is required by Section 2 (B) (i), (ii) and Section 2(C) of P. L. 109-307. The information requested on the addition or deletion of programs provides part of the information required by Section 2 (B) (v).

B. <u>Hospital Level Information and CHGME Payment Program Training Program Specific Information: (HRSA 100-2 and HRSA 100-3)</u>

The forms (data sheets in these workbooks) focus on GME training associated with the care of children who are underserved for reasons of family income, socio-cultural diversity, geographic location (including urban and rural location), and/or medical reasons and on specific information about each training program sponsored by the hospital as identified by the hospital in form HRSA 100-1. The HRSA 100-2 forms request information on hospital discharges according to source of payment for patients (private insurance, Medicaid/ SCHIP, Medicare, other public payers, self-pay, and uncompensated care) geographic location of patients (discharges by zip code for inpatient stays, outpatient visits, and emergency department visits), and selected patient chronic and rare conditions (discharges by selected ICD-9 codes). Also requested is information about hospital patient safety training. The HRSA 100-2 form will capture information required by Section 2(B)(iii) of P. L. 109-307 and information about patient safety training as required by Section 2(B)(iv) of P.L. 109-307.

The HRSA 100-3 program specific worksheets request information on training provided for residents related to the health care needs of different populations and on specific types of training provided including, for example, didactic experiences such as formal courses and lectures, clinical experiences such as bedside training and patient rounds, and community-based experiences such as working in a community health center, public health department, homeless shelter or other community-based sites. The HRSA 100-3 also requests information on changes in residency training since the beginning of the CHGME Payment Program and the reasons for and benefits of any changes. The workbook also requests information about changes in training for the purposes of training the residents in the measurement and improvement of the quality of patient care. Information on changes in the numbers of residents and faculty members and the benefits resulting from these changes and practice locations of residents completing training is also requested. The information requested in the HRSA 100-3 is required by Section 2(B)(iii), Section 2(B)(iv), and Section 2(B)(v) of P. L. 109-307.

C. Annual Report Certification ( HRSA 100-4)
By signing the certification statement, the hospital's certifying official is attesting that all information requested in the HRSA 100-1 and the HRSA 100-2, and HRSA 100-3, have been provided as required and is accurate and complete.

D. Annual Report Checklist (HRSA 100-5)
This form is a checklist for hospital's to use to ensure that all relevant items of the annual report have been included in the annual report submission.

2. Purpose and Use of Information

The Health Resources and Services Administration (HRSA) will use the data from the annual report to review the CHGME Payment Program performance each year.

Information from multiple years' annual reports will be used for the required Report to Congress, due at the end of FY2011.

Public Law Section 2(D) requires that

*"Not later than the end of fiscal year 2011, the Secretary, acting through the Administrator of the Health Resources and Services Administration, shall submit a report to the Congress—*

*(i) summarizing the information submitted in reports to the Secretary under subparagraph (B) [the annual report];*

*(ii) describing the results of the program carried out under this section [The CHGME Payment Program]; and*

*(iii) making recommendations for improvements to the program."*

The tentative outline for the required Report to Congress is included as an attachment to this request.

3. Use of Improved Information Technology

The HRSA annual report forms will be available for downloading electronically via the CHGME Payment Program website to allow for the submission of the information from the children's hospitals. Information will be submitted both on paper and electronically.

4. Efforts to Identify Duplication

Contract work was performed to specifically identify existing data sources and to determine their appropriateness for the inclusion as part of each children's hospital's CHGME Payment Program annual report. The evaluation concluded that existing data are not suitable for purposes of the annual report as discussed below.

- Information on the number of full-time equivalent residents included in each *children's hospital's annual application for CHGME payment* refers to the hospital's annual Medicare Cost Reporting (MCR) period. There is a two-year delay between the MCR year and the fiscal year for which the hospital is applying for funds. Public Law 109-310 specifies that information to be provided in the CHGME Payment Program annual report shall be for the *immediate prior academic year*, i.e. the data reported for FY2010 should be for the academic year beginning July 1, 2008 and ending on June 30, 2009. Therefore, the resident FTE data from the application itself that relies on MCR data does not satisfy the annual report data requirement.

- Available data from the *Accreditation Council for Graduate Medical Education* (ACGME) regarding accredited pediatric specialty and subspecialty training programs were examined and considered for possible use in reporting on the number of accredited and filled training positions for each hospital, but these data were found to be inadequate for the purpose of the hospitals' annual reports

required by Congress in Public Law 109-307. The ACGME data refer only to programs accredited by ACGME and do not include information on all the rotation-only hospitals supported by CHGME Payment Program. Searching ACGME data for rotation sites as opposed to sponsoring institutions in extremely tedious as well.

- The *American Board of Pediatrics* (ABP) collects data on most of the pediatric residents training in children=s hospitals. However, the ABP collects information by programs rather than by hospitals, and it does not collect counts on non-pediatric specialties. Moreover, ABP data are unlikely to include residents who rotate into the children=s hospital from programs in other hospitals.

- *CHAMPUS* obtains resident counts from some children=s hospitals for the purpose of reimbursement. However, the weighting rules and reporting periods differ from that of the Medicare and CHGME programs. CHAMPUS does not collect educational related data.

- The *Association of American Medical Colleges* (AAMC) is initiating its new AGME Track@ system, which will supplant the resident count survey previously used by the American Medical Association and AAMC. The system requests resident numbers data from teaching hospitals and programs to be furnished between July and September each year. However, the system will not likely produce accurate counts on a timely basis, as the counts can be modified as late as March of the following year.

5. Involvement of Small Entities

This project does not have a significant impact on small business or other small entities.

6. Consequences if Information is Collected Less Frequently

The information is required to be collected annually by statute (Pubic Law 109-307).

7. Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

This data collection is consistent with the guidelines under 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the *Federal Register* on May 4, 2010 (75 FR 23771). Three previous respondents were consulted on burden hour estimates. Those contacted include:

- Julie Dempsey
  Children's Hospital Boston
  300 Longwood Avenue
  Boston, MA 02115

857-218-3312

- Nancy Corona, CPA
  The Children's Hospital of Alabama
  1600 7th Avenue South
  Birmingham, AL 35233
  205-939-9607

- Joan Chesney, MD
  St. Jude Children's Research Hospital
  262 Danny Thomas Place
  Memphis TN 38105
  901-595-3926

9. Remuneration of Respondents

There will be no remuneration of respondents.

10. Assurance of Confidentiality

No personal identifiers will be collected.

11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

12. Estimates of Annualized Cost Burden to Respondents:

The estimated annual burden is as follows:

| **Form Name** | **Number of Respondents** | **Responses per Respondent** | **Total Number of Responses** | **Hours per Response** | **Total Burden Hours** | **Wage Rate ($/ hr.)** | **Total Hour Cost** |
|---|---|---|---|---|---|---|---|
| **Screening Instrument (HRSA 100-1)** | 56 | 1 | 56 | 9.2 | 515.2 | 56.38 | 29,046.98 |
| **Annual Report: Hospital and Program-Level Information (HRSA 100-2 and 3)** | 56 | 1 | 56 | 78.7 | 4407.2 | 56.38 | 248,477.93 |
| **Total** | 56 | | 56 | 87.9 | 4922.4 | 56.38 | 277,524.91 |

The data collection instruments for the annual report were originally pre-tested by nine (9) participating CHGME Payment Program hospitals in 2007. Each hospital provided an estimate of the number of hours required to complete each part of the annual report. The current burden hour estimates below is based on an average provided by three previous respondents after their examination of the original 2007 pre-tested estimated hours of burden.

Basis for Hours Costs:

Hospital finance staff are expected to be responsible for collating the information requested in the CHGME Annual Report forms. It has been estimated that an average wage rate for hospital finance staff is $56.38 per hour. This estimated wage rate reflects an update of 3.3 percent from the $54.58 wage rate estimated for the CHGME Payment Program application forms in 2006.

Total hour costs are estimated at $277,524.91. For a participating hospital to complete the HRSA 100-1 Screening Instrument, it is estimated to take 9.2 hours at a cost of $29,046.98. For participating hospitals to complete the Annual Report components 100-2 and 100-3, it is estimated to take 78.7 hours at a cost of $248,477.93.

14. Estimates of Annualized Cost to the Government

Federal Staff Time

The cost to the Federal Government is increased due to the review by staff of the annual reports. The revised costs to the Federal Government are estimated to be **$32,165.64** as follows:

$ Receipt Control: Review incoming annual reports from the children=s hospitals to ensure the annual reports are complete and include all required forms and signatures.

s (.50 hours)

per application. **$1279.80**

$ Review of Reports. Review and assess completed screening instruments and annual reports from the children's hospitals to ensure that (1) the forms were completed in accordance with stated guidance and instructions and (2) data reported are logical and consistent. Communicate with hospitals, as needed, to resolve discrepancies.

[GS13/1 @ $42.66/hour X 56 applications X 3 hours per application] **$7678.80**

Data Entry. Data entry of children=s hospitals finalized/approved annual reports into data analysis system.

application] **$2559.60**

Preliminary Data Analysis
[GS13/1 @ $42.66/hour X 400 hours] **$17,064.00**

$ Programming Payment Data Base. Program payment data base for the possible eventuality that a hospital does not submit a completed annual report and by law must have an annual payment reduction of 25% with funds redistributed to the other participating hospitals.

[GS 13/1@42.66/hour X 80 hours] **$3,412.80**

Implementation of Potential 25 Percent Reduction.

[GS 13/1@42.66/hour X 4 hours] **$170.64**

15. Changes in Burden

Based on comments from the three previous respondents, the estimated total burden hours had a very slight increase from 84.8 to 87.9 due to the extended time required to collect and conduct quality control checks of hospital and program level information (HRSA 100-2 and HRSA 100-3).

This is an extension of existing activity.

16. Time Schedule, Publication and Analysis Plans

Data will be analyzed in order to prepare a Report to Congress about the CHGME Payment Program required by the Program's authorizing legislation. The report is due to Congress in 2011. Annual data will be analyzed for internal administrative purposes.

Data analysis will address the following topics: characteristics of children's hospitals, characteristics of populations served by children's hospitals, characteristics of GME training programs including training approaches to meet the healthcare needs of different populations, training content to meet the healthcare needs of underserved populations; initial employment of CHGME Payment Program graduates, changes in types of training programs and resulting benefits, changes in training related to the measurement and improvement of health care quality; and changes in training related to the measurement and improvement of patient safety.

**Analytical Plan**

The Children's Hospital Graduate Medical Education (GME) Support Reauthorization Act of 2006 (PL 109-307) requires a report to Congress that includes: (1) a summary of

annual reports submitted by participating children's teaching hospitals for the period of 2008 through 2011; (2) a description of results related to GME in freestanding children's hospitals that were supported by the existence of the CHGME Payment Program (OMB # 0915-0247); and (3) recommendations, as appropriate, for improvements to the CHGME Payment Program.

Annual reports by freestanding children's teaching hospitals receiving funding from the CHGME Payment Program are required and approved through this OMB information collection request. The data being collected will be used to create an analytical file with freestanding children's hospitals GME- related information. These data will be analyzed to respond to this new legislative mandate. This section outlines in detail the type of analysis that will be done and incorporated in the report to Congress.

The data are responsive to the type of data outlined in the legislative mandate. Freestanding children's teaching hospitals are being required to submit data on the state of GME in their institutions across following five general domains: (1) infrastructure and capacity to offer GME training, (2) incorporation of advances in medicine and patient care in GME training, (3) incorporation of GME training and related training experiences associated with caring for underserved populations, 4) identification of practice locations of graduates from these GME training programs, and (5) changes in GME and/or training experiences led by these freestanding children's hospitals since the inception of the CHGME Payment Program.

1. *Infrastructure and capacity to offer GME training*. GME training is an integral part of preparing physicians to provide patient care. The infrastructure and capacity to train pediatricians, pediatric specialists and other physicians in freestanding children's teaching hospitals is important as they report training about 30 percent of pediatricians and pediatric sub-specialists in the country while they represent only about 1% of all short-term acute care hospitals in the U.S. In FY 2009, children's hospitals reported training an estimated 5,631 interns, residents and fellows, of whom 4,082 were trained in pediatrics and pediatric sub-specialties. The estimated total number of pediatric and pediatric sub-specialists being trained in the U.S. in academic year 2007-2008 was 13,075.

In order to capture the current infrastructure and capacity to offer GME training, the analysis of the data submitted by these freestanding children's hospitals will focus on:

- The types and the number of GME training programs offered by freestanding children's hospitals by type of accreditation (sponsoring institutions, major participating institutions, or a rotation sites); and

- The number of residency training positions approved, recruited and filled for each academic year.

Specific summaries will include maps, tables and narrative of:

*The number and geographic distribution of GME programs in freestanding children's hospitals, specifically*

- ❖ Number of GME programs by specialty and by geographic area to include distribution by census region;
- ❖ Number and location of primary care GME programs (pediatrics, pediatric/ internal medicine);
- ❖ Number and geographic location (census region) of specialty and sub-specialty programs; and
- ❖ Number of GME programs that meet the legislative requirement for reporting more details about their GME program.

*The number and distribution of interns, residents and fellows by specialties and sub-specialty represented. Specifically,*

- ❖ The number of accredited slots, the number of residents recruited and trained in these GME programs;
- ❖ The number of residents that spend at least 75 percent of their training at the children's hospital;
- ❖ Distribution of the number of residents by geographic location and specialty; and
- ❖ Fill rates based on accredited slots by geographic location and specialty and sub-specialty.

2. *Incorporation of advances in medicine, treatment of relatively "new diseases", and patient care in GME training*. This portion of the analysis will focus on:

   - ❖ Identification of additional or different education modules and training experiences from the traditional GME training (e.g. training in genomics or DNA); and

   - ❖ Changes in curricula and/or training experiences to incorporate changes in the field of medicine such as the teaching of genomics, advances in health information technology and patient safety.

3. *Incorporation of GME training associated with caring for underserved populations*.

Freestanding children's teaching hospitals vary in their patient care volume as well as the number and diversity of their graduate medical education programs. Some hospitals have fewer than 100 beds and care for fewer than 1,000 children a year while others have over 400 beds and treat more than 25,000 children each year. The characteristics of the population served are also those of patient populations that the residents have to care for. This type of hands-on training provides skills beyond those of science that prepare physicians to care his/her patients. We will attempt to distinguish among didactic, clinical, and research training when documenting the breadth of education and the patient population being cared for when documenting the hands-on experience and training that interns, residents and fellows are being exposed to and will provide some insights into the

complexity and the breadth of GME training. Exposure of future pediatricians and pediatric sub-specialists to underserved patient populations may better prepare them to care for the underserved upon graduation and may influence the place and the type of practice they choose.

GME approaches (didactic, clinical and research) and associated content areas to meet the healthcare needs of patients:

- ❖ Underserved for financial reasons
- ❖ Underserved for socio-cultural reasons
- ❖ Underserved for geographic reasons
- ❖ Underserved for medical reasons

The summary will detail the approaches used by institutions (didactic, clinical community based and other approaches) and their status (elective, required, or not currently used).

Identification of populations being served and associated changes in training experiences will be described by:

- ❖ Percent of patients served by source of payment (e.g., public insurance, uninsured);
- ❖ Distribution of patients being served by geographic location (e.g., metropolitan status, MUA, HPSA, etc.);
- ❖ Distribution of patients with serious and chronic, complex and rare diseases being served (based on selected ICD-9 codes); and
- ❖ Changes in curricula and/or training experiences to prepare physicians to care for underserved populations which include those that are underserved because of family income, geography, extreme children related medical conditions.

4. *Identification of practice locations of graduates from these GME training programs*.

This section will focus on the choices of graduates of these GME training programs as practice locations (HPSA, MUAs, urban/ rural) and with respect to the proximity to the hospital service areas and underserved populations, as well as graduates specialty choices with respect to primary care pediatrics (e.g., general practice, pediatric allergy).

- Practice type choices upon graduation ( private practice, hospitals, community health centers);
- Number of graduates by primary care/specialty care;
- Number of graduates from combined programs (pediatric/internal medicine);
- Number of pediatric sub-specialists among the graduates; and
- Choice of practice location choices since completing GME:

  - ❖ Number of graduates choosing to practice in the children's hospitals service areas;

- ❖ Number of graduates choosing to practice in proximity to an MUA, an MUP, or an urban/rural areas; and
- ❖ The number of graduates choosing to practice and care for children within the State where the hospital is located.

5. *Changes in graduate medical education programs in freestanding children's teaching hospitals: FY2000 through FY 2011*. One focus of the legislative mandate is on changes in GME and/or training experiences as one of the outcomes of receiving CHGME funding. Furthermore, the legislative mandate asked that each of the participating children's hospitals report on any changes in GME and/or training experiences associated with quality and safety of patient care. Each of the children's hospitals participating in the CHGME Payment Program are asked to identify such changes that were made either in curricula or training experiences since the inception of the CHGME Payment Program. The report to Congress will include a summary of such changes, GME enhancements or other highlights identified by the children's hospitals with a particular emphasis on the teaching of the measurement of quality and safety of patient care. Specifically it will identify frequency of newly offered didactic training areas in basic science, health promotion, and dental care and community health systems. For these same training areas, we will examine whether such changes vary by state and/or by census region.

   For clinical training, children's hospitals were asked to identify new or different community based rotations/experiences, or other clinical experiences which might enhance graduates' ability to care for children, especially children from "underserved" populations. For each of these new or different clinical training experiences, the analysis will examine the frequency of newly offered training areas, identify changes in previously offered training areas (training expanded, revised, requirement changed). Information on reasons for changes made and the benefits of such changes will also be provided. To the extent possible, the Report to Congress will discuss the rationales and benefits of the reported educational changes.

   As indicated above, Congress put special emphasis in identifying changes in efforts associated with the training of measurement and improvement of quality for patient care and patient safety. A special section will summarize changes in didactic, clinical, and research training that are especially focused on health care quality, quality measurements, and quality improvements. For each, frequency of newly offered training areas will be identified, as well as changes in previously offered training areas (training expanded, revised, requirement changed)

It is important to caution about the expectation of substantial changes in curricula and/or training experiences. Education curricula and training experiences are directed and monitored by accreditation bodies such as the Accreditation Council on Graduate Medical Education (ACGME). The faculty, within the training institutions, is required to adhere to accreditation requirements and have limited discretion for expanding the GME training beyond what is required. It is known that with the publications of the IOM reports *To Err is Human* and *Crossing the Quality Chasm*, medical schools and

teaching hospitals are trying to increase awareness and teach about measuring the quality and safety of patient care. In addition, there may be some other areas where education and training have been expanded such as in the area of genomics and new uses of technology.

One of the major points of interest stressed through this legislative requirement is whether interns, residents and fellows are sufficiently exposed and trained to care for underserved populations. Underserved populations include those residing in underserved areas (such as rural areas), those that are undeserved because of income, and those who are experiencing medical conditions that require sub-specialty treatment. These efforts can be realistically captured as proxies by capturing the characteristics of the population being cared for at the hospitals.

The recommendations for improvement of the CHGME Payment Program will be in the context of data that is being collected and within the realm that the CHGME Payment Program may suggest. There are certain areas, such curricula development, that is not within the purview of the government to affect and as such recommendations within that sphere will be limited. The report can point out areas where changes in education and curriculum were made and their potential benefits to the community.

17. Exemption for Display of Expiration Date

The expiration date will be displayed.

18. Certifications

This fully complies with the guidelines set forth in 5 CFR 1320.9.