Supporting Statement – Part A

Surveys of Physicians and Home Health Agencies to Assess Access Issues for Specific Medicare Beneficiaries as Defined in Section 3131(d) of the ACA

CMS-10429, OMB 0938-New

Background

The Centers for Medicare and Medicaid Services (CMS) has contracted with L&M Policy Research (L&M) and its partners, Avalere Health (Avalere), Mathematica Policy Research (MPR), and Social & Scientific Systems, Inc. (SSS) to support the Agency in responding to provisions of the Patient Protection and Affordable Care Act (ACA) Section 3131(d) and concerns that some subsets of the Medicare population may have decreased access to home health services. This study is a follow-on study to a Think Tank project on the same subject led by L&M to explore potential revisions to the home health prospective payment system (HH PPS) that account for costs related to severity of illness and access to care improvement. The proposed surveys are one small facet of the large follow-on study that, taken together, may yield recommendations for revisions to the HH PPS to ensure that home health agencies (HHAs) are adequately reimbursed for providing services to vulnerable populations as defined by the ACA – low income beneficiaries, those living in medically underserved areas, and beneficiaries with high levels of severity of illness.

To supplement the larger quantitative analyses conducted as part of this follow-on study, the research team plans to conduct two surveys. The surveys are designed to be both explanatory and confirmatory in nature. The questions posed in the surveys were informed by the research conducted during the Think Tank project including multiple discussions with the Think Tank Technical Expert Panel, as well as additional conversations with stakeholders, and are being asked in a survey because the answers are not available in claims data or from other data sources. They will help the research team confirm what we will learn through our analysis of claims, but the questions will also help us identify and in some instances, confirm, characteristics of beneficiaries who have been reported too difficult to place in home health care. They will also help the research team explore whether there are any access issues that we may not expect to detect through our analysis of claims data, which may then result in recommendations for further study. To learn more about the beneficiaries who experience access issues, respondent specific surveys have been developed to administer to (1) physicians who refer vulnerable patients to the Medicare home health benefit, and (2) Medicare certified home health agencies. Both target populations offer unique perspectives on the characteristics of Medicare beneficiaries who may have access issues and can help answer questions that cannot be addressed as well through other research methods (primarily through analysis of administrative claims).

A. Justification

1 . Need and Legal Basis

This data collection is part of a larger study called for under section 3131(d) of the Patient Protection and Affordable Care Act (ACA). The larger study is focused on two major issues (1) supporting CMS' efforts to improve payment accuracy and (2) understanding issues of access for the ACA populations under the existing home health prospective payment system.

The larger quantitative portion of the project aims to understand payment accuracy for the specific study populations through claims and cost data analyses. Regression analyses on home health claims data, patient-level OASIS data on functional and clinical status, Medicare beneficiary eligibility status and characteristics, and agency level cost reports will inform potential HH PPS revisions. The samples for these analyses are large—hundreds of variables across millions of episodes will inform any potential HH PPS revision. The quantitative analyses serve as the foundation for any potential policy recommendation.

Responses to the survey instruments will supplement the quantitative analyses by identifying access issues for the ACA defined populations and the extent to which further study is necessary. These surveys will help the study team better understand the characteristics of Medicare beneficiaries who are not able to gain access to or have experienced delays in gaining access to home health services.

2. Information Users

As a new collection, the information collected is expected to support CMS' efforts to improve the HH PPS payment accuracy for vulnerable populations and thereby ensure the payment system does not inadvertently cause avoidable access problems. The questions are designed to provide insights into access issues for vulnerable populations that cannot be learned through analyses of administrative data.

3. Use of Information Technology

The research team is proposing a multi-mode data collection, with a self-administered paper survey mailed to participants, along with telephone prompting for participants who fail to complete and return the mailed questionnaire within the designated time period. During the phone prompt, interviewers will encourage participants to return the questionnaire by mail or fax and will offer to complete the survey over the phone.

Additionally, subsequent follow-up mailings (up to two) will be made using USPS

Priority mail services. Reminder postcards will be sent to those participants who have not responded or who have misplaced or lost their packets, followed by a second packet and, if necessary, a third packet. The survey instrument itself has been kept brief has been formatted and will be printed as to minimize respondent burden. We will also provide options for submitting the questionnaire via mail, fax, or over the telephone if requested.

The research team will not make the tool available electronically in order to keep the resources used to field the survey to a minimum. Based on past experiences, the research team has found it more productive and cost effective to collect information from providers in a paper survey than in an electronic format when available resources are limited to using one primary means of data collection. This collection method is supplemented with telephone prompting and assistance to those otherwise unable to complete the questionnaire. The survey does not require a signature from participants.

4. Duplication of Efforts

The research team conducted an extensive literature review to understand access issues for the vulnerable populations defined in the ACA. During the literature review, the team found that no surveys focused on access issues for the specific study populations. Some research has been completed on the topic of access to home health services for Medicare beneficiaries, but it has focused on a limited number of stakeholder interviews, which were completed in early to mid 2000. Due to both the age and the research methods of the previous research, the proposed new collection is not redundant, as these surveys focus on specific target populations and issues related to their access to home health services. Further, both surveys will be conducted on larger samples than has been done previously.

5. Small Businesses

The completion of the survey instruments is not likely to impose a larger burden on small entities (HHAs or physician practices) than on larger sized entities (HHAs or physician practices). There may be a smaller absolute burden for a smaller organization, due to the fact that the administrator may be able to complete the survey entirely from recall, while in a larger organization the administrator may not have all of the information as readily at hand.

In order to estimate the number of small entities included in the sample, the research team conducted a review of the literature. Per the Small Business Administration's Office of Advocacy "most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than $7.0 million to

$34.5 million in any given year." 1 For purposes of the small entities analysis, the research team is assuming that 90% of the HHAs in the survey sample, which equates to 540 HHAs, are small entities due to the following statement from the Office of Advocacy, "90 percent or more of the health care providers [HHAs and Hospices] meet the SBA's size standards as measured either by their annual receipts or nonprofit status." 2 The research team is also assuming that 78% of the physician practices included in the survey sample, which equates to 215 physician practices, are small businesses based on a statement made by the American Medical Association to the House Committee on Small Business Subcommittee on Contracting and Workforce.3

6. Less Frequent Collection

The focus of the instruments is to ask questions that the team cannot collect through data analyses. By forgoing this data collection, CMS would lose the opportunity to gather insights into the patient, caregiver and agency characteristics associated with those beneficiaries who have been denied or experienced delayed access to home health services. Without this information, CMS' payment accuracy activities will only be focused on claims and cost related analyses using administrative data. While administrative data may improve our understanding of the characteristics of patients who actually received home health services, it can not be used to understand the beneficiary, caregiver and agency characteristics associated for those whose access is denied, delayed or not fully provided consistent with the services ordered.

7. Special Circumstances

This information collection will not involve any of the special circumstances.

8. Federal Register/Outside Consultation

OSORA PRA staff will prepare any required Federal Register announcements for publication.

Throughout the development period of the survey instruments, the research team has consulted with members of the technical expert panel (TEP) established under a recently completed project addressing the Section 3131(d) mandate. The TEP was convened to provide expertise regarding the home health industry and input into how

1 2010. " Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices (RIN: 0938-AP88)". Small Business Administration Office of Advocacy. Retrieved from: http://archive.sba.gov/advo/laws/comments/hhs10_0914.html#5

2 2010. " Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices (RIN: 0938-AP88)". Small Business Administration Office of Advocacy. Retrieved from: http://archive.sba.gov/advo/laws/comments/hhs10_0914.html#5

3 2011. "Defer No More: The Need to Repeal the 3% Withholding Provision." Retrieved from: http://www.ama-assn.org/resources/doc/washington/three-percent-withhold-written-comments.pdf

best to identify and measure home health access issues. The TEP members represented HHAs, national home health care associations, state and federal agencies, consumer advocacy organizations, home health physicians, and home health research experts. During the TEP meetings, TEP members recommended the research team pursue surveys in order to better understand issues of access for the ACA populations, since analyses of administrative data would not be able to provide insights into some of the more nuanced issues. Since these meetings, the research team has consulted with a few of the individual members and a few of their associates to obtain more input on the type of collection, availability of data, and the types of data elements that could be collected using a survey.

9. Payments/Gifts to Respondents

Incentives have been shown to increase response rates in mail surveys, and prepaid incentives tend to yield higher response rates than incentives that are promised (Singer et al., 1999). Based on our experience conducting provider surveys, we expect that the $50 incentive will be cost-effective by saving resources that would have been needed for additional fieldwork. The purpose of the payment is to signal respect for the physician's time and to establish trust, which has been shown to result in higher response rates. We propose to include a prepaid incentive of $50 in the initial mail packets to physicians. Because of the potential problems in providing an incentive payment to an employee, we will not offer incentives to HHAs.

10. Confidentiality

Information will be kept secure to the extent permitted by law.

11. Sensitive Questions

This collection does not contain any sensitive questions.

12. Burden Estimates (Hours & Wages)

Table A provides an estimate of time burden for the data collection activities for which approval is being sought. The total average burden hours for which we are seeking approval in this package is 218.75 hours. Both the Physician Survey and the Home Health Survey will be primarily self-administered through a mail-distributed paper survey. Interviewers will conduct a follow up with non-respondents by telephone to prompt completion of the survey and will provide an opportunity to complete the paper survey over the phone. We estimate that no more than 5 percent of total completed cases will complete the survey in this manner. The surveys are estimated to take each respondent no more than 15 minutes to complete. A total of 275 physicians and 600 home health administrators are expected to complete the survey. According to the Employment and Wages May 2010 national estimates from the Occupational Employment Statistics (OES) survey, the mean hourly wage of

general internists and family and general practitioners is $86 and the mean hourly wage for medical and health services managers working in the home health care services industry is $41.

TABLE A. AVERAGE BURDEN TO RESPONDENTS IN HOURS

Data Collection Activities	Number of Respondents	Average Burden Hours/ Respondent	Total Average Burden Hours	Average Hourly Rate	Estimated Monetary Cost Burden To Respondents
Physician Survey	***275***	***.25***	***68.75***	***$86***	***$5,912.50***
Mail Surveys	261	.25	65.25	$86	$5,611.50
Phone Surveys	14	.25	3.5	$86	$301.00
Home Health Survey	***600***	***.25***	***150***	***$41***	***$6,150.00***
Mail Surveys	570	.25	142.5	$41	$5,842.50
Phone Surveys	30	.25	7.5	$41	$307.50
Estimated Total for Both Surveys	**875**	**.25**	**218.75**	**$55**	**$12,062.50**
ANNUAL ESTIMATES	**291.7**	**.25**	**72.9**	**$55**	**$4,020.83**

13. Capital Costs

No capital costs will accrue to respondents.

14. Cost to Federal Government

$445,527 is the total estimated cost to the Federal Government, allocated across two years to include design, field testing and analysis of the finding. Annually, the costs are estimated to be for Year 1: $214,844; for Year 2: $230,683, with no additional costs thereafter.

15. Changes to Burden

This is a new collection.

16. Publication/Tabulation Dates

The purpose of the survey instruments is to allow the research team to analyze potential problems of home health referral, placement, and access issues confronting

referring physicians as well as beneficiaries. In order to address this central research question, the team will perform several simple univariate and bivariate analyses including descriptive statistics to summarize pertinent variables regarding the use of home health services, as well as referrals, placement, and access issues. Frequency counts and cross-tabulations will also be used to show distributions of physicians' and HHAs' responses regarding problems facing home health referrals, placement, and access issues. From this process we will fill several data shells showing the distributions of these characteristics.

We will utilize questions on providers' and HHAs' perceptions of access to home health services to perform subgroup analyses. We anticipate being able to make comparisons between two subgroups of interest, though the ability to detect differences will depend on a number of factors including the sample sizes for each of the two subgroups and where the estimate is in the distribution. The ability to make these comparisons will also depend on actual sample yield and will not be made for more than two subgroups at a time. Table B below shows the main comparisons likely to be made for the HHAs. If we are comparing two subgroups—for example, with 200 HHAs serving ACA populations and 400 other HHAs—we will be able to report that a difference of 9 to 12 percentage points is statistically different.

TABLE B. POSSIBLE COMPARISON GROUPS FOR SURVEY OF HOME HEALTH AGENCIES

Comparison	**Anticipated sample size**	**Detectable difference at 80% power, in percentage points**	
		True proportions less than 20% or greater than 80%	True proportions approximately 50%
Location of HHA—Rural vs. Urban	125 vs. 475	10	14
Ownership—Proprietary vs. Voluntary/Non-profit/Gov't	435 vs. 165	9	13
Population served: Primarily ACA populations vs. Others	200 vs. 400	9	12
Size, no. episodes or revenue—greater than or less than median	300 vs. 300	8	12

The physician survey data will be used to make univariate estimates only. The sample of physicians will yield an estimate that is plus or minus 4 to 6 percentage points at the .05 level of significance. Due to the relatively small sample sizes, no subgroup comparisons, or itemetric analyses, are planned.

Results of summary statistics of pertinent variables will be presented in tables. For example, tabulations of results may include:

- Distribution of providers (HHA/physicians) in their overall assessment of the current availability of home health care services to Medicare beneficiaries in their locality;

- Average ratings of issues related to access delays in the different domains, that is, “Medical”, “Non-medical”, “factors related to the provider” issues.
- Average ratings of issues related to home health placement in the different domains, that is, “Medical”, “Non-medical”, “factors related to the provider” issues.

Table C below provides an example of such a table.

TABLE C. EXAMPLE DATA SHELL

HHA/PHYSICIAN SURVEY	**Respondents Reporting 1-3 (Relatively Unimportant)**	**Respondents Reporting 4 (Neutral)**	**Respondents Reporting 5 - 7 (Relatively Important)**	**Average Respondent Rating**
Issue related to home health agency				
a. Nursing staff with needed skill set not available				
b. Therapy staff not available (e.g., PT, OT, ST)				
c. Staff not experienced with medical conditions(s)				
d. Required equipment/supplies not available				
e. Reimbursement not sufficient				
Medical issue related to patient				
f. Severity/complexity of patient's medical condition				
g. More than two 60 day periods (episodes) of care expected				
h. Two or more visits per day expected				
i. Routine evening or weekend care expected				
j. Patient does not qualify for Medicare home health benefit (e.g., not homebound)				
Non-medical issue related to patient				
k. Patient living conditions or local area unsafe				
l. Patient located in hard-to-reach area or travel distance/time too great				
m. Patient/family/caregiver cannot be or is unwilling to be trained				
n. Family/caregiver is unable to provide necessary support				
o. Language barrier/communication problems				
p. Patient or family refused services				

Other Analysis:
The research team will use chi-squared analysis to test whether or not differences exist between subgroups of HHAs' responses. For example, we can use chi-squared tests for pertinent variables measuring access to home health. A statistically significant difference in response categories, that is, a *p-value* less than 0.05, will be interpreted to indicate that the differences in HHAs' responses are systematic rather than just being due to chance.

Finally, the team may estimate one or more basic regression models to identify correlates of outcome measures that are pertinent to home health access issues. For example, we may want to explain variations in the mean number of how many times a physician experiences delays in finding a home health agency willing and able to admit Medicare fee-for-service patients as a function of number of physicians in the admitting facility, payer mix, and other relevant explanatory variables. We may also estimate another model to explain the probability of finding a placement for potential home health patients as a function of the explanatory variables in the model just mentioned.

The regression specification below gives a general sense of what these analyses may entail.

$$Y = \beta_0 + \mathrm{X}_i\beta_i + M_j\beta_j + P_k\beta_k + \varepsilon$$

Y	This represents a set of dependent variables measuring access issues. Examples include mean number of physician delays (OLS or count regression model) or whether or not a beneficiary finds a placement for home health (logistic regression model).
X	This is a vector of issues related to the home health agency.
M	This is a vector of medical issues related to the patient.
P	This is a vector of non-medical issues related to the patient.

The coefficients of determination (r^2) from such models give an indication of the proportion of variations in the outcome variables being explained by explanatory variables included in the models. It should be noted that the regression analyses, if performed, will be only exploratory in nature.

Timelines:
Depending on OMB approval, the collection is expected to start no later than January 2013. The surveys will be in the field for approximately four months. The research team will share the analysis and findings with CMS as part of the analysis report due no later than July 15, 2013. The findings will also be included in the report to Congress called for under section 3131(d) of the ACA. This report must be submitted to Congress no later than March 1, 2014, requiring the research team to submit the

materials to CMS no later than August 31, 2013.

17. Expiration Date

CMS would like to display the expiration date.

18. Certification Statement

CMS does not request any exemptions from the certification statement.