Supporting Statement A for CAHPS Survey for Physician Quality Reporting

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Michael Wroblewski, Project Officer

RAND Corporation
1776 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138

HEALTH

TABLE OF CONTENTS

SUPPORTING STATEMENT
CAHPS SURVEY FOR PHYSICIAN QUALITY REPORTING

Introduction

The Centers for Medicare & Medicaid Services (CMS) request a three-year clearance from the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 to implement the CAHPS Survey for Physician Quality Reporting. This request for approval takes the OMB control number 0938-NEW.

Under Contract Number HHSM-500-2005-00028I T0007, the project team will develop, implement, and analyze a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for use with the Physician Quality Reporting Program. Specifically, the Center for Medicare & Medicaid Services (CMS) will implement a CAHPS survey to collect data on fee-for-service Medicare beneficiaries' experiences of care with providers participating in the Physician Quality Reporting Program for use in quality reporting and the Physician Compare website.

A. Justification

A1. Necessity of Information Collection

The Physician Quality Reporting System (Physician Quality Reporting, or PQRS), was established in 2006 and initially authorized by Tax Relief and Health Care Act of 2006 (TRHCA), as a voluntary "pay-for-reporting" program that allows physicians and other eligible healthcare professionals to report information to Medicare about the quality of care they give to people with Medicare who have certain medical conditions. PQRS provides incentive payments to physicians who report quality data. Since program inception, these results have not been publicly available for use by consumers.

The Physician Compare Web site was launched December 30, 2010, to meet requirements set forth by Section 10331 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). The Affordable Care Act requires CMS to establish a Physician Compare website by January 1, 2011 containing information on physicians enrolled in the Medicare program and other eligible professionals who participate in the Physician Quality Reporting Initiative. By no later than January 1, 2013 (and for reporting periods beginning no earlier than January 1, 2012), CMS is required to implement a plan to make information on physician performance publicly available through Physician Compare. A key component of the reporting requirements under the Affordable Care Act is public reporting, through Physician Compare, of information on physician performance that includes patient experience measures. The collection and reporting of a CAHPS survey for Physician Quality Reporting will fulfill this requirement.

The patient experience data collected in the proposed survey for reporting on Physician Compare, is the most relatable data to consumers as it a) is similar to existing data

currently reported to consumers providing comparisons of health care providers and b) contains the types of care experiences consumers identify as useful to informing choice, and useful when comparing physician groups. In particular, several current initiatives within CMS promote reporting to consumers of patient experience with care coordination and shared decision-making, two domains contained in the proposed survey.

Additionally, the U.S. Department of Health and Human Services (HHS) has developed the National Quality Strategy that was called for under the Affordable Care Act to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. This strategy has established six priorities that support the three-part aim. The three-part aim focuses on better care, better health, and lower costs through improvement. The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. Because the CAHPS Survey for Physician Quality Reporting focuses on patient experience implementation of the survey supports the six national priorities for improving care, particularly engaging patients and families in care and promoting effective communication and coordination.

A2. Purpose and Use of Information

This survey supports the administration of the Quality Improvement Organizations Program (QIO). The Social Security Act, as set forth in Part B of Title XI - Section 1862(g), established the Utilization and Quality Control Peer Review Organization Program, now known as the Quality Improvement Organizations Program. The statutory mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. This survey will provide patient experience of care data that is an essential component of assessing the quality of services delivered to Medicare beneficiaries. It also would permit beneficiaries to have this information to help them choose health care providers that provide services that meet their needs and preferences, thus encouraging providers to improve quality of care that Medicare beneficiaries receive.

A3. Technological Collection Techniques

The survey vendor will collect the data via a mixed mode data collection strategy that involves two rounds of mailed surveys followed by phone interviews. The mailed survey formatted for data scanning and data from all returned surveys will be scanned into an electronic data file. Computer Assisted Telephone Interview (CATI) will be used as the secondary mode of data collection if a beneficiary does not respond to two mailed requests to complete the survey.

A4. Identifying Duplication

The CAHPS Survey for Physician Quality Reporting is comprised of the core Clinician & Group CAHPS Survey (CG-CAHPS) and additional supplemental items covering domains of patient experience specific to the information needs of CMS and the PQRS. The survey is being designed to gather only the necessary data that CMS needs for assessing physician quality performance, and related public reporting on physician performance, and should complement, not replace data that providers are currently collecting that support improvement in patient-centered care.

No standardized survey to collect data reflecting patient experience with a physician group for the purposes of the PQRS is currently in use.

A5. Impact on Small Businesses

Survey respondents are Fee-for-Service Medicare Beneficiaries who have received care from physician group practices participating in PQRS during the 12 months prior to the survey. The survey should not impact small businesses or other small entities.

A6. Consequences of Less Frequent Data Collection

The consequence of collecting data on a less frequent basis than annually is that the beneficiaries will be less able to recall their specific experiences with care over longer periods of time. If the survey asks about patient experiences over longer periods, responses may be less reliable.

Additionally, if data was collected on less than an annual basis the patient experience scores information reported on Physician Compare would be less current and as a result less useful to beneficiaries and consumer intermediaries who may visit the website.

A7. Special Circumstances

There are no special circumstances associated with this information collection request.

A8. CMS Federal Register Notice

The 60-day *Federal Register* notice (77 FR 73032) published on December 6, 2012. There were comments received and they have been addressed.

A9. Respondent Payments or Gifts

This data collection will not include respondent incentive payments or gifts.

A10. Assurance of Confidentiality

Individuals contacted as part of this data collection will be assured of the confidentiality of their replies under 42 U.S.C. 1306, 20 CFR 401 and 422, 5 U.S.C. 552 (Freedom of Information Act), 5 U.S.C. 552a (Privacy Act of 1974), and OMB Circular A-130.

A11. Sensitive Questions

The survey does not include any questions of a sensitive nature.

A12. Burden of Information Collection

Exhibit 1 shows the estimated annualized burden for the respondents' time to participate in this data collection. The CAHPS Survey for Physician Quality Reporting will be administered to 234,600 beneficiaries total over two years, or an annualized figure of 117,300 beneficiaries per year. The survey contains 83 items and is estimated to require in an average administration time of 18.4 minutes in English (at a pace of 4.5 items per minute) and 22 minutes in Spanish (assuming 20% more words in the Spanish translation), for an average response time of 20.24 minutes or 0.337 hours (see attachment 1 for a copy of the survey). These burden and pace estimates are based on CMS' experience with surveys of similar length that were fielded with Medicare beneficiaries. As indicated below, the annual total burden hours are estimated to be 34,800 hours.

Exhibit 1. Estimated annualized burden hours

Survey Version	Number of Respondents	Number of responses per respondent	Hours per response	Total Burden hours
CAHPS Survey for Physician Quality Reporting	117,300	1	.337	39,530
Total	117,300	1	.337	39,530

Exhibit 2 shows the survey participants' cost burden associated with their time to complete a survey. The annual total cost burden is estimated to be $900,100.

Exhibit 2. Estimated annualized cost burden

Form Name	Number of Respondents	Total Burden hours	Average Hourly Wage Rate*	Total Cost Burden
CAHPS Survey for Physician Quality Reporting	117,300	39,530	$22.77	$900,100
Total	117,300	39,530	$22.77	$900,100

*Based upon mean hourly wages, "National Compensation Survey: All United States December 2009 – January 2011," U.S. Department of Labor, Bureau of Labor Statistics.

A13. Capital Costs

Survey participants will incur no capital costs as a result of participation.

A14. Cost to the Federal Government

The annual cost for sampling, data collection, analysis and reporting of scores is $2,120,324. The annual cost to CMS will be equal to one FTE at GS 13 or $89,033.

A15. Program Changes or Adjustments to Annual Burden

This is a new information collection request. This request seeks approval of 117,300 hours of respondent burden to assess patient experience for Physician Quality Reporting. The additional hours are required to 1) assess the patient experience at the beneficiary level, and 2) provide sufficient response to generate group practice reports of experience.

A16. Tabulation and Publication of Results

We anticipate that the analysis plan will include (1) psychometric evaluation of the survey items, (2) development and evaluation of case-mix adjustment models and nonresponse weights, (3) development of adjusted physician group-level results, and (4) development of national, regional, and subgroup estimates. All aspects of these analyses will be described in a final project report to CMS.

(1) Psychometric Evaluation. Analyses will include evaluation of item missing data, item distribution (including ceiling and floor effects), and assessment of contract-level reliability of items. We will compute these statistics overall, and separately by mode of administration, and language.

(2) Case-mix adjustment and nonresponse. In consultation with CMS, we will consider mixed effect regression models of performance measures for ACOs and PQRS practices. These models would include fixed effects for patient-mix adjustors, such as self-reported health, age, and education.

(3) Adjusted Physician Group-Level Estimates. We will produce case-mix adjusted estimates of patient experience at the physician group-level.

(4) National, Regional, and Subgroup Estimates. RAND will use adjustments as appropriate, to produce national and regional estimates of patient experience. Hierarchical variance-component models will assess the extent to which variation in each measure reflects practices.

Publication of Results: CMS may confidentially share physician group-level estimates with participating physician groups for quality improvement purposes. However,

physician-level data from this survey will not be made publicly available to Medicare beneficiaries or the general public. CMS may present more general data and patterns on Physician Compare.

Public Reporting of Physician Performance: Section 10331(a)(2) of the Affordable Care Act also requires that CMS publicly report, through Physician Compare, information on physician performance that includes patient experience measures. The collection and reporting of a CAHPS survey for Physician Quality Reporting is a component of CMS's plan for public reporting of the required experience of care measures.

A17. Display of OMB Expiration Date

The expiration date for OMB approval of this information collection will be displayed on the survey.

A18. Exceptions to the Certification Statement

There are no exceptions to the certification statement identified in item 19 of OMB Form 83-I associated with this data collection effort.