

Supporting Statement A

Children's Hospital Graduate Medical Education Payment Program Annual Report

OMB Control No. 0915-0313

Terms of Clearance: None

A. Justification

1. Circumstances Making the Collection of Information Necessary

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 CHGME Payment Program statute P.L. 109-307 requires that CHGME-participating hospitals provide information about their residency training programs in an annual report to HRSA that will be an addendum to the hospitals' annual applications for funds.

The legislative 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 the following detailed reporting requirements: 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 legislation 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 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. CHGME Payment Program Annual Report Screening Form (HRSA 100-1)

The HRSA 100-1 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. The information collected in the HRSA 100-1 form 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. CHGME Payment Program Hospital Level Information and Program Specific Information: (HRSA 100-2 and HRSA 100-3)

The HRSA 100-2 and 100-3 forms 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, measurement and improvement in quality and patient safety, and practice location of graduates. The HRSA 100-2 forms request information on hospital discharges according to source of payment for patients (private insurance, Medicaid/CHIP, 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), selected patient chronic and rare conditions (discharges by selected ICD-9 codes) and patient safety initiatives. 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 further 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)

(Not a data collection form.) 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)

(Not a data collection form.) 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 Collection

The CHGME Payment Program statute P.L. 109-307 requires that CHGME-participating hospitals continue to provide information about their residency training programs in an annual report to HRSA that must address statutory reporting requirements including types of training, number of training positions, types of training to care for underserved children, changes in residency training and practice location of graduates.

3. Use of Improved Information Technology and Burden Reduction

The HRSA annual report forms will be available for downloading electronically via the CHGME Payment Program website for submission. Information will be submitted both on paper and electronically. CHGME is taking steps within the coming year to integrate the annual report questionnaire into a web or web-portal format to make the reporting tool more efficient and reduce burden to the hospitals. However, the contents of the annual report will remain the same.

4. Efforts to Identify Duplication and Use of Similar Information

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 FY2012 should be for the academic year beginning July 1, 2010 and ending on June 30, 2011. 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 is 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.
- The *Association of American Medical Colleges* (AAMC) resident tracking 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. Impact on Small Businesses or Other Small Entities

No small businesses will be involved in this study.

6. Consequences of Collecting the Information Less Frequently

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

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This data collection is consistent with the guidelines under 5 CFR 1320.5.

8. Comments in Response to the Federal Register Notice/Outside Consultation

Section 8A:

A 60-day Federal Register Notice was published in the *Federal Register* on May 28, 2013, vol. 78, No. 102; pp.31946-47 (see attachment). There were no public comments.

Section 8B:

Three respondents were consulted in June 2013 on burden hour estimates for the availability of data, frequency of collection, the clarity of instructions and record keeping, disclosure, or reporting format, and on the data elements to be recorded, disclosed, or reported. Those contacted include:

- Julie Dempsey
Children's Hospital Boston
300 Longwood Avenue
Boston, MA 02115
857-218-3312
E-mail: Julie.dempsey@childrens.harvard.edu
- Nancy Corona, Director of Reimbursement
The Children's Hospital of Alabama
1600 7th Avenue South
Birmingham, AL 35233
205-638-9607
E-mail: nancy.corona@childrensal.org
- Cindy Derby, Reimbursement Manager
St. Louis Children's Hospital
One Children's Place
St. Louis, MO 63110
314-362-0616
E-mail: cad4924@bjc.org

9. Explanation of any Payment/Gift to Respondents

No payments or gifts were provided to respondents.

10. Assurance of Confidentiality Provided to Respondents

No personal identifiers will be collected and this project does not require IRB.

11. Justification for Sensitive Questions

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour and Cost Burden

The current burden hour estimates below is based on an average of the three respondents reported burden hours for the HRSA 100-1 form (screening instrument) and HRSA 100-2 and 100-3 (annual report) forms.

12A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Hospital Finance Staff	HRSA 100-1	54	1	10.4	561.6
Hospital Finance Staff	HRSA 100-2 and 100-3	54	1	74	3996.0
Total		54	1	84.4	4557.6

12B.

Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Hospital Finance Staff (HRSA 100-1 Form)	561.6	\$59.26	\$33,280.42
Hospital Finance Staff HRSA 100-2 and 100-3 Forms)	3996.0	\$59.26	\$236,802.96
Total			\$270,083.38

Basis for Burden 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 \$59.26 per hour based on wage rates provided on The Department of Labor website.

Total annualized burden costs are estimated at \$270,083.38. For participating hospitals to complete the HRSA 100-1 Screening Instrument, it is estimated to take 10.4 hours at a cost of \$33,280.42. For participating hospitals to complete the Annual Report components 100-2 and 100-3 forms, it is estimated to take 74.0 hours at a cost of \$236,802.96.

13. Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

The respondent did not purchase or maintain capital items that would have not been required in the absence of this information collection. There are no additional costs that are not included in the cost of any hour burden shown in Item 12.B and 14.

14. Annualized Cost to Federal Government

Federal Cost

The cost to the Federal Government has decreased because the number of annual report applications to be reviewed and processed has reduced from 56 to 54. The costs to the Federal Government are estimated to be **\$31,013.82** 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.

[GS13/1 @ \$42.66/hour X 54 applications X 30 minutes (.50 hours) per application. **\$1151.82**

\$ 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 54 applications X 3 hours per application] **\$6910.92**

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

[GS13/1 @ \$42.66/hour X 54 applications X 1 hour per application] **\$2303.64**

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% Reduction.

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

15. Explanation for Program Changes or Adjustments

The burden has changed with a reduction in total burden hours from 4,922.4 to 4,557.6. The reduction in total burden hours are due to fewer number of respondents from 56 to 54 per form and a reduction in respondent burden hour estimates secondary to experienced staff, increased efficiency and streamlining the reporting process over the years.

16. Plans for Tabulation, Publication, and Project Time Schedule

The Children's Hospital Graduate Medical Education (GME) Support Reauthorization Act of 2006 (P. L. 109-307) requires that CHGME-participating hospitals continue to provide HRSA information about their residency training programs in an annual report that documents data from the academic year completed immediately prior to each fiscal year for which the hospital applies for funds.

Data collected across the academic years will provide insight for future GME research and policy demands, internal administrative evaluation and research and track performance since program inception. As statute requires, the collection of information will continue annually from the first week of December through the first week of February. In light of the recurring data collection requirement, CHGME is requesting the maximum 3-year clearance.

Analytical Plan

The data collection instrument is responsive to the reporting requirements 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 CHGME-funded GME training programs, and (5) changes in GME and/or training experiences led by freestanding children's hospitals since the inception of the CHGME Payment Program. Summary measures (outputs and to the extent possible outcomes) will be defined and determined using the data collected from each of the freestanding children hospitals participating in the 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 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 analytical summaries will include maps, tables and narrative of:

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

- ❖ Number of GME programs by specialty and sub-specialty by census region
- ❖ Number of primary care GME programs (pediatrics, pediatric/ internal medicine) by census region

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 specialty and sub-specialty and by census region
- ❖ Fill rates based on accredited slots by specialty and sub-specialty

2. *Incorporation of advances in medicine and patient care in GME training.* This portion of the analysis will focus on:

- ❖ Identification of additional or advanced education modules and training experiences beyond 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 advances in health information technology and patient safety

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

This part of the analysis we will attempt to distinguish among didactic, clinical, and research training in the content of caring for underserved populations. 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.

The analysis will detail the GME approaches (didactic, clinical and research) used by institutions and training status (elective, required, or not currently used) as it relates the healthcare needs of the following patients:

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

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., urban/rural, MUA, HPSA, etc.)
- ❖ Distribution of patients with serious and chronic, complex and rare diseases being served (based on selected ICD-9 codes)
- ❖ Changes in curricula and/or training experiences to prepare physicians to care for underserved populations which includes those that are underserved because of family income, geography, acute and chronic medical conditions

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

This section will focus on the choices of graduates from CHGME-funded 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 and sub-specialty (e.g., general practice, pediatric allergy).

- ❖ Number of graduates by primary care and sub-specialty type
- ❖ Number of graduates by practice types (private practice, hospitals, community health centers)
- ❖ Number of graduates practice location by census regions
- ❖ Number of graduates choosing to practice in proximity to an MUA, an MUP, or an urban/rural area
- ❖ 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.*

Changes in residency training for residents which the hospitals have made during and academic year and since the inception of the program will be examined. Changes in curricular, training experiences, types of training programs and benefits that have resulted in such changes will be evaluated. Furthermore, legislation requires a focused examination of changes in training residents in quality measurement and patient care safety.

- ❖ Number and percentage of training topics offered and expanded across academic years
- ❖ Number and percentage of training topics offered and expanded by program specialty across academic years
- ❖ Narrative summary of the qualitative information provided by the hospitals on the benefits that have resulted in the changes made to the training curriculum
- ❖ Number and percentage of quality care topics and patient safety initiatives offered and expanded across academic years

The summaries and analyses will be done using univariate and bivariate statistical methods. The data will be displayed in tables, graphs and maps to address statutory reporting requirements. Trend analysis and descriptive data will be used to measure and track changes of the number and types of specialty programs, residents, and training topics by national and regional census regions across academic years and since CHGME Payment Program inception.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

The expiration date will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.