Supporting Statement A

Medicare Rural Hospital Flexibility Grant Program Performance

OMB Control No. 0915-0363

Revision

Terms of Clearance: None

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA)'s Federal Office of Rural Health Policy (FORHP) is authorized (SEC. 711. [42 U.S.C. 912]), with "administering grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas."

The mission of FORHP is "to collaborate with rural communities and partners to support programs and shape policy that will improve health in rural America." The Medicare Rural Hospital Flexibility Grant (Flex) Program is a key contributor to FORHP's mission. The Flex program is authorized by Title XVIII, § 1820(g)(1-2) of the Social Security Act (42 U.S.C. 1395i-4), as amended, in which the Secretary can establish grants to States for:

(1) Medicare rural hospital flexibility program.

(A) engaging in activities relating to planning and implementing a rural health care plan;

(B) engaging in activities relating to planning and implementing rural health networks;

(C) designating facilities as critical access hospitals (CAHs); and

(D) providing support for critical access hospitals for quality improvement, quality reporting, performance improvements, and benchmarking.

With its inception in 1997 and subsequent program iterations since with the latest being in 2015, Flex has been instrumental in converting many small rural hospitals to CAH

designation, and providing technical assistance opportunities through designated grantees for CAHs to improve quality, financial and operational indicators. Through these activities the Flex program provides technical assistance and resources to state designated entities so CAHs) maintain high-quality and economically viable facilities ensuring that residents in rural communities, and particularly Medicare beneficiaries, have access to high quality health care services.

However, policy and industry trends are rapidly pushing health care from a volume to value based model. CAHs are in a delicate balance of operating in a volume model while working toward a value based model that emphasizes quality reporting and improvement for payment.

Currently, unless required via state statute, a majority of CAHs are not required to report on many of the quality metrics Medicare requires other hospitals to report on for payment purposes. As a result, many CAHs have lagged in quality benchmarking, reporting and improvement and are in a precarious position as health care reform moves toward a value based health care system - built upon quality reporting and improvement. To prepare for a future driven by quality reporting and improvement, the Flex program instituted the Medicare Beneficiary Quality Improvement Program (MBQIP) assisting states in improving quality reporting participation among CAHs and prioritizing quality improvement activities based on quality data. MBQIP participation has become a required portion of the Flex program, as has working on financial and operational improvement activities.

Assisting CAHs maintain a financially viable facility given the challenging variables of patient volume, payer mix, and population needs is equally paramount to quality improvement. CAHs can benefit by the resources and technical assistance provided to them via the Flex program for improving their finances and operations

Therefore, the Flex program has focused program area requirements, activities, and resources toward initiatives to help CAHs remain financially and operationally viable as well preparing them for a value based model of care. Because of the increased importance of population health management as it relates to value, the latest iteration of the Flex program encourages states to facilitate activities around this initiative. Due to the unique nature in which a variety of value based models may arise, the Flex program is encouraging grantees to explore and integrate innovative models of care that could assist CAHs in their transition to a value based system.

While there is pliability in the program, each of the 45 state designated grantees are held to standard program areas and required activity types so cross-cutting measures can be applied to initiatives implemented under the Flex grant program. Therefore, FORHP is requesting continued approval from OMB of a revised electronic data collection tool supporting this endeavor. Specifically, 45 grantees receiving support administered under the Flex grant program would be subject to reporting on only program initiatives in which they proposed, as well as information to meet requirements under the GPRA Modernization Act of 2010 (GPRAMA).

2.

Purpose and Use of Information Collection

The purpose of the performance measures contained in this information collection request is to provide standardized data about funded activities, to internally monitor and track grantee progress, identify potential best practices, and determine if program activities should be applied more broadly or discontinued. Grantees only report on measures applicable to their awarded project and selected Flex program activities. The information collected aligns strategically with HRSA required grant components such as the work plan and grantee self-assessments.

FORHP collects this information on an annual basis for determining overall program progress and the advancement of CAHs making improvements based on Flex funded activities. This report provides data on the number of program activity types selected, CAH participation, and progress towards improvement. In addition, the report provide aggregated data that can be triangulated with publicly reported quality and finance data allowing for the creation of state, regional and national CAH trends, which is scant. Therefore, it is crucial for FORHP to continue to collect information related to the progress of Flex program initiatives, especially during a time in which CAHs and rural health faces mounting challenges. Such data allows FORHP to identify leading practices based on outcome targets or identifying a state that could utilize more technical assistance and support with the goal of leading to improved outcomes. Furthermore, the information captured and coupled with quality data would provide a better picture of rural health care in America, and serves as source material for FORHP in informing policy, regulations and rules to HHS and the secretary.

It is important to note that the measures presented in this document align with key topics, goals and objectives set forth in the HRSA and FORHP strategic plans. Specifically, improving access to quality health care and services and strengthening health systems to support the delivery of quality health services. Several measures are used for this program and will inform the FORHP's progress toward meeting the goals set in GPRA. Specifically, these measures include: (a) quality reporting participation and (b) consumer quality improvement;

- Increase the percent of Critical Access Hospitals reporting at least one measure to Hospital Compare, and
- Increase the percent of Critical Access Hospitals participating in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Current HRSA Measures aimed at capturing initiative and activity type include:

- Number of Critical Access Hospitals Reporting on Outpatient Measures

- Number of Critical Access Hospitals Reporting on HCAHPS
- Number of Critical Access Hospitals engaged in a quality improvement activity
- Number of Critical Access Hospitals engaged in a financial improvement activity

Future HRSA Measures to capture progress in improvement include:

- Number of Critical Access Hospitals showing improved quality.
- Number of Critical Access Hospitals showing financial improvement
- Number of Critical Access Hospitals showing improved operations

As previously stated, FORHP is able to triangulate the proposed measures with currently available metrics (quality, finance, and population health) to observe data trends around Flex related activities, identify appropriate benchmarks for CAHs, detecting grantees in need of further technical assistance, detecting potential best practices and promoting those best practices.

For this submission to OMB, FORHP revised the tool to: 1) align with revised activities in current cycle of the grant Program; and 2) minimize responder burden by simplifying requested information. Specifically, nearly 100 measures were removed from the original tool with the remaining measures being simplified and consolidated to improve data consistency and validity. The remaining 149 measures reflect all five Flex program area activities and associated measures in which a grantee could respond.

3. Use of Improved Information Technology and Burden Reduction

This activity is fully electronic. Data are collected through and maintained in a database in HRSA's Electronic Handbook (EHB). Grantees submit the data electronically via a HRSA managed website at https://grants.hrsa.gov/webexternal. This reduces the paper burden on the grantee and on the program staff.

4. Efforts to Identify Duplication and Use of Similar Information

The data collection for this program is not available elsewhere, and aligns well with respondents required work plans and self-assessment activities. In an effort to reduce the overall burden on grantees and their subcontract recipients, the Flex program has utilized publicly reported data to Hospital Compare for Quality Improvement reporting and the financial cost reports submitted to the Centers for Medicare and Medicaid by CAHs. FORHP and its partners can utilize this data and

triangulate it with other publicly reported data to observe the progress of Flex program activities, observe trends, and pinpoint strengths and weaknesses of state Flex programs.

FORHP and its partners, the Flex Monitoring Team (http://www.flexmonitoring.org/) and National Rural Health Resource Center (https://www.ruralcenter.org/tasc/content/flex-program), utilize the data elements to provide a snapshot of rural health as it relates to CAHs and the communities it serves, as well as sharing with grantees for their own use and analysis.

5. Impact on Small Businesses or Other Small Entities

6. No small businesses or other entities will be involved in this study. **Consequences of Collecting the Information Less Frequently**

Data in response to these performance measures are collected on an annual basis. Grant dollars for these programs are awarded annually. This information is needed by the programs, FORHP and HRSA in order to measure effective use of grant dollars to report on progress toward strategic goals and objectives.

Data collected and its timely analysis provides important information about rural health care quality, the financial vitality of CAHs, and overall impact of CAHs on rural health, which is a crucial area to track to best inform programmatic and policy decisions.

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

The request fully complies with the regulation.

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 27, 2015, vol. 80, No. 101; pp. 30255-56 (see attachment A: Flex FRN 60Day 2015-12700 ; Medicare Rural Hospital Flexibility Grant Program Performance OMB No. 0915-0363-Rev).

Comments (see Attachment B) were received by current Flex grantee indicating a willingness to review the data collection tool and provide feedback.

A comment was received by a current Flex grantee about the importance of ensuring that the data collection tool does not duplicate the quality reports submitted on a quarterly basis

The National Organization of State Offices of Rural Health (NOSORH) provided

commentary on behalf the State Offices of Rural Health in which many of the state designated Flex programs reside. The commentary indicated the desire for a data collection tool that reduces burden and doesn't duplicate quality and financial reports. The proposed tool does not provide duplicated information in such reports. NOSORH indicated FORHP look into a paid subscription service to a third party source, called TruServ, which some State Offices of Rural Health utilize for data tracking. It was deemed at this time, that it is best to revise the current electronic tool utilized by FORHP, which is at no cost to the grantees.

FORHP is well aware of these concerns and has worked diligently to ensure this collection tool minimizes burden, aligns with the grantee work plan for more organized reporting, and does not duplicate data submitted in quality and financial reports.

Section 8B:

The Flex Monitoring Team (FMT) is a consortium of the Rural Health Research Centers at three institutions: The University of Minnesota, The University of Southern Maine and the University of North Carolina. FMT provides evaluative expertise to the Flex Program. The following members provided input from July 2015 - November 2015. FMT indicated their ability to work with FORHP in triangulating publicly reported quality and financial data with Flex work plan data to trend CAH progress and detect best practices, areas for needed technical assistance, etc.

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9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payments or gifts.

10. Assurance of Confidentiality Provided to Respondents

The data system does not involve the reporting of information about identifiable individuals; therefore, the Privacy Act is not applicable to this activity. The proposed performance measures will be used only in aggregate data form for program activities.

11. Justification for Sensitive Questions

There are no sensitive questions.

12. Estimates of Annualized Hour and Cost Burden

12A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Total Responses	Average Burden per Response (in hours)	Total Burden Hours
Grant Coordinator	Medicare Rural Hospital Flexibility (Flex) Grant Program Performance	45	1	45	70	3150
Total		45		45		3150

This allows for 5 hours of program monitoring per month over a 12 month period and 10 hours for final data aggregation and reporting submission.

12B.

Estimated Annualized Burden Costs

Type of	Total Burden	Hourly	Total Respondent

Respondent	Hours	Wage Rate	Costs
Program Coordinator	3,125	$35.00	$109,375
Total	3,125		$109,375

Due to the vast disparity in wage ranges and occupational categories, the hourly wage rate was calculated by sampling 10 out of 45 grantee program coordinator positions and averaging the hourly rate of those program coordinators performing 1.0 FTE.

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

Other than their time, there is no cost to respondents.

14. Annualized Cost to Federal Government

Staff at FORHP monitor the contracts and provide guidance to grantee project staff at a cost of $3,240 per year (72 hours per year at approximately $45 per hour at a GS-13 salary level) for three years. The total annualized cost to the government for this project is $9,720.

15. Explanation for Program Changes or Adjustments

The current inventory provides for 9720 burden hours. This revision is requesting 3150. The decrease is due to the lower number of measures that will be reported on by grantees.

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

At this time, FORHP has no intention to publish the data. This information is collected to comply with GPRA and PART requirements. The data are used on an aggregate program level to document the progress and success of rural health, state-based grant programs. The information is accessible to the state-based grantees and evaluation cooperative agreements for data manipulation as the data relates to them and may be used for comparisons of National and/or regional benchmarks.

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

The OMB number and expiration date is displayed on every page of every form/instrument.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.