Supporting Statement A

Medicare Rural Hospital Flexibility Program Performance
OMB Control No. 0915-0363
Reinstatement without change

Terms of Clearance: None

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA) is requesting the Office of Management and Budget's continued approval of the 0915-0363 information collection request with a current expiration date of 7/30/2022. This is a *reinstatement* request.

This submission includes the addition of minor revisions in the organization of the measures to align with the changes to the organization of the program areas within the Flex Program. The revisions include changes to align with current language and a broadening of scope for some activities. The measures will remain unchanged. For example: previously, population health improvement activities were combined with rural EMS integration, and these measures will be separated into two distinct program areas. The burden remains unchanged with these changes.

HRSA's Federal Office of Rural Health Policy (FORHP) is authorized (Title VII, §711 of the Social Security Act [42 U.S.C. 912]), to "administer 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 (Flex) Program is a key contributor to FORHP's mission. The Flex program is authorized by Title XVIII, §1820(g)(1) and (2) of the Social Security Act (42 U.S.C. 1395i-4), as amended (see Attachment A), in which the Secretary can establish grants to States for a:

> (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; 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 Flex has been instrumental in converting many small rural hospitals to critical access hospital (CAH) designation, and providing technical assistance opportunities through state recipients for CAHs to improve quality, financial and operational indicators. Through these activities the Flex Program provides technical assistance and resources to state designated entities to help CAHs maintain high-quality and economically viable operations ensuring that residents in rural communities, and particularly Medicare beneficiaries, have access to high quality health care services. However, policy and industry trends continue to push health care from a volume to value-based model. CAHs are in a delicate balance of operating in a volume-driven payment system while working toward a value-based model that emphasizes quality reporting and improvement.

Currently, unless required via state statute, most CAHs are not required to report the quality metrics Medicare requires other hospitals to report 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 with a foundation of quality reporting and improvement. To prepare for a future driven by quality reporting and improvement, the Flex program created 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 is a required area of the Flex program, as is working on financial and operational improvement activities with CAHs.

Assisting CAHs to maintain a financially viable health care operation given the challenging variables of patient volume, payer mix, and population needs is equally important for high quality health care services. CAHs can benefit from the training 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. Due to the unique nature in which a variety of value-based models may arise, the Flex program is encouraging recipients to explore and integrate innovative models of care that could assist CAHs in their transition to a value-based payment system.

While there is flexibility in the program, each of the 45 state designated recipients are

held to standard program areas and required and optional activity categories so cross-cutting measures can be applied to initiatives implemented under the Flex program. Therefore, FORHP is requesting continued approval from OMB of the electronic data collection tool supporting this endeavor. Specifically, 45 recipients receiving support administered under the Flex program would be subject to reporting on only program areas in which they actively work, as well as information to meet requirements under the GPRA Modernization Act of 2010 (GPRAMA).

2. Purpose and Use of Information Collection

FORHP uses the data from performance measures as approved in this information collection request to monitor the performance of state recipients of Flex awards and to report program outcomes in the annual Congressional Justification for the HRSA Budget.

Specifically for the annual Congressional Justification, we calculate the number of CAHs that show improved quality of care following participation in required and optional Flex-funded quality improvement initiatives. The annual reports submitted by recipients under this information collection are the only way to collect these data and calculate these program outcome measures.

In addition to calculating the annual outcome measures, we use data from this information collection to monitor progress at the program level and by individual recipients. We also use these data to provide summary reports about program activities for recipients and program stakeholders. Without these data, we would be unable to provide a clear summary of Flex activities nationwide to program stakeholders.

Finally, the Flex Monitoring Team, a consortium of the Rural Health Research Centers at the University of Minnesota, the University of Southern Maine, and the University of North Carolina, which evaluates the Flex Program under a HRSA-funded cooperative agreement, is using data collected under this information collection in their studies evaluating the Flex Program. The researchers are currently studying the relationship between CAH participation in Flex-funded performance improvement projects and CAH performance as measured by national standardized quality measures, financial metrics, and operational efficiency indicators.

Previously in 2016, we revised the Flex Program information collection tool to align with program areas and activity categories in the current period of performance in addition to minimizing responder burden by simplifying requested information and making the information collection flexible to reflect the variation in needs and Flex projects in different states. We have since implemented this information collection in an online electronic data collection system, and we will continue to use the same information collection tool with minor revisions in the organization of the measures to align with the changes to the organization of the program areas within the Flex Program.

3. Use of Improved Information Technology and Burden Reduction

This activity is fully electronic. We collect and maintain the data in a database in HRSA's Electronic Handbooks (EHB). Recipients submit information electronically via a HRSA managed website at https://grants.hrsa.gov/webexternal. This reduces the paper burden on the recipient and on the program staff.

In addition to the online electronic reporting system, we have developed and implemented basic data logic checks that automatically evaluate the data reported by respondents in real time and inform them of possible errors before they submit reports. These logic and validation checks also help to reduce respondent burden by preventing accidental errors and minimizing the time they spend answering questions and making revisions following their project officers' review of their initial report.

"Flex Program – measure list" is a spreadsheet listing the measures used in this information collection.

"Flex Program – screenshots" has screenshots of all of the electronic data submission forms for this information collection. Note that respondents will only report a subset of the measures as applicable to their chosen Flex projects so no respondent will use all of the measures displayed in these screenshots.

4. Efforts to Identify Duplication and Use of Similar Information

The recipient-specific state data collected 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 recipients and their subcontract recipients, the Flex program collects the minimum data necessary from recipients and utilizes other publicly reported data to augment this data collection and support program monitoring efforts. Other public data used to monitor the Flex program, in addition to this data collection, include quality data reported by CAHs in Medicare Hospital Compare (https://www.medicare.gov/hospitalcompare/search.html) and public cost report data submitted to the Centers for Medicare and Medicaid by CAHs. FORHP and its partners triangulate this publicly reported data with the program data collection to observe the progress of Flex program activities, observe trends, and pinpoint strengths and weaknesses of state Flex programs.

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

Data in response to these performance measures are collected on an annual basis. Federal dollars for these programs are awarded annually. This information is needed by the Flex Program, FORHP, and HRSA in order to measure effective use of federal dollars, for required Congressional reporting, and to monitor progress toward strategic goals and objectives.

HRSA must collect these program performance data annually in order to provide performance data in the annual Federal budget justification and in order to conduct oversight and ensure program integrity for the annual award of funds. Less frequent data collection would result in gaps in the data used for program monitoring and annual program reporting.

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 Notice published in the Federal Register, Vol. 87, No. 46, Fed. Reg. pp. 13300-13301 (March 9, 2022). There were no public comments.

A 30-Day Notice published in the Federal Register, Vol 87, No. 98, Fed. Reg. pp. 30906-30907 (May 20, 2022). There were no public comments.

Section 8B:

We consulted with Flex award recipients (the respondents to this information collection) using a webinar platform open to all Flex recipients in 2017 and in 2018. Approximately 40 of the 45 recipients participated in each webinar.

In these webinars, we reviewed the national Flex Program data collected for the year and discussed reporting challenges and opportunities for improvement with recipients. As a result of feedback provided in these review and consultation webinars, we developed an Excel-based data collection tool to help recipients organize information throughout the year to be ready for the annual online report. We also developed the data logic checks noted in item 3, above, to help respondents review and correct their reports before submission.

In addition to consulting directly with all 45 Flex recipients, in 2018, we consulted with members of the Flex Monitoring Team (FMT), a consortium of three Rural Health Research Centers at the University of Minnesota, the University of Southern Maine, and the University of North Carolina. FMT researchers reviewed the timing of data collection, the clarity of instructions, the data elements that are collected, and the format

of the data files produced by the electronic collection system. Based on the researchers' feedback we are in the process of reformatting the output data files to make them easier to use for research and analysis. We also refined the reporting instructions based on their feedback (the latest version of the instructions is included as Attachment E).

We consulted with the following FMT researchers about this information collection:

- Mariah Quick, MPH, Research Fellow, School of Public Health, University of Minnesota, quick078@umn.edu
- Megan Lahr, MPH, Research Fellow, School of Public Health, University of Minnesota, lahrx074@umn.edu
- Ira Moscovice, PhD, Mayo Professor in the Division of Health Policy and Management, School of Public Health, University of Minnesota, mosco001@umn.edu
- George Pink, PhD, Humana Distinguished Professor, Department of Health Policy and Management, University of North Carolina at Chapel Hill, gpink@email.unc.edu
- Kristin Reiter, PhD, Professor and Associate Chair, Department of Health Policy and Management, University of North Carolina at Chapel Hill, reiter@email.unc.edu
- John Gale, MS, Senior Research Associate, Maine Rural Health Research Center, Muskie School of Public Service, University of Southern Maine, john.gale@maine.edu
- Zach Croll, MPH, Research Analyst, Maine Rural Health Research Center, Muskie School of Public Service, University of Southern Maine, zachariah.croll@maine.edu

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 performance measures are used in aggregate to report 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
State Program Coordinator	Medicare Rural Hospital Flexibility Program	45	1	45	70	3,150
Total		45		45		3,150

The estimated burden per respondent is based on 5 hours of program monitoring and data collection per month over a 12-month period and 10 hours for final data aggregation and electronic report submission.

12B.

Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State Office of Rural Health staff	3,150	$37.50	$118,125
Total	3,150		$118,125

A recent survey of staff salaries conducted by the National Organization of State Offices of Rural Health reported that the median wage for program directors and project coordinators in State Offices of Rural Health was $50,001 – $70,000 per year, not including benefits and fringe. This study is available at https://nosorh.org/wp-content/uploads/2019/03/Compensation-Survey-Final-3-4-2019.pdf, accessed 4/8/2022.

This hourly cost estimate uses the midpoint of this wage range, $60,000 per year. The hourly staff cost is calculated as follows, $60,000 per year / 2080 hours per year

= hourly rate of $28.85. Benefits and fringe are estimated as 30% of the hourly cost or $8.65 per hour. The total hourly cost of SORH staff is therefore estimated at $37.50 per hour composed of $28.85 (wage) + $8.65 (fringe).

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

The electronic reporting system is part of HRSA EHB and is maintained by an information technology (IT) contractor. The annual cost of the Flex program share of this IT contract is estimated to be $230,000.

Staff at FORHP monitor the contract and provide guidance to recipient project staff at a cost of $4,774 per year. This cost is estimated as 72 hours of staff time per year at a GS-13 salary level, estimated hourly wage of $51 plus 30% for benefits and fringe ([$51 per hour + $15.30 fringe per hour] x 72 hours = $4,773.60).

The total cost to the government of this project for three years is $704,322. The total annual cost to the government for this project is $234,774.

15. Explanation for Program Changes or Adjustments

We will continue to use the same information collection tool with minor revisions in the organization of the measures to align with the changes to the organization of the program areas within the Flex Program. The estimated burden has not changed from the current burden inventory of 3,150 total hours.

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 requirements and certain measures are published in the annual Budget for HRSA. Aggregate data are also used to assess the progress and success of this rural health, state-based program. The information is accessible to the state-based recipients as the data relate to them. Data may also be used by evaluation cooperative agreement recipients for comparisons of national and regional performance and secondary analysis as part of their ongoing evaluation of the Flex Program.

This is a recurring data collection that program recipients report once a year. We are requesting clearance of this information collection for the next three years. The next reporting period is scheduled for September 1, 2019, to October 30, 2019.

This information collection will not use statistical methods such as sampling, imputation,

or other statistical estimation techniques.

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.