

Supporting Statement A

Medicare Rural Hospital Flexibility Program Performance

OMB Control No. 0915-0363

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 10/31/2025.

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 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 the 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 helps 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. To prepare for a future driven by quality reporting and improvement, the Flex Program created the Medicare Beneficiary Quality Improvement Project (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 so cross-cutting measures can be applied to initiatives implemented under the Flex Program. Therefore, HRSA 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). HRSA is requesting to change the formatting of the data collection tool to align with a work plan submission, making the process more streamlined. Instead of needing to maintain information in multiple documents and then transferring that to another central data system, all of the information can be maintained in one place. The new platform will include a series of dropdown lists, where recipients can choose from common projects across the program areas of the Flex Program, as well as common outcome measures. Recipients will not be required to report on all outcome measures, only those which they are actively working in. There will be no changes to the data the recipients are collecting, this is information they have been collecting previously.

2. Purpose and Use of Information Collection

For this submission to OMB, HRSA is requesting to change the current information collection approval. Currently, data reported to HRSA is very broad, and Flex Program recipients have reported it is difficult for them to use these reports to monitor their own program progress. The proposed changes reduce grantee burden and keep the information collection tool aligned with program areas and flexible to reflect the variation in needs and Flex projects in different states, while allowing them to report more specific outcome measures tracking trend data over time. Previously, the information collection occurred in an online electronic data system, the Electronic Handbooks, and we are proposing to move this collection tool into a different electronic data collection platform.

HRSA 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, HRSA uses 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. The change to collecting more specific measures will allow HRSA to see which program activities are most effective and see more detailed information regarding state and hospital-level progress. Without these data, we would be unable to provide a clear summary of Flex activities nationwide to program stakeholders.

Flex Program recipients of this funding use these data to monitor their own progress, both overall as a state as well as at the individual hospital level. States can track which hospitals are participating year over year and see trending data regarding their progress. State award recipients have stated the current data collection tool is broad but does not help them in determining improvement progress, as they need to capture this information in other outside systems. They can use their state summary data as well as hospital level data to speak to their program partners and hospitals regarding program progress and allow them to adjust their work for any newly arising needs.

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.

3. Use of Improved Information Technology and Burden Reduction

This activity is fully electronic. HRSA currently collects and maintains 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.

The new data collection portal will be in a different online platform that is 508 compliant and has better collection and reporting capabilities and will remain fully electronic. We are proposing to change the formatting and organization of the performance measures, so the submission will mimic a work plan submission. Utilizing dropdown menus with pre-populated values for common projects and common outcome measures will reduce burden on the recipients while reporting the information and allow for creation of more valuable and detailed summary reports, for all involved parties to use to track performance (state recipients of funding, HRSA, and national evaluation partners). We will implement 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. In addition, the pre-populated values in the dropdown menus will utilize skip logic so only corresponding values can be chosen.

Attachment A is a document listing the common project types and their associated outcome measures used in this information collection.

Attachment B is a PDF mockup of what the data submission form will look like. The collection tool will mimic a work plan submission.

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.

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. HRSA 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.

HRSA continues to use other publicly available data to augment state recipient data collection. The PIMS data collection tool will be able to show data specifically related to Flex-funded interventions, where the other publicly available data shows hospital information overall.

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 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 to provide performance data in the annual Federal budget justification, to conduct oversight activities, 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 Federal Register Notice was published in the *Federal Register* on November 6, 2024, vol. 89, No. 215; pp. 88053-88055. Three comments were received:

- One commenter to the 60-day FRN noted the difficulty in reporting their annual spending, and this is due to the coding behind the scenes in the previous system. In the new electronic data collection platform, that specific form would be removed and instead, the spending can be reported elsewhere without the specific problems of the coding background.
- One commenter to the 60-day FRN noted that this change to align more closely with the work plan would move to a better reporting system. They noted that the current system of a series of checkboxes does not give enough detail in what the program is currently doing and increases challenges in reporting as errors are more likely to occur.
- One commenter to the 60-day FRN noted that dropdown menus could be more effective if they are organized by program topic or funding area, rather than by hospital, and should also include an option of "other." The proposed changes to the data collection platform would organize the dropdown menus by program topic and would contain skip logic, meaning only an outcome measure related to the specific program topic would be allowed to be chosen, and all dropdowns would include an option for "other". The commenter also noted that making the data collection directly reflective of the work plan could reduce the administrative burden of tracking measures that may not be related to their work plan. The same commenter also noted the preference to use the data collection platform to report their required work plan, and the

functionality for which we are building into the system as well.

A 30-day Federal Register Notice was published in the *Federal Register* on September 22, 2025, vol. 90, No. 181; pp. 45388-45390.

Section 8B:

We facilitated a discussion with Flex award recipients (the respondents to this information collection) during public meetings (webinars) and the participants were not surveyed or asked identical questions. Therefore, this webinar did not require PRA approval.

Approximately 40 recipients participated in the webinars. Webinar participants were not surveyed or asked identical questions. As a result of feedback provided in these webinars, three smaller calls were held with less than 10 people per call, based on their role within the Flex Program (including Flex Program coordinators newer in their role, those who are more experienced in their role, data evaluators on staff with the Flex Program recipients, as well as technical assistance and evaluation cooperative agreement recipients who aid in the work of the Flex Program). These calls were open discussions where no data collection instruments were used.

Each individual who provided feedback on the data collection tool has stated that the data currently collected is too broad and is not helpful for them to evaluate their own progress. There are currently multiple spreadsheets that recipients must use in order to track this data, and they have reported that an online portal where everything can be housed in one place, as well as more specific guidance on common outcome measures they can use, will help them see state-level progress and make any needed adjustments to their work.

We consulted with the following individuals:

- Listening session 1: Grantees with Virginia Department of Health, Pennsylvania State University, Ohio Department of Health
- Listening session 2: Grantees with Oklahoma State University, University of Wisconsin Madison
- Listening session 3: Grantees with Michigan Center for Rural Health, University of North Dakota, Vermont Agency of Human Services, Minnesota Department of Health, Nevada System of Higher Education, Georgia Department of Community Health
- Listening session 4: Program Stakeholders with Telligen, National Rural Health Resource Center, University of Minnesota, University of North Carolina Chapel Hill, University of Southern Maine

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. Data will be kept private to the extent allowed by law.

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	Average Burden per Response (in hours)	Total Burden Hours
Funding Recipient	Performance Improvement Management System	45	1	55	2,475
Total		45	1	55	2,475

The estimated burden per respondent is based on an average of the time needed for completion. This was determined by current respondents to this submission providing the amount of time it would take for them to complete a form in this manner. Different respondents were engaged and this number represents the average of those times. This is a decrease in the estimated burden hours from the previous ICR, as information will be consolidated into one location, rather than entities needing to maintain data in multiple locations to report back to HRSA.

12B. Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State Office of Rural Health Staff	2,475	\$43.28	\$107,118
Total			\$107,118

A 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 3/5/2019.

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 50% of the hourly cost or \$14.43 per hour. The total hourly cost of SORH staff is therefore estimated at \$43.28 per hour composed of \$28.85 (wage) + \$14.43 (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 HRSA 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, Step 1, estimated hourly wage of \$58 multiplied by 1.5 for benefits and fringe $(\$58 \text{ per hour} + \$29 \text{ fringe per hour}) \times 72 \text{ hours} = \$6,264$.

The total cost to the government of this project for three years is \$708,792. The total annual cost to the government for this project is \$236,264.

15. Explanation for Program Changes or Adjustments

This is a program change. State-level funding recipients, HRSA Project Officers and leadership, and national-level evaluation partners find the current reporting system to be vague and broad, making it difficult to monitor the true progress of recipients and the impact of federal dollars. The data and changes that HRSA is requesting will make the reporting system align with a work plan. Previously, respondents would need to keep information in multiple spreadsheets, and this would put everything in one place resulting in a reduced overall burden.

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

HRSA is working with our agency's Data Disclosure Review Board to develop a Public Use Data File, which will provide the data in a machine-readable format within a year of information collection approval. HRSA is determining where the data will ultimately be published or if it will be available upon request pending consideration of cost constraints. 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 five years. The next reporting period is scheduled for September 1, 2025, to November 30, 2025.

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 will be displayed on every page of every form/instrument.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.