

July 2018

**National Implementation of the Hospital Consumer
Assessment of Healthcare Providers and Systems
(HCAHPS) Survey**

CMS-10102 (OMB 0938-0981)

Supporting Statement - Part A

Prepared by

Division of Consumer Assessment & Plan Performance
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

TABLE OF CONTENTS

Section	Page
A. Background.....	3
B. Justification.....	4
1. Need and Legal Basis.....	4
2. Information Users.....	5
3. Use of Information Technology.....	5
4. Duplication of Effort.....	6
5. Small Businesses.....	6
6. Less Frequent Collection.....	7
7. Special Circumstances.....	7
8. Federal Register/Outside Consultation.....	7
9. Payments/Gifts to Respondents.....	8
10. Confidentiality.....	8
11. Sensitive Questions.....	8
12. Burden Estimates (Hours & Wages).....	8
13. Capital Costs.....	9
14. Cost to the Federal Government.....	9
15. Changes to Burden.....	10
16. Publication/Tabulation Dates.....	10
17. Expiration Date.....	10
18. Certification Statement.....	10

EXHIBITS

Exhibit A-12: Annual Hours/Cost Burden of the HCAHPS Survey.....	9
--	---

LIST OF ATTACHMENTS

- Attachment A -- HCAHPS Survey Instrument (Mail)
- Attachment B -- HCAHPS Survey Instrument (Telephone Script)
- Attachment C -- HCAHPS Survey Instrument (AVIR Script)

**SUPPORTING STATEMENT – Part A:
National Implementation of the Hospital CAHPS Survey
CMS-10102 (OMB 0938-0981)**

Background

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is the first national, standardized, publicly reported survey of patients’ perspectives of their hospital care. HCAHPS is a 32-item survey instrument and data collection methodology for measuring patients’ perceptions of their hospital experience. Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally.

Three broad goals have shaped HCAHPS. First, the standardized survey and implementation protocol produce data that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of HCAHPS results creates new incentives for hospitals to improve quality of care. Third, public reporting enhances accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

The HCAHPS Survey asks recently discharged patients about aspects of their hospital experience that they are uniquely suited to address. The core of the survey contains 22 items that ask “how often” or whether patients experienced a critical aspect of hospital care, rather than whether they were “satisfied” with their care. Also included in the survey are four screener items that direct patients to relevant questions, five items to adjust for the mix of patients across hospitals, and two items that support Congressionally-mandated reports. (See Attachment A: HCAHPS Survey Instrument (Mail) and Supporting Materials.)

Since March of 2008, results from the HCAHPS survey have been publicly reported on the Hospital Compare website which can be found at www.hospitalcompare.hhs.gov or through a link on www.medicare.gov. The HCAHPS Survey and its implementation protocols can be found in the current version of the HCAHPS Quality Assurance Guidelines (Version 13.0, March 2018), located at: www.hcahponline.org/en/quality-assurance/.

In this 2018 iteration, we are adjusting the number of individuals surveyed from 3,100,000 to 3,104,200 participants (an increase of 4,200 survey respondents). As our estimated response time remains unchanged (8 minutes), the increased number of survey participants would adjust our total time estimate from 413,230 to 413,790 hours (an increase of 560 hours).

We are not changing or adjusting our hospital burden estimates. See section 15 for a more complete discussion of this iteration’s changes.

1. Justification

1. Need and Legal Basis

Beginning in 2002, CMS partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the federal Department of Health and Human Services, to develop and test the HCAHPS Survey. AHRQ and its CAHPS Consortium carried out a rigorous and

multi-faceted scientific process, including a public call for measures; literature review; cognitive interviews; consumer focus groups; stakeholder input; a three-state pilot test; extensive psychometric analyses; consumer testing; and numerous small-scale field tests. CMS provided three separate opportunities for the public to comment on HCAHPS and responded to over a thousand comments. The survey, its methodology and the results it produces are in the public domain.

In May 2005, the HCAHPS Survey was endorsed by the National Quality Forum, a national organization that represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research organizations. In December 2005, the federal Office of Management and Budget gave its final approval for the national implementation of HCAHPS for public reporting purposes. CMS implemented the HCAHPS Survey in October 2006 and the first public reporting of HCAHPS results occurred in March 2008.

Enactment of the Deficit Reduction Act of 2005 created an additional incentive for acute care hospitals to participate in HCAHPS. Since July 2007, hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions ("subsection (d) hospitals") must collect and submit HCAHPS data in order to receive their full annual payment update.

The incentive for IPPS hospitals to improve patient experience was further strengthened by the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), which specifically included HCAHPS performance in the calculation of the value-based incentive payment in the Hospital Value-Based Purchasing program beginning with October 2012 discharges.

2. Information Users

As noted above, there are three broad goals of the HCAHPS Survey. These goals are of value to consumers and providers of health care services as well as to CMS. First, the standardized survey and implementation protocol produce data that allow objective and meaningful comparisons of hospitals on topics that are important to consumers. Second, public reporting of HCAHPS results creates new incentives for hospitals to improve quality of care. Third, public reporting enhances accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. HCAHPS scores have been publicly reported on the Hospital Compare Web site since 2008 and since 2012 have been used in the payment determination for Inpatient Prospective Payment System (IPPS) hospitals that participate in the Hospital Value-Based Purchasing (Hospital VBP) program.

3. Use of Information Technology

The national implementation of HCAHPS is designed to allow third-party CMS-approved survey vendors to administer HCAHPS using mail-only, telephone-only, mixed-mode (mail with telephone follow-up), or active IVR (interactive voice response).

With respect to a telephone-only or mixed-mode survey, the CMS-approved survey vendors use electronic data collection or CATI systems. CATI is also used for telephone follow-up with mail survey non-respondents. With respect to IVR survey administration, the IVR technology gathers

information from respondents by prompting respondents to answer questions by pushing the numbers on a touch-tone telephone. Patients selected for IVR mode are able to opt out of the interactive voice response system and return to a “live” interviewer if they wish to do so. There are numerous advantages to administering a telephone interview using a CATI system or IVR technology, including the following:

- costs less than in-person data collection;
- allows for a shorter data collection period;
- allows for less item nonresponse because the system controls the flow of the interview;
- increases data quality by allowing consistency and data range checks on respondent answers;
- creates a centralization of process/quality control; and
- reduces post-interview processing time and costs.

CMS has tested new modes for the HCAHPS Survey, specifically a Speech Enabled-Interactive Voice Response mode and a Web-based mode, but concluded that issues stemming from differences in response rate and mode effects across implementations make such models unsuitable for the HCAHPS Survey at this time. Results of the investigation for using these modes of survey implementation are presented in Elliott, Brown, et al. (2013), “A Randomized Experiment Investigating the Suitability of Speech-Enabled IVR and Web Modes for Publicly Reported Surveys of Patients’ Experience of Hospital Care”, Medical Care Research and Review, 70 (2): 165-184.

The HCAHPS Survey does not require a signature from respondents. In fact, all information obtained through the survey is reported in the aggregate and no individual respondent’s information is ever reported independently or with any identifying information.

4. Duplication of Efforts

HCAHPS collects information that is fundamentally different from other CAHPS or patient experience of care surveys. CMS is not aware of any existing validated survey instrument where the unit of analysis is the acute care hospital and the focus of the survey is patient-reported experience of care. The information collected through this survey will therefore not duplicate any other effort and is not obtainable from any other source.

Many hospitals carry out their own patient experience of care surveys. These diverse, proprietary surveys do not allow for comparisons across hospitals. Making comparative performance information available to the public assists consumers in making informed choices when selecting an acute care hospital and creates incentives for facilities to improve the care they provide.

5. Small Businesses

Hospitals are not generally considered to be small businesses. All hospitals have the option to conduct HCAHPS as a stand-alone survey or to integrate it with their existing survey activities. They can choose to administer HCAHPS by mail, phone, mail with telephone follow-up, or active IVR. Costs associated with collecting HCAHPS will vary depending on:

- o The method hospitals currently use to collect patient survey data,
- o The number of patients surveyed (target is 300 completed surveys per year), and
- o Whether it is possible to incorporate HCAHPS into their existing survey.

Some smaller hospitals that participate in HCAHPS might be unable to reach the target of 300 completed surveys in a 12-month period. In such cases, the hospital should sample all discharges (census) and attempt to obtain as many completes as possible. HCAHPS scores based on fewer than 100 or 50 completed surveys are publicly reported but the lower reliability of these scores is noted by an appropriate footnote.

6. Less Frequent Collection

Great effort was expended considering how often HCAHPS data should be collected. We solicited and received much comment on this issue. Two options for the frequency of data collection were suggested: once during the year or continuous sampling. The majority of hospitals/vendors suggested continuous sampling would be easier to integrate into their current data collection processes. Thus we decided to require sampling of discharges on a continuous basis (i.e., a monthly basis) and cumulate these samples to create rolling estimates based on 12-months of data. We chose to pursue the continuous sampling approach for the following reasons:

- It is more easily integrated with many existing survey processes used for internal improvement,
- Improvements in hospital care can be more quickly reflected in hospital scores (e.g., 12-month estimates could be updated on a quarterly or semi-annual basis),
- Hospital scores are less susceptible to unique events that could affect hospital performance at a specific point in time,
- It is less susceptible to gaming (e.g., hospitals being on their best behavior at the time of an annual survey), and
- There is less variation in time between discharge and data collection.

7. Special Circumstances

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

8. Federal Register/Outside Consultation

The 60-day notice published in the Federal Register on May 9, 2018 (83 FR 21296). We received comments from one commenter who made the following two points:

- (1) the Hospital CAHPS tool is not effective in measuring the quality of care provided to patients because patients are not capable of evaluating the quality of care they received; and
- (2) that HCAHPS scored can be greatly influenced by the types of services provided and by the characteristics of the patients a hospital serves.

9. Payments/Gifts to Respondents

There are no provisions for payments or gifts to survey respondents.

10. Confidentiality

All information obtained through the HCAHPS Survey is reported in the aggregate. No individual

respondent's information is reported independently or with identifying information. We have designed the data files so that the hospital/vendor submits a de-identified dataset to CMS through a QIO according to 45 CFR Section § 164.514. No protected health information is submitted to CMS. In all the modes of survey administration, guidelines are included on issues related to confidentiality:

- Cover letters are not to be attached to the survey
- Respondents' names are not to appear on the survey
- Interviewers are not to leave messages on answering machines or with household members since this could violate a respondent's privacy

Please see HCAHPS Quality Assurance Guidelines, V13.0, pp. 53-54, for detailed information on patient confidentiality, www.hcahpsonline.org/en/quality-assurance/.

11. Sensitive Questions

There are no questions of a sensitive nature on the HCAHPS Survey.

12. Burden Estimates (Hours & Wages)

Wage Estimates

Individuals To derive average costs for individuals we used data from the U.S. Bureau of Labor Statistics' May 2017 National Occupational Employment and Wage Estimates for our salary estimate (www.bls.gov/oes/current/oes_nat.htm). We believe that the burden will be addressed under All Occupations (occupation code 00-0000) at \$24.34/hr since the group of individual respondents varies widely from working and nonworking individuals and by respondent age, location, years of employment, and educational attainment, etc.

Unlike our private sector adjustment to the respondent hourly wage (see below), we are not adjusting this figure for fringe benefits and overhead since the individuals' activities would occur outside the scope of their employment.

Private Sector To derive average costs for HHAs, we used data from the U.S. Bureau of Labor Statistics' May 2017 National Occupational Employment and Wage Estimates for all salary estimates (www.bls.gov/oes/current/oes_nat.htm). We believe that the burden will be addressed by a Medical Records Reviewer (occupation code 29-2071) at \$20.59/hr. As indicated below we are adjusting our employee hourly wage estimate by a factor of 100 percent to \$41.18/hr.

The 100 percent adjustments are rough estimates, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Information Collection Requirements and Burden Estimates

The HCAHPS survey averages approximately 3,104,200 participating survey respondents (completed surveys) a year, as evidenced throughout the 2012 through 2016 reporting periods. On average, it takes respondents 8 minutes (0.1333 hours) to complete the survey. In aggregate we estimate an annual burden of 413,790 hours (3,104,200 respondents x 0.1333 hours) at a cost of

\$10,071,649 (413,790 hr x \$24.34/hr).

Over the next three years, we anticipate that about 4,200 hospitals will participate in HCAHPS. Since 2015 the number of hospitals participating in HCAHPS has been fairly stable at approximately 4,200 hospitals for each four quarter period. We continue to estimate 1.0 hour per hospital response. In aggregate we estimate an annual burden of 4,200 hours at a cost of \$172,956 (4,200 hr x \$41.18/hr).

Burden Summary

Survey Respondents	Respondents	Total Responses (per year)	Time per Response (hr)	Total Time (hr)	Labor Rate (\$/hr)	Total Cost (\$)
Patients	3,104,200	3,104,200	0.1333	413,790	24.34	10,071,649
Hospitals	4,200	4,200	1.0	4,200	41.18	172,956
TOTAL	3,108,400	3,108,400	varies	417,990	varies	10,244,605

Information Collection Instruments and Instruction/Guidance Documents

Attachment A -- HCAHPS Survey Instrument and Supporting Materials (Mail)

Attachment B -- HCAHPS Survey Instrument (Telephone Script)

Attachment C -- HCAHPS Survey Instrument (AVIR Script)

13. Capital Costs

Hospitals have the option to conduct HCAHPS as a stand-alone survey or to integrate it with an existing survey. Hospitals can choose to administer HCAHPS by mail, phone, mail with telephone follow-up, or active IVR. Costs associated with collecting HCAHPS will vary depending on:

- o The method hospitals currently use to collect patient survey data,
- o The number of patients surveyed (target is 300 completed surveys per year), and
- o Whether it is possible to incorporate HCAHPS into their existing survey.

Over the next three years, we anticipate that about 4,200 hospitals will participate in HCAHPS. Using the estimate of \$4,000 per hospital for HCAHPS data collection, the annual cost burden is \$16,800,000.

14. Cost to the Federal Government

Costs to the government include: hospital/vendor training and technical assistance; approving hospitals/vendors for conducting surveys; ensuring the integrity of the data; accumulating the data; analyzing the data; making adjustments for patient-mix and mode of administration; and public reporting. The annual cost to the Federal Government is estimated to be \$3,230,000.

15. Changes to Burden

Using more recent data we are adjusting the number of individuals surveyed from 3,100,000 to

3,104,200 participants (an increase of 4,200 survey respondents). As our estimated response time remains unchanged (8 minutes), the increased number of survey participants necessitates an adjustment of our total time estimate from 413,230 to 413,790 hours (an increase of 560 hours).

We are not adjusting our hospital burden estimates. Since 2015, the number of hospitals participating in HCAHPS has been fairly stable at approximately 4,200 hospitals. We estimate that the number of hospitals will remain fairly stable over the next three years.

For Attachment A, the placement of the expiration date has been moved to the top right hand corner of the page 1. While Attachments B (Telephone Script) and C (AVIR Script) have been added to this 2018 iteration, their use has been discussed in previous packages. The survey itself is unchanged.

Labor costs were mistakenly added to the ROCIS burden table. Costs are removed from that table, but continue to be set out in section 12 of this Supporting Statement.

16. Publication/Tabulation Dates

Since October 2006, the HCAHPS Survey has been administered on a continuous basis, and since March 2008, HCAHPS results have been publicly reported on the Hospital Compare website four times per year. This pattern will continue into the foreseeable future.

17. Expiration Date

CMS will display the OMB number and expiration date.

18. Certification Statement

This information collection request does not involve any exceptions to the certification statement.