DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality Agency Information Collection Activities

Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: ''Medical Expenditure Panel Survey (MEPS) Household Component and the MEPS Medical Provider Component'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

DATES: Comments on this notice must be received by August 13, 2012.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email at *doris.lefkowitz@AHRQ.hhs.gov.*

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by email at *doris.lefkowitz@AHRQ.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project

Medical Expenditure Panel Survey (MEPS) Household Component and the MEPS Medical Provider Component

For over thirty years, results from the MEPS and its predecessor surveys (the 1977 National Medical Care Expenditure Survey, the 1980 National Medical Care Utilization and Expenditure Survey and the 1987 National Medical Expenditure Survey) have been used by OMB, DHHS, Congress and a wide number of health services researchers to analyze health care use, expenses and health policy.

Major changes continue to take place in the health care delivery system. The MEPS is needed to provide information about the current state of the health care system as well as to track changes over time. The MEPS permits annual estimates of use of health care and expenditures and sources of payment for that health care. It also permits tracking individual change in employment, income, health insurance and health status over two years. The use of the National Health Interview Survey (NHIS) as a sampling frame expands the MEPS analytic capacity by providing another data point for comparisons over time.

Households selected for participation in the MEPS Household Component (MEPS–HC) are interviewed five times in person. These rounds of interviewing are spaced about 5 months apart. The interview will take place with a family respondent who will report for him/herself and for other family members.

The MEPS–HC has the following goal:

- To provide nationally representative estimates for the U.S. civilian noninstitutionalized population for health care use, expenditures, sources of payment and health insurance coverage.

The MEPS Medical Provider Component (MEPS–MPC) will contact medical providers (hospitals, physicians, home health agencies and institutions) identified by household respondents in the MEPS–HC as sources of medical care for the time period covered by the interview, and all pharmacies providing prescription drugs to household members during the covered time period. The MEPS–MPC is not designed to yield national estimates. The sample is designed to target the types of individuals and providers for whom household reported expenditure data was expected to be insufficient. For example, households with one or more Medicaid enrollees are targeted for inclusion in the MEPSMPC because this group is expected to have limited information about payments for their medical care.

The MEPS–MPC has the following goal:

- To provide an imputation source to supplement/replace household reported expenditure and source of payment information. This data will supplement, replace and verify information provided by household respondents about the charges, payments, and sources of payment associated with specific health care encounters.

This study is being conducted by AHRQ through its contractors, Westat and RTI International, pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the cost and use of health care services and with respect to health statistics and surveys. 42 U.S.C. 299a(a)(3) and (8); 42 U.S.C. 299b–2.

Method of Collection

To achieve the goals of the MEPS–HC the following data collections are implemented:

1. *Household Component Core Instrument.* The core instrument collects data about persons in sample households. Topical areas asked in each round of interviewing include condition enumeration, health status, health care utilization including prescribed medicines, expense and payment, employment, and health insurance. Other topical areas that are asked only once a year include access to care, income, assets, satisfaction with health plans and providers, children's health, and adult preventive care. While many of the questions are asked about the entire reporting unit (RU), which is typically a family, only one person normally provides this information.

2. *Adult Self Administered Questionnaire.* A brief self-administered questionnaire (SAQ) will be used to collect self-reported (rather than through household proxy) information on health status, health opinions and satisfaction with health care for adults 18 and older. The satisfaction with health care items are a subset of items from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The health status items are from the Short Form 12 Version 2 (SF–12 version 2), which has been widely used as a measure of self-reported health status in the United States, the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ–2).

3. Diabetes Care SAQ. A brief self administered paper-and-pencil questionnaire on the quality of diabetes care is administered once a year (during rounds 3 and 5) to persons identified as having diabetes. Included are questions about the number of times the respondent reported having a hemoglobin A1c blood test, whether the respondent reported having his or her feet checked for sores or irritations, whether the respondent reported having an eye exam in which the pupils were dilated, the last time the respondent had his or her blood cholesterol checked and whether the diabetes has caused kidney or eye problems. Respondents are also asked if their diabetes is being treated with diet, oral medications or insulin.

4. *Permission forms for the MEPS–MPC Provider and Pharmacy Survey.* As in previous panels of the MEPS, we will ask respondents for permission to obtain supplemental information from their medical providers (hospitals, physicians, home health agencies and institutions) and pharmacies.

To achieve the goal of the MEPS–MPC the following data collections are implemented:

1. *MPC Screening Call.* An initial screening call is placed to determine the type of facility, whether the practice or facility is in scope for the MEPS–MPC, the appropriate MEPS–MPC respondent and some details about the organization and availability of medical records and billing at the practice/facility. All hospitals, physician offices, home health agencies, institutions and pharmacies are screened by telephone. A unique screening instrument is used for each of the seven provider types in the MEPS–MPC.

2. *Home Care Provider Questionnaire for Health Care Providers.* This questionnaire is used to collect data from home health care agencies which provide medical care services to household respondents. Information collected includes type of personnel providing care, hours or visits provided per month, and the charges and payments for services received.

3. *Home Care Provider Questionnaire for Non-Health Care Providers.* This questionnaire is used to collect information about services provided in the home by non-health care workers to household respondents because of a medical condition; for example, cleaning or yard work, transportation, shopping, or child care.

4. *Medical Event Questionnaire for Office-Based Providers.* This questionnaire is for office-based physicians, including doctors of medicine (MDs) and osteopathy (DOs), as well as providers practicing under the direction or supervision of an MD or DO (e.g., physician assistants and nurse practitioners working in clinics). Providers of care in private offices as well as staff model HMOs are included.

5. *Medical Event Questionnaire for Separately Billing Doctors.* This questionnaire collects information from physicians identified by hospitals (during the Hospital Event data collection) as providing care to sampled persons during the course of inpatient, outpatient department or emergency room care, but who bill separately from the hospital.

6. *Hospital Event Questionnaire.* This questionnaire is used to collect information about hospital events, including inpatient stays, outpatient department, and emergency room visits. Hospital data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay or visit. In many cases, the hospital administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the hospital itself; the doctors that do bill separately from the hospital will be contacted as part of the Medical Event Questionnaire for Separately Billing Doctors. HMOs are included in this provider type.

7. *Institutions Event Questionnaire.* This questionnaire is used to collect information about institution events, including nursing homes, rehabilitation facilities and skilled nursing facilities. Institution data are collected not only from the billing department, but from medical records and administrative records departments as well. Medical records departments are contacted to determine the names of all the doctors who treated the patient during a stay. In many cases, the institution administrative office also has to be contacted to determine whether the doctors identified by medical records billed separately from the institution itself.

8. *Pharmacy Data Collection Questionnaire.* This questionnaire requests the national drug code (NDC) and when that is not available the prescription name, date prescription was filled, payments by source, prescription strength and form (when the NDC is not available), quantity, and person for whom the prescription was filled. When the NDC is available, we do not ask for prescription name, strength or form because that information is embedded in the NDC; this reduces burden on the respondent. Most pharmacies have the requested information available in electronic format and respond by providing a computer generated printout of the patient's prescription information. If the computerized form is unavailable, the pharmacy can report their data to a telephone interviewer. Pharmacies are also able to provide a CD–ROM with the requested information if that is preferred. HMOs are included in this provider type.

The MEPS is a multi-purpose survey. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, the MEPS also provides estimates of measures related to health status, consumer assessment of health care, health insurance coverage, demographic characteristics, employment and access to health care indicators. Estimates can be provided for individuals, families and population subgroups of interest. Data from the MEPS, both the HC and MPC components, are intended for a number of annual reports required to be produced by AHRQ, including the National Health Care Quality Report and the National Health Care Disparities Report.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondents' time to participate in the MEPS–HC and MEPS–MPC. The MEPS–HC Core Interview will be completed by 12,500 ''family level'' respondents, also referred to as RU respondents. Since the MEPS–HC consists of 5 rounds of interviewing covering a full two years of data, the annual average number of responses per respondent is 2.5 responses per year. The MEPS–HC core requires an average response time of 1½ hours to administer. The Adult SAQ will be completed once a year by each person in the RU that is 18 years old and older, an estimated 22,000 persons. The Adult SAQ requires an average of 7 minutes to complete. The Diabetes care SAQ will be completed once a year by each person in the RU identified as having diabetes, an estimated 1,700 persons, and takes about 3 minutes to complete. The permission form for the MEPS–MPC Provider Survey will be completed once for each medical provider seen by any RU member. Each of the 12,500 RUs in the MEPS–HC will complete an average of 5.2 forms, which require about 3 minutes each to complete. The permission form for the MEPS–MPC Pharmacy Survey will be completed once for each pharmacy for any RU member who has obtained a prescription medication. Each RU will complete an average of 3.1 forms, which take about 3 minutes to complete. The total annual burden hours for the MEPS–HC are estimated to be 54,715 hours.

All 37,600 medical providers and pharmacies included in the MEPS–MPC will receive a screening call which will take 2 minutes on average. The MEPS–MPC uses 7 different questionnaires; 6 for medical providers and 1 for pharmacies. Each questionnaire is relatively short and requires 3 to 5 minutes to complete. The total annual burden hours for the MEPS–MPC are estimated to be 20,565 hours. The total annual burden hours for the MEPS–HC and MPC is estimated to be 75,280 hours.

Exhibit 2 shows the estimated annual cost burden associated with the respondents' time to participate in this information. The annual cost burden for the MEPS–HC is estimated to be $1,189,505; the annual cost burden for the MEPS–MPC is estimated to be $309,798. The total annual cost burden

for the MEPS–HC and MPC is estimated to be $1,499,303.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
MEPS–HC				
MEPS–HC Core Interview	12,500	2.5	1.5	46,875
Adult SAQ	22,000	1	7/60	2,567
Diabetes care SAQ	1,700	1	3/60	85
Permission form for the MEPS–MPC Provider Survey	12,500	5.2	3/60	3,250
Permission form for the MEPS–MPC Pharmacy Survey	12.500	3.1	3/60	1,938
Subtotal for the MEPS–HC	61,200	na	na	54,715
MEPS–MPC				
MPC Screening Call*	37,600	1	2/60	1,253
Home care for health care providers questionnaire	465	6.5	5/60	252
Home care for non-health care providers questionnaire	35	6.6	5/60	19
Office-based providers questionnaire	12,000	5.8	5/60	5,800
Separately billing doctors questionnaire	12,000	2	3/60	1,200
Hospitals questionnaire	5,000	6.5	5/60	2,708
Institutions (non-hospital) questionnaire	100	1.5	5/60	13
Pharmacies questionnaire	8,000	23.3	3/60	9,320
Subtotal for the MEPS–MPC	75,200	na	na	20,565
Grand Total	136,400	na	na	75,280

* There are 7 different screening forms; one for each event type. The burden estimates for the individual forms ranges from 1 to 3 minutes. The estimate of 2 minutes used here is an average across all 7 screening forms.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate	Total cost burden
MEPS–HC				
MEPS–HC Core Interview	12,500	46,875	$21.74*	$1,019,06
Adult SAQ	22,000	2,567	21.74	55,807
Diabetes care SAQ	1,700	85	21.74	1,848
Permission form for the MEPS–MPC Provider Survey	12,500	3,250	21.74	70,655
Permission form for the MEPS–MPC Pharmacy Survey	12.500	1,938	21.74	V42,132
Subtotal for the MEPS–HC	61,200	54,715	na	1,189,505
MEPS–MPC				
MPC Screening Call	37,600	1,253	15.59**	19,534
Home care for health care providers questionnaire	465	252	15.59	3,929
Home care for non-health care providers questionnaire	35	19	15.59	296
Office-based providers questionnaire	12,000	5,800	15.59	90,422
Separately billing doctors questionnaire	12,000	1,200	15.59	18,708
Hospitals questionnaire	5,000	2,708	15.59	42,218
Institutions (non-hospital) questionnaire	100	13	15.59	203
Pharmacies questionnaire	8,000	9,320	14.43***	134,488
Subtotal for the MEPS–MPC	75,200	20,560	na	309,798
Grand Total	136,400	75,275	na	1,499,303

* Based upon the mean of the average wages for All Occupations (00–0000).
** Based upon the mean of the average wages for Medical Secretaries (43–6013).
*** Based upon the mean of the average wages for Pharmacy Technicians (29–2052).
Occupational Employment Statistics, May 2011 National Occupational Employment and Wage Estimates United States, U.S. Department of Labor, Bureau of Labor Statistics. *http://www.bls.gov/oes/current/oes_nat.htm#b29-0000.*

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the total and annualized cost of this information collection. The cost associated with the design and data collection of the MEPS–HC and MEPS–MPC is estimated to be $51,401,596 in each of the three years covered by this information collection request.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

Cost component	Total cost	Annualized cost
Sampling Activities	$3,002,731	$1,000,910
Interviewer Recruitment and Training	9,190,168	3,063,389
Data Collection Activities	93,611,428	31,203,809
Data Processing	23,087,605	7,695,868
Production of Public Use Data Files	21,079,118	7,026,373
Project Management	4,233,739	1,411,246
Total	154,204,789	51,401,596

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ healthcare research and healthcare information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: June 1, 2012.

Carolyn M. Clancy,

Director.

[FR Doc. 2012–14204 Filed 6–12–12; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day-12–12NF]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 and send comments to Kimberly S. Lane, CDC 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

Comments are invited on (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

School Environment Study: Evaluating the Effects of CTG-supported School-based Nutrition and Physical Activity Policies on Students' Diet, Physical Activity, and Weight Status—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Prevention and Public Health Fund (PPHF) of the Patient Protection and Affordable Care Act of 2010 (ACA) provides an important opportunity for states, counties, territories, and tribes to advance public health across the lifespan and to reduce health disparities. The PPHF authorizes Community Transformation Grants (CTG) for the implementation, evaluation, and dissemination of evidence-based community preventive health activities. The CTG program emphasizes five strategic directions: (1) Tobacco-free living; (2) active lifestyles and healthy eating; (3) high impact, evidence-based clinical and other preventive services; (4) social and emotional well-being; and (5) healthy and safe physical environments.

The CTG program is administered by the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). As required by Section 4201 of the ACA, CDC is responsible for conducting a comprehensive evaluation of the CTG program which includes assessment over time of measures relating to each of the five strategic directions. CDC is requesting OMB approval to collect information needed for these assessments. This information collection will enable a multi-method evaluation of the school nutrition and physical activity environments and on related health indictors among students. The School Environment Study involves a quasi-experimental design that will assess nutrition-, physical activity-, and obesity-related outcomes and impacts, and compare differential changes in these outcomes and impacts between students sampled in middle schools supported by the CTG program and students sampled in middle schools not supported by the CTG program.

Four CTG program awardees (Broward County, Florida; Travis County, Texas; eight counties in Massachusetts (excludes the city of Boston and surrounding area); and Los Angeles County, California) were selected to participate in the School