

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents *	Total burden hours	Average hourly wage rate **	Total cost burden
In-person preliminary interviews with leaders/decisionmakers	33	33	^a \$94.47	\$3,117.51
Remote follow-up interviews with leaders/decisionmakers	33	33	^a 94.47	3,117.51
Remote follow-up interviews with clinical staff	22	22	^b 52.13	1,146.86
Review of materials prior to BOTH preliminary and follow-up interviews—LHS leaders/decisionmakers	33	16.5	^a 94.47	1,558.76
Review of materials prior to interviews—clinical staff	22	5.5	^b 52.13	286.72
Interview scheduling and other staff assistance ^c	11	44	^c 20.34	894.96
Implementation check-ins (documented for the evaluation as structured notes on implementation progress)	11	60.5	^a 94.47	5,715.44
Total	165			15,837.76

* The numbers in this column give the maximum number of respondents for each listed activity based on a range in the number of recruits per site (e.g., “2–3 LHS leaders/decisionmakers”). As noted in the comment to Exhibit 1, the balance may shift some between LHS leaders/decisionmakers and clinical staff depending on implementation team and leadership composition at each site. In any case, 88 interviews (33 + 33 + 22 = 88) is a maximum possible.

** National Compensation Survey: Occupational wages in the United States May 2018 “U.S. Department of Labor, Bureau of Labor Statistics.”

^aBased on the mean wages for *Internists, General, 29–1063; annual salary of \$196,490.*

^bBased on the mean wages for *Physician Assistants, 29–1071; annual salary of \$108,430.*

^cBased on the mean wages for *Secretaries and Administrative Assistants, 43–6010; annual salary of \$42,320.*

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’s health care research and health care 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: April 7, 2020.

Virginia L. Mackay-Smith,

Associate Director.

[FR Doc. 2020–07664 Filed 4–10–20; 8:45 am]

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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: “*Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Database.*” In accordance with the Paperwork Reduction Act of 1995, AHRQ invites the public to comment on this proposed information collection. This proposed information collection was previously published in the **Federal Register** on January 28, 2020 and allowed 60 days for public comment. AHRQ did not receive comments from members of the public. The purpose of this notice is to allow an additional 30 days for public comment. **DATES:** Comments on this notice must be received by 30 days after date of publication of this notice.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to www.reginfo.gov/public/do/PRAMain. Find this particular information collection by selecting “Currently under 30-day Review—Open

for Public Comments” or by using the search function.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Database

AHRQ requests that OMB reapprove AHRQ’s collection of information for the AHRQ Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Database: OMB Control number 0935–0165, expiration May 31, 2020 (the CAHPS Health Plan Database). The CAHPS Health Plan Database consists of data from the AHRQ CAHPS Health Plan Survey. Health plans in the U.S. are asked to voluntarily submit data from the survey to AHRQ, through its contractor, Westat. The CAHPS Health Plan Database was developed by AHRQ in 1998 in response to requests from health plans, purchasers, and the Centers for Medicare & Medicaid Services (CMS) to provide comparative data to support public reporting of health plan ratings, health plan accreditation and quality improvement.

This research has the following goals:

(1) To maintain the CAHPS Health Plan Database using data from AHRQ’s standardized CAHPS Health Plan Survey to provide results to health care purchasers, consumers, regulators and policy makers across the country.

(2) To offer several products and services, including aggregated results presented through an Online Reporting

System, summary chartbooks, custom analyses, and data for research purposes.

(3) To provide data for AHRQ’s annual National Healthcare Quality and Disparities Report.

(4) To provide state-level data to CMS for public reporting on *Medicaid.gov* and *Data.Medicaid.gov* that does not display the name of the health plans.

Survey data from the CAHPS Health Plan Database are used to produce four types of products: (1) An annual chartbook available to the public on the CAHPS Database website (<https://www.cahpsdatabase.ahrq.gov/CAHPSIDB/Public/Chartbook.aspx>); (2) individual participant reports that are confidential and customized for each participating organization (e.g., health plan, Medicaid agency) that submits their data; (3) a research database available to researchers wanting to conduct additional analyses; and (4) data tables provided to AHRQ for inclusion in the National Healthcare Quality and Disparities Reports.

This study is being conducted by AHRQ through its contractor, Westat, 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 quality, effectiveness, efficiency, appropriateness and value of healthcare services; quality measurement and development, and database development. 42 U.S.C. 299a(a)(1), (2) and (8).

Method of Collection

To achieve the goals of this project the following data collections will be implemented:

- Health Plan Registration Form—The point-of-contact (POC), often the sponsor from Medicaid agencies and health plans, completes a number of

data submission steps and forms, beginning with the completion of the online registration form. The purpose of this form is to collect basic contact information about the organization and initiate the registration process.

- Data Use Agreement—The purpose of the data use agreement, completed by the participating sponsor organization, is to state how data submitted by health plans will be used and provide confidentiality assurances.

- Health Plan Information Form—The purpose of this form, completed by the participating sponsor organization, is to collect background characteristics of the health plan.

- Questionnaire Submission—POCs upload a copy of the questionnaire used to ensure that it meets CAHPS Health Plan Survey standards (the survey instrument must include all core questions, not alter the wording of any core questions, and must not omit any of the survey items related to respondent characteristics that are used for case mix adjustment.)

- Data Files Submission—POCs upload their data file using the Health Plan data file specifications to ensure that users submit standardized and consistent data in the way variables are named, coded, and formatted.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated burden hours for the respondents to participate in the database. The burden hours pertain only to the collection of Medicaid data from State Medicaid agencies and individual Medicaid health plans because those are the only entities that submit data through the data submission process (other data are obtained from CMS). The 85 POCs in Exhibit 1 are a combination of an estimated 75 State Medicaid agencies and individual health plans, and 10 vendor organizations.

Each State Medicaid agency, health plan or vendor will register online for submission. The online registration form will require about 5 minutes to complete. Each submitter will also complete a health plan information form about each health plan, such as the name of the plan, the product type (e.g., HMO, PPO), and the population surveyed (e.g., adult Medicaid or child Medicaid). Each year, the prior year’s plan data are preloaded in the plan table to lessen burden on the POC. The POC is responsible for updating the plan table to reflect the current year’s plan information. The online health plan information form takes on average 30 minutes to complete per health plan with each POC completing the form for four plans on average. The data use agreement will be completed by the 75 participating State Medicaid agencies or individual health plans. Vendors do not sign or submit DUAs. The DUA requires about 5 minutes to sign and upload. Each submitter will provide a copy of their questionnaire and the survey data file in the required file format. Survey data files must conform to the data file layout specifications provided by the CAHPS Health Plan Database. Since the unit of analysis is at the health plan level, submitters will upload one data file per health plan. Once a data file is uploaded the file will be checked automatically to ensure it conforms to the specifications and a data file status report will be produced and made available to the submitter. Submitters will review each report and will be expected to fix any errors in their data file and resubmit if necessary. It will take about 1 hour to submit the questionnaire and data for each plan, and each POC will submit data for four plans on average. The total burden is estimated to be 463 hours annually.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents/ POCs	Number of responses per POC	Hours per response	Total burden hours
Registration Form	85	1	5/60	7
Health Plan Information Form	75	4	30/60	150
Data Use Agreement	75	1	5/60	6
Questionnaire and Data Files Submission	75	4	1	300
Total	310	NA	NA	463

Exhibit 2 shows the estimated annualized cost burden based on the respondents’ time to complete one

submission process. The cost burden is estimated to be \$22,083 annually.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total cost burden
Registration Form	85	7	^a 54.68	\$383
Health Plan Information Form	75	150	^a 54.68	8,202
Data Use Agreement	75	6	^b 96.22	577
Questionnaire and Data Files Submission	75	300	^c 43.07	12,921
Total	310	463	NA	\$22,083

* National Compensation Survey: Occupational wages in the United States May 2018, “U.S. Department of Labor, Bureau of Labor Statistics.”

^a Based on the mean hourly wage for Medical and Health Services Managers (11–9111).

^b Based on the mean hourly wage for Chief Executives (11–1011).

^c Based on the mean hourly wages for Computer Programmer (15–1131).

Request for Comments

In accordance with the Paperwork Reduction Act of 1995, 44 U.S.C. 3501–3521, 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 health care research and health care 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: April 7, 2020.

Virginia Mackay-Smith,
Associate Director.

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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: “*Evaluating the Dissemination and Implementation of PCOR to Increase Referral, Enrollment, and Retention through Automatic Referral to Cardiac Rehabilitation (CR) with Care Coordination.*” This proposed information collection was previously published in the **Federal Register** on February 4th, 2020 and allowed 60 days for public comment. AHRQ did not receive comments from members of the public. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by 30 days after date of publication of this notice.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to www.reginfo.gov/public/do/PRAMain. Find this particular information collection by selecting “Currently under 30-day Review—Open for Public Comments” or by using the search function.

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

Evaluating the Dissemination and Implementation of PCOR To Increase Referral, Enrollment, and Retention Through Automatic Referral to Cardiac Rehabilitation (CR) With Care Coordination

The aim of AHRQ’s TAKEheart project is to (a) raise awareness about the benefits of cardiac rehabilitation (CR) after myocardial infarction or coronary revascularization, then to (b)

disseminate knowledge about the best practices to increase referrals to CR, and, finally, (c) to increase CR uptake. Currently over two-thirds of eligible cardiac patients are not referred to CR despite extensive evidence of its effectiveness in preventing subsequent morbidity; national estimates of referral range from 10–34%. To help improve CR rates, the Million Hearts® Cardiac Rehabilitation Collaborative—an initiative co-led by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS)—developed a Cardiac Rehabilitation Change Package (CRCP) and established a national goal of 70% participation in CR by 2022 for eligible patients. Recognizing that widespread adoption of the CRCP could help hospitals enhance CR rates, the CDC turned to AHRQ with a request that AHRQ consider disseminating and implementing evidence for CR and practices that promote CR. The CRCP is designed to facilitate this dissemination and implementation process. AHRQ reviewed this request in the context of its Patient Centered Outcomes Research Dissemination and Implementation initiative and judged the CDC nomination to have a high level of fit with AHRQ’s criteria of having a substantial evidence base, high potential impact, and high feasibility for wide dissemination and implementation. Outreach with stakeholders indicates that this initiative aligns well but does not duplicate work by NIH; PCORI; CMS and CDC.

The core recommendations in the CDC package are, first to spread adoption of automatic referral system—where patients after cardiovascular events are referred by the Electronic Health Record to rehabilitation unless the cardiologist actively decides not to refer because of medical ineligibility. The second core recommendation is use of a care coordinator to guide patients through referral has resulted in the most significant increases in referral to CR.