PAPERWORK REDUCTION ACT SUBMISSION WORKSHEET
Part I: Information Collection Request

This template is intended for staff without an ICRAS account. Please fill out and submit to the appropriate Operating Division to enter into ICRAS. The form mirrors the screens available in the ICRAS 4 system. To request an account to log into ICRAS.

Instructions for filling out the form are available at www.paperworkreduction.gov.

1. Agency/Subagency originating request
Centers for Medicare & Medicaid Services
Office of Research, Development, and Information

2. Title
Evaluation of the Home Health Pay for Performance Demonstration: Survey instrument

3. Type of information collection *(check one)*
(See instructions)
X New collection (Request for a new OMB Control Number)
__Extension without change of a currently approved collection
__ Revision of a currently approved collection
__Reinstatement without change of a previously approved collection
__ Reinstatement with change of a previously approved collection
__ Nonmaterial or nonsubstantive change to a currently approved collection (formerly 83C)
__Existing collection in use without and OMB Control Number

4. OCN: _____

5. Type of review requested *(check one)*

a. X Regular
b. __ Emergency - Approval requested by: _____/_____/
c. __ Delegated

If Emergency, please attach justification.(4000 characters maximum)

6. Requested expiration date *(check one)*

a. X Three years from approval date
b. __ Six Months from approval date (Maximum for Emergency reviews)
c. Other

Specify:_____/_____ (mm/yy)
or Number of Months from Approval Date

7. Abstract (4000 characters maximum, attach additional sheets as necessary)

The Home Health Pay for Performance Demonstration is part of a movement by the Centers for Medicare & Medicaid Services toward performance-based purchasing for a variety of provider types. The current phase of the Home Health Pay for Performance Demonstration (HHP4PD) relies on the voluntary participation by home health agencies within several states, with random assignment of participating agencies to treatment or control groups within each state, where the control group will not be eligible for incentive payments. These two groups form the primary comparison for determining if the HHP4PD was effective in creating improved, targeted outcomes for patients served by home health agencies.

As part of the multifaceted evaluation protocol for the demonstration, all treatment and control group providers will be asked to complete a survey questionnaire twice during the demonstration--once during year one and once during year two of the demonstration implementation. This document supports the year one request for the survey questionnaire. Data elements collected include information about agency organization, clinical practices, and quality improvement activities, limited financial information, perceptions of the demonstration, and perceptions of the community environment. No personal health information will be collected as part of this survey. All data collected on the survey questions are focused on the home health agency as an entity.

The self-administered online questionnaire (19 items for the treatment home health agencies and 12 items for the control home health agencies) will be hosted on a secure Web site at the University of Colorado. The data from the survey questions are automatically sent to a different secure server at the Division of Health Care Policy and Research at the University of Colorado (our organization) for data analysis. The information collected will be used as part of the evaluation of the Home Health Pay for Performance Demonstration sponsored by the Centers for Medicare and Medicaid Services. This information will be at an aggregate level; no individually identifiable HHA data will be released to the public.

8. Authorizing Statute(s)

Public Law:

Congress Number	Sequence Number	Section	Name

US Code:

Title	Section	Name

Executive Order:

Number	Name

Statute:

Title	Subtitle

9. Associated Rulemaking Information
RIN: __ __ __ __ - __ __ __ __

Stage of Rulemaking *(check one)*
a. __ Proposed Rule
b. __ Interim Final or Final Rule

Federal Register Citation
Volume__ __ Page number_____
Publication Date _____/_____/____

For a Proposed Rule, OMB will not consider an ICR complete until the Notice of Proposed Rulemaking has been published.
For a Final Rule, please put the ICR reference number for the ICR reviewed at the proposed rule stage in Box 4.
For ICRs associated with Interim Final or Final rules that are not significant under EO

10. Federal Register Notices & Comments

Federal Register Citation

60-day Notice: Volume__ __ Page number __ __ __ __ __ __ Publication Date _____/_____/_____

30-day Notice: Volume__ __ Page number __ __ __ __ __ __ Publication Date _____/_____/_____

Did the Agency receive public comments on this ICR? _Yes _No
Unless submitted as an Emergency or Associated with Rulemaking, OMB will not consider an ICR complete until the 30-day notice has been published.
12866, please attach a draft of the Federal Register document.

11. Annual Cost to Federal Gov:

$ 4,508

12. Does this ICR contain surveys, censuses, or employ statistical methods?
X Yes (Attach Part B of Supporting Statement) __ No

13. Is the Supporting Statement intended to be a Privacy Impact Assessment required by the E-Government Act of 2002?
__ Yes X No

14. Agency contact:
Name William J. Buczko
Phone (410)786-6593
E-mail william.buczko@cms.hhs.gov

PAPERWORK REDUCTION ACT SUBMISSION WORKSHEET
Part I: Information Collection Request (continued)
Information Collection Budget (ICB)

If a change in burden is due to a Program Change Due to New Statute, identify the Citations for New Statutory Requirements:

Public Law:

Congress Number	Sequence Number	Section	Name

US Code:

Title	Section	Name

Executive Order:

Number	Name

Statute:

Title	Subtitle

If Program Change is due to Agency Discretion, please categorize the reduction. Burden reduction from (select one):

a. __ Cutting Redundancy
b. __ Using Information Technology
c. __ Changing Regulations
d. __ Changing Forms
e. __ Miscellaneous Actions

If Program Change is due to Agency Discretion, please categorize the increase in burden. Burden increase caused by (select one):

a. __ Changing Regulations
b. X __ Miscellaneous Actions

Explain the reasons for any program changes or adjustments reported; that is, provide a short statement how the reduction in burden was achieved or why the increase in burden occurred. (If you need more space, please provide a short summary here and elaborate in the Supporting Statement.) Burden increase reflects the resources required to collect information from demonstration participants. See item 12 on p. 4 Part A.