SUPPORTING STATEMENT
HEALTH RESOURCES AND SERVICES ADMINISTRATION
CLIENT-LEVEL DATA REPORTING SYSTEM

JUSTIFICATION

1. Circumstances of Information Collection

The Health Resources and Services Administration (HRSA) is requesting approval from the Office of Management and Budget (OMB) for the new Client-Level Data Reporting System (CLDRS). The CLDRS will be used to collect information from grantees and their subcontracted service providers funded under Parts A, B, C, D, and F of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White HIV/AIDS Program), as codified under title XXVI of the Public Health Service Act. Signed into law in December 2006 (P.L. 109-415), the Ryan White HIV/AIDS Program reauthorizes the Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) through 2009. The CARE Act was enacted in 1990 and, in addition to 2006, was reauthorized in 1996 and 2000.

The purpose of the Ryan White HIV/AIDS Program is to provide emergency assistance to localities that are disproportionately affected by the human immunodeficiency virus (HIV) epidemic. It makes financial assistance available for the development, organization, coordination, and operation of more effective and cost-efficient systems for the delivery of essential core medical and support services to persons with HIV disease. The Ryan White HIV/AIDS Treatment Modernization Act of 2006 provides Federal HIV/AIDS programs the flexibility to respond effectively to the changing epidemic.

The HIV/AIDS Bureau (HAB) within the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (DHHS) administers funds for all Parts of the Ryan White HIV/AIDS Program. Each Program Part is authorized by the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006, in the following sections: Part A under Sections 2601 and 2609; Part B under section 2611; Part C, Early Intervention Services, under Section 2651; Part D under section 2671; and Part F under section 2693.

OMB approval is being requested for the collection of de-identified client-level data from grantees and their service providers funded under Parts A, B, C, D, and F of the Ryan White HIV/AIDS Program. These data collection activities utilize online grantee- and provider-level reports, and de-identified client-level data by electronic upload. The U.S. Congress mandated that client-level data be collected under the Ryan White HIV/AIDS Treatment Modernization Act of 2006. These data will provide HRSA with information about the allocation of funds by grantees of record, the unduplicated number of clients served and services provided, demographic information about clients served, and the cost of providing services.

The different Parts of the Ryan White HIV/AIDS Program awards grants to cities, States and

territories, and community-based organizations. Seventy-five percent of Part A, B, and C funds must be used to fund core medical services, which include:

- Outpatient and ambulatory health services;
- HIV/AIDS medications;
- Oral health care;
- Early intervention services;
- Health insurance premium and cost sharing assistance;
- Home health care;
- Medical nutrition therapy;
- Hospice care;
- Community-based health services;
- Mental health services;
- Substance abuse outpatient care; and
- Medical case management, including treatment adherence services.

The remaining 25 percent may fund support services that are needed for individuals with HIV/AIDS to achieve their medical outcomes, such as: respite care for individuals with HIV/AIDS; outreach services; medical transportation; linguistic services; and referrals for health care and support services.

Part A of the Ryan White HIV/AIDS Program provides for two types of awards—grants to Eligible Metropolitan Areas (EMAs) and grants to Transitional Grant Areas (TGAs). Grants are awarded based on counts of people living with HIV/AIDS for the most recent calendar year:

- Metropolitan areas with a cumulative total of more than 2,000 cases of HIV/AIDS during the most recent 5-year period and a population of 50,000 or more are eligible for funding as EMAs.
- Metropolitan areas with a cumulative total of at least 1,000, but not more than 1,999, cases of HIV/AIDS during the most recent 5-year period and a population of 50,000 or more are eligible for funding as TGAs.

The new method for determining eligibility for Part A funds gives priority to urban areas with the highest number of people living with HIV/AIDS, while also helping midsize cities and areas with emerging needs. Adding the count of HIV-positive people to the formula for determining funding distributions allows medical care and support services to be provided in a way that reflects the spread of the virus in urban areas. By linking the current count of people who are HIV-positive to funding levels, the new law encourages outreach and testing, which will get people into treatment earlier, for the purpose of saving more lives.

Part B of the Ryan White HIV/AIDS Program provides grants to States and territories to improve the quality, availability, and organization of HIV/AIDS health care and support services. Base Part B grants are awarded using a formula that is based on living cases of HIV/AIDS. Additional Part B funds are “earmarked” for the AIDS Drug Assistance Program (ADAP), which primarily provides medications. Part B providers may include public or nonprofit entities. For-profit entities are eligible only if they are the sole available providers of quality HIV care in the area. Some States provide some services directly, while others work through subcontracts with Part B

HIV Care Consortia or with fiscal intermediary agencies. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease. A fiscal intermediary is an agency that the grantee contracts with to award service contracts and monitor funding use.

Part C of the Ryan White HIV/AIDS Program provides grants directly to service providers (e.g. ambulatory medical clinics) to support outpatient HIV early intervention services and ambulatory care. Specifically, the law assures that public and nonprofit organizations receiving Part C funds provide core medical and early intervention services, including HIV counseling and testing.

Part D of the Ryan White HIV/AIDS Program provides comprehensive, community-based, and family-centered services to children, youth, and women living with HIV and their families. Grantees are expected to provide care, treatment, and support services or to create a network of medical and social service providers who collaborate to supply services. Part D also funds a Youth Initiative, which supports youth-specific programs across the nation.

The Part F Minority AIDS Initiative (MAI) of the Ryan White HIV/AIDS Program is a national initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. Enacted to address the disproportionate impact of the disease in such communities, Part F MAI seeks to strengthen organizational capacity and expand HIV-related services in minority communities. Part F is also known as Part A MAI and Part B MAI.

All Parts of the Ryan White HIV/AIDS Program specify HRSA's responsibilities in the administration of grant funds, the allocation of funds, the evaluation of programs for the population served, and the improvement of the quantity and quality of care. Accurate records of the providers receiving Ryan White HIV/AIDS Program funding, the services provided, and the clients served continue to be critical to the implementation of the legislation and thus are necessary for HRSA to fulfill its responsibilities.

Valid and complete information about the characteristics of clients and the services provided to them is needed from all grantees to document the equitable distribution of funds used to serve diverse population groups in need of care, identify gaps in service delivery, and to ensure coordination and quality of care. HRSA, in close collaboration with grantees, service providers, and people living with HIV, has assessed the obstacles to and the benefits of establishing a client-level reporting system.

The current data reporting method for Ryan White HIV/AIDS Program grantees includes aggregate-level data. Since 2005, a HAB internal workgroup representing all HAB Divisions and a workgroup specific to the Division of Science and Policy (DSP) have been meeting to analyze and discuss the nature of the data reporting conducted by HAB, as well as designing a new draft data reporting system to support clinical quality management, performance measurement, service delivery, and client monitoring at both the system and client levels (see attachment for the workgroup members). The goal of the resulting CLDRS is to enhance the quality and usefulness of the data reported. HRSA plans to implement the CLDRS for reporting 2009 calendar-year

data.

The collection and submission of data for the Ryan White HIV/AIDS Program (RWHAP) is a public health activity and is consistent with provisions of the Ryan White HIV/AIDS Program (P.L. 101-381 as amended by P.L. 109-415) and enabling directives, rules, and guidelines governing the use of Federal monies.

The RWHAP requires the submission of Annual Reports by the Secretary of Health and Human Services to the appropriate committees of Congress. Client level data is one requirement for the Secretarial submission; however, the client level data is to consist of individual-level records that *do not* include personally identifiable information.

The submission of client level data from recipients of the Ryan White HIV/AIDS program funds will meet OMB's request for collection of race and ethnicity data at the grantee level. In addition, client level information is needed by HRSA in order to respond to OMB's Performance and Assessment Rating Tool (PART) reviews. OMB uses PART reviews to assess program performance and for strategic planning. The information that is needed for PART reviews is client level; however, the client level information does not include <u>any</u> personally identifiable health information.

2. Purpose and Use of Information

The purpose of collecting these data is to compile and analyze de-identified client-level data to address performance measures including the Government Performance Results Act (GPRA), Program Assessment Rating Tool (PART), and HRSA core clinical performance measures (see attachments for the client-level data elements and rationale for inclusion of each element in the CLDRS).

In the proposed system, agencies will only report data on funded services and selected clinical data associated with those services. This will allow HRSA to obtain accurate counts of the number of clients served by the Ryan White HIV/AIDS Program. In addition, the data submitted to HRSA/HAB will be used for monitoring the outcomes achieved on behalf of HIV/AIDS clients and their impacted families receiving care and treatment through RWHAP grantees and/or providers; monitoring the use of RWHAP funds for the appropriate use to address the HIV/AIDS epidemic in the United States; and addressing the needs and concerns of U.S. Congress and the DHHS Secretary concerning the HIV/AIDS epidemic and the RWHAP.
The CLDRS data provides a multitude of uses at the Federal, State and grantee levels. Grantees and service providers will collect information on the CLDRS and submit the data twice annually for the first year and once annually in subsequent years, for review by their respective Part A, B, C, D, and/or F (MAI) grantee(s). The various responsibilities are distributed as follows (see attachments for the CLDRS instruction manual):

- Provider organizations collect information about their clients, the services provided to their clients, and information about their organization;
- Providers upload this information to HRSA's secure server;
- Providers may, if they wish, generate descriptive reports and conduct analyses for

their internal use;
- Grantees review the information about the provider organization, and an aggregate report of the client-level data;
- Grantees approve the data and submit them to HRSA;
- Grantees may generate descriptive reports and conduct analyses for internal use or for use by their providers, consortia, or planning councils;
- Grantees may distribute analyses and reports to their providers, and may assist providers in preparing analyses for their internal use; and
- HRSA generates descriptive reports about the uses of funds and the types of providers receiving them, and conducts detailed analyses of national and regional information about clients and services.

3. Use of Improved Information Technology

This collection of information is fully electronic. Use of information technology varies greatly among grantees. Some grantees have established data systems that are capable of producing the required reports with minimal effort, while other grantees and providers have requested technical assistance to establish effective systems. Grantees can improve data quality, reporting efficiency, and responsiveness to the public by having their providers use an automated system that determines the number of clients served, the services provided to them, and the health status of these clients.

In order to report client-level data, grantees and providers will need access to the Internet. The grantee and provider reports should be completed online through a secure Web-based data entry system developed by HRSA. Many of the items on the Grantee Report and Service Provider Report will be pre-populated based on information already existing in the system. The client-level data set should be uploaded to the system in the required Extensible Markup Language (XML) format.

HRSA has developed its own database system, CAREWare, available at no cost to all Ryan White HIV/AIDS Programs. For smaller agencies that do not utilize an electronic client data system, HRSA is also developing a "light" version of CAREWare. This "light" version of CAREWare will allow users to enter only the variables required for the Client Report, and will be available on HRSA's Web site. After installing the program, the provider enters the de-identified client information into the program and exports the data in the required format. In addition, HRSA is working with a number of vendors of proprietary, HIV-care database systems to ensure that the systems are compatible with the proposed CLDRS.

Agencies that use a custom-built system will need to use the XML schema provided by HRSA to write a program that will extract data from the system and create the XML file. Technical support will be available through the HRSA Web site and HAB Project Officers to assist these agencies in devising a method of extracting and converting their data into the required format.

4. Efforts to Identify Duplication

Data of the type required to evaluate or monitor each of the Ryan White HIV/AIDS Program Parts are not available elsewhere. No known studies of people living with HIV or sample studies of people in defined demographic or risk groups provide comprehensive, overall program information specifically about grantees, providers, and beneficiaries of the RWHAP. The CLDRS is the only comprehensive source of grantee, provider, and client level information that will adequately address and meet HAB's data collection needs and objectives.

5. Involvement of Small Entities

This information collection includes small entities; however, this activity does not impose a significant impact on such entities. The information being requested or required has been held to the minimum required for the intended use. The information collection system is designed so that small organizations that provide fewer Ryan White HIV/AIDS Program services will skip more of the requested information than larger organizations that provide more services.

6. Consequences If Information Collected Less Frequently

Without annual reporting on the use of grant funds, HRSA would not be able to carry out its responsibility to oversee compliance with the intent of congressional appropriations in a timely manner. Because the epidemiology of HIV/AIDS is changing constantly, annual reporting of the characteristics of individual beneficiaries of the Ryan White HIV/AIDS Program grants is necessary to determine whether the administration of funds is responding to changes in the affected population. Data from the first 6 months of 2009 are also needed to inform the next reauthorization in the fall of 2009.

If the information is not collected at all, HRSA will not know, and will not be able to report:

- Whether program funds are being spent for their intended purposes;
- How program funds are being distributed among several discretionary categories by State and local grantees;
- How many and what types of individuals are receiving services, and how various services are distributed across various types of individuals;
- How rearrangement of the Part A program to more effectively direct funds to areas hardest hit by the epidemic is affecting the number and characteristics of individual service recipients; and
- How the distribution of program funds, the distribution of services, and the characteristics of individual beneficiaries are changing from one year to the next.

7. Consistency With the Guidelines in 5 CFR 1320.5(d)(2)

The data will be collected in a manner fully consistent with the guidelines in 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required in 5 CFR 1320.8(d) was published in the Federal Register on July 8, 2008 (Vol. 73, No. 131, pp. 39018-39020). Comments were received from seven entities (see attachment). Four people requested to review the forms and instruction manual.

HRSA conducted a year-long, external review process in which all RWHAP grantees, AIDS national constituency groups, and Federal agencies with HIV/AIDS programs and expertise were invited to provide input on various versions of the CLDRS, as the materials and processes developed. This was accomplished through regional consultations, which were held in each Federal DHHS region between January and March 2008, a Federal partner consultation in November 2007, and a non-Federal partner consultation in February 2008. Seventy-one percent of grantee organizations (312) were represented at the meetings (see attachments for meeting participants). Following each meeting, grantees reviewed the proposed materials and provided HRSA with additional feedback.

Reviewers consulted with HRSA on individual items, item instructions, definitions of terms, timeframes for implementation of the new reporting system, and the amount of resources that would be necessary to start reporting under the new system. Based on the input received, HRSA staff revised the report form and instruction manual and uploaded a second version for review in June 2008. Over one hundred grantees provided substantive feedback to HAB during the second round of user testing. This feedback was incorporated into the documents as appropriate.

AIDS national constituency groups that participated were:

- AIDS Action
- AIDS Alliance for Children, Youth, & Families
- American Academy of HIV Medicine
- CAEAR (Communities Advocating Emergency AIDS Relief) Coalition
- National Alliance of State & Territorial AIDS Directors (NASTAD)
- National Association of Community Health Centers, Inc. (NACHC)
- National Minority AIDS Council
- Southern AIDS Coalition
- The AIDS Institute
- Title II Community AIDS Network

Federal agencies that participated were:

- Agency for Health Care Research and Quality
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- Department of Health and Human Services
- Department of Housing and Urban Development
- Department of Veterans Affairs
- Indian Health Service
- Substance Abuse and Mental Health Services Administration

9. Remuneration of Respondents

The proposed collection of information does not involve any remuneration of respondents beyond the contracted agreement to collect data.

10. Assurance of Confidentiality

Client level or individual level information is collected; however, No personally identifiable information on individuals will be collected. Under the legislation, the client level data collection complies with the HIPAA requirements for de-identification of data. In addition, measures have been incorporated into the CLDRS to fully protect the confidentiality of clients receiving services. The following precautions have been instituted in the collection and analysis of data:

- All RWHAP clients will be assigned a Unique Client ID (UCI), which will be encoded through a hashing algorithm embedded within the data management system at the service provider site before the data set is submitted to HRSA;
- Grantees will not provide HRSA with any information that could identify individual clients. The data submitted are de-identified and cannot be used alone or in combination to re-identify specific Ryan White clients;
- All CLDRS reports and tabulated data that are released to the general public will be summarized across providers to eliminate confidentiality threats posed by cells containing data from providers that see a small number of clients.

11. Questions of a Sensitive Nature

All clients described in the CLDRS will be HIV-positive or members of the HIV-affected population. The purpose of the data collection will be to describe the demographics of these clients and their health status, as well as the quality of services being provided to them by Ryan White HIV/AIDS Program-funded providers. Data will be drawn from de-identified client-level databases and reports collected by providers. The reports will provide client-level information on the characteristics of clients served, the types of services provided, and the current health status of clients, based on core clinical performance measures established by HRSA. The data sent to HRSA will not include any information that could be used to identify the clients.

12. Estimates of Annualized Hour Burden

The estimated average annualized hour burden for the 2009–2011 program years is 88,191 hours per year. Burden estimates are broken out by burden to grantee respondents and burden to service provider respondents, as seen in Table 1 (Estimates of Average Annualized Hour Burden to Respondents for the First Year) and Table 2 (Estimates of Average Annualized Hour Burden to Respondents for the Second and Third Years). Estimates for grantees and service providers are further divided by CLDRS component. Estimates for grantees and providers are based on prior experience in collecting, maintaining, and reporting data using the current reporting forms;

interviews with volunteers from grantee agencies; and input from those who attended the regional meetings and responded to versions of the CLDRS posted online.

Grantee Report

The Grantee Report will have 646 respondents, representing the 646 grants allocated by HRSA. Each grantee will submit one Grantee Report for each of its grants per reporting period. Based on discussions with grantees representing each Program Part, we averaged the response time associated with completing the Grantee Report for each Part, multiplied the average response time by the total number of grants for each Part, and summed across all Parts. Since grantees will submit a Grantee Report twice in Year 1 for each grant, we multiplied the response time by two for a total of 1,967 burden hours in Year 1. In Year 2 and Year 3, one Grantee Report will be submitted for each grant, and the total annual hour burden will decrease to 983.

Provider Report

The Provider Report will have 2,253 respondents. Each provider agency will submit one Provider Report per reporting period. This includes agencies that provide services directly to agencies as well as providers of administrative support services. Based on discussions with grantee representatives, many of whom are also direct service providers, we determined that it will take each provider agency an average of 2.35 hours to complete the Provider Report. For Year 1, the report will be submitted twice, for a total hour burden of 10,589. In Year 2 and Year 3, the report will be submitted once annually, for a total hour burden of 5,295 each year.

Client Report

The Client Report will have 1,511 respondents in 2009 and 2,112 total respondents in 2010 and 2011. HAB is phasing in the requirement to submit client-level data, such that the 1,511 agencies that provide outpatient/ambulatory medical care and medical and non-medical case management will submit the Client Report in 2009, and the remaining 601 agencies that provide other core and/or support services to clients will submit the Client Report starting in 2010. The number of responses for the Client Report is based on 881,703 clients, which is the number of unduplicated clients reported by direct service providers in the 2007 Ryan White HIV/AIDS Program Annual Data Report (RDR). The amount of time the service provider takes to collect and process a Client Report in the new system takes into consideration the amount of time to enter client-level data into data collection systems (accounting for the fact that it will take longer to enter a new client record than to update a continuing client's record), and the amount of time to compile and report the data, for the grantee to review a provider report and the amount of time to correct any validation errors. The estimated amount of time for the Client Report differs for providers who do not have electronic data systems. We have estimated that each year, three percent of all direct service providers do not have electronic data systems and may each take 106.25 hours to collect and process a Client Report; an increase from the 3.75 hours for providers that do have electronic data systems.

We estimate 20,558 burden hours to complete the Client Report in Year 1 since the report will be submitted twice in the first year. We estimate 14,378 burden hours per year to complete the Client Report in Years 2 and 3. The time per provider response remains the same; however, the

total burden hours for providers submitting Client Reports decreases since we approximate that the 2,112 direct service providers will report client-level data once per year, in 2010 and in 2011.

CLD Collection System

Providers will need to either develop new client-level data collection systems or adjust their current systems to collect the elements that HAB is requesting. Consequently, burden associated with the client-level data collection system component is included in Table 1 for the 1,466 outpatient/ambulatory medical care and case management providers that will report client-level data in 2009, and in Table 2 for the remaining 583 direct service providers that will begin reporting client-level data in 2010. The amount of time to develop or adjust client-level data collection systems depends on the type of system the providers are already using; we estimate that it will take an average of 92.8 hours per provider to adjust their systems to collect the client-level data elements requested in the Client Report. This is a one-time burden for providers and will not be a factor in Year 3.

TABLE 1.

Estimates of Average Annualized Hour Burden to Respondents for the First Year (Two 6-Month Reporting Periods)

Grantee Response Burden						
COMPONENT	**Source of funding**	**Number of respondents**	**Responses per grantee**	**Total Responses**	**Hours to complete/ coordinate receipt of data reports**	**Total burden hours**
Grantee Report	Part A	56	2	112	1.27	142
	Part B	57	2	114	6.00	684
	Part C	357	2	714	0.39	278
	Part D	90	2	180	0.67	121
	Part A MAI	56	2	112	1.27	142
	Part B MAI	30	2	60	10.00	600
	Subtotal	646				**1,967**

Service Provider Response Burden						
COMPONENT		**Number of respondents**	**Responses per provider**	**Total Responses**	**Hours to develop/adjust CLD system**	**Total burden hours**
CLD Collection System		1,466	1	1,466	92.80	**136,045**

COMPONENT		**Number of respondents**	**Responses per provider**	**Total Responses**	**Hours per response**	**Total burden hours**
Provider Report		2,253*	2	4,506	2.35	**10,589**

COMPONENT	**Providers' Electronic Data Systems Capability**	**Number of respondents**	**Responses per provider**	**Total Responses**	**Hours to collect/report data per response**	**Total burden hours**
Client Report (client-level data)	No	45	2	90	106.25	9,563
	Yes	1,466	2	2,932	3.75	10,995
	Subtotal	1,511**				**20,558**

TOTAL BURDEN, YEAR 1	**169,159**

**All providers, including direct service providers and administrative support service-only providers.*

***Outpatient/ambulatory medical care, medical case management, and/or nonmedical case management providers that will submit a Client Report in 2009.*

TABLE 2.
Estimates of Average Annualized Hour Burden to Respondents for the Second and Third Years (One Reporting Period Per Year)

Grantee Response Burden						
COMPONENT	**Source of funding**	**Number of respondents**	**Responses per grantee**	**Total Responses**	**Hours to complete/ coordinate receipt of data reports**	**Total burden hours**
Grantee Report	Part A	56	1	56	1.27	71
	Part B	57	1	57	6.00	342
	Part C	357	1	357	0.39	139
	Part D	90	1	90	0.67	60
	Part A MAI	56	1	56	1.27	71
	Part B MAI	30	1	30	10.00	300
	Subtotal	646				**983**

Service Provider Response Burden						
COMPONENT		**Number of respondents**	**Responses per provider**	**Total Responses**	**Hours to develop/adjust CLD system**	**Total burden hours**
CLD Collection System		583	1	583	92.80	**54,102**

COMPONENT		**Number of respondents**	**Response per provider**	**Total Responses**	**Hours per response**	**Total burden hours**
Provider Report		2,253*	1	2,253	2.35	**5,295**

COMPONENT	**Providers' Electronic Data Systems Capability**	**Number of respondents**	**Responses per provider**	**Total responses**	**Hours to collect/report data per response**	**Total hour burden**
Client Report (client-level data)	No	63	1	63	106.25	6,694
	Yes	2,049	1	2,049	3.75	7,684
	Subtotal	2,112**				**14,378**

TOTAL BURDEN, YEAR 2	**74,758**
TOTAL BURDEN, YEAR 3†	**20,656**

**All providers, including direct service providers and administrative support service-only providers.*
*** All direct service providers, including those outpatient/ambulatory medical care, medical case management, and/or nonmedical case management providers that will submit a Client Report in 2009 as well as other direct service providers that will submit a Client Report in 2010.*
†There is no CLD Collection system adjustment in Year 3, so the total burden is less.

13. Estimates of Annualized Cost Burden to Respondents

Grantees are responsible for maintaining their own data system or using the CLDRS module of CAREWare, the system provided without cost by HRSA to collect CLDRS data. There are no direct costs to respondents other than their time in adjusting their data collection systems for the

initial reporting period (see Table 1), and participating in the data collection and quality assurance.

14. Estimate of Annualized Cost to the Federal Government

Table 3 shows the estimated annual cost to the Federal government.

The annual cost to HRSA for a contractor to provide data support, training, and technical assistance for the CLDRS is estimated to be approximately $350,000, based on similar services for the current RDR data collection. The annual cost to HRSA for Web data collection support and technical assistance is estimated to be approximately $370,000, based on similar services for RDR data collection and pilot CLDRS data collection.

TABLE 3.
Estimated Annual Cost to the Federal Government

Analysis and Reporting of CLDRS Data by Staff from the Division of Science and Policy	
160 hours by Supervisory Health Scientist (GS-15) at $130,700/year ($62.62/hour)	$10,019.20
1,040 hours by Health Statistician (GS-13) at $94,025/year ($45.05/hour)	$46,852.00
160 hours by Clerk Typist (GS-3) at $25,279/year ($12.11/hour)	$1,937.60
Total	$58,808.80
Revisions of CAREWare Software to Conform to the CLDRS	
260 hours by Supervisory Public Health Analyst (GS-14) at $111,104/year ($53.24/hour)	$13,842.40
Uploading CLDRS Software, Report Form, and Instruction Manual to HAB Web Site and Importing Client-Level Data	
160 hours by Program Analyst (GS-9) at $48,108/year ($23.05/hour)	$3,688.00
Data and Reporting System Support, Training, and Technical Assistance	
Data Support Contractor	$350,000.00
Reporting System Contractor	$370,000.00
Total	$720,000.00

15. Changes in Burden

This is a new collection of information.

16. Time Schedule, Publication, and Analysis Plans

In Year 1, the two reporting periods are January–June, and January–December. Biannual reports in year 1 and the annual reports in subsequent years from the grantees should be submitted to HRSA approximately 2 months following the end of each reporting period. HRSA compiles the data received from the grantees and produces an annual report for the Secretary of DHHS and Congress. In addition, HRSA staff produces national summaries that are distributed to constituency and advocacy groups and are uploaded to the HIV/AIDS Bureau Web site. Summaries consist of aggregate level data only.

Upon approval by OMB, the CLDRS forms and instructions will be made available to grantees to allow them as much time as possible to modify their data collection systems to conform to the new report.

17. Exemption for Display of Expiration Date

No exemption is requested.

18. Exceptions to Certifications for PRA Submissions

This information collection fully complies with the guidelines in 5 CFR 1320.9. The necessary certifications are included in the package.