

Asthma Information Reporting System (AIRS)

OMB Control No. 0920 - 0853 (Expiration Date: 5/31/2020)

Request for Revision

Supporting Statement Part A –

Justification

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Part A. Justification

Goal of the study: The National Center for Environmental Health's (NCEH's) National Asthma Control Program (NACP) supports state, local and territorial health departments to better understand the impact of asthma and to encourage a comprehensive public health approach to asthma control. The purpose of this information collection (IC) is to continue NACP's monitoring of recipient programs' planning and delivery of public health activities and the programs' collaboration with health care systems under a new cooperative agreement (CDC-RFA-EH19-1902). CDC collects information related to each recipient's strategies and activities, and the process and outcome PMs outlined by the cooperative agreement program. NACP-funded asthma programs report their progress on NACP-developed performance measures (PMs), as well as state-level asthma emergency department (ED) visit and hospital discharge (HD) data. A new PM electronic reporting tool has been developed, which will allow recipients to report PM information. Recipients receive funding to implement a variety of public health strategies and activities.

Intended use of the resulting data: Information will be used for multiple purposes: 1) monitoring state and national progress toward achieving the outcomes identified in the NACP's logic model; 2) facilitating aggregate reporting of outcomes to state and national stakeholders; 3) identifying and responding to technical assistance needs; and 4) promoting continuous quality improvement at the state program and CDC level.

Methods to be used to collect: Recipients will submit standardized PM data on an annual basis via a newly developed electronic reporting tool in SharePoint. The SharePoint site was created to allow recipients to electronically input information for eight core PMs. State-level ED visit and HD surveillance data will be submitted electronically by recipients to a dedicated electronic mailbox.

Subpopulation to be studied: Respondents include up to 30 cooperative agreement recipients (state, local, and territorial health departments).

How data will be analyzed: Data are aggregated by CDC staff using simple tabulations and displayed in tables and charts. Statistical methods are not used in the analysis of the information.

A.1. Circumstances Making the Collection of Information Necessary

Asthma affects 25 million people in the U.S., including 6.0 million children under the age of 18. It is a significant health and economic burden to patients, their families, and society. In 2016, 1.8 million people visited an emergency room for asthma related care and in 2016, 189,000 people were hospitalized because of asthma. Since 1999, the U.S. Congress has provided funding for the Centers for Disease Control and Prevention (CDC) National Asthma Control

Program (NACP) to support public health asthma programs. As funding allows, NACP administers five-year cooperative agreements to state, local, and territorial asthma programs to help improve asthma surveillance and to focus efforts and resources where needed.

In 2019, Congress approved funding for the NACP, which allowed CDC to formally issue a Notice of Funding Opportunity (NOFO) announcement of the availability of Federal funding. As a result of the NOFO, CDC provided funding to 24 state, territorial, and municipal partners to improve the reach, quality, effectiveness, and sustainability of asthma control services and to reduce asthma morbidity, mortality and disparities by implementing evidence-based strategies through a new 5-year cooperative agreement.

The NACP helps its recipients maximize the reach, impact, efficiency, and sustainability of comprehensive asthma control services. Attaining this goal will entail providing a seamless alignment of the full array of services across the public health and health care sectors to ensure people with asthma receive all, not just some, of the services they need. Information from evaluations and performance measures (PMs) are necessary to monitor and facilitate this alignment. The current cooperative agreement, entitled *A Comprehensive Public Health Approach to Asthma Control through Evidence-Based Interventions* (CDC-RFA-EH19-1902 program period: September 2019 – August 2024), funds 24 recipients.

All funded recipients are required to submit continuation applications and annual progress reports consistent with federal requirements in response to the Government Performance and Results Act of 1993 (GPRA). All funded recipients provide work plans, evaluation plans, and report minimum data elements that are used to evaluate the program at the national level. The purpose of this revision is to obtain OMB Paperwork reduction Act (PRA) approval to collect PMs and state-level asthma ED visit and HD data from newly funded recipients under the Asthma and Community Health Branch's new cooperative agreement, CDC-RFA-EH19-1902, *A Comprehensive Public Health Approach to Asthma Control through Evidence-Based Interventions*.

The CDC is requesting to revise the information collection request (ICR) titled *Asthma Information and Reporting System (AIRS)* (OMB Control No. 0920-0853, expiration date 5/31/2020) and obtain approval for a 3-year Paperwork Reduction Act (PRA) clearance. Details of the requested revisions are provided in Section A.15.

In summary, the changes to the original ICR are as follows:

- 1) We request to increase the number of respondents from 25 to 30. Currently, CDC funds 24 state, local, and territorial health departments for asthma management and surveillance activities (see **Attachment 3**, List of Funded Recipients). CDC is also planning to fund up to 6 additional recipients over the next fiscal year (total n=30).
- 2) We request to increase the number of burden hours from 89 to 105, due to an increase in the number of recipients.

- 3) We request to reduce and consolidate the PMs from 18 to eight core measures in the current cooperative agreement. This is in accordance with language in the Notice of Funding Opportunity (NOFO) announcement that CDC “will periodically review the use of performance measures and discontinue those that are not informative” (see **Attachment 4**, NOFO CDC-RFA-EH19-1902).
- 4) We request to change the collection method for receipt of PMs, from an Excel spreadsheet to a newly developed electronic reporting tool (SharePoint site).
- 5) We request to include instructions for the new electronic reporting tool that will be utilized to report the eight performance measures (see **Attachment 5c**, Instructions for Performance Measures Reporting Tool).
- 6) We request to change the collection method for receipt of surveillance data, from uploading to a now retired SharePoint site to submitting by email to a dedicated electronic mailbox.
- 7) We request to update the estimated annualized cost to the government to reflect current funding for the cooperative agreement, updated salaries for staff, and contractor costs for development of the new electronic reporting tool.

The NACP is authorized under sections 301(a) and 317b (k) (2) of the Public Health Service (PHS) Act, [42 U.S.C. sections 241(a) and 247b (k) (2)] (see **Attachments 1a and 1b**). The 60-day Federal Register Notice was published on 12/06/2019 (see **Attachment 2**) and is further discussed in Section A.8.

A.2. Purpose and Use of the Information Collection

The goal of this information collection effort is to collect asthma recipient data related to the recipients’ program planning and delivery of public health activities and the programs’ collaboration with health care systems. This information collection is necessary to assure that programs are progressing toward achievement of their stated goals and objectives and consistently demonstrating efficient and appropriate use of federal funds. Funded asthma programs report their progress on NACP-developed PMs as well as state-level asthma ED visit and HD data. The recipients’ reports also inform CDC evaluation staff about program evaluation efforts and technical assistance needs. Some of the PMs include: documentation that surveillance findings are used to target populations with a disproportionate burden of asthma; evidence that programs are identifying and leveraging opportunities available through health care reform; and documentation that the services and health systems strategies as implemented by the states lead to better asthma control and reduced hospitalizations and ED use (**Attachment 5a**).

The PM reporting tool provides a systematic format to collect these data consistently across all recipients. Having all this information in a single and secure database will allow CDC to analyze and synthesize information across multiple recipients, help ensure consistency in documenting progress and technical assistance, enhance accountability of the use of federal funds, and

provide timely reports on program implementation. CDC will then have the capacity to respond in a timely manner to requests for information about the program, improve real-time communications between CDC and recipients, and strengthen CDC's ability to monitor and evaluate recipients' progress and performance.

In the past three-years under previous cooperative agreements CDC-RFA-EH14-1404 (*Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration*, program period: September 2014 – August 2019) and CDC-RFA-EH16-1606 (*Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration*, program period: September 2016 – August 2019), AIRS data was used to:

- Serve as a resource to the branch, division, and center when addressing congressional, departmental and institutional inquiries. For example, the PMs allow us to report the number and age distribution of people reached with intensive asthma self-management education through the recipients and their partners.
- Help the branch align its current interventions with CDC goals and allowed the monitoring of progress toward these goals. For example, recipient efforts to establish public health–health care collaboration has been integrated into CDC's 6 | 18 initiative which connects healthcare purchasers, payers, and providers with CDC researchers, economists, and policy analysts to find ways to improve health and control costs with the 6 | 18 interventions.
- Allow the NACP and the state asthma programs to make more informed decisions about activities to achieve objectives. For example, PM information identified a problem with enrolling patients most in need of intervention into recipient programs. This led to cross-state discussions and changes in recruitment strategies.
- Facilitate communication about interventions across states and enable inquiries regarding interventions by populations with a disproportionate burden, age groups, geographic areas and other variables of interest.
- Provide feedback to the recipients about their performance relative to others through the distribution of two written reports and several presentations (webinar and in-person) summarizing the results.
- Motivate use of data and evaluation findings. For example, the requirement to report actions taken based on evaluation findings encourages program managers and health departments officials to act on recommendations in evaluation reports.

Over the past three years, CDC reviewed all PM information provided by recipients and worked with recipients to ensure internal consistency of information, and consistency in reporting across states. A report of aggregated data from AIRS was prepared for each funding cycle and distributed to the recipients and other stakeholders. CDC held webinars with recipients to present key findings and answer questions.

CDC used each recipients' PMs and evaluation findings in one-on-one technical assistance with a focus on action planning for program improvement. The analysis of PMs and synthesis of evaluation findings across recipients guided CDC's technical assistance approach and supported the creation of a data-driven community of practice in which recipients shared successful models as well as program challenges.

Additionally, evaluation and PM data help demonstrate achievement of program outcomes, build a stronger practice base for specific program strategies, clarify applicability of the evidence-based interventions to different populations, settings, and contexts, and support continuous quality improvement (CQI). Evaluation and PMs also can determine if program activities are scalable and effective at reaching target populations (people with a disproportionate burden of asthma as determined by each state's surveillance data).

A.3. Use of Improved Information Technology and Burden Reduction

CDC has developed the data entry interface for reporting of PMs using a SharePoint site. The user-friendly online interface will require very little training and will be easy and intuitive for recipients to use.

With the use of the PM reporting tool, the use of a standard set of data elements, definitions and specifications at all levels will help to improve the quality and comparability of performance information reported by recipients to CDC. Further, standardization will enhance the consistency of plans and reports, enable examination of cross-program performance and strategies, and facilitate a higher degree of reliability by ensuring that the same information is collected on all strategies and performance measures. Finally, the report generation capabilities of the PM reporting tool will reduce the burden associated with paper-based reports. Without the PM reporting tool and the integrated approach to information collection and reporting, both recipients and CDC would need to continue to use time consuming, labor-intensive procedures for information collection and reporting.

A.4. Efforts to Identify Duplication and Use of Similar Information

The collection of this information is part of a federal reporting requirement for funds received by recipients. AIRS does not cause duplication. There are no current data/information systems that meet the needs of the proposed data/information collection.

Asthma recipients collect state ED visit and HD data and report them using the data collection instruments (**Attachments 6a and 7a**) previously approved by OMB. Aggregate counts for ED visit and HD are then compiled and aggregated as part of CDC's regular surveillance tracking. There is no duplication of the data/information collection.

A.5. Impact on Small Businesses or Other Small Entities

No small businesses participate in this data collection.

A.6. Consequences of Collecting the Information Less Frequently

CDC will collect recipient reports annually. The annual progress report is due 120 days before the end of the budget period and serves as a non-competing continuation application. Less frequent reporting would negatively impact monitoring progress of national and state efforts to reduce the burden of asthma and undermine accountability efforts at both levels. Asthma recipients routinely collect asthma ED visit and HD data annually. Requesting data at the same interval minimizes additional burden on asthma recipients. The yearly reporting rate allows the NACP to respond in a timely manner with up-to-date information to inquiries from Congress and other stakeholders. In terms of negative consequences, without this information the NACP will be less effective at helping state programs reach their target goals. There are no technical or legal obstacles to reducing burden.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A 60-day Federal Register Notice was published in the Federal Register on 12/06/2019, Vol. 84, No. 235, pp. 66904 (**Attachment 2**). CDC received one non-substantive comment; no response was required (**Attachment 2a**).

The data collection instruments were designed collaboratively by CDC staff and the contractor, Deloitte Consulting LLP. Consultation will continue throughout the implementation process. Usability testing for the electronic reporting system was conducted with staff within the Asthma and Community Health Branch.

The contractor will provide a training with recipients on the use of the PM reporting tool.

Table A.8.1: Performance Measures Consultations

Name	Title	Affiliation	Phone	Email
Jennifer Camp	Project Manager	Deloitte Consulting LLP	(470) 755-3678	jecamp@deloitte.com
Oohaa Vennapusa	PowerBI	Deloitte Consulting	(470) 755-3678	ovennapusa@deloitte.com

	Developer	LLP		
Kristen Roskob	SharePoint Developer	Deloitte Consulting LLP	(470) 755-3678	kroskob@deloitte.com
Rodney Garland	Epidemiologist	Oregon State Asthma Program	(971) 673-1348	Rodney.Garland@state.or.us
Meredith Milet	Epidemiologist	California State Asthma Program	(510) 620-3634	Meredith.Milet@cdph.ca.gov
Pam York	Principal Investigator	Minnesota State Asthma Program	(651) 201-5659	Pam.York@state.mn.us
Trang Nguyen, MD, DrPH	Epidemiologist	New York State Asthma Program	(518) 474-2543	Trang.Nguyen@health.ny.gov
Ava Nepal	Evaluator	Connecticut State Asthma Program	(860) 509-8239	Ava.Nepaul@ct.gov

A.9. Explanation of Any Payment or Gift to Respondents

Respondents will not receive payments or gifts for providing information.

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The CDC Office of the Chief Information Officer has determined that the Privacy Act does not apply to this information collection request. The Privacy Impact Assessment (PIA) is attached (**Attachment 9**). Controls described are adequate for protecting aggregate and non-sensitive data. The data collection does not involve collection of sensitive and/or personally identifiable information. As this system does not collect personally identifiable information, there is no need for respondent consent. Information collected through progress reports is used to identify training and technical assistance needs; monitor compliance with cooperative agreement requirements; evaluate progress made in achieving national and program-specific goals; and to respond to inquiries regarding program activities and effectiveness.

The respondents completing the reporting elements within the SharePoint site are the state asthma program staff. The data will be securely stored within the SharePoint site. Each state, local and territorial asthma program recipient has access to its own information and surveillance data. The state, local, or territorial cooperative agreement recipient decides the level of access for each user, and to what extent local partners may access that information. State, local, and territory cooperative agreement recipients are required to report periodically as a condition of their award from CDC. The information collected will be neither sensitive nor proprietary in nature. Reporting spreadsheets containing aggregate ED visit and HD data will be uploaded and stored on the ACHB's SharePoint site.

A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions

The AIRS does not collect sensitive information or personal identifiers. The NCEH/ATSDR Human Subjects Contact has determined that the data collection is not research involving human subjects and IRB approval is not required (**Attachment 10**).

A.12. Estimates of Annualized Burden Hours and Costs

a) Estimated annualized burden hours

Respondents include the recipients of the Asthma Program cooperative agreement. Respondents will report information to CDC using the PM reporting tool and by emailing the ED Visits Reporting Form and HD Reporting Form. Past experience with recipients funded by the Program informed the estimate of burden hours for the responses listed in Table A12.1. Data will be collected annually. Table A12.1 (below) displays the annualized report burden computations.

Table A12.1: Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State Asthma Program Recipients	Performance Measures Reporting Tool	30	1	150/60	75
	Emergency Department Visits Reporting Form	30	1	30/60	15
	Hospital Discharge Reporting Form	30	1	30/60	15
Total					105

b) Estimated annualized cost to respondents

Estimates for the average hourly wage for respondents are based on the U.S. Department of Labor Bureau (DOL) of Labor Statistics May 2018 National Industry-Specific Occupational Employment and Wage Estimates (https://www.bls.gov/oes/current/oes_nat.htm#13-0000). Based on DOL data, the average hourly wage for a Management Analyst (Occupation Code 13-1111) is estimated to be \$45.38. The total estimated annualized cost is summarized in Table A12.2.

Table A12.2: Estimated Annualized Burden Hours

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State Asthma Program Recipients	Performance Measures Reporting Tool	75	\$45.38	\$3,403.50
	Emergency Department Visits Reporting Form	15	\$45.38	\$680.70
	Hospital Discharge Reporting Forms	15	\$45.38	\$680.70
Total				\$4,764.90

A.13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

The PM reporting tool is designed to use existing hardware within funded sites. No capital or maintenance costs are expected. Additionally, there are no start-up, hardware or software costs.

A.14. Annualized Cost to the Federal Government

The annualized cost to the federal government for the total cooperative agreement is \$15,425,425 as summarized in Table 4. The estimated annualized cost to the federal government of implementing AIRS, based on program experience in the previous three years is 5% of the total, or \$771,271.25 plus the contractor costs for development of the PM reporting tool (\$70,000). The total cost of the AIRS component of cooperative agreement per year is \$841,271.25.

AIRS costs factors include initial development of the electronic reporting tool by the contractor, and costs associated with reviewing reports, providing feedback, synthesizing and analyzing the information, and making program recommendations and adjustments.

Table 4: Estimated Annualized Cost to the Federal Government

Category	Number of staff	% effort	Average Yearly salary	Total Costs
Cooperative agreements per year	N/A	N/A	N/A	\$14,410,000
Effort of project officers per year	2	100%	\$105,719	\$211,438
	3	30%	\$123,929	\$111,536
Effort of evaluation technical assistants per year	4	100%	\$105,719	\$422,876
Effort of epi/surveillance staff per year	1	80%	\$105,719	\$84,575
Effort of principal investigator per year	1	50%	\$150,000	\$75,000
Effort of senior management per year	2	25%	\$150,000	\$75,000
Travel for site visits per year	N/A	N/A	N/A	\$35,000
Total costs of the cooperative				\$15,425,425

agreement per year		
Contractor Costs for Development of SharePoint Site		\$70,000
Total cost of the AIRS component of cooperative agreement per year		\$841,271.25

A.15. Explanation for Program Changes or Adjustments

From 2014 to 2016, a total of 25 recipients received funding under cooperative agreements CDC-RFA-EH14-1404 (program period: September 2014 – August 2019) and CDC-RFA-EH16-1606 (program period: September 2016 – August 2019), titled *Comprehensive Asthma Control Through Evidence-based Strategies and Public Health-Health Care Collaboration*. In September 2019, a new cooperative agreement was implemented (CDC-RFA-EH19-1902, *Comprehensive Public Health Approach to Asthma Control through Evidence-Based Interventions*, program period: September 2019 – August 2024) and 24 recipients were funded under this cooperative agreement. CDC is also planning to fund up to six additional recipients over the next fiscal year (total n=30).

In addition to increasing the number of recipients from 25 to 30, the following revisions are requested:

- 1) We request to increase the number of respondents from 25 to 30. Currently, CDC funds 24 state, local, and territorial health departments for asthma management and surveillance activities (see **Attachment 3**, List of Funded Recipients). CDC is also planning to fund up to 6 additional recipients over the next fiscal year (total n=30).
- 2) We request to increase the number of burden hours from 89 to 105, due to an increase in the number of recipients.
- 3) We request to reduce and consolidate the PMs from 18 to eight core measures in the current cooperative agreement. This is in accordance with language in the Notice of Funding Opportunity (NOFO) announcement that CDC “will periodically review the use of performance measures and discontinue those that are not informative” (see **Attachment 4**, NOFO EH19-1902). The reduction and consolidation of the PMs is based on feedback received from funded recipients during previous grantee meetings and through feedback provided to recipients’ project officers during regularly scheduled

monthly calls. A comparison table of the previous PMs to the new, consolidated PMs is displayed in **Attachment 8**.

- 4) We request to change the collection method for receipt of PMs, from an Excel spreadsheet to a newly developed electronic reporting tool (SharePoint site).
- 5) We request to include instructions for the new electronic reporting tool that will be utilized to report the eight performance measures (see **Attachment 5c**, Instructions for Performance Measures Reporting Tool).
- 6) We request to change the collection method for receipt of surveillance data, from uploading to a SharePoint site to submitting by email to a dedicated electronic mailbox. Previously, surveillance data was submitted by recipients to a now retired SharePoint site. For this new 5-year cooperative agreement, recipients will instead submit surveillance data by email to a dedicated electronic mailbox.
- 7) We request to update the estimated annualized cost to the government to reflect current funding for the cooperative agreement, updated salaries for staff, and contractor costs for development of the new electronic reporting tool.

A revision to this data collection is necessary because: 1) the number of recipients has increased from 25 to 30; 2) the burden hours have increased from 89 to 105 as a result of the five additional recipients; 3) in an effort to reduce burden on recipients, the program has reduced the number of PMs that are required from 18 performance measures to eight performance measures; and 4) instructions for the new PM reporting tool were developed to reflect changes in PM requirements and to provide recipients with a step-by-step guide for using the new PM reporting tool.

A.16. Plans for Tabulation and Publication and Project Time Schedule

- a) Time schedule for the entire project

OMB approval is requested for three years and this request for revision would permit data collection to continue for three years of the total five-year cooperative agreement. A schedule for the collection of information is provided in Table 4 below.

Table 5: Timeline

Activity	Time Schedule
Performance measures, state-level ED visit and HD data	October 2020 – October 2023

b) Publication plan

Information collected through AIRS is reported in internal NACP documents and shared with state programs. Results are presented during webinars with recipients during which the implications of the finding are discussed and questions answered. Aggregated information may also be included in reports to CDC leadership, Congress, and other stakeholders.

c) Analysis plan

The NACP does not use complex statistical methods for analyzing the PMs. All PM information is aggregated and reported in a secure database using SharePoint and internal documents. Statistical analyses are limited to simple tabulations.

The ED visit and HD data collection and analysis timeline begins with notifications sent to asthma recipients outlining the data collection process one month after OMB approvals. These notifications include instructions on submitting ED visit and HD data and details on the process of using SharePoint to submit the data.

Three to six months after OMB approval, the ED and HD datasets submitted through SharePoint will be downloaded, archived, and validated by CDC. Any issues/discrepancies will be resolved with states.

In the time period 6-12 months after OMB approval, final analysis occurs. In the final analysis, age-adjusted ED and HD visit rates per 100,000 population automatically calculated in the data collection templates are tabulated by state over time.

Additionally, the overall aggregated HD age-adjusted rate per 100,000 population for all asthma state recipients is calculated and trended over time. These rates are then compared to the overall US HD rates per 100,000 values referenced from the National Hospital Discharge Survey (NHDS).

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is appropriate.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.