

Supporting Statement Part A
Medicaid and the Children’s Health Insurance Program; Eligibility Changes under the
Affordable Care Act of 2010
CMS-10410, OMB 0938-1147

Background

The Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111- 152, enacted on March 30, 2010) are collectively referred to as the Affordable Care Act. The Affordable Care Act expands access to insurance affordability programs through improvements in Medicaid eligibility, enrollment simplification, the establishment of Affordable Insurance Exchanges ("Exchanges"), and coordination between Medicaid, the Children's Health Insurance Program (CHIP), and Exchanges.

Relevant to this Supporting Statement (or Statement), the Affordable Care Act promotes a high level of coordination, simplification, and data sharing among State and Federal agencies for the purpose of a seamless and streamlined eligibility system. The Affordable Care Act allows for significant use of Web-based technology to provide information to the public and facilitate application and renewal functions. It creates a "no wrong door" approach to insurance affordability programs so that individuals will not have to apply to multiple programs. Nor will they have to repeat the application process if they initially apply to a program for which they are not ultimately determined eligible. It also provides a simplified process for maintaining coverage through a streamlined renewal process.

This information collection request is a revision of prior State burden estimates related to updated eligibility populations proposed in CMS-9894-P (RIN: 0938-AV23). The changes proposed to 42 CFR 435.4 and 457.320(c) would codify a definition of “lawfully present” that would be applicable to eligibility for Medicaid and CHIP in States that have elected the option to cover “lawfully residing” pregnant individuals and children under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (hereinafter “CHIPRA 214 option”). In addition, the rule proposes to remove the exception for Deferred Action for Childhood Arrivals (DACA) recipients from the definition of “lawfully present” used to determine eligibility to enroll in Medicaid and CHIP in States that have elected the CHIPRA 214 option, and to instead treat such DACA recipients the same as all other deferred action recipients.

The changes are discussed in section 12 of this Supporting Statement.

We note that this collection includes impacts related to the Medicaid and CHIP applications. For the purposes of this revision, impacts related to application updates, if the related proposed rule is finalized, are addressed in OMB control number: 0938-1191 (CMS-10440) for the streamlined application.

A. Justification

1. Need and Legal Basis

Sections 1413 and 2201 of the Affordable Care Act provide for a simplified, coordinated, and streamlined system of eligibility for Medicaid, CHIP, and the Exchanges. Specifically, section 1413 requires a streamlined system for individuals to apply for, be determined eligible for, and be enrolled in insurance affordability programs-the Exchanges, Medicaid, CHIP, and the Basic Health Plan as applicable. Section 2201, which amends section 1943 of the Social Security Act, requires a simplified and coordinated eligibility and enrollment system of Medicaid and CHIP with the Exchanges.

The provisions discussed in this collection of information request revision are necessary for the establishment of coordinated and efficient systems as called for by the Affordable Care Act. The eligibility systems are essential to the goal of increasing coverage in insurance affordability programs while reducing administrative burden for States and consumers. As this revision relates solely to an expanded eligibility population, there would be no way to achieve this goal through alternate means.

2. Information Users

State Medicaid and CHIP agencies will collect all information needed to determine and redetermine eligibility for Medicaid and CHIP and will transmit information, as appropriate, to other insurance affordability programs. The information collection requirements will assist the public to understand information about health insurance affordability programs and will assist CMS in ensuring the seamless, coordinated, and simplified system of Medicaid and CHIP application, eligibility determination, verification, enrollment, and renewal.

3. Use of Information Technology

All of the information collections, 100 percent, will be available in electronic form. Requirements related to Internet Web sites will be electronic, and notices will be automated. Interagency agreements will allow for the use of electronic data sharing. The eligibility determination and renewal process will be significantly streamlined and automated using information technology. All of the information collections are designed to take advantage of information technology and be completed in a user-friendly format, in order to minimize burden to the greatest extent possible.

A signature will not be required of respondents under the information collections. Many of the information collections may currently be submitted electronically.

3. Duplication of Efforts

This information collection does not duplicate any other Federal effort.

5. Small Businesses

This information collection does not impact small businesses or other small entities.

6. Less Frequent Collection

Application through the web site occurs only once, when an individual or family first applies for Medicaid or CHIP. Renewal of eligibility occurs once per year for most Medicaid beneficiaries and all CHIP beneficiaries, which is less frequent than some States' practices prior to 2014. The frequency of collection is the minimum required to ensure adequate compliance with Federal statutory requirements.

If eligibility renewals were to occur less frequently, the result may be inaccurate eligibility determinations and improper payments of Federal financial participation. If the information collections discussed in this collection of information request were not approved, the coordination, streamlining, simplification, and efficiencies envisioned by the Affordable Care Act would not be realized, leading to greater reporting burdens on individuals and greater administrative and recordkeeping burdens on States.

7. Special Circumstances

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

Federal Register

A 60-day notice will publish in the Federal Register on **INSERT**. Comments must be received by **INSERT**.

Outside Consultation

CMS did not perform any outside consultation specific to this revision.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided to respondents.

10. Confidentiality

Because no personal identifying information is being collected, there is no issue of confidentiality.

11. Sensitive Questions

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private.

12. Burden Estimates

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS's) May 2021 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, Table 1 presents BLS's mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupational Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
All Occupations	00-0000	28.01	n/a	n/a
Business Operations Specialists	13-1000	38.64	38.64	77.25
Computer Programmer	15-1251	46.46	46.46	92.92
Database and Network Administrator & Architect	15-1240	49.25	49.25	98.50
Eligibility Interviewers, Govt Programs	43-4061	23.35	23.35	46.70
Information and Record Clerks	43-4000	18.59	18.59	37.18
Interpreter and Translator	27-3091	28.08	28.08	56.16
Medical and Health Services Managers	11-9111	57.61	57.61	115.22

Occupation Title	Occupational Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Network and Computer Systems Administrators	15-1244	43.87	43.87	87.74

Except where noted, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. We believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

To derive average costs for individuals we believe that the burden will be addressed under All Occupations (BLS occupation code 00-0000) at \$28.01/hr. Unlike our State government adjustment to the respondent hourly wage, we are not adjusting this figure for fringe benefits and overhead since the individuals' activities would occur outside the scope of their employment.

Adjustment to State Cost Estimates

To estimate the financial burden on States pertaining to Medicaid and CHIP information collection changes, it was important to consider the Federal Government's contribution to the cost of administering the Medicaid program. The Federal Government provides funding based on a Federal medical assistance percentage (FMAP) that is established for each State, based on the per capita income in the State as compared to the national average. FMAPs for care and services range from a minimum of 50 percent in States with higher per capita incomes to a maximum of 83 percent in States with lower per capita incomes. For Medicaid, all States receive a 50 percent matching rate for administrative activities. States also receive higher Federal matching rates for certain administrative activities such as systems improvements, redesign, or operations. For CHIP, States can claim enhanced FMAP for administrative activities up to 10 percent of the State's total computable expenditures within the State's fiscal year allotment. As such, and taking into account the Federal contribution to the costs of administering the Medicaid and CHIP programs for purposes of estimating State burden with respect to collection of information, we elected to use the higher end estimate that the States would contribute 50 percent of the costs, even though the State burden may be much smaller, especially for CHIP administrative activities.

Collection of Information Requirements and Associated Burden Estimates

Burden for the subject information collections are organized into the following two sections: Periodic Eligibility Renewals and Web Sites. Burden associated with the verification plan is approved by OMB under control number 0938-1148 (CMS-10398 #11).

Periodic Eligibility Renewals (§§ 435.916, 457.343, and 457.350)

For individuals whose eligibility is based on Modified Adjusted Gross Income (MAGI) per the Affordable Care Act, § 435.916 requires that Medicaid eligibility be redetermined only once each year, unless there is a change in circumstance. It also sets out a data-driven redetermination process that first uses information already available to the agency. If continued eligibility cannot be determined, a State agency's eligibility system issues a streamlined pre-populated renewal form for the individual's review. Section 457.343 aligns the standards for redeterminations in CHIP with the standards in the Medicaid program as described in § 435.916.

We estimate that the 53 Medicaid agencies and 43 CHIP agencies will be subject to the provision above, for a total of 96 agencies. We estimate that of the approximately 51 million individuals enrolled in Medicaid and CHIP whose eligibility will be based on MAGI, half (25.5 million individuals) will have their eligibility redetermined using the information already available to the agency. This approach greatly simplifies the renewal process and will ultimately reduce costs for States.

We estimate that it will take each Medicaid and CHIP agency 16 hours annually to develop, automate, and distribute a notice of eligibility determination based on use of existing information. Of the 16 hours, we estimate it will take a business operations specialist 10 hours at \$77.25/hr and a medical and health services manager 6 hours at \$115.22/hr to complete the notice. In aggregate we estimate a burden of **1,536 hours** (96 agencies x 16 hr/response) at a cost of \$140,527 [96 x ((10 hr x \$77.25/hr) + (6 hr x \$115.22/hr))] or \$ 1,464 per agency. When considering the State share of 50%, we estimate a total annual cost burden of \$70,263 or \$732 per agency, while the burden of 1,536 hours is not impacted.

For those individuals whose eligibility cannot be redetermined using available information (25.5 million individuals), a prepopulated form will be issued, so that the individual can provide the additional information needed to the State so that their eligibility can be renewed. The process is much less burdensome than the processes currently in place in many States that require individuals to complete a new application at renewal. We estimate that it will take an individual 20 minutes to complete the streamlined renewal process. The total annual hour burden is **8.5 million hours** [(20 minutes x 25.5 million individuals)/60 minutes] for 25.5 million individuals at a cost of **\$238,055,000** (8.5 million hr x \$28.01/hr). We note that the number of people who need to provide additional information may be smaller than our estimate, but we used a higher end estimate to account for the greatest potential impact on States and individuals.

States will keep records of each renewal that is processed in Medicaid and CHIP. The amount of time for recordkeeping will be the same for renewals based on information available to the agency as for renewals that require additional information from individuals. We estimate that it will take the State agency 15 minutes (0.25 hour) at \$37.18/hr for an information and record clerk to conduct the required recordkeeping for each of the 51 million renewals. We estimate a total annual burden of **12,750,000 hours** (51 million renewals x 0.25 hr) at a cost of \$474,045,000 (12,750,000 hr x \$37.18/hr) or \$4,937,969 per agency (\$474,045,000 / 96 agencies). When considering the State share of 50%, we estimate a total annual cost burden of **\$237,022,500** or \$2,468,984 per agency while the burden of 12,750,000 hours is not impacted.

Web Sites (§§ 435.1200 and 457.340)

Sections 435.1200 and 457.340 require State Medicaid and CHIP agencies to have a Web site that allows an individual to apply, renew coverage, and select a health plan. Also, a Web site will allow the State agency to transmit data, for individuals found ineligible, to other insurance affordability programs and to provide coordinated notices with other insurance affordability programs. The burden is the time and effort necessary for the State to develop and disclose information on the Web site, develop and automate the required notices, and transmit (report) the application data to the appropriate insurance affordability program.

We estimate that 53 Medicaid agencies and an additional 43 CHIP agencies would be subject to the provisions above. To achieve efficiency, we assume that States will develop only one Web site to perform the required functions. Therefore, we base our burden estimates on 50 States, the District of Columbia, the Northern Mariana Islands, and American Samoa (53 agencies) and do not include the 43 separate CHIP programs.

We estimate that it will take each State an average of 320 hours to develop the additional functionality to meet the requirements, including developing an online application, automating the renewal process, and adding a health plan selection function.

Of the 320 hours, we estimate it will take a business operations specialist 85 hours at \$77.25/hr, a medical and health services manager 50 hours \$115.22/hr, and network and computer systems administrators 185 hours at \$87.74/hr to meet the requirements related to web site development. Approximately 70 percent of States have completed all of these necessary requirements and have a fully functioning Web site, so only 16 agencies are included in this specific estimate. We estimate a total burden of **5,120 hours** (320 hr x 16 agencies) at a cost of \$456,946 [16 x ((85 hr x \$77.25/hr) + (50 hr x \$115.22) + (185 hr x \$87.74))] or \$28,559 per agency. When considering the State share of 50%, we estimate a total annual cost burden of **\$228,473** or \$14,280 per agency, while the burden of 5,120 hours is not impacted.

We estimate that it will take each State entity 16 hours annually to develop and automate each of the two required notices (or 32 hours for both notices).

Of the 32 hours, we estimate it will take a business operations specialist 20 hours at \$77.25/hr and a medical and health services manager 12 hours at \$115.22 to complete each notice. We estimate a total burden of **1,696 hours** (32 hr/notice x 53 agencies) at a cost of \$155,165 [53 x ((20 hr x \$77.25/hr) + (12 hr x \$115.22))] or \$2,928 per agency. When considering the State share of 50%, we estimate a total annual cost burden of **\$77,582**, while the burden of 1,696 hours is not impacted.

We also estimate that it will take a network and computer systems administrator 150 hours at \$87.74/hr to transmit the application data of ineligible individuals to the appropriate insurance affordability program and meet this information reporting requirement for each State (53). We estimate a total burden of **7,950 hours** (150 hr x 53 agencies) at a cost of \$697,533 or \$13,161 per agency. When considering the State share of 50%, we estimate a total annual cost burden of \$348,766, or 6,580 per agency, while the burden of 7,950 hours is not impacted.

Revision Regarding the CHIPRA 214 Option (§§ 435.4 and 457.320(c))

The changes proposed to the definition of “lawfully present” would impact eligibility for Medicaid and CHIP in States that have elected the CHIPRA 214 option. This proposal would impact the 35 States, the District of Columbia, and three territories that have elected the CHIPRA 214 option for at least one population of children or pregnant individuals in their CHIP or Medicaid programs. For simplicity, in the calculations that follow we will refer to this total as “States.” For the purposes of these estimates, we will assume that these proposals do not cause any States to opt in or out of the CHIPRA 214 option. We further note that currently, 10 States cover either children, or children and pregnant individuals regardless of immigration status using State-only funds. However, we are including those States in our estimates, because States may need to adjust their systems to reflect the change in the route of eligibility, or to address the new availability of Federal matching funds for certain individuals.

The effort to update State systems and also submit Medicaid and CHIP SPAs as necessary to allow coverage of this population includes one-time burdens reflected in section 15.

Burden Summary for States

Regulatory Section(s) in Title 42 of the CFR	Respondents	Responses per Agency	Time per Response (hours)	Total Annual Time (hours)	Labor Cost	Cost (\$)	Adjusted Cost (\$)
435.916, 457.343, and 457.350: Generate Renewal Notices	96	1	16	1,536	Varies	140,527	70,263
435.916, 457.343, and 457.350: Process Renewals	96	531,250	0.25	12,750,000	\$37.18/hr	474,045,000	237,022,500
435.1200 and 457.340: Develop Web Site	16	1	320	5,120	Varies	456,946	228,473
435.1200 and 457.340: Develop Notices	53	1	32	1,696	Varies	155,165	77,582
435.1200 and 457.340: Transmit Information	53	1	150	7,950	\$87.74/hr	697,533	348,766
SUBTOTAL	96	Varies	Varies	12,766,302	Varies	475,495,171	237,747,586

Burden Summary for Beneficiaries

Regulatory Section(s) in Title 42 of the CFR	Respondents	Responses per Respondent	Burden per Response	Total Annual Burden (hours)	Labor	Total Cost (\$)
435.916, 457.343, and 457.350: Process Renewals	25,500,000	1	20 minutes	8,500,000	\$28.01/hr	238,085,000
SUBTOTAL	25,500,000	1	20 minutes	8,500,000	\$28.01/hr	238,085,000

Burden Summary (Total)

Respondent Type	Respondents	Responses (Total)	Burden per Response (hours)	Total annual Burden (hours)	Labor Cost	Total Cost (\$)
States (annual)	96	51,000,218	Varies	12,766,302	Varies	237,747,586
Beneficiaries	25,500,000	25,500,000	20 min	8,500,000	\$28.01/hr	238,085,000
TOTAL	25,500,096	76,500,218	Varies	21,266,302	Varies	475,832,586

Burden Summary for Revision Requirements (one-time)

Regulation Section(s)/ ICR Provision	Year	Number of Respondents	Number of Responses	Time per Response (hrs)	Total Time (hr)	Hourly Labor Rate (\$/hr)	Total Labor Cost (\$)	State Share (\$)	Total Beneficiary Cost (\$)
42 CFR 435.4 and 457.320(c) Medicaid and CHIP System Changes and Enrollment	2023	39	39	100	3,900	Varies	\$367,828	\$183,914	N/A
42 CFR 435.4 Medicaid SPA submissions	2023	39	39	3	117	Varies	\$10,347	\$5,174	N/A
42. CFR 457.320(c) CHIP SPA submission	2023	28	28	3	84	Varies	\$7,429	\$3,714	N/A
Total	-	39	106	106	4,101	Varies	\$385,604	\$192,802	-

Collection of Information Instruments and Instruction/Guidance Documents

None. All of the requirements and instructions are in statute and in the CFR.

13. Capital Costs

There are no capital or maintenance costs incurred by the collections. Any capital costs that may be incurred with respect to these information collections, for example the development of a new eligibility system or improvement of an existing electronic system were addressed through separate rulemaking. Such capital costs were described in the "Federal Funding for Medicaid Eligibility Determination and Enrollment Activities" final rule (April 19, 2011; 76 FR 21950).

14. Cost to Federal Government

Section 12 of this Supporting Statement presented the total costs and the State share of those costs. The total cost minus the State share equals the Federal share. The Federal share also equals 50 percent of the total cost, as simplified for Medicaid and CHIP combined estimates.

This revision will create one-time costs to the federal government related to the federal share. We are also evaluating whether we would require all states that have elected the CHIPRA 214 option to submit SPAs for Medicaid and CHIP in order to document this the proposed regulation changes to the definition of lawfully present in their state plans. If states are required to submit SPAs, updating the SPA template, and the cost to review and approve SPA submissions.

Information Collection	Total Cost (\$)	State Share (\$)	Federal Share (\$)
Renewal of Eligibility (§§ 435.916, 457.343, and 457.350)	464,748,109	232,374,054	232,374,054
Web Sites (§§ 435.1200 and 457.340)	1,284,806	642,403	642,403
42 CFR 435.4 and 457.320(c) systems changes and SPA submissions	385,604	192,802	192,802
Totals	466,418,519	233,209,260	233,209,260

15. Changes to Collections of Information and Burden

As a result of the change in definition to “lawfully present” as proposed in CMS-9894-P, which updates eligible populations in the CHIPRA 214 option group, we estimate a one-time burden increase for States of 100 hours to develop and code the changes to its Medicaid or CHIP eligibility systems to correctly evaluate and verify eligibility under the expanded definition. As discussed in section 12, of those 100 hours, we estimate it would take a database and network administrator and architect 25 hours at \$98.50 per hour and a computer programmer 75 hours at \$92.92 per hour. In aggregate, we estimate a one-time burden of 3,900 hours (39 States × 100 hours) at a cost of \$367,829 (39 States × [(25 hours × \$98.50 per hour) + (75 hours × \$92.92 per hour)]) for completing the necessary updates to Medicaid systems. Taking into account the 50

percent Federal contribution to Medicaid program administration, the estimated State one-time cost would be \$4,716 per State, and \$183,914 in total for all States.

We note that this collection includes impacts related to the Medicaid and CHIP applications. For the purposes of this revision, impacts related to application updates, if the related proposed rule is finalized, are addressed in OMB control number: 0938-1191 (CMS-10440) for the streamlined application.

In addition, current CMS Medicaid and CHIP SPA templates require the exclusion of the DACA populations. We are evaluating whether we would require all states that have elected the CHIPRA 214 option to submit SPAs for Medicaid and CHIP in order to document the proposed regulation changes to the definition of lawfully present in their state plans. These changes would be finalized as revisions to OMB control number 0938-1188 (CMS-10434 #15) and OMB control number 0938-1148 (CMS-10398 #17), respectively.

If states are required to submit SPAs, we estimate it would take an average of 3 hours in each of the 39 Medicaid CHIPRA 214 option States and an average of 3 hours in each of the 28 CHIP CHIPRA 214 option States to produce and submit Medicaid and CHIP SPAs in order to no longer include the DACA exclusion and to include minor revisions in other certain immigration statuses proposed to be considered lawfully present.

We estimate it would take a General and Operations Manager 1 hour at \$110.82/hr and a Business Operations Specialist 2 hours at \$77.25/hr for a per SPA per State total of \$265. In aggregate for Medicaid, we estimate a one-time burden for all States of 117 hours (39 States × 3 hr) and \$10,347 $[(1 \text{ hrs} \times \$110.82/\text{hr}) + (2 \text{ hrs} \times \$77.25/\text{hr})] \times 39 \text{ States}$ for completing the necessary Medicaid SPA updates. In aggregate for CHIP, we estimate a one-time burden for all States of 84 hours (28 States × 3 hr) and \$7,429 $[(1 \text{ hrs} \times \$110.82/\text{hr}) + (2 \text{ hrs} \times \$77.25/\text{hr})] \times 28 \text{ States}$ for completing the necessary CHIP SPA updates. Taking into account a simplified average of 50 percent Federal contribution to Medicaid and CHIP program administration, the estimated State share would be \$133 per State for Medicaid only CHIPRA 214 States and \$265 per State for States that have elected the CHIPRA 214 option for both Medicaid and CHIP, and \$8,888 total for all States.

Regulation Section(s)/ ICR Provision	Year	Number of Respondents	Number of Responses	Time per Response (hrs)	Total Time (hr)	Hourly Labor Rate (\$/hr)	Total Labor Cost (\$)	State Share (\$)	Total Beneficiary Cost (\$)
42 CFR 435.4 and 457.320(c) Medicaid and CHIP System Changes and Enrollment	2023	39	39	100	3,900	Varies	\$367,828	\$183,914	N/A

Regulation Section(s)/ ICR Provision	Year	Number of Respondents	Number of Responses	Time per Response (hrs)	Total Time (hr)	Hourly Labor Rate (\$/hr)	Total Labor Cost (\$)	State Share (\$)	Total Beneficiary Cost (\$)
42 CFR 435.4 Medicaid SPA submissions	2023	39	39	3	117	Varies	\$10,347	\$5,174	N/A
42. CFR 457.320(c) CHIP SPA submission	2023	28	28	3	84	Varies	\$7,429	\$3,714	N/A
Total	-	39	106	106	4,101	Varies	\$385,604	\$192,802	-

16. Publication/Tabulation Dates

There are no plans to publish the information for statistical use.

17. Expiration Date

The expiration date is displayed.

18. Certification Statement

There is no exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-1.

B. Collection of Information Employing Statistical Methods

This collection does not employ any statistical methods.