SUPPORTING STATEMENT FOR THE MINORITY AIDS INITIATIVE: SUBSTANCE USE DISORDER PREVENTION AND TREATMENT PILOT PROGRAM DATA COLLECTION INSTRUMENTS

Check off which applies:
☒ New
☐ Revision
☐ Reinstatement with Change
☐ Reinstatement without Change
☐ Extension
☐ Emergency
☐ Existing

A. JUSTIFICATION

A.1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) are requesting approval from the Office of Management and Budget (OMB) to monitor the Minority AIDS Initiative: Substance Use Disorder Prevention and Treatment Pilot Program (MAI PT Pilot) through administration of a suite of data collection instruments for grant compliance and programmatic performance monitoring. This package describes the data collection activities and proposed instruments. Two instruments will facilitate grant compliance monitoring, and the third instrument is designed for program performance monitoring.

- The *MAI PT Pilot Organizational Readiness Assessment (MAI-ORA)* is a one-time self-assessment tool intended to guide MAI PT Pilot grant recipients to objectively assess their capacity to provide substance use prevention, substance use disorder or co-occurring mental health disorder treatment, and HIV, viral hepatitis, and sexually transmitted infection prevention, screening, testing, and referral services for racial and ethnic minority individuals vulnerable to these conditions. Results from the MAI-ORA will allow SAMHSA to determine grantee readiness and capacity to implement their grant program, so that SAMHSA can provide additional support, as needed, to ensure grant compliance.

- The *MAI PT Pilot Programmatic Progress Report (MAI-PPR)* is a template that grantees will use to report annual progress and will be used to monitor grant compliance.

- The *MAI PT Pilot Online Reporting Tool (MAI-PORT)* will be used to conduct programmatic performance monitoring. The MAI-PORT is comprised of two main sections: 1) Annual Targets Report (ATR) section for MAI PT Pilot grant recipients to report annual federal fiscal year programmatic goals, and 2) Quarterly Performance Report (QPR) for grantees to report grant activities implemented during each federal fiscal quarter. In developing the MAI-PORT ATR and QPR, SAMHSA sought the ability to elicit programmatic information that demonstrates impact at the program aggregate level.

Data collected through the MAI-PORT are necessary to ensure SAMHSA and grantees comply with requirements under the Government Performance and Results Act Modernization Act of 2010 (GPRA) that requires regular reporting of performance measures. Additionally, data collected through these tools will provide critical information to SAMHSA's Government Project Officers (GPOs) related to grant oversight, including barriers and facilitators that the grantees have experienced, and an understanding of the technical assistance needed to help grantees implement their programs. The information also provides a mechanism to ensure grantees are meeting the requirements of the grant funding announcement as outlined in their notice of grant award. In addition, the tools reflect CSAP and CSAT's desire to elicit pertinent program level data that can be used not only to guide future programs and practices, but also to respond to stakeholder, congressional, and agency inquiries.

SAMHSA requests approval for the following suite of data collection instruments as shown in Table 1.

Table 1. Data Collection Tools

Instrument Name	Attachment
Grant Level Compliance	
MAI PT Pilot Organizational Readiness Assessment (MAI-ORA)	1
MAI PT Pilot Programmatic Progress Report (MAI-PPR)	2
Program Level Performance Monitoring	
MAI PT Pilot Online Reporting Tool (MAI-PORT)	3

Background and Purpose

According to the Centers for Disease Control and Prevention (CDC), the spread of HIV in the United States is mainly through anal or vaginal sex or by sharing drug-use equipment. Although these risk factors are the same for everyone, due to a range of social, economic, and demographic factors, such as stigma, discrimination, income, education, and geographic region, some racial and ethnic groups are more affected than others. In 2021, CDC reported that although Black/African Americans represented 13 percent of the US population, they accounted for 42 percent (15,305) of the 36,801 new HIV diagnoses; Latino/Hispanic people represent 18.7 percent of the US population but accounted for 29 percent (10,494) of HIV diagnoses (CDC, 2024; United States Census Bureau, 2024).[1,2] Between 2017 and 2021, American Indian/Alaska Native (AI/AN), Native Hawaiian and other Pacific Islander populations were the only demographic group identified by the CDC with an increase in HIV diagnoses in the United States (CDC, 2024).[3] Of the 31,800 new HIV infections in 2022, CDC reports that 71% (22,500) were among gay and bisexual men.[4]

Viral hepatitis also impacts some racial and ethnic groups disproportionally. In 2020, non-Hispanic blacks were 1.4 times as likely to die from viral hepatitis, as compared to non-Hispanic whites (Office of Minority Health, 2022). Non-Hispanic Blacks were almost twice as likely to

[1] 2020 Census Illuminates Racial and Ethnic Composition of the Country
[2] HIV Diagnoses
[3] HIV in the United States by Race/Ethnicity: HIV Diagnoses
[4] Fast Facts: HIV and Gay and Bisexual Men

die from hepatitis C as compared to the White population, and while having comparable case rates for hepatitis B in 2020, non-Hispanic Blacks were 2.5 times more likely to die from hepatitis B than non-Hispanic Whites (Office of Minority Health, 2022). Additionally, the percentage of people aged 12 or older with past year substance use disorder (SUD) differed by race and ethnicity with the highest rates among American Indian/Alaska Native populations (24.0 percent), followed by non-Hispanic Black populations (18.4 percent) (SAMHSA, 2023).[5]

The data clearly show the disproportionate burden faced by racial and ethnic minority groups and that these three issues should not be regarded as separate diseases acting independently, rather as a syndemic. To address this, SAMHSA is taking a syndemic approach to the prevention and treatment of HIV, viral hepatitis, and substance use disorders through the MAI PT Pilot program. The purpose of this program is to provide substance use prevention, SUD treatment, HIV, and viral hepatitis prevention and treatment services for racial and ethnic minorities that are medically underserved and vulnerable to SUD and/or mental health conditions, HIV, viral hepatitis, and other infectious diseases (e.g., sexually transmitted infection (STI)). The populations of focus for this program are individuals who are particularly vulnerable to or living with HIV/AIDS, including an emphasis on gay, bisexual, and other men who have sex with men, men who have sex with men and women (MSMW), Black, Latino, and AI/AN men who have sex with men (MSM), Asian and Pacific Islander, Black women, transgender men and women, youth aged 13–24 years, and People who Inject Drugs (PWID).

SAMHSA's MAI PT Pilot is informed by the key strategies and priority jurisdictions outlined in the "Ending the HIV Epidemic in the U.S. (EHE) initiative, "Viral Hepatitis National Strategic Plan," and "STI National Strategic Plan." The program also supports the National HIV/AIDS Strategy (NHAS) and 2023-2026 SAMHSA Strategic Plan. Recipients will be expected to take a syndemic approach to SUD, HIV, viral hepatitis, and STI by providing SUD prevention and treatment to racial and ethnic individuals at risk for or living with HIV. MAI PT Pilot is authorized under Sections 509 and 516 of the Public Health Service Act, as amended.

A.2. Purpose and Use of Information

The MAI-ORA, MAI-PPR and MAI-PORT are tools that will enable GPOs and other CSAP and CSAT staff to monitor grantee activities. The MAI-PORT gathers information through a web-based data collection system that uses clickable radio buttons, check boxes, drop-down choice items, and a limited number of open-ended text boxes as relevant. It also allows grantees to upload required documents requested by their GPO and as required in their Notice of Funding Announcement (NOFO). The MAI-PORT will likely be completed by the grantee Project Director, Evaluator, or designee. The ATR section will be completed annually and the QPR section each quarter. The MAI-ORA will only be completed once within the first four months of the grant and will be uploaded to SPARS. The MAI-PPR will be completed annually and will be uploaded to the grantee's official electronic grant folder, located in electronic Research Administration (eRA) Commons.

[5] Substance Abuse and Mental Health Services Administration. (2023). Strategic Plan: Fiscal Year 2023-2026. Publication No. PEP23-06-00-002. National Mental Health and Substance Use Policy Laboratory. https://www.samhsa.gov/sites/default/files/samhsa-strategic-plan.pdf

The information is used by individuals at three different levels: 1) Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services (HHS), and SAMHSA leadership, 2) program-level SAMHSA staff, including CSAP and CSAT leadership and GPOs, and 3) grantees:

- **Assistant Secretary Level** – The information is used to inform the Assistant Secretary for Mental Health and Substance Use of the performance and outcomes of the programs funded through the Agency. The performance is based on the goals of the grant program. This information serves as the basis of the annual GPRA report to Congress contained in the Justifications of Budget Estimates.

- **Program Level** – In addition to providing information about the performance of the various programs, the information is used to monitor and manage individual grant projects within each program. The information is used by GPOs to identify program strengths and weaknesses, to provide an informed basis for providing technical assistance and other support to grantees, to inform funding decisions, and to identify potential issues for additional evaluation.

- **Grantee Level** – In addition to monitoring performance and outcomes, the grantee staff use the information to monitor the requirements of the grant funding announcement as outlined in their notice of grant award.

In summary, the data collected through these three data collection instruments will be a crucial resource for CSAP and CSAT in setting prevention policy priorities, measuring program performance, and designing and promoting optimally effective prevention program initiatives.

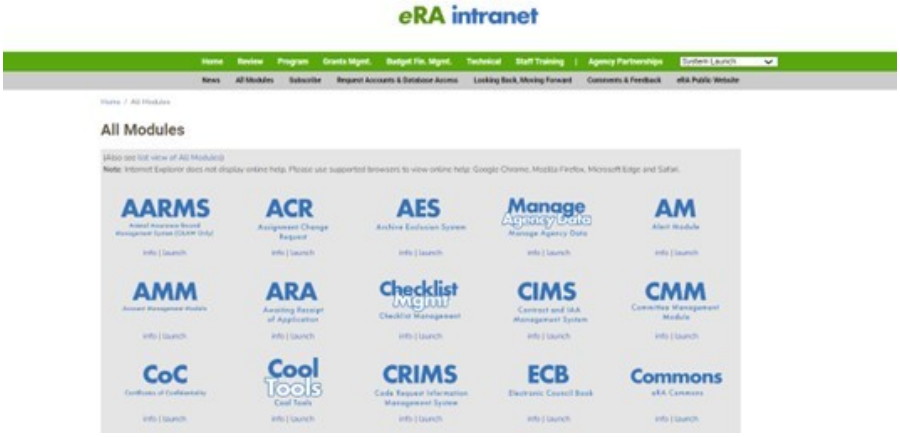
A.3. Use of Information Technology

Grant Level Compliance

All SAMHSA awards require grantees to submit progress reports through the eRA Commons, an end-to-end Grants Management system. (See Exhibit 1). The frequency (ranging from quarterly to annually) and program-specific instructions for preparation and submission of these reports are identified in the terms and conditions found in the Notice of Award. Grant recipients of the MAI PT Pilot will utilize eRA for submission of the MAI- PPR for grant compliance.

The system requires a web browser and access to the Internet. Users are able to access the system 24 hours a day, 7 days a week, aside from scheduled maintenance windows, through the use of an encrypted username and password. Levels of access have been defined for users based on their authority and responsibilities regarding the data and reports.

Exhibit 1. Main Screen of eRA



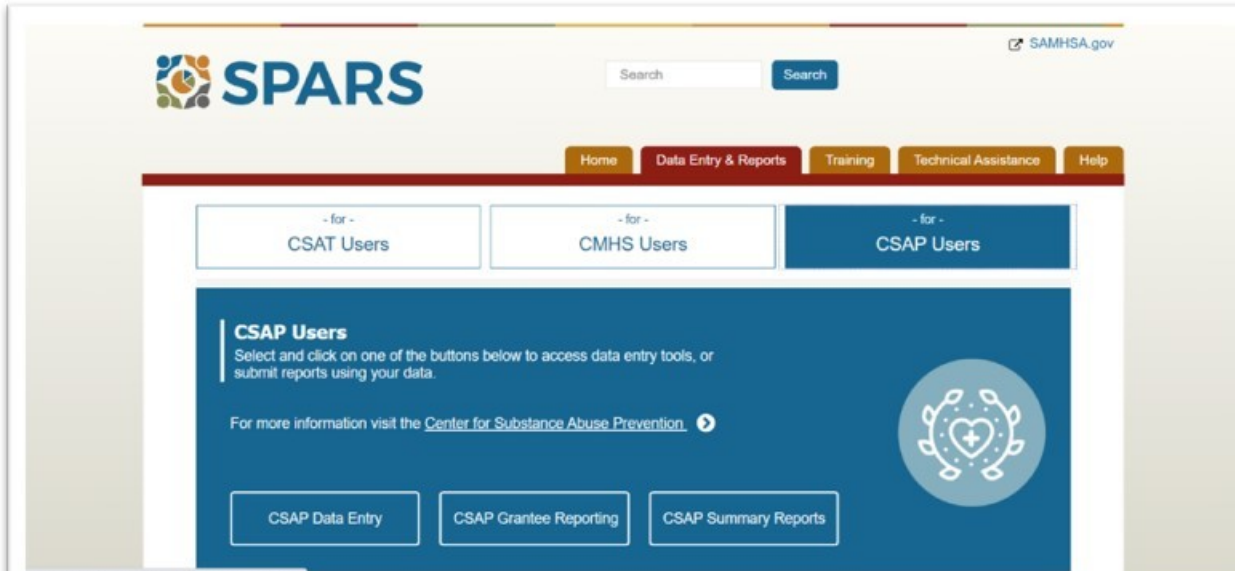
Program Level Performance Monitoring

CSAP and CSAT grant programs collect information using a variety of methods, including paper-and-pencil and electronic methods. This project will not interfere with ongoing program collection operations that facilitate information collection at each site.

To maximize data accuracy and reliability, a web-based data collection and entry system, SAMHSA's Performance Accountability and Reporting System (SPARS), has been developed and is currently used and available to all programs for data collection. MAI PT Pilot grant recipients will utilize this system to submit program level performance data via the MAI-PORT and to upload the MAI-ORA upon completion. The system requires a web browser and access to the Internet. Users are able to access the system 24 hours a day, 7 days a week, aside from scheduled maintenance windows, through the use of an encrypted username and password. Levels of access have been defined for users based on their authority and responsibilities regarding the data and reports.

Upon logging into a system-assigned account, grantees are able to enter data on their program, upload documents for project officer review, and generate reports of their activities. Skip patterns facilitate navigation through the instrument by only displaying items that apply to the respondent, based on information already entered into the system. The system also allows SAMHSA GPOs to review and approve submitted reports or ask grantees to provide additional information regarding their activities. GPOs also have the capability to generate online summary reports on grantee progress. A screenshot of the data entry screen on SPARS is below (Exhibit 2):

Exhibit 2. SPARS Data Entry Screen.



A.4. Effort to Identify Duplication

The items collected are necessary to assess grantee performance. CSAP and CSAT are promoting the use of consistent performance and outcomes measures across all CSAP and CSAT grant programs. This effort will result in less overlap and duplication and will substantially reduce the burden on grantees that results from data demands associated with individual programs.

SAMHSA will work closely with the grantees to identify whether other data are being collected by the grantee, which may be redundant to the respective CSAP and CSAT grant programs. When duplication is identified, SAMHSA and the grantees will identify a plan to reduce the duplicative efforts and streamline the data items to reduce burden.

A.5. Involvement of Small Entities

Grantees will usually consist of state agencies, tribal organizations, and other jurisdictions. Every effort has been made to minimize the number of data items collected from all programs down to the least number of items necessary to accomplish the objectives described within and meet GPRA reporting requirements. Therefore, there is no significant impact to small entities.

A.6. Consequences If Information Collected Less Frequently

The multiple data collection points for the suite of data collection instruments are necessary to track and monitor grant compliance and programmatic performance monitoring over time. In addition, SAMHSA will use the data for the purposes of evaluation, as appropriate. Less frequent reporting will affect SAMHSA's and the grantees' ability to do so effectively. For example, SAMHSA's federal requirements require them to report on performance and GPRA measures once each year. Federal health disparities priorities require periodic reports of the activities used to address those priorities.

SAMHSA has made every effort to ensure that data are collected only when necessary and that extraneous collection will not be conducted. As part of this effort, cognitive testing will be performed that will include CSAP and CSAT grantees. Feedback that is received from the cognitive testing may result in revisions to the MAI-ORA, MAI-PPR, and MAI-PORT.

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

This information collection complies with the guidelines in 5 CFR 1320.5(d)(2). However, SAMHSA seeks an exception to OMB's Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity posted to the federal register on 3/29/2024. Specifically, SAMHSA is requesting to use the minimum categories outlined in Figure 3 of the Directive No. 15 for the MAI-PORT instrument. The MAI-PORT is not a tool designed for program participants to complete. Rather, it is a way for grantees to report aggregate information about their program. Definitions and examples of each race and ethnicity category are found in the instrument's Appendix A - List of Definitions. OMB's approach using more detailed categories outlined in Figure 1 of Directive No. 15 would require grantees to submit a massive number of written responses to SAMHSA. We would ultimately aggregate this information, and it could be very burdensome for grantees to report. We don't need the write-in responses; we only need the total of individuals that provide a written response. In addition, because SAMHSA is asking grantees to report aggregate-level data for race/ethnicity on the MAI-PORT, we have included an "other" category for each higher-level race/ethnicity category. Including this "other" category will allow grantees to report additional race/ethnicity details reflective of their grant populations of focus that are not included among the detailed race/ethnicity categories provided.

A.8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the *Federal Register* on [July 5, 2024 (89 FR 55631). No comments were received.

A.9. Payment to Respondents

No cash incentives or gifts will be given to respondents.

A.10. Assurance of Confidentiality

Data will be kept private to the extent allowed by law. SAMHSA has statutory authority to collect data under GPRA (Public Law 1103(a), Title 31) and is subject to the Privacy Act for the protection of these data. Only aggregate data will be collected with the MAI-ORA, MAI-PPR, and MAI-PORT instruments. SAMHSA and its contractors will not receive identifiable client records from the grantee staff. Grantee staff will provide information about their organizations and activities, rather than detailed information about each individual they serve.

The contracting team takes responsibility for ensuring that the Web and data system is properly maintained and monitored. Server staff will follow standard procedures for applying security patches and conducting routine maintenance for system updates. Data will be stored on a password-protected server, and access to data in the system will be handled by a hierarchy of

user roles, with each role conferring only the minimum access to system data needed to perform the necessary functions of the role.

While not collecting individual-level data, contractor staff are trained on the importance of privacy and in handling sensitive data.

A.11. Questions of a Sensitive Nature

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for mental and substance use disorders, including co-occurring disorders, to improve health and reduce illness, death, disability, and cost to society. These instruments will be used to report on performance at the aggregate level. There are no questions of a sensitive nature that are asked of individuals as the data collection is focused at the grantee level and not the individual participant level.

A.12. Estimates of Annualized Hour Burden

Table 2 and Table 3 provides an overview of the data collection method, frequency of data collection, and number of data collections for each data collection instruments.

Table 2. Grant Compliance: MAI-ORA and MAI-PPR

Instrument	Data Collection Method	Frequency of Data Collection	Maximum Number of Data Collections	Attachment Number
MAI-ORA	Grantees submit into SPARS	Once	Once in Year 1	1
MAI-PPR	Grantees submit into eRA	Annually	Annually: 5 times (1 time per year in Years 1-5)	2

Table 3. - Program Performance Monitoring: MAI-PORT

Instrument	Data Collection Method	Frequency of Data Collection	Maximum Number of Data Collections	Attachment Number
MAI-PORT	Grantees submit into SPARS	Yearly: Annual Targets Report (ATR) Quarterly: Quarterly Performance Report (QPR)	Yearly: 5 times (1 time per year in Years 1-5) Quarterly: 20 times (4 times per year in Years 1-5)	3

The estimated time to complete each instrument by year is shown in Tables 4 through 9.

Table 4. Estimates of Annual Burden for MAI PT Data Collection: Year 1

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage[1]	Total Respondent Cost
MAI-ORA	8	1	8	14	112	$48.35	$5,415.20
MAI-PPR	8	1	8	3	24	$48.35	$1,160.40
MAI-PORT/ATR	8	1	8	1	8	$48.35	$386.80
MAI-PORT/QPR	8	4	32	2	64	$48.35	$3,094.40
TOTAL	**8**	**7**	**56**	**20**	**208**	**$48.35**	**$10,056.80**

[1]*Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at https://www.bls.gov/oes/current/naics4_999200.htm#11-0000 Accessed on January 15, 2024.*

Table 5. Estimates of Annual Burden for MAI PT Data Collection: Year 2

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage[1]	Total Respondent Cost
MAI-ORA	8	0	0	14	0	$48.35	$0.00
MAI-PPR	8	1	8	3	24	$48.35	$1,160.40
MAI-PORT/ATR	8	1	8	1	8	$48.35	$386.80
MAI-PORT/QPR	8	4	32	2	64	$48.35	$3,094.40
TOTAL	**8**	**6**	**48**	**20**	**96**	**$48.35**	**$4,641.60**

[1]*Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at https://www.bls.gov/oes/current/naics4_999200.htm#11-0000 Accessed on January 15, 2024.*

Table 6. Estimates of Annual Burden for MAI PT Data Collection: Year 3

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage[1]	Total Respondent Cost
MAI-ORA	8	0	0	14	0	$48.35	$0.00
MAI-PPR	8	1	8	3	24	$48.35	$1,160.40
MAI-PORT/ATR	8	1	8	1	8	$48.35	$386.80
MAI-PORT/QPR	8	4	32	2	64	$48.35	$3,094.40
TOTAL	**8**	**6**	**48**	**20**	**96**	**$48.35**	**$4,641.60**

[1]*Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at https://www.bls.gov/oes/current/naics4_999200.htm#11-0000 Accessed on January 15, 2024.*

Table 7. Estimates of Annual Burden for MAI PT Data Collection: Year 4

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage[1]	Total Respondent Cost
MAI-ORA	8	0	0	14	0	$48.35	$0.00
MAI-PPR	8	1	8	3	24	$48.35	$1,160.40
MAI-PORT/ATR	8	1	8	1	8	$48.35	$386.80
MAI-PORT/QPR	8	4	32	2	64	$48.35	$3,094.40
TOTAL	**8**	**6**	**48**	**20**	**96**	**$48.35**	**$4,641.60**

[1]*Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at https://www.bls.gov/oes/current/naics4_999200.htm#11-0000 Accessed on January 15, 2024.*

Table 8. Estimates of Annual Burden for MAI PT Data Collection: Year 5

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage[1]	Total Respondent Cost
MAI-ORA	8	0	0	14	0	$48.35	$0.00
MAI-PPR	8	1	8	3	24	$48.35	$1,160.40
MAI-PORT/ATR	8	1	8	1	8	$48.35	$386.80
MAI-PORT/QPR	8	4	32	2	64	$48.35	$3,094.40
TOTAL	**8**	**6**	**48**	**20**	**96**	**$48.35**	**$4,641.60**

[1]*Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at https://www.bls.gov/oes/current/naics4_999200.htm#11-0000 Accessed on January 15, 2024.*

Table 9. Estimates of Annual Burden for MAI PT Data Collection: All years

Instrument	Number of Respondents	Responses per Respondent	Total Number of Responses	Hours per Response	Total Burden Hours	Average Hourly Wage[1]	Total Respondent Cost
MAI-ORA	8	1	8	14	112	$48.35	$5,415.20
MAI-PPR	8	5	40	3	120	$48.35	$5,802.00
MAI-PORT/ATR	8	5	40	1	40	$48.35	$1,934.00
MAI-PORT/QPR	8	20	160	2	320	$48.35	$15,472.00
TOTAL	**8**	**31**	**248**	**20**	**592**	**48.35**	**$28,623.20**

[1]*Average hourly wage is based on the mean hourly wage for state government managers, as reported in the 2022 Occupational Employment (OES) by the Bureau of Labor Statistics (BLS) found at https://www.bls.gov/oes/current/naics4_999200.htm#11-0000 Accessed on January 15, 2024.*

A.13. Estimates of Annualized Cost Burden to Respondents

There are no respondent costs for capital or start-up or for operation or maintenance.

A.14. Estimates of Annualized Cost to the Government

The total estimated cost to the government for the data collection from FY 2025 through FY 2029 is $1,130,261. This includes approximately $145,837 per year for SAMHSA costs to manage/administer the data collection and analysis for 25% each of four employees, two from CSAP and two from CSAT (GS-13-5, $133,692 and GS-14-5, $157,982 annual salary). This also includes approximately $80,215 per year for SAMHSA costs to monitor and approve grantee reporting in these instruments (10% time of 6 GPOs, three from CSAP and three from CSAT (GS-13-5) at $133,692 annual salary). The total annualized cost is approximately $226,052.20.

A.15. Changes in Burden

Since the publication of the 60-day Federal Registry Notice, changes were made to the burden estimates. No comments were received during the 60-Day Federal Register comment period. However, changes were made to the burden estimates based on the feedback received from respondents during the cognitive testing.

A.16. Time Schedule, Publications, and Analysis Plan

Time Schedule

Table 10. Time Schedule for Data Collection

Activity	Time Schedule
Obtain OMB approval for data collection	December 2024
Collect data	January 2025–September 2029
Analyze data	March 2025–September 2029
Disseminate of findings: Annual evaluation reports	Ongoing for monitoring purposes.

Publications

Reports summarizing the MAI-ORA, MAI-PPR, and MAI-PORT data will be prepared for the internal use of SAMHSA. MAI-PORT will primarily be used by SAMHSA Government GPOs to monitor the progress of their grantees. Additional audiences for these reports will include Congress, SAMHSA Contracting Officer's Representatives (CORs), grantees, and the broader substance use prevention field (e.g., academia, researchers, policymakers, providers). Also, data from the reports will be used for evaluation purposes, as the process data may inform specific outcomes.

The data also may be shared at professional conferences, such as American Public Health Association Annual Meeting and Expo, National Prevention Network, SAMHSA's Prevention Day, Society for Prevention Research, and other conferences.

Analysis

Both quantitative and qualitative analysis will be conducted.

- Quantitative analysis will include descriptive statistical procedures, including frequency counts and percentages. Some cross-tabulations will be used to help identify patterns within the responses.
- Qualitative analyses will focus primarily on open-ended responses grantees will report regarding the results from their MAI-ORA as well as their overall accomplishments, challenges/barriers, successes and innovations, accomplishments and barriers report in programmatic progress reports.

Analysis will be at the aggregate level for all measures found in the MAI-ORA, MAI-PPR, and MAI-PORT instrument (Attachments 1 – 3).

A.17 Display of Expiration Date

OMB approval expirations dates will be displayed.

A.18. Exceptions to Certification for Statement

There are no exceptions to the certification statement. The certifications are included in this submission.

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