

Supporting Statement A: Revision Request for Clearance
NATIONAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0234
(Expires 11/30/2025)

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Supporting Statement A

National Center for Health Statistics National Ambulatory Medical Care Survey (NAMCS)

- Goal of the study: To assess the health of the population through 1) data on physicians and advance practice providers, and Health Centers (HCs), and 2) data on ambulatory patient visits collected through electronic health records.
- Intended use of the resulting data: These data are used to monitor public health, used by the U.S. Department of Health and Human Services for program planning and to inform national policies, and used by health care researchers, medical schools, policy analysts, congressional staff, the news media, and many others to improve our knowledge of medical practice patterns and patients.
- Methods to be used to collect data: A stratified, random sample of providers is selected from a universe of physicians and advanced practice providers of ambulatory care. Basic provider characteristics are collected. A separate sample will be used to collect electronic patient visit data. For Health Centers (HCs), a stratified random sample of HCs is selected from a universe of HCs which have electronic health record systems. Data from all electronic patient medical records are collected for the full calendar year from the sample of HCs.
- The subpopulation to be studied: The subpopulation is created from three separate populations. The Provider Survey Component samples ambulatory care providers to collect information on their characteristics and the characteristics of their practice. The Provider Electronic Component gathers information on a sample of electronic data providers including characteristics of the provider, as well as a full year of electronic patient visit data. Lastly, the HC Component samples HCs and collects characteristics of the center as well as a full year of electronic patient visit data.
- How data will be analyzed: NAMCS data are weighted and analyzed using appropriate statistical approaches. Public-use files will be made available where possible. Findings will be released in NCHS reports, journal articles, and research papers, as well as released to researchers for analysis.

The National Center for Health Statistics (NCHS) requests approval for a revision of an approved data collection, the ongoing NAMCS (OMB No. 0920-0234: Exp. Date 11/30/2025). On 11/22/2022, NAMCS was approved to collect data for the three years – 2023, 2024, and 2025. The current approval being requested is to collect data for the 2025, 2026, and 2027 NAMCS cohorts using updated sample sizes and to complete the remaining 2024 NAMCS activities for Health Centers (HCs). In addition, we also request the approval to submit non-substantive change packages, as needed, for modifications occurring throughout the 2025-2027 study period.

In summary of this revision request, overall OMB approval is being sought to:

- Continue previously approved survey activities for the next 3 years, i.e., completion of the 2024 data year for HCs, conducting the full 2025, 2026, and 2027 data years.
- Approval to use non-substantive change requests to make small modifications or incorporate experimental and developmental work, including the implementation of planned changes for which the methodology has been explained in the currently approved supporting statements.

New/modified activities planned for the 2025-2027 survey period:

- Decrease HC Component and Provider Survey Component (formerly known as the Provider Interview Component) sample sizes due to budget.
- Modify HC Facility Interview Questionnaire due to recruitment feedback.
- Update the Ambulatory Care Provider Interview (ACPI) race response options according to OMB's updated SPD 15.
- Update ACPI gender response options for consistency across NCHS surveys.
- Remove COVID-19 section from HC Facility Interview and ACPI.
- Modify Provider Facility Interview to correspond with ACPI.
- Update the confidentiality text on instruments and materials for all components.

Continuing data collection activities:

Provider Survey Component:

- Continue with the sample of advanced practice providers, started with PAs (physician associates/physician assistants) in 2023, and in successive survey years possibly rotating to other types of advanced practice providers if funds permit and methodological research demonstrates the feasibility.
- Continue fielding a redesigned Ambulatory Care Provider Interview questionnaire in 2025, 2026, and 2027.
- Continue modular format of ACPI targeting topics of interest on rotating basis.
- Continue to conduct tracing on ambulatory care provider contact information.

Provider Electronic Component:

- Continue to include the potential for a supplemental sample of providers from which visit data are collected through submission of EHRs and weighted through Provider Facility Interview (PFI), with approved 2022 sample size and methodology, applied to 2025-2027
- Continue to include the exploration and potential of implementation of the provision of up to \$10,000 set-up fee for the Provider Electronic Component.
- Continue to conduct research on supplementing electronic visit data with electronic data obtained from third-party sources.

Health Center Component:

- Continue patient visits to HCs.
- HCs will continue to remain in the sample unless they request to no longer participate.
- Continue to field HC Facility Interview Questionnaire.
- Conduct research on providing a set-up fee for the HCs via Set-up Fee Questionnaire.

A. Justification

1. Circumstances Making the Collection of Information Necessary

NAMCS is a national survey of ambulatory medical care services with three components: the Provider Survey Component, the Provider Electronic Component, and the HC Component, and is conducted by the NCHS, Centers for Disease Control and Prevention (CDC). The survey is conducted under authority of Section 306 of the Public Health Service Act (42 USC 242k) (**Attachment A**).

An overarching purpose of NAMCS is to meet the needs and demands for statistical information about the provision of ambulatory medical care services in the United States, and fulfill NCHS' mission to collect, analyze, and disseminate timely, relevant, and accurate health data and statistics. Additional justifications for conducting NAMCS include the need for more complete data to study: (1) the performance of the U.S. health care system, (2) care for the rapidly aging population, (3) changes in services such as health insurance coverage, (4) the introduction of new medical technologies, (5) the use of HCs in the health care community, and (6) the use of EHRs.

The Provider Survey Component samples ambulatory care providers (physicians and advanced practice providers), and the HC Component samples health centers. The Provider Survey Component interview contains fixed and rotational components, which will allow swift updates/additions when quick turnaround is necessary, for example the addition of COVID-19 questions during the 2020 data collection year. Currently, the HC Component has plans to reintroduce Urban Indian Health Centers to the sample if funds permit and methodological research demonstrates the feasibility. As approved in the previous OMB package, the Provider Electronic Component samples physicians, while exploring the possibility of collecting electronic data from advanced practice providers, large medical conglomerates, medical groups, and practices. The Provider Electronic Component will also explore the using of data collected from third party entities such as IQVIA, the American Board of Family Medicine, or others to supplement NAMCS visit data.

Due to OMB expiration dates and the annual survey year timetable, this package includes the ability to complete the remaining 2024 NAMCS activities for HCs, along with the requested 2025-2027 survey changes below.

New/modified activities planned for the 2025-2027 survey period:

The Assurance of confidentiality language will be updated in all instruments and appropriate survey materials to correspond with updated Confidential Information Protection and Statistical Efficiency Act guidance. Additionally there will be component specific changes detailed below:

Health Center Component

Two questions were moved to occur earlier in the survey due to feedback from recruitment contractors after a mode change that occurred in the previous OMB package approval (**Attachments C2**). Because the web portal has been implemented, the contact information question for the EHR personnel has been moved from the EHR sections to the beginning of the

survey, along with other contact information questions. This will allow for more timely completion of testing and validation (T&V). Additionally, the COVID-19 questions have been removed, due to decreased relevance. Because of the small quantity of COVID-19 questions, we assume the overall burden will remain unchanged. The numbering and skip patterns have also been adjusted accordingly.

Provider Survey Component

NAMCS is now working with a contractor instead of the U.S. Census Bureau, slight text modifications have been made to the survey materials. Previously, the U.S. Census Bureau logo or name appeared on or within the text of the materials; this information has been removed or replaced. Additionally, because of the introduction of the rotating provider types, the ACPI will be separated into two versions: one for physicians (**Attachments D**) and one for advanced practice providers (**Attachments E**). As with the Health Center Component, the COVID-19 questions have been removed, due to decreased relevance. Because of the small quantity of COVID-19 questions, we assume the overall burden will remain unchanged. The numbering and skip patterns have also been adjusted accordingly. Additionally, responses to race/ethnicity questions were updated according to OMB's updated SPD 15 standards. Lastly, response options to sex/gender questions were updated to correspond with other NCHS surveys, making responses more cohesive across the agency.

Provider Electronic Component

To be consistent across NAMCS components, small modifications to the Provider Facility Interview (PFI) (**Attachments L**) questions and response options have been made (e.g. adding the ACPI clarifications to outpatient office-based settings, updating "physician" to "provider", and adding a response option for advanced practice providers on the provider type question). These question and response updates will make the PFI consistent with the previously approved ACPI.

NAMCS Sample Size

The sample size for both the HC Component and the Provider Survey Component will be decreased, based on current funding information. Details for how we plan to continue to adequately survey ambulatory care services see details of changes below.

- Provider Survey Component

For the 2025 survey we were approved for a sample increase of up to a total of 20,000 physicians and 40,000 advanced practice providers. However, allocated funds for the 2025 survey will only cover a sample size of 10,000 providers (rotating between physicians and advanced practice providers on alternating survey years). The same levels of funding are anticipated for 2026 and 2027. Additional funds may be available in future years. Given the limited funding, CDC will sample a total of 10,000 providers yearly, and will rotate provider types per year. Rotating provider types will allow us to continue to collect data about provider types approved in the previous OMB package in spite of limited funding. By doing so, we will continue to gain insight

on major areas of health care such as advanced practice provider autonomy, EHR usage, cultural/language barriers, pain treatment and opioid prescription management despite current budget constraints.

- Provider Electronic Component

For the Provider Electronic Component, we are proposing to continue with the previously approved 3,000 providers a year.

- Health Center Component

For the HC Component, up to 200 HCs were approved for 2024. Because we carry over HCs from previous years, but lose some due to attrition, a target of only up to 151 HCs for 2024 was possible. For 2025, allocated funds will cover 20 additional HCs. The same number is anticipated for 2026, and we will decrease our recruitment to 10 additional HCs in 2027. To ensure we have the maximum chance to reach our targeted number of HCs in each survey year, we have a primary and a reserve sample. As a respondent from the primary sample declines, we activate corresponding HCs from the reserve sample. Since we cannot predict how many HCs will be contacted, we have included all of the primary and the reserve sample in the burden and cost calculations for the HC Facility Interview Questionnaire, as with previously approved packages. Also, not all who are contacted submit visit data so burden for data submission and T&V will be based solely on the total target sample for each data year (i.e., up to 151 HCs in 2024, up to 171 HCs in 2025, up to 191 HCs for 2026, and up to 201 HCs in 2027). Lastly, because the Set-up Fee is only offered for the first year of participation, completion of the Set-up Fee Questionnaire will be based solely on the newly sampled HCs for each data year (i.e., up to 50 HCs in 2024, up to 20 HCs in 2025, up to 20 HCs for 2026, and up to 10 HCs in 2027). Currently, the Health Center Component has plans to reintroduce Urban Indian Health Centers to the sample as if funds permit and methodological research demonstrates the feasibility. Lastly, due to attrition, HCs will not be dropped from the sample every 5 years; they will continue to remain in the sample unless they request to no longer participate.

We plan to continue to research and explore what else can be done to increase response rate, especially in areas with underserved populations. Methods to achieve this goal may include utilizing abstraction, increased outreach and tracing, utilizing nonresponse bias analyses, a supplemental sample, an incentive, etc.

2. Purpose and Use of the Information Collection

The purpose of this study is to collect information about ambulatory care providers and patient characteristics and clinical data (e.g., diagnoses, services/tests, medications, and visit disposition). The resulting published statistics and data sets help health care providers and professionals plan for more effective health services, improve medical and health education, and assist the public health community in understanding the patterns of diseases and health conditions. In addition, policy makers use NAMCS data to identify: (1) quality of care issues, (2) medical resource utilization, and (3) changes in health care over time.

If NAMCS data were not collected, there would be no national estimates of health care issues

faced by ambulatory care providers, HCs, or their patients. Items on the ACPI (**Attachments D and E**) will result in data that will allow researchers to examine a variety of health topics, including telemedicine/telehealth, health equity, and the autonomy of advanced practice providers.

NAMCS provides a range of data on the characteristics of ambulatory care providers and HC facilities providing ambulatory medical care. Visit data, collected through the Provider Electronic Component and the HC Component, include the demographic characteristics of patients, medical diagnoses, medications, and visit disposition that are used to make annual estimates as well as estimate trends that are used to monitor the effects of change in the health care system and provide new insights into ambulatory medical care.

NAMCS utilizes the collection of electronic visit data in a continued effort to modernize data collection. More specifically, through the Office of the HHS Secretary Patient Center Outcomes Research Trust Fund (PCORTF), NCHS was awarded monies to conduct two projects expanding the utility of EHR data collected from HCs. The specific goals of the first PCORTF project are to: (1) leverage existing infrastructure and optimize advances in health information technology (health IT) in order to expand the collection and processing of EHRs for maternal health visits to HRSA supported HCs and (2) link these clinical visit data to mortality data available in the National Death Index (NDI) and to social determinants of health measures available in administrative data from the U.S. Department of Housing and Urban Development (HUD); and (3) make available a nationally representative dataset on maternal health care, including its relation to COVID-19, from HC visits in the United States. The second project expands on this work and will link the HC clinical visit data to the Centers for Medicare and Medicaid Services Transformed Medicaid Statistical Information System (T-MSIS) administrative data.

Users of NAMCS include numerous governmental agencies, state and local governments, medical schools, schools of public health, colleges and universities, private businesses, non-profit foundations, corporations, and professional associations, as well as individual practitioners, researchers, administrators, and health policymakers. Uses vary from the inclusion of a few selected statistics in a large research effort, to in-depth analyses of the entire NAMCS data set covering multiple years.

3. Use of Improved Information Technology and Burden Reduction

This current data collection's respondent burden has been reduced, compared to the previously approved OMB package, due to the sizeable reduction in the newly proposed sample sizes.

Ambulatory Care Provider Interview

The use of a self-administered web instrument, that can also be completed by mail, for the ACPI (**Attachments D and E**) data has simplified the data collection activities by reducing chance of data entry errors and omissions. Overall, using a computerized data entry system has significantly reduced recruitment contractor burden and respondent burden; ultimately improving field operations and overall data quality. Additionally, the web and paper instruments incorporate skip patterns and logic checks to reduce respondent burden and improve data quality. Lastly, by collecting the data electronically, transmission and processing speed has increased.

The Provider Survey Component also conducts additional tracing (**Attachment F**) of the sampled ambulatory care providers' contact information, due to the change in data collection procedures. The goal of tracing is to increase response rate and decrease needed follow-up contact attempts.

Health Center Facility Interview

The HC Facility Interview Questionnaire (**Attachment C2**) utilizes a telephone interview for half of the questionnaire and a self-administered web instrument for the second half. The second half can also be completed via phone, if preferred. Both options incorporate skip patterns and logic checks with the goal of reducing burden and improving data quality.

Visit Data

For NAMCS all visit data are acquired electronically. NAMCS electronic visit data are submitted to the NCHS Healthcare Electronic Health Record (HEHR) System as described in Section A10. The HEHR system and the adoption of a standardized transmission format for the electronic data also reduce respondent burden by simplifying data transmission.

NAMCS is included in the Medicare Promoting Interoperability Program (Promoting Interoperability [PI]). Registered providers who are selected to participate in NAMCS can use their electronic visit data submission to fulfill the program's requirements. Multiple Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) rules require providers in the PI Incentive Program to use Certified Electronic Health Record Technology (CEHRT) that has been updated to meet 2015 Edition Cures Update criteria. The standard, and format requested for NAMCS, is currently the Health Level Seven International (HL7) Clinical Document Architecture (CDA®) R2 Implementation Guide (IG): National Health Care Surveys, R1 DTSU, Release 1.2 or Release 3 - US Realm; created by NCHS for the National Health Care Surveys. If and when NCHS updates this IG, NAMCS will move to include the new formats in their acceptable submission formats.

To meet the requirements of the Provider Electronic and HC Components, the goal is for respondents to transmit electronic data in the format of the National Health Care Surveys IG (or a custom extract, Fast Health Interoperability Resources [FHIR] messaging, or potentially other future updated IGs with similar data elements) and go through T&V before final production can be submitted. NCHS staff and/or contractors will work with HCs during the T&V stage to ensure all the critical HCs data elements of interest are included. To further reduce burden, HCs in the HC Component are offered a one-time set-up fee of up to \$10,000 to help offset the cost of setting up data transmission method or module developed by their EHR vendor based on the National Health Care Surveys IG. For the Provider Electronic Component, a one-time set-up fee, up to \$10,000, may be offered to physician groups/conglomerates not enrolled in the National Health Care Surveys Registry to help offset costs, pending available funding. Sampled EHR providers and the HCs will be asked to provide all patient visits for a designated reporting period (for example, a full calendar year).

Lastly, to further reduce respondent burden, NAMCS will explore the use of electronic visit data collected from third party entities such as IQVIA, the American Board of Family Medicine, and

others to supplement electronic data collected for the Provider Electronic Component. IQVIA collects uniform billing (UB)-04 administrative claims and electronic data with similar data elements required by the NAMCS. These third-party data sources would be used to research if/how third-party data can increase the reliability of national visit data estimates made by NAMCS while reducing respondent burden.

4. Efforts to Identify Duplication and Use of Similar Information

NCHS staff have had extensive contacts regarding survey items with organizations and individuals in both the private and public sectors who are familiar with ambulatory care provider and HC utilization data. Advice from consultants, attendance at relevant meetings, and literature reviews have been used to identify other sources that collect nationally representative data similar to those collected by NAMCS, and three have been identified and are discussed below.

The National Health Interview Survey, or NHIS (OMB No. 0920-0214, Exp. Date 12/31/2026) is a population-based survey in which information is obtained through household interviews. In addition to the recall problems that may be associated with household respondents, NHIS respondents cannot provide the detailed medical information about diagnoses, diagnostic/therapeutic procedures, or medications. They can only be expected to provide counts of physician visits and general medical information.

The Medical Expenditures Panel Survey, or MEPS (Agency for Healthcare Research and Quality, OMB No. 0935-0118, Exp. Date 09/30/2026), is a survey of households and their members' health care providers (including physicians in office-based practices), health insurance companies, and employers. As with NHIS, household respondents cannot supply detailed medical information. Medical information collected from physician respondents does not include detailed data on medications, and other therapeutic services. Both NHIS and MEPS also experience an unknown degree of reporting bias because it is likely that respondents may be reluctant to report medical contacts for sensitive problems (e.g., psychiatric disorders).

The Bureau of Primary Health Care at HRSA has their Uniform Data System (UDS) (OMB No. 0915-0193; Exp. Date 04/30/2026), which is a mandatory reporting system of Federally Qualified Health Centers (FQHCs) who are funded under Section 330 of the Public Health Service Act. While the UDS collects general characteristics and information on the funded HCs, it does not include visit data to the extent of which are collected by NAMCS. Also, Urban Indian Health Centers are not required to submit these data to the UDS; NAMCS plans to collect data on these types of HCs.

These data sources include useful information but are not adequate for collecting and providing the detailed health care provider and patient visit data from ambulatory care providers and HC facilities that are collected by NAMCS. The depth of visit data collected in NAMCS about ambulatory patients allows for rich analysis regarding the provision of ambulatory medical care and is an ideal source of data for understanding the care provided in these settings.

5. Impact on Small Businesses or Other Small Entities

A portion of the Provider Survey Component respondents are physicians and advanced practice providers who work in solo or small group practices. Based on 2023 ACPI data, we assume that 88% of the physician responders and 97% of the advanced practice providers will be responding to the ACPI and contact tracing by the providers themselves. To reduce burden for these, and all respondents, NAMCS selects only a sample of ambulatory care providers to be contacted. The sample each year will not overlap with samples from which data were collected for any NAMCS, NAMCS supplement, or other physician surveys conducted by NCHS in the prior two years.

A reduction in NAMCS respondent burden per encounter has been noted for providers who submit electronic visit data relative to those whose visit data were collected through abstraction (as done in previous iterations of NAMCS). Based on the HC Component, we assume that most of our sampled providers who work in large medical group practices or are employed by large health care integrated delivery networks will not be personally involved in submitting electronic visit data. For the remaining sampled providers who submit data electronically and are practicing in small medical practices, we also expect a majority will have their staff work on NAMCS tasks. Also, use of the National Health Care Surveys' IG (**Attachments G, H, and I**) will allow for NAMCS data elements to come from already available information captured by their respective EHR systems. Furthermore, once a HC is sampled for participation in NAMCS and the initial set-up is completed, burden will be further reduced in future years.

6. Consequences of Collecting the Information Less Frequently

Collecting ambulatory care information less frequently would make it difficult to track the rapidly changing environment in ambulatory health care delivery. NAMCS data are important to have for decision making, describing the public's use of provider and HC services, monitoring the effects of change, and planning possible changes in payment policies. This information has become even more crucial with the need to track the effects of the health care industry's changing arrangements for delivering care by having continuous data collection before, during, and after major health care and public health changes, such as the opioid epidemic and the COVID-19 pandemic. Less frequent collection would also limit the study of rare visit characteristics, for which NAMCS data can be used to study by combining data across years to increase reliability.

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

This request fully complies with the regulation 5 CFR 1320.5.

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

Federal Register Notice

This project fully complies with all guidelines of 5 CFR 1320.8(d). A 60-day Federal Register Notice was published in the Federal Register on September 20, 2024, volume 89, page number 77158 (**Attachment B**). No comments were received.

Efforts to Consult Outside the Agency

NAMCS is an ongoing survey, and experts are consulted by NCHS on survey advice as needed. NCHS will continue to work closely with these outside individuals and agencies as the need for consultation arises. Currently, there are no unresolved issues with the survey. A list containing the names of the consultants is provided in **Attachment J**.

9. Explanation of Any Payment or Gift to Respondents

Per previous OMB approval, if funds allow and/or the need arises, NAMCS would like to continue utilizing non-monetary tokens for the Provider Survey Component. Some studies have shown that non-monetary incentives have been shown to boost physician response rates.¹ Other studies have shown that, while non-monetary incentives did not increase overall response, they did encourage earlier response, which saved survey costs.² Examples of potential non-monetary tokens that NAMCS might include are pens, post-it notes or other items of similar value, around \$1.00 per sampled provider.

Per previous OMB approval, if funds allow and/or the need arises, NCHS plans to offer a one-time set-up fee, up to \$10,000, for the Provider Electronic Component as currently done in the HC Component. This fee will be offered to physician groups/conglomerates not enrolled in the National Health Care Surveys Registry to help offset participation costs and to obtain participation from providers that are not enrolled.

Per previous OMB approval, NCHS is employing a one-time set-up fee of up to \$10,000 provided to every HC which participates in the HC Component. This fee will assist HCs with the administrative and technical costs of installing the National Health Care Surveys' IG (**Attachments G, H, and I**) (or the cost of creating a custom extract), and the activation of this certified EHR module that their respective EHR vendor has developed. While the exact costs incurred are currently unknown, the Set-up Fee Questionnaire (**Attachment K**) serves as an opportunity for NCHS to garner that data and help plan for future expansion.

Any future plans to offer additional payment or gifts would be submitted to OMB for review and potential approval.

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

Data will be kept private to the extent allowed by law.

This submission has been reviewed by the Information Collection Review Office (ICRO), which determined that the Privacy Act does apply. The NCHS Privacy Act Coordinator and the NCHS Confidentiality Officer have also reviewed this package and have determined that the Privacy Act is applicable because this study includes the collection of information in identifiable form. The applicable System of Records Notices are 09-20-0167 Health Resources Utilization Statistics (**Attachment Q**) and 09-20-0164 Health and Demographic Surveys Conducted in

¹ Beatty, P., Jamoom, E.W. "The Effect of Non-Monetary Incentives in a Longitudinal Physician Survey." AAPOR, Boston, MA, May 17, 2013.

² Jamoom, E.W., Beatty, P. "Investigating the Relationship Between Nonmonetary Incentives, Questionnaire Length and Response Rates in a Physician Survey." AAPOR, Hollywood, Florida, May 15, 2015.

Probability Samples of the U.S. Population (**Attachment Q**).

An assurance of confidentiality is provided to all respondents, according to section 308 (d) of the Public Health Service Act (42 USC 242m) which states:

“No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section...306 (NCHS legislation),...may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose and (1) in the case of information obtained in the course of health statistical or epidemiological activities under section...306, such information may not be published or released in other form if the particular establishment or person supplying the information or described in it is identifiable unless such establishment or person has consented (as determined under regulations of the Secretary) to its publication or release in other form,...”

In addition, legislation covering confidentiality is provided according to section 513 of the Confidential Information Protection and Statistical Efficiency Act or CIPSEA (44 U.S.C. 3561-3583) which states:

“Whoever, being an officer, employee, or agent of an agency acquiring information for exclusively statistical purposes, having taken and subscribed the oath of office, or having sworn to observe the limitations imposed by section 512, comes into possession of such information by reason of his or her being an officer, employee, or agent and, knowing that the disclosure of the specific information is prohibited under the provisions of this title, willfully discloses the information in any manner to a person or agency not entitled to receive it, shall be guilty of a class E felony and imprisoned for not more than 5 years, or fined not more than \$250,000, or both.”

Information in Identifiable Form (IIF)

NAMCS provides numerous and varied national estimates on provider, visit, and practice characteristics. The medical record number aids in the identification of separate visits among records. An example of the value of PII is that it allows the potential for linkage to the NDI, HUD administrative data, and other sources for the electronic visit data collection. The list of requested PII includes the data elements listed in the following for patients, providers, and HCs. A list of all IIF data items is highlighted below, and all were approved by OMB in the previous packages to be collected on survey forms. None of these data are released to the public or become part of public-use files.

Information in Identifiable Form Categories:

Provider/Facility Information (Attachments G, C1, C2, D, E, and L):

- Provider name
- Provider address
- Provider telephone number
- Provider National Provider Identifier (NPI)

- Provider Federal Tax ID/Employer Identification Number (EIN)
- HC executive director name
- HC address
- HC contact person
- HC contact email and telephone number
- Provider/HC office staff name
- NPI number of Provider

Patient information (Attachment G):

- Name
- Birth date
- Address
- ZIP Code
- Date of visit
- Date of departure
- Encounter number
- Social security number (where available)
- Medical record number (where available)
- Medicare health insurance benefit/claim number

NAMCS will include a routine set of measures to safeguard confidentiality, including the following: all staff, including contractors, who have access to confidential information are given instruction by NCHS staff on the requirement to protect confidentiality; are required to sign a pledge to maintain confidentiality; and only such authorized personnel are allowed access to confidential records, and only when their work requires it. When confidential information is not in use, it is stored in secure conditions. Transmission of NAMCS electronic visit data will be sent to NCHS via Secured File Transmission Protocol (SFTP) through the Secure Access Management Services (SAMS) and/or DIRECT secure messaging. SAMS is accessed through a website and will provide secure transmission for the NAMCS data submissions.

Participating providers and HCs who submit EHR data will be asked to transmit all data to the HEHR system at NCHS, which was developed to support the receipt of data from eligible providers in accordance with the PI Program rules and comply with the Confidential Information Protection Statistical Efficiency Act (CIPSEA). They may need to support functions including (but not limited to) planning, designing, developing, and maintaining the infrastructure necessary to operate the surveys registry portal to allow for registration of eligible providers and sites that intend to participate in the survey and submit data. Upload interfaces via CDC's SAMS and/or DIRECT secure messaging are also included.

SAMS provides a secure data transfer service along with a strong suite of security controls to host applications and exchange data between CDC programs and public health partners while providing a high level of data integrity, confidentiality, reliability, and security. This meets NCHS/CDC policies for data transmission via the Internet. Users accessing systems protected by SAMS are required to adhere to the identity verification and authentication requirements for the Electronic Authentication Assurance Level (EAAL) of the protected system. SAMS provides system monitoring on a 24/7 basis, data redundancy features, and disaster recovery features for

select information systems. DIRECT is a national encryption standard for securely exchanging clinical healthcare messages/data via the internet. DIRECT provides strong security and privacy protection using a unified standard that all systems can leverage.

On receipt of the data within the HEHR system, all data considered PII, both direct and indirect, and non-PII will be loaded/saved to specially designated and configured file servers and database servers that are in accordance with the CIPSEA. HEHR system servers are secured physical components that are only accessible by NCHS-designated staff. We are in the process of migrating the HEHR system on the Microsoft Azure Cloud utilizing enterprise analytical platform called Enterprise Data Analytics and Visualization (EDAV) CIPSEA enclave managed by CDC OCIO. The data will be stored on the cloud. The integration and processing of data will also migrate to the cloud. Until the migration is complete, some datasets will continue to reside on the Consolidated Statistical Platform (CSP) which is also CIPSEA-compliant, while others will be migrated to the EDAV CIPSEA enclave. Once the entire migration is complete, all data will reside on the cloud.

In keeping with NCHS policy, NAMCS has a goal to make data available via public-use data files on the NAMCS website once individually identified information is removed. Confidential data are never released to the public. All personal identifiers such as provider name, patient name, patient address, patient date of birth, and any other specific information are removed from the public release files. All data releases are reviewed by the NCHS Disclosure Review Board to avoid data breaches, such as release of detailed geographic information that may allow anyone to identify practices or individuals in the general population.

The ambulatory health care data website dedicated to the NAMCS Provider Survey Component (https://www.cdc.gov/nchs/ahcd/namcs_participant.htm) describes the survey, answers questions respondents may have on why they should participate and describes how the Privacy Rule permits data collection. The ambulatory health care data website dedicated to the NAMCS HC Component (<https://www.cdc.gov/nchs/namcs/hcc/participant.htm>) describes the survey, answers questions respondents may have on why they should participate and describes how the Privacy Rule permits data collection.

11. Ethics Review Board (ERB) and Justification for Sensitive Questions

The NAMCS data collection plan has been approved by NCHS's Ethics Review Board (ERB) (Protocol #2021-03) based on 45 CFR 46 and is presented in **Attachment M**. The NCHS Human Subjects Contact determined that NAMCS is a public health surveillance activity under the 2018 requirements of the Common Rule (45 CFR 46.102(1)(2)). As a surveillance activity, HIPAA permits sharing of PII with public health authorities authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability without a waiver; therefore, justifications for waiver of informed consent are not necessary.

For each sampled provider or HC, an introductory letter (**Attachments N1, N2 and N3**) is sent that states that participation in NAMCS is voluntary and there is no effect on the respondent for not participating. The letter describes the purpose of the survey and highlights the benefits of

participation. The introductory letters are the primary tools to obtain informed consent to participate in the study. The legal authority for NAMCS data collection is Section 306 of the Public Health Service Act (42 U.S.C. 242k).

NAMCS collects PII. These PII elements have been cleared in a prior approval of this package (OMB # 0920-0234, Exp. Date 11/30/2025). One example of the value of PII is that it allows linkage to the NDI and other data sources such as CMS and HUD data. A list of requested items considered to be sensitive includes the following data elements for patients, providers, and HCs:

Provider/Facility Information (Attachments G, C1, C2, D, E, and L):

- Provider name
- Provider address
- Provider telephone number
- Provider National Provider Identifier (NPI)
- Provider Federal Tax ID/Employer Identification Number (EIN)
- HC executive director name
- HC address
- HC contact person
- HC contact email and telephone number
- Provider/HC office staff name
- NPI number of Provider

Patient information (Attachment G):

- Name
- Birth date
- Address
- ZIP Code
- Date of visit
- Date of departure
- Encounter number
- Social security number (where available)
- Medical record number (where available)
- Medicare health insurance benefit/claim number

It is necessary for NAMCS to collect some protected and approved health information, such as date of visit, birth date, and ZIP code. These data are used internally to create certain composite variables, such as patient age, which contains 6 mutually exclusive groups. Strict procedures are utilized to prevent disclosure of identified PII data. At no time are the patients contacted to obtain information.

Electronic visit data are submitted to NCHS in the format of the IG. These data include patient first and last name, social security number (SSN), and patient address in their submitted visit records. This is in addition to birth date, zip code, and sex which are also collected in the visit data. These PII data elements are collected and retained to aid in the goal of linking to the NDI, HUD, and other data sources. Although linkages could be made to the NDI without the SSN, researchers planning to use the NDI are encouraged to collect or compile as many of the NDI

data linkage items as possible. For more information on the NDI, see the web link, NCHS - National Death Index Home Page at <http://www.cdc.gov/nchs/ndi.htm>.

Since 2012, we have been collecting medical record numbers for internal survey operations purposes. This process will continue throughout this package's survey years, but through electronic visit data and not abstraction as in prior years. The retention of the medical record number for electronic visit data submissions will allow the collection of a single patient's data from several sources within a provider's office or the HC. This will provide access to more comprehensive and detailed clinical information, as well as additional outcomes and quality measures. It will also aid the identification of separate visits among electronic records.

Federal Tax Identification number and NPI number will also be collected. A federal tax identification number, also known as an EIN, is used to identify a business entity (e.g., medical practice) in the administration of tax laws and helps in the identification of sampled provider offices and HCs. NPI is used to uniquely identify a health care provider in standard transactions. HIPAA requires that covered entities use NPIs in standard transactions. NPI of providers participating in NAMCS is collected as part of the Office-based Physician Induction Interview and along with electronic visit data submission, offering the ability to link the patient's care with the specialty of the providers from whom care was received. Information linking provider identifiers to their characteristics (e.g., specialty, provider age) is available from CMS for research purposes (<https://nppes.cms.hhs.gov/NPPES#/>). We will not disclose in any manner the identity of specific providers but only analyze the data in aggregate according to physician characteristics.

12. Estimates of Annualized Burden Hours and Cost

Burden Hours

For the 2024 data collection, the NAMCS Provider Survey Component should be completed at time of approval, and the HC Component will continue until spring 2025. The HC Component targets 50 new HCs for 2024. For 2025-2027, the goal is to sample 10,000 providers; rotating between advanced practice providers and physicians. There is also a goal to sample up to 3,000 providers yearly for the Provider Electronic Component, for 2025-2027. In 2025, the HC Component goal is to target up to 171 HCs. In 2026 we plan to target up to 191 HCs (if funds are available). Lastly, if funds allow, in 2027 we will target up to 201 HCs. Once selected, HCs are retained in the sample unless they request to no longer participate. HCs that are retained repeat some of the Facility Interview Questionnaire (**Attachment C2**) in order to update weights and year specific data. As in previously approved OMB packages, a primary and reserve sample of new HCs (see "**Sample Size**" of **Section A1** for details), is utilized for each survey year's Facility Interview Questionnaire, to ensure we maximize the chance to reach our targeted number of HCs for electronic visit data submission. Since we cannot predict how many HCs in the reserve sample will be contacted to participate and complete the Facility Interview Questionnaire, we include the total number of HCs from the primary and reserve sample in the tables below when calculating HC Facility Interview Questionnaire burden. We will only collect visit data from our target sample so burden hours for data submission and the T&V will only include the target sample. Lastly, because the Set-up Fee is only offered for the first year of participation, completion of the Set-up Fee Questionnaire (**Attachment K**) will be based solely on the newly recruited HCs for that data year.

This submission requests OMB approval for the completion of the 2024 NAMCS data collection for HCs and for the following three survey years, 2025-2027, of NAMCS data collection.

The estimated annualized burden is 22,107 hours and is summarized in Table 1 below. As done in past submissions, NAMCS activities are presented separately for the Provider Survey, Provider Electronic, and HC Components.

Completion of 2024 data collection

- *Health Center Component*

For the 2024 HC Component respondents receive a welcome packet with an introductory letter (**Attachment N1**), FAQ, and Public Relations (PR) materials (endorsement letter(s), postcard, etc.). Respondents receive additional outreach letters phone calls, emails, PR materials, etc. if there is no response to the initial welcome packet. While we have begun data collection for the 2024 HC Component, the burden table includes 100% of the 2024 HC Component data collection (HC Facility Interview Questionnaire [**Attachment C1**], patient visit data transmission [**Attachment O**], and the Set-up Fee Questionnaire [**Attachment K**]). Please note, due to attrition and budget constraints the 2024 sample is smaller than expected. Currently, 101 HCs have been retained from previous survey years. There is funding available to target 50 (or primary) HCs for 2024, and the 2024 reserve sample contains 100 HCs. The retained HCs, primary sample, and reserve sample are included in the burden calculation of the HC Facility Interview Questionnaire for 2024, which results in an annualized number of 63 hours annualized over three years. The HC Facility Interview Questionnaire burden includes all of the target and reserve sample because we cannot predict how much of the reserve sample will be contacted in order to reach the target sample goal.

After completion of the HC Facility Interview Questionnaire, HCs will prepare and transmit EHR visit data. This entails submitting a file for T&V, then submitting the HC's annual visit data. Lastly, the HC will complete the Set-up Fee Questionnaire. In 2024, 50 new HCs were targeted and 101 were rolled over from previous years, totaling 151 HCs. For 2024, the expected response burden to prepare and transmit EHR visit data quarterly, including T&V, is estimated at 200 hours annualized over three years. The expected response burden for the Set-up Fee Questionnaire is estimated at 4 hours annualized over three years. Please be reminded only the target sample and the retained HCs are used to calculate burden for preparing and transmitting EHR visit data, while only target sample completes the Set-up Fee Questionnaire each year.

2025-2027

- *Provider Survey Component*

For the 2025-2027 data collection, each sampled provider will receive email and mail invitations (**Attachment N2**), PR materials (if funds allow), and non-monetary incentives (if funds allow). Providers will be able to complete the ACPI (**Attachments D and E**) via web or a mailed paper instrument. Respondents receive additional invitations and survey packets with a paper survey via mail and email dependent on their response status. The ACPI takes approximately 30 minutes. For 2025-2027, the goal is to sample up to 10,000 providers annually. In previously

approved OMB packages, the Provider Survey Component planned to expand the types of providers included in the survey, in 2023, DHCS included physicians and physician associates. Due to current budget restraints DHCS will no longer be expanding the sample but will rotate provider types by year. In order to account for provider type rotation in Table 1 and Table 2, data years 2025 and 2027 are being attributed to advanced practice provider samples and 2026 is being attributed to physician sampling (see “**Sample Size**” of **Section A1** for details). The previously approved 2023-2025 NAMCS ACPI was 5,834 hours annualized over three years for physicians and 10,834 hours annualized over three years for advanced practice providers. The sample size has decreased, thus decreasing the burden hours. The 2025-2027 NAMCS ACPI is now expected to be 1,667 hours annualized over three years for physicians and 3,334 hours annualized over three years for advanced practice providers.

Since the 2023 data collection, a Tracing Questionnaire (**Attachment F**) has been implemented to conduct additional locating of ambulatory care provider contact information (potential phone numbers, addresses, emails, etc.). The Tracing questionnaire takes approximately 10 minutes. The goal is for tracing to be conducted for the entire targeted sample of 10,000 providers annually for 2025-2027. The 2025-2027 NAMCS Tracing Questionnaire is expected to be 556 hours annualized over three years for physicians and 1,111 hours annualized over three years for advanced practice providers.

- *Provider Electronic Component*

In the 2025-2027 Provider Electronic Component, each sampled provider will receive an introductory letter (**Attachment N3**). Staff will submit their PFI (**Attachment L**) and electronic visit data (**Attachment O**); all burden associated with electronic data submission will be with their staff. The three-year annualized average burden associated with completing the modified PFI for each of 3,000 providers is still 45 minutes. As previously approved, visit data will be prepared and transmitted electronically for a full year’s worth of data. For each year, approximately 3,000 providers will be asked to complete the PFI and submit electronic visit data. The total response burden for the 2025-2027 PFI is expected to be 2,250 hours annualized over three years. The total expected response burden for the 2025-2027 electronic transmission is expected to be 12,000 hours annualized over three years.

We also plan to supplement our Provider Electronic Component data with data collected from third party entities such as IQVIA, the American Board of Family Medicine, etc. There should be no respondent burden from this activity as we will be utilizing data already collected for other sources as a resource. Due to the lack of respondent burden, this activity is not mentioned in Table 1 or Table 2 below.

- *Health Center Component*

For the 2025-2027 HC Component, respondents receive a welcome packet with an introductory letter (**Attachment N1**), FAQ, and PR materials, (endorsement letter(s) [**Attachment P**], postcard, etc.). Respondents receive additional outreach letters phone calls, emails, PR materials, etc. if there is no response to the initial welcome packet. HCs will be asked to complete the HC Facility Interview Questionnaire (**Attachment C2**), prepare and transmit EHR visit data (**Attachment O**), and complete the Set-up Fee Questionnaire (**Attachment K**). The HC Facility

Interview Questionnaire (**Attachment C2**) takes approximately 45 minutes. The Set-up Fee Questionnaire (**Attachment K**) takes approximately 15 minutes. The respondent will complete the interview by phone or web portal. The HC will then submit a file for T&V and transmit their annual visit data. Lastly, newly recruited HCs will complete the Set-up Fee Questionnaire. We plan to increase to a total of 171 HCs in 2025, then up to 191 HCs in 2026, and up to 201 in 2027. There will be an additional reserve sample of up to 40 HCs in 2025, then an additional 40 HCs in 2026, and up to another 20 in 2027. The total expected response burden for the 2025-2027 HC Facility Interview Questionnaire is estimated at 166 hours annualized over three years. The HC Facility Interview Questionnaire burden includes both the primary and reserve samples that will be contacted to reach the target sample goal. The total 2025-2027 expected response burden for the HCs to prepare and transmit EHR visit data quarterly, including T&V, is estimated at 752 hours annualized over three years. The total 2025-2027 expected response burden for the Set-up Fee Questionnaire is estimated at 4 hours annualized over three years.

Table 1. Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Avg. Burden per Response (in hrs.)	Total Burden (in hrs.)
HC's Staff	HC Facility Interview Questionnaire (Survey year: 2024)	84	1	45/60	63
	Prepare and transmit EHR for Visit Data (quarterly) (Survey year: 2024)	50	4	60/60	200
	Set-up Fee Questionnaire (Survey year: 2024)	17	1	15/60	4
Provider or Staff	ACPI (Survey year: 2026)	3,333	1	30/60	1,667
	Contact Tracing (Survey year: 2026)	3,333	1	10/60	556
Advanced Practice	ACPI (Survey year: 2025 & 2027)	6,667	1	30/60	3,334

Provider or Staff	Contact Tracing (Survey year: 2025 & 2027)	6,667	1	10/60	1,111
Ambulatory Care Provider's or Group's or Conglomerate's Staff	PFI (Survey year: 2025-2027)	3000	1	45/60	2,250
	Prepare and transmit Electronic Visit Data (quarterly) (Survey year: 2025-2027)	3000	4	60/60	12,000
HC's Staff	HC Facility Interview Questionnaire (Survey year: 2025-2027)	221	1	45/60	166
	Prepare and transmit EHR for Visit Data (quarterly) (Survey year: 2025-2027)	188	4	60/60	752
	Set-up Fee Questionnaire (Survey year: 2025-2027)	17	1	15/60	4
Total					22,107

Note: Burden hours annualized over three years.

Burden Cost

The cost to providers for each data collection cycle is estimated to be \$996,363.95. This is a decrease of \$334,974.94 from the current estimate of \$1,331,338.89 that was submitted in the last OMB change package. This decrease is due to the decrease in total burden hours, caused primarily by the decrease in sample sizes. For the Provider Survey Component, it is estimated that 88% of physicians and 97% of advanced practice providers complete the ACPI themselves versus their staff. This ratio was also applied to contact tracing efforts. The hourly wage estimates for completing various NAMCS forms and activities used in the table below are based on information obtained from the Bureau of Labor Statistics (BLS) web site (<http://www.bls.gov>). Specifically, we used the “May 2022 National Occupational Employment and Wage Estimates” for the categories including: (1) management occupations, (2) healthcare practitioners and technical occupations, and (3) office and administrative support occupations.

Data were gathered on mean hourly wages in 2022 for (1) physicians (“physicians, broad” and “surgeons, broad” wages used as a proxy for physicians), (2) advanced practice providers (physician assistants, nurse practitioners, and nurse midwives’ wages used as a proxy for advanced practice providers), (3) other professionals involved in managing either an physician or ambulatory care provider’s practice (e.g., nurses, receptionists, etc. wages as a proxy for

Physician or Advanced Practice Provider’s Staff), and (4) other professionals involved in managing either an HC (e.g., nurses, receptionists, “physicians, broad”, physician assistants, etc. wages as a proxy for HC Staff). The total cost estimate for NAMCS is detailed by the type of respondent who will complete the associated components of the survey.

Overall, the average hourly wages presented in Table 2 were averaged across different positions to capture who may complete each applicable form. The numbers indicated below represent an estimated annualized respondent cost for survey years 2025-2027.

Table 2. Annualized Respondent Cost

Type of Respondents	Form Name	Total Burden Hours	Average Hourly Wage Rate	Total Respondent Costs
Physician	ACPI	1,467	\$141.82	\$208,049.94
Physician’s Staff	ACPI	200	\$27.75	\$5,550.00
Physician	Contact Tracing	489	\$141.82	\$69,349.98
Physician’s Staff	Contact Tracing	67	\$27.75	\$1,859.25
Advanced Practice Provider	ACPI	3,234	\$59.68	\$193,005.12
Advanced Practice Provider’s Staff	ACPI	100	\$27.75	\$2,775.00
Advanced Practice Provider	Contact Tracing	1,078	\$59.68	\$64,335.04
Advanced Practice Provider’s Staff	Contact Tracing	33	\$27.75	\$915.75
Ambulatory Care Provider’s or Group’s or Conglomerate’s Staff	PFI	2,250	\$27.75	\$62,437.50
Ambulatory Care Provider’s or Group’s or Conglomerate’s Staff	Prepare and transmit Electronic Visit Data (quarterly)	12,000	\$27.75	\$333,000.00
HC’s Staff	HC Facility Interview Questionnaire	229	\$46.33	\$10,609.57
HC’s Staff	Prepare and transmit EHR for Visit Data (quarterly)	952	\$46.33	\$44,106.16
HC’s Staff	Set-up Fee Questionnaire	8	\$46.33	\$370.64
Total				\$996,363.95

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

For this project there will be no annual capital or maintenance costs to the respondent resulting from the collection of information.

14. Annualized Cost to the Federal Government

The estimate of average annual (one-data cycle) cost to the government for the NAMCS is given below.

Table 3. Annualized Cost to the Government

Expense Description	Total Cost
Contract costs for collecting and processing physician interview data	\$950,000
Printing	\$10,901
Contract costs for collecting and processing provider EHR data	\$3,000,000
Contract costs for collecting and processing HC interview and EHR data	\$ 2,123,333
Sponsoring agency expenses: Staff salaries, benefits, other miscellaneous costs	\$802,440
Total cost for 12 months	\$6,886,674

15. Explanation for Program Changes or Adjustments

Currently there are 37,744 hours in the OMB inventory for NAMCS. The Program is requesting 22,107 total burden hours. The decreased sample size for the HC Component and the Provider Survey Component in the current NAMCS OMB package will decrease the requested burden by 15,637 hours.

16. Plans for Tabulation and Publication and Project Time Schedule

This clearance request covers the completion of the 2024 survey year for the HC Component and the following three survey years, 2025-2027, of data collection. The planned timetable for the tabulation and publication and project timeline for the 2025 survey is provided in Table 4.

Table 4. Project Time Schedule

Timeline	Activity
Within one month of OMB approval	Begin data collection for 2025 survey
Within six months of OMB approval	Begin processing and cleaning of data on flow basis
One year after OMB approval	Formally end reporting period
One year and three months after OMB approval	Begin preliminary data linkage work on collected data
One year and six months after OMB approval	Begin data analysis
Two years and five months after OMB approval	Public-use data available on Internet Publish reports and on-line data summary tables

The NCHS regularly publishes NAMCS data on the Internet and in various *NCHS Data Briefs* and other reports, such as the most recent NAMCS *Data Brief* titled “Characteristics of Office-based Physician Visits, 2018.”³

The standard tables from the traditional summaries, referred to as *Summary Tables*, will continue to be produced in PDF format on the web. The NAMCS –Community Health Centers 2020

³ Ashman JJ, Santo L, Okeyode T. Characteristics of office-based physician visits, 2018. NCHS Data Brief, no 408. Hyattsville, MD: National Center for Health Statistics. 2021.
DOI: <https://dx.doi.org/10.15620/cdc:105509>

Summary Tables are available at: https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2020-namcs-chc-web-tables-508.pdf. The NAMCS 2019 *Summary Tables* are available at: https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2019-namcs-web-tables-508.pdf. Other tables are also available, some combining data across surveys or across years at: https://www.cdc.gov/nchs/ahcd/web_tables.htm.

NCHS is also exploring methods to publish preliminary estimates and dashboards that highlight areas of interest, for researchers to have access to more timely data. NAMCS datasets are made available to researchers through the NCHS Research Data Center (RDC). NAMCS will also publish public use files containing information on visit data when possible.

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

The OMB expiration date will be displayed.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

The data collection fully complies with the guidelines in 5 CFR 1320.9, and no exception is requested to the certification for Paperwork Reduction Act for this submission.