

PAPERWORK REDUCTION ACT SUBMISSION WORKSHEET  
Part I: Information Collection Request

**This template is intended for staff without an ICRAS account. Please fill out and submit to the appropriate Operating Division to enter into ICRAS. The form mirrors the screens available in the ICRAS 4 system. To request an account to log into ICRAS.**

Instructions for filling out the form are available at [www.paperworkreduction.gov](http://www.paperworkreduction.gov).

1. Agency/Subagency originating request <b>HHS/CMS/CM/CCPG/DCR</b>																	
2. Title <b>Hospice Cost and Data Report and supporting regulations 42 CFR 413.20 and 42 CFR 413.24</b>																	
3. Type of information collection (check one) (See instructions) <input type="checkbox"/> New collection (Request for a new OMB Control Number) <input checked="" type="checkbox"/> Extension without change of a currently approved collection <input type="checkbox"/> Revision of a currently approved collection <input type="checkbox"/> Reinstatement without change of a previously approved collection <input type="checkbox"/> Reinstatement with change of a previously approved collection <input type="checkbox"/> Nonmaterial or nonsubstantive change to a currently approved collection (formerly 83C) <input type="checkbox"/> Existing collection in use without and OMB Control Number	4. OCN: <b>0938-0758</b>																
5. Type of review requested (check one)  a. <input checked="" type="checkbox"/> Regular b. <input type="checkbox"/> Emergency - Approval requested by: ____/____/ c. <input type="checkbox"/> Delegated  <i>If Emergency, please attach justification. (4000 characters maximum)</i>	6. Requested expiration date (check one)  a. <input checked="" type="checkbox"/> Three years from approval date b. <input type="checkbox"/> Six months from approval date (Maximum for emergency reviews) c. <input type="checkbox"/> Other  Specify: ____/____ (mm/yy) or Number of Months from Approval Date																
7. Abstract (4000 characters maximum, attach additional sheets as necessary) <b>The Hospice Cost and Data Report provides for the collection of data from providers for rate evaluations for the Prospective Payment System (PPS). The data is used by CMS to update the PPS as mandated by Congress.</b>																	
8. Authorizing Statute(s)																	
Public Law:																	
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9. Associated Rulemaking Information                      Stage of Rulemaking (check one)                      Federal Register Citation																	
RIN: ____ - ____ - ____                      a. <input type="checkbox"/> Proposed Rule                      Volume ____ Page number ____																	

Publication Date \_\_\_\_/\_\_\_\_/\_\_\_\_

b. ☐ Interim Final or Final Rule

*For a Proposed Rule, OMB will not consider an ICR complete until the Notice of Proposed Rulemaking has been published.*

*For a Final Rule, please put the ICR reference number for the ICR reviewed at the proposed rule stage in Box 4.*

*For ICRs associated with Interim Final or Final rules that are not significant under EO*

10. Federal Register Notices & Comments

Federal Register Citation

60-day Notice: Volume\_\_ \_\_ Page number \_\_ \_\_ \_\_ \_\_ \_\_ Publication Date \_\_\_\_/\_\_\_\_/\_\_\_\_

30-day Notice: Volume\_\_ \_\_ Page number \_\_ \_\_ \_\_ \_\_ \_\_ Publication Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Did the Agency receive public comments on this ICR? ☐ Yes ☐ No

*Unless submitted as an Emergency or Associated with Rulemaking, OMB will not consider an ICR complete until the 30-day notice has been published.*

*12866, please attach a draft of the Federal Register document.*

11. Annual Cost to Federal Gov:

\$ 42,000

14. Agency contact:

Name: **Gail S. Duncan**

Phone: **410-786-7278**

E-mail: **[gail.duncan@cms.hhs.gov](mailto:gail.duncan@cms.hhs.gov)**

12. Does this ICR contain surveys, censuses, or employ statistical methods?

☐ Yes (Attach Part B of Supporting Statement) ☒ No

13. Is the Supporting Statement intended to be a Privacy Impact Assessment required by the E-Government Act of 2002?

☐ Yes ☒ No

# PAPERWORK REDUCTION ACT SUBMISSION WORKSHEET

Part I: Information Collection Request (continued)

## Information Collection Budget (ICB)

If a change in burden is due to a Program Change Due to New Statute, identify the Citations for New Statutory Requirements:

Public Law: **No Change**

Congress Number	Sequence Number	Section	Name

US Code:

Title	Section	Name

Executive Order:

Number	Name

Statute:

Title	Subtitle

If Program Change is due to Agency Discretion, please categorize the reduction. Burden reduction from (select one):

- a. ☐ Cutting Redundancy
- b. ☐ Using Information Technology
- c. ☐ Changing Regulations
- d. ☐ Changing Forms
- e. ☐ Miscellaneous Actions

If Program Change is due to Agency Discretion, please categorize the increase in burden. Burden increase caused by (select one):

- a. ☐ Changing Regulations
- b. ☒ Miscellaneous Actions

Explain the reasons for any program changes or adjustments reported; that is, provide a short statement how the reduction in burden was achieved or why the increase in burden occurred. (If you need more space, please provide a short summary here and elaborate in the Supporting Statement.)

**The burden increase is due to the increase in the number of respondents from 1, 938 respondents as of June 22, 2007 to 2,303 respondents as of March 15, 2010.**