resilience. Even when these domains have been included, there is no evaluation of whether these efforts have resulted in improved resilience outcomes among seniors (*e.g.,* greater self-sufficiency). This study will quantify the contribution that AFIs and SVs have made to improving resilience outcomes for older adults and provide guidance to local health departments (LHDs) for improving their engagement with AFIs/SVs.

The Office of Public Health Preparedness and Response proposes to conduct a new information collection, *Examining How Local Health Departments Can Leverage Age-Friendly Cities Initiatives to Build Resilience in Elderly Populations.* Information collection activities will target four groups. Respondents will include AFI Staff, Village Directors, LHD Representatives, and adults aged 65+ within the AFI and SV communities.

The study will outline where current AFIs and CR efforts align; conduct interviews in AFIs and SVs across the U.S. to understand relationships with LHDs; clarify the process through which policymakers can incorporate CR into AFIs; survey test sites in a quasi-experimental design of AFIs currently underway; and develop a toolkit to help LHDs identify the need for AFIs, evaluate and monitor AFIs ability to improve resilience, develop effective and efficient partnerships with AFIs to expand AFI–LHD efforts across the U.S to build community resilience.

OMB approval is requested for two years. Participation in the survey is voluntary. There are no costs to respondents other than their time. The total estimated annual burden hours are 302. A summary of annualized burden hours is below.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs)
Age Friendly Initiative Staff	Interview Guide for Age Friendly Initiative Staff.	16	1	30/60
Senior Village Director	Interview Guide for Senior Village Director	15	1	30/60
Local Health Department Representative	Interview Guide for Local Health Department Representative.	8	1	30/60
Older Adult—Screened Out	Senior Village Survey	716	1	2/60
Older Adult—Participant	Senior Village Survey	775	1	20/60

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2015–18424 Filed 7–27–15; 8:45am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6059–N3]

Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of the Extended Temporary Moratoria on Enrollment of Ambulance Suppliers and Home Health Agencies in Designated Geographic Locations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Extension of temporary moratoria.

SUMMARY: This document announces the extension of temporary moratoria on the enrollment of new ambulance suppliers and home health agencies, subunits, and branch locations in specific locations within designated metropolitan areas in Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey to prevent and combat fraud, waste, and abuse.

DATES: *Effective Date:* July 29, 2015.

FOR FURTHER INFORMATION CONTACT: Belinda Gravel, (410) 786–8934.

News media representatives must contact CMS' Public Affairs Office at (202) 690–6145 or email them at *press@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

A. CMS' Imposition of Temporary Enrollment Moratoria

Section 6401(a) of the Affordable Care Act added a new section 1866(j)(7) to the Social Security Act (the Act) to provide the Secretary with authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines a moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. For a more detailed explanation of these authorities, please see the July 31, 2013 notice (78 FR 46339) or February 4, 2014 extension and establishment of a temporary moratoria document (hereinafter referred to as the February 4, 2014 moratoria document or notice) (79 FR 6475).

Based on this authority and our regulations at § 424.570, we initially imposed moratoria to prevent enrollment of new home health agencies, subunits, and branch locations [1] (hereafter referred to as HHAs) in Miami-Dade County, Florida and Cook County, Illinois, as well as surrounding counties, and part B ambulance suppliers in Harris County, Texas and surrounding counties, in a notice issued on July 31, 2013 (78 FR 46339). We then exercised this authority again in a notice published on February 4, 2014 (79 FR 6475) when we extended the existing moratoria for an additional 6 months and expanded it to include enrollment of HHAs in Broward County, Florida; Dallas County, Texas; Harris County, Texas; and Wayne County, Michigan and surrounding counties, and enrollment of ground ambulance suppliers in Philadelphia, Pennsylvania and surrounding counties. Then, we further extended the previously mentioned moratoria in moratoria documents issued on August 1, 2014 (79 FR 44702) and February 2, 2015 (80 FR 5551).

[1] As noted in the preamble to the final rule implementing the moratorium authority (February 2, 2011, CMS–6028–FC (76 FR 5870), home health agency subunits and branch locations are subject to the moratoria to the same extent as any other newly enrolling home health agency.

B. Determination of the Need for Moratorium

In imposing these enrollment moratoria, CMS considered both qualitative and quantitative factors suggesting a high risk of fraud, waste, or abuse. CMS relied on law enforcement's longstanding experience with ongoing and emerging fraud trends and activities through civil, criminal, and administrative investigations and prosecutions. CMS' determination of a high risk of fraud, waste, or abuse in these provider and supplier types within these geographic locations was then confirmed by CMS' data analysis, which relied on factors the agency identified as strong indicators of risk. (For a more detailed explanation of this determination process and of these authorities, see the July 31, 2013 notice (78 FR 46339) or February 4, 2014 moratoria document (79 FR 6475)).

1. Consultation With Law Enforcement

In consultation with the HHS-Office of Inspector General (OIG) and the Department of Justice (DOJ), CMS identified two provider and supplier types in nine geographic locations that warrant a temporary enrollment moratorium. For a more detailed discussion of this consultation process, see the July 31, 2013 notice (78 FR 46339) or February 4, 2014 moratoria document (79 FR 6475).

2. Beneficiary Access to Care

Beneficiary access to care in Medicare, Medicaid, and CHIP is of critical importance to CMS and its state partners, and CMS carefully evaluated access for the target moratorium locations. Prior to imposing these moratoria, CMS reviewed Medicare data for these areas and found no concerns with beneficiary access to HHAs or ground ambulance suppliers. CMS also consulted with the appropriate State Medicaid Agencies and with the appropriate State Departments of Emergency Medical Services to determine if the moratoria would create access to care concerns for Medicaid and CHIP beneficiaries in the targeted locations and surrounding counties. All of CMS' state partners were supportive of CMS analysis and proposals, and together with CMS, determined that these moratoria would not create access to care issues for Medicaid or CHIP beneficiaries.

3. Lifting a Temporary Moratorium

In accordance with § 424.570(b), a temporary enrollment moratorium imposed by CMS will remain in effect for 6 months. If CMS deems it necessary, the moratorium may be extended in 6-month increments. CMS will evaluate whether to extend or lift the moratorium before any subsequent moratorium periods. If one or more of the moratoria announced in this document are extended or lifted, CMS will publish a document to that effect in the **Federal Register**.

Once a moratorium is lifted, the provider or supplier types that were unable to enroll because of the moratorium will be designated to CMS' high screening level under § 424.518(c)(3)(iii) and § 455.450(e)(2) for 6 months from the date the moratorium is lifted.

II. Extension of Home Health and Ambulance Moratoria—Geographic Locations

As noted earlier, we previously imposed moratoria on the enrollment of new HHAs in the Florida counties of Broward, Miami-Dade, and Monroe; the Illinois counties of Cook, DuPage, Kane, Lake, McHenry, and Will; the Michigan counties of Macomb, Monroe, Oakland, Washtenaw, and Wayne; and the Texas counties of Brazoria, Chambers, Collin, Fort Bend, Galveston, Dallas, Harris, Liberty, Denton, Ellis, Kaufman, Montgomery, Rockwall, Tarrant, and Waller. Further, we previously imposed moratoria on the enrollment of new ground ambulance suppliers in the Texas counties of Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller; the Pennsylvania counties of Bucks, Delaware, Montgomery, and Philadelphia; and the New Jersey counties of Burlington, Camden, and Gloucester. These moratoria became effective upon publication in the **Federal Register** of a notice on July 31, 2013 (78 FR 46339) and a moratoria document on February 4, 2014 (79 FR 6475), and were subsequently extended by documents published in the **Federal Register** on August 1, 2014 (79 FR 44702) and February 2, 2015 (80 FR 5551).

As provided in § 424.570(b), CMS may deem it necessary to extend previously-imposed moratoria in 6-month increments. Under this authority, CMS is extending the temporary moratoria on the Medicare enrollment of HHAs and ground ambulance suppliers in the geographic locations discussed herein. Under regulations at § 455.470 and § 457.990, these moratoria also apply to the enrollment of HHAs and ground ambulance suppliers in Medicaid and CHIP. Under § 424.570(b), CMS is required to publish a document in the **Federal Register** announcing any extension of a moratorium, and this extension of moratoria document fulfills that requirement.

CMS consulted with the HHS–OIG regarding the extension of the moratoria on new HHAs and ground ambulance suppliers in all of the moratoria counties, and HHS–OIG agrees that a significant potential for fraud, waste, and abuse continues to exist in these geographic areas. The circumstances warranting the imposition of the moratoria have not yet abated, and CMS has determined that the moratoria are still needed as we monitor the indicators and continue with administrative actions, such as payment suspensions and revocations of provider/supplier numbers. (For more information regarding the monitored indicators, see the February 4, 2014 moratoria document (79 FR 6475)).

Based upon CMS' consultation with the relevant State Medicaid Agencies, CMS has concluded that extending these moratoria will not create an access to care issue for Medicaid or CHIP beneficiaries in the affected counties at this time. CMS also reviewed Medicare data for these areas and found there are no current problems with access to HHAs or ground ambulance suppliers. Nevertheless, the agency will continue to monitor these locations to make sure that no access to care issues arise in the future.

Based upon our consultation with law enforcement and consideration of the factors and activities described previously, CMS has determined that the temporary enrollment moratoria should be extended for an additional 6 months.

III. Summary of the Moratoria Locations

CMS is executing its authority under sections 1866(j)(7), 1902(kk)(4), and 2107(e)(1)(D) of the Act to extend these moratoria in the following counties for these providers and suppliers:

TABLE 1—HHA MORATORIA

State	City/metro area	Counties
FL	Fort Lauderdale	Broward.

TABLE 1—HHA MORATORIA—Continued

State	City/metro area	Counties
FL	Miami	Monroe, Miami-Dade.
IL	Chicago	Cook, DuPage, Kane, Lake, McHenry, Will.
MI	Detroit	Macomb, Monroe, Oakland, Washtenaw, Wayne.
TX	Dallas	Collin, Dallas, Denton, Ellis, Kaufman, Rockwall, Tarrant.
TX	Houston	Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, Waller.

TABLE 2—PART B AMBULANCE MORATORIA

State	City/metro area	Counties
PA/NJ	Philadelphia	Bucks, Burlington (NJ), Camden (NJ), Delaware, Gloucester (NJ), Montgomery, Philadelphia.
TX	Houston	Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, Waller.

IV. Clarification of Right to Judicial Review

Section 1866(j)(7)(B) of the Act states that there shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed on the enrollment of new providers of services and suppliers if the Secretary determines that the moratorium is necessary to prevent or combat fraud, waste, or abuse. Accordingly, our regulations at 42 CFR 498.5(l)(4) state that for appeals of denials based on a temporary moratorium, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. The agency's basis for imposing a temporary moratorium is not subject to review. Our regulations do not limit the right to seek judicial review of a final agency decision that the temporary moratorium applies to a particular provider or supplier. In the preamble to the February 2, 2011 (76 FR 5918) final rule with comment period establishing this regulation, we explained that ''a provider or supplier may administratively appeal an adverse determination based on the imposition of a temporary moratorium up to and including the Department Appeal Board (DAB) level of review.'' We are clarifying that providers and suppliers that have received unfavorable decisions in accordance with the limited scope of review described in § 498.5(l)(4) may seek judicial review of those decisions after they exhaust their administrative appeals. We reiterate, however, that section 1866(j)(7)(B) of the Act precludes judicial review of the agency's basis for imposing a temporary moratorium.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Statement

CMS has examined the impact of this document as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health, and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major regulatory actions with economically significant effects ($100 million or more in any 1 year). This document will prevent the enrollment of new home health providers and ambulance suppliers in Medicare and new home health providers and ambulance suppliers in Medicaid and CHIP. Though savings may accrue by denying enrollments, the monetary amount cannot be quantified. After the imposition of the moratoria on July 31, 2013, 848 HHAs and 14 ambulance companies in all geographic areas affected by the moratoria had their applications denied. We have found the number of applications that are denied after 60 days declines dramatically, as most providers and suppliers will not submit applications during the moratoria period. Therefore, this document does not reach the economic threshold, and thus is not considered a major action.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.0 million to $35.5 million in any one year. Individuals and states are not included in the definition of a small entity. CMS is not preparing an analysis for the RFA because it has determined, and the Secretary certifies, that this document will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if an action may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, CMS defines a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. CMS is not preparing an analysis for section 1102(b) of the Act because it has determined, and the Secretary certifies, that this document will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any regulatory action whose mandates require spending in any 1 year of $100

million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately $144 million. This document will have no consequential effect on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed regulatory action (and subsequent final action) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Because this document does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this document.

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

Dated: July 1, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–18327 Filed 7–24–15; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects

Title: Disaster Information Collection Plans.

OMB No.: NEW.

Description: This request is for approval of a plan for conducting more than one information collection that is very similar, voluntary, low-burden and uncontroversial. The Information collections under this generic clearance will be activated during a disaster. These forms will be used after a disaster to develop a technical assistance plan for affected ACF programs.

Presidential Policy Directive-8 (PPD–8), which was signed into law in 2011, provides federal guidance and planning procedures under established phases—protection, preparedness, response, recovery, and mitigation. The data collection addresses response, and recovery for ACF programs with a statutory preparedness planning requirement and other programs without that requirement.

ACF/Office of Human Services Emergency Preparedness and Response (OHSEPR) has a requirement under PPD–8, the National Response Framework, and the National Disaster Recovery Framework to report impacts of disasters to ACF-supported human services programs to the HHS Secretary's Operation Center (SOC). ACF/OHSEPR works in conjunction with the Assistant Secretary for Preparedness and Response (ASPR), and the Federal Emergency Management Agency (FEMA) to ensure that impacted ACF programs are returned to their normal or close to normal operations.

The primary purpose of the information collection pertains to ACF's initiative to provide real time updates during the response and recovery phases of a disaster; the information will be used to respond to inquiries about human services response and recovery efforts, specifically for individuals, children, and families that need support from ACF programs. Further, the information collection will be used to support ACF/OHSEPR's goal to quickly identify critical gaps, resources, needs, and services to support State, local and non-profit capacity for disaster case management and to augment and build capacity where none exists.

Respondents: Varies, depending on programmatic impact (could be state administrators, or grantees).

Annual Burden Estimates

The estimate is based on a single disaster per year. The estimate is for one state administrator to go through all the applicable questions with the Regional and Central Office staff, if applicable.

Instrument	Number of respondents	Number of responses per respondent	Burden hours per response	Total burden hours
Program Specific Disaster Information Collection	50	15	0.5	25

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Planning, Research and Evaluation, 370 L'Enfant Promenade SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. Email address: *infocollection@acf.hhs.gov.* All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2015–18440 Filed 7–27–15; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Administration for Native Americans; Notice of Meeting

AGENCY: Administration for Children and Families, HHS.

ACTION: Notice of Tribal Consultation.

SUMMARY: The Department of Health and Human Services (HHS), Administration for Children and Families (ACF), will host a Tribal Consultation to consult on ACF programs and tribal priorities.

DATES: September 14, 2015.

ADDRESSES: 901 D Street SW., Washington, DC.