questionnaire, which provides a set of shared health indicators for all BRFSS partners. The BRFSS core questionnaire consists of fixed core, rotating core, and emerging core questions. Fixed core questions are asked every year. Rotating core questions cycle on and off the core questionnaire in two- or three-year cycles, depending on the question. Emerging core questions are included in the core questionnaire as needed to collect data on urgent or emerging health topics such as infectious disease. In addition, the BRFSS includes a series of optional modules on a variety of topics. In off years, when the rotating questions are not included in the core questionnaire, they are offered to states as optional modules. This framework allows each state to produce a customized BRFSS survey by appending selected optional modules to the core survey. States may select which, if any, optional modules to administer. As needed, CDC provides technical and methodological assistance to state BRFSS coordinators in the construction of their state-specific surveys. Each state administers its BRFSS questionnaire throughout the calendar year.

CDC periodically updates the BRFSS core survey and optional modules. The purpose of this Revision request is to add the following topics to the questionnaires: COVID vaccination, impact of the COVID pandemic, periodontal disease, additional questions on heart attack and stroke, disaster/pandemic preparedness, veterans' health, and the use of newly available tobacco products. In addition, this request seeks approval for reinstating topics which have been included in BRFSS in the past, dependent upon state interest and funding.

Participation in BRFSS is voluntary and there is no cost to participate. The average time burden per response will be 22 minutes. The total time burden across all respondents will be approximately 287,798 hours.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
U.S. General Population	Landline Screener	173,000	1	1/60
	Cell Phone Screener	694,000	1	1/60
	Field Test Screener	900	1	1/60
Annual Survey Respondents (Adults >18 Years).	BRFSS Core Survey by Phone Interview	480,000	1	15/60
	BRFSS Optional Modules by Phone Interview	440,000	1	15/60
	BRFSS Core Survey by Online Survey	100,000	1	10/60
	BRFSS Optional Modules by Online Survey	80,000	1	10/60
Field Test Respondents (Adults >18 Years).	Field Test Survey by Phone Interview	500	1	45/60

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

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BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6063–N7]

Medicare Program; National Expansion Implementation for All Remaining States and Territories of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports

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

ACTION: Notice.

SUMMARY: This notice announces the implementation dates for all remaining states and territories for the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports.

DATES: This expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports will begin on December 1, 2021 for independent ambulance suppliers garaged in Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas; and no earlier than: February 1, 2022 for independent ambulance suppliers garaged in Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands and Tennessee; April 1, 2022 for independent ambulance suppliers garaged in Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands; June 1, 2022 for independent ambulance suppliers garaged in Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont; and August 1, 2022 for independent ambulance suppliers garaged in Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming.

FOR FURTHER INFORMATION CONTACT: Angela Gaston, (410) 786–7409.

Questions regarding the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports should be sent to *AmbulancePA@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

In the November 23, 2020 **Federal Register** (85 FR 74725), we published a notice titled ''Medicare Program; National Expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transport,'' which announced the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports under section 1834(l)(16) of the Act, as added by section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10). The states that participated in the model under section 1115A of the Social Security Act (the Act), which included Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia, previously transitioned to the national model on December 2, 2020. Due to the COVID–19 Public Health Emergency, we delayed the implementation of the expansion to any additional states.

II. Provisions of the Notice

This notice announces the implementation dates for all remaining states and territories for the national expansion of the Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transports under section 1834(l)(16) of the Act, as added by section 515(b) of MACRA (Pub. L. 114–10). This expansion of the model will begin on December 1, 2021 for independent ambulance suppliers garaged in Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas; and no earlier than—

- February 1, 2022 for independent ambulance suppliers garaged in Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands and Tennessee;
- April 1, 2022 for independent ambulance suppliers garaged in Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands;
- June 1, 2022 for independent ambulance suppliers garaged in Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont; and
- August 1, 2022 for independent ambulance suppliers garaged in Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming.

We will continue to test in the remaining states and territories whether prior authorization helps reduce expenditures, while maintaining or improving quality of care, by using the prior authorization process described in the November 23, 2020 **Federal Register** (85 FR 74725) to reduce utilization of services that do not comply with Medicare policy. Prior authorization helps ensure that all relevant clinical or medical documentation requirements are met before services are furnished to beneficiaries and before claims are submitted for payment. It further helps to ensure that payment complies with Medicare documentation, coverage, payment, and coding rules. Prior authorization also allows ambulance suppliers to address coverage issues prior to furnishing services.

The model establishes a process for requesting prior authorization for repetitive, scheduled non-emergent ambulance transports. The use of prior authorization does not create new clinical documentation requirements. Instead, it requires the same information that is already required to support Medicare payment, just earlier in the process.

Submitting a prior authorization request for repetitive, scheduled non-emergent ambulance transports is voluntary. However, an ambulance supplier or beneficiary is encouraged to submit to the Medicare Administrative Contractor (MAC) a request for prior authorization along with all relevant documentation to support Medicare coverage of the transports. If prior authorization has not been requested by the fourth round trip in a 30-day period, the subsequent claims will be stopped for prepayment review. Please see the November 23, 2020 **Federal Register** (85 FR 74725) for additional details on the prior authorization model and process.

We will expand outreach and education efforts on this model to affected ambulance suppliers in all states and territories, through such methods as an operational guide, frequently asked questions (FAQs) on our website, a physician letter explaining the ambulance suppliers' need for the proper documentation, open door forums, and educational events and materials issued by the MACs. We will work to limit any adverse impact on beneficiaries and to educate affected beneficiaries about the model process. Beneficiaries will continue to have all applicable administrative appeal rights for denied claims associated with a non-affirmed prior authorization decision.

Additional information is available on the CMS website at *http://go.cms.gov/PAAmbulance.*

III. Collection of Information Requirements

As required by chapter 35 of title 44, United States Code (the Paperwork Reduction Act of 1995), the information collection burden associated with this national model (Form CMS–10708—Ambulance Prior Authorization) is currently approved under OMB control number 0938–1380 which expires on August 31, 2023.

IV. Regulatory Impact Statement

We have examined the impact of this rule 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 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 rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

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 less than $8.0 million to $41.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this notice 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 an RIA if a rule 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, we define 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. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this notice 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 rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2021, that threshold is approximately $158 million. This rule 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 rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this regulation 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, this notice was not reviewed by the Office of Management and Budget.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: August 24, 2021.

Lynette Wilson,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2021–18543 Filed 8–26–21; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Head Start Family and Child Experiences Survey (FACES) (OMB #0970–0151)

AGENCY: Office of Planning, Research, and Evaluation, Administration for Children and Families, HHS.

ACTION: Request for public comment.

SUMMARY: The Office of Planning, Research, and Evaluation (OPRE), Administration for Children and Families (ACF), U.S. Department of Health and Human Services (HHS), is proposing to collect data for a new wave of the Head Start Family and Child Experiences Survey (FACES) as well as a follow-up to a special data collection fielded in the fall of 2021.

DATES: *Comments due within 60 days of publication.* In compliance with the requirements of the Paperwork Reduction Act of 1995, ACF is soliciting public comment on the specific aspects of the information collection described above.

ADDRESSES: Copies of the proposed collection of information can be obtained and comments may be forwarded by emailing *OPREinfocollection@acf.hhs.gov.* Alternatively, copies can also be obtained by writing to the Administration for Children and Families, Office of Planning, Research, and Evaluation, 330 C Street SW, Washington, DC 20201, Attn: OPRE Reports Clearance Officer. All requests, emailed or written, should be identified by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: The purpose of the FACES data collection is to support the 2007 reauthorization of the Head Start program (Pub. L. 110–134), which calls for periodic assessments of Head Start's quality and effectiveness. FACES 2019 focuses on Head Start Regions I through X (which are geographically based); AIAN (American Indian and Alaska Native) FACES 2019 focuses on Region XI (which funds Head Start programs that serve federally recognized American Indian and Alaska Native tribes). Both studies will provide data on a set of key indicators for Head Start programs. Information about the Head Start program recruitment and center selection processes and on the fall 2019, spring 2020, and fall 2021 data collection activities for both FACES and AIAN FACES can be found here: *https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=202005-0970-009.*

This 60-day notice describes:

- The spring 2022 round of FACES program- and classroom-level data collection.
- A follow-up in spring 2022 of the fall 2021 FACES and AIAN FACES child-level data collection.

FACES spring 2022 data collection will take place in 180 Head Start programs nationwide. Of the 180 programs, 60 will have participated in fall data collection and 120 will be added to participate in classroom- and program-data collection only. AIAN FACES will continue in the same 22 programs that participated in 2019, 2020, and 2021 data collection. Data collection activities will include teacher sampling (for the 120 FACES programs not part of fall 2021), parent surveys, teacher child reports, staff surveys, and, for FACES, classroom observations.

In the additional 120 programs added to FACES in spring 2022, data collection will begin with sampling of FACES teachers in 240 Head Start centers. Study team members will request a list of all teachers working with Head Start-funded children.

As in fall 2021, for the spring 2022 follow-up data collection, FACES will survey the parents of 2,400 Head Start children in Regions I–X (FACES 2019) and 800 children in Region XI (AIAN FACES 2019) and ask their Head Start teachers to rate children's learning skills and social and emotional skills. Parents of sampled children (2,400 for FACES and 800 for AIAN FACES) will complete surveys on the web or by telephone about their children and family. In all 202 programs (180 for FACES and 22 for AIAN FACES), Head Start teachers will rate each sampled child (approximately 10 children per teacher) using the web or paper-and-pencil forms. Teachers, program directors, and center directors will also complete a survey, also using the web or paper-and-pencil forms, about themselves and the services and instruction in Head Start.

Respondents: Parents of Head Start children; Head Start staff.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents (total over request period)	Number of responses per respondent (total over request period)	Average burden per response (in hours)	Total burden (in hours)	Annual burden (in hours)
FACES 2019 spring 2022 special teacher sampling form from Head Start staff	240	1	.17	41	14
FACES 2019 special Head Start parent survey	2,400	1	.58	1,392	464
FACES 2019 special Head Start teacher child report	240	10	.17	408	136
FACES 2019 Head Start teacher survey	720	1	.67	482	161
FACES 2019 Head Start center director survey	360	1	.58	209	70
FACES 2019 Head Start program director survey	180	1	.67	121	40
AIAN FACES 2019 special Head Start parent survey	800	1	.58	464	155