

*Authority:* 6 U.S.C. 279; 8 U.S.C. 1232; *Flores v. Reno Settlement Agreement*, No. CV85–4544–RJK (C.D. Cal. 1996)

**Mary B. Jones,**

*ACF/OPRE Certifying Officer.*

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Resources and Services Administration

#### Agency Information Collection

#### Activities: Proposed Collection: Public Comment Request Information

#### Collection Request Title: The Maternal, Infant, and Early Childhood Home Visiting Program: Advancing Health Equity in Response to the COVID–19 Public Health Emergency, 0906–XXXX, New

**AGENCY:** Health Resources and Services Administration (HRSA), Department of Health and Human Services.

**ACTION:** Notice.

**SUMMARY:** In compliance with the requirement for opportunity for public comment on proposed data collection projects of the Paperwork Reduction Act of 1995, HRSA announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). OMB will accept further comments from the public during the review and approval period. OMB may act on HRSA's ICR only after the 30 day comment period for this Notice has closed.

**DATES:** Comments on this ICR should be received no later than August 15, 2022.

**ADDRESSES:** Submit your comments to [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov) or mail the HRSA Information Collection Clearance Officer, 14N136B, 5600 Fishers Lane, Rockville, MD 20857.

**FOR FURTHER INFORMATION CONTACT:** To request a copy of the clearance requests submitted to OMB for review, email Samantha Miller, the acting HRSA Information Collection Clearance Officer at [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov) or call (301) 443–9094.

#### SUPPLEMENTARY INFORMATION:

*Information Collection Request Title:* The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Advancing Health Equity in Response to the COVID–19 Public Health Emergency, OMB No. 0906–XXXX, NEW.

*Abstract:* The MIECHV Program is authorized by Social Security Act, Title V, § 511 (42 U.S.C. 711) and Congress made available supplemental appropriations to carry out the program through the American Rescue Plan Act (Pub. L. 117–2). American Rescue Plan Act funds are being used to support the MIECHV: Advancing Health Equity in Response to the COVID–19 Public Health Emergency project. The MIECHV Program: Advancing Health Equity in Response to the COVID–19 Public Health Emergency project aims to understand how health equity can be advanced during the COVID–19 public health emergency in communities with MIECHV-funded home visiting programs. The project includes five case studies to be conducted in communities across the United States. Communities will be selected based on a county level assessment from the County Response Index to Support Equity in Home Visiting (County RISE–HV), the variation in COVID–19 patterns including indicating disproportionality in experiences of COVID–19, and the presence of MIECHV-funded local implementing agencies. The five communities will represent a mix of urban and rural counties, will include a Tribal community, and will include communities with existing health disparities by race and ethnicity. The case studies will lead to a deeper understanding of the ways in which COVID–19 has shaped families' experiences, and the role home visiting plays (and could play) in addressing the inequities that continue to accrue from the pandemic within a community. Information gained from these case studies can inform the development of more responsive home visiting systems and more equitable health and family support systems, in general. Data collection activities include key informant interviews, focus groups, and online surveys. The data collection activities have been revised based on the public comments received during the 60-day comment period. The purpose of these changes is to address concerns with the burden estimate and to modify items for clarity. To address the burden estimates, the number of items on each of the data collection instruments has been reduced. To reduce items, the project team identified item content where there was unnecessary overlap across instruments and identified items that were extraneous to addressing research questions. The burden estimate was only increased for the completion of the program data tool. All specific recommendations for revisions to item

wording and instructions for participants to improve clarity have been incorporated into the revised data collection instruments. All necessary human subjects protections will be adhered to, including seeking Institutional Review Board approval of data collection and analysis plans prior to commencing any data collection activities.

A 60-day notice for public comments on the proposed data collection activities required by Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 was published in the **Federal Register** on March 17, 2022, (Document Number 2022–05635; document citation 87 FR 15254, pages 15254–15255). Public comments were requested by May 16, 2022. There were public comments from three organizations.

*Need and Proposed Use of the Information:* HRSA is seeking additional information about the strategies and partners home visiting programs have used to advance health equity in communities disproportionately impacted by the COVID–19 public health emergency. HRSA intends to use this information to provide technical assistance and disseminate best practices to MIECHV awardees, publish findings for lay and research audiences to advance the field's knowledge of home visiting's role in COVID–19 response, and to prepare state and local home visiting programs for future public health emergencies.

*Likely Respondents:* MIECHV Program awardees that are states, territories, and, where applicable, nonprofit organizations receiving MIECHV funding to provide home visiting services within states; state and local representatives from home visiting, public health, health care, and other human service agencies in the early childhood system; community organizers, Tribal elders, religious leaders; families (including families participating in MIECHV-funded home visiting services and those with shared experiences); community members, including community-based program administrators and community service providers, including home visitors.

*Burden Statement:* Burden in this context means the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; to train

personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the

information. Compared to the versions submitted for the 60-day approval process in March, estimated burden hours have increased as a result of implementing the feedback provided in

public comments during the 60-day comment period and pre-testing data collection protocols. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN HOURS <sup>1</sup>

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Community Interview Protocol .....	60	1	60	1.50	90
Family and Community Focus Group Guide .....	240	1	240	2.00	480
Community and Home Visitor Survey Instrument .....	500	1	500	0.75	375
Program Data .....	15	1	15	10.00	150
<b>Total .....</b>	<b>815</b>	<b>.....</b>	<b>815</b>	<b>.....</b>	<b>1095</b>

HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

**Maria G. Button,**

*Director, Executive Secretariat.*

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Indian Health Service**

**Tribal Self-Governance Negotiation Cooperative Agreement Program**

*Announcement Type:* New.

*Funding Announcement Number:* HHS-2022-IHS-TSGN-0002.

*Assistance Listing (Catalog of Federal Domestic Assistance or CFDA) Number:* 93.444.

**Key Dates**

*Application Deadline Date:* August 31, 2022.

*Earliest Anticipated Start Date:* September 30, 2022.

**I. Funding Opportunity Description Statutory Authority**

The Indian Health Service (IHS) is accepting applications for Negotiation Cooperative Agreements for the Tribal Self-Governance Program (TSGP). This program is authorized under the Snyder Act, 25 U.S.C. 13; the Transfer Act, 42 U.S.C. 2001(a); and Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. 5383(e). This program is described in the Assistance Listings located at <https://sam.gov/content/home> (formerly known as Catalog of Federal Domestic Assistance) under 93.444.

**Background**

The TSGP is more than an IHS program; it is an expression of the government-to-government relationship between the United States (U.S.) and Indian Tribes. Through the TSGP, Tribes negotiate with the IHS to assume Programs, Services, Functions, and Activities (PSFAs), or portions thereof, which gives Tribes the authority to manage and tailor health care programs in a manner that best fits the needs of their communities.

Participation in the TSGP affords Tribes the most flexibility to tailor their health care needs by choosing one of three ways to obtain health care from the Federal Government for their citizens. Specifically, Tribes can choose to: (1) receive health care services directly from the IHS; (2) contract with the IHS to administer individual programs and services the IHS would otherwise provide (referred to as Title I Self-Determination Contracting); and (3) compact with the IHS to assume control over health care programs the IHS would otherwise provide (referred to as Title V Self-Governance Compacting or the TSGP). These options are not exclusive and Tribes may choose to

combine options based on their individual needs and circumstances.

The TSGP is a tribally-driven initiative and strong Federal-Tribal partnerships are essential to the program's success. The IHS established the Office of Tribal Self-Governance (OTSG) to implement the Tribal Self-Governance authorities under the ISDEAA. The primary OTSG functions are to: (1) serve as the primary liaison and advocate for Tribes participating in the TSGP; (2) develop, direct, and implement TSGP policies and procedures; (3) provide information and technical assistance to Self-Governance Tribes; and (4) advise the IHS Director on compliance with TSGP policies, regulations, and guidelines. Each IHS Area has an Agency Lead Negotiator (ALN), designated by the IHS Director to act on his or her behalf, who has authority to negotiate Self-Governance Compacts and Funding Agreements (FA). Tribes interested in participating in the TSGP should contact their respective ALN to begin the Self-Governance planning and negotiation process. Tribes currently participating in the TSGP that are interested in expanding existing or adding new PSFAs should also contact their respective ALN to discuss the best methods for expanding or adding new PSFAs.

**Purpose**

The purpose of this Negotiation Cooperative Agreement is to provide Tribes with resources to help defray the costs associated with preparing for and engaging in TSGP negotiations. TSGP negotiations are a dynamic, evolving, and tribally-driven process that requires careful planning, preparation, and sharing of precise, up-to-date information by both Tribal and Federal parties. Because each Tribal situation is unique, a Tribe's successful transition

<sup>1</sup> There may be variation in the number of study participants and home visiting programs in each community (e.g., some selected communities may have fewer home visitors). The total burden hours presented here provide information assuming the maximum number of respondents in each community.