information collection request (ICR) titled ''Awardee Lead Profile Assessment (ALPA)'' (OMB Control No. 0920–1215; Exp. Date 03/31/2024). The goal of this ICR is to build on the CDC's existing childhood lead poisoning prevention program. CDC requires that ongoing and new CDC Childhood Lead Poisoning Prevention Programs (CLPPPs), including the FY21 ''Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children'' (CDC–RFA–EH21–2102), complete the ALPA annually. This annual information collection will be used to identify jurisdictional legal frameworks governing CDC-funded childhood lead poisoning programs (CLPPPs) in the United States and strategies for implementing childhood lead poisoning prevention activities. CDC will use this information to inform guidance, resource development, and technical assistance activities in support of the ultimate goal, which is eliminating lead exposure in children. The dissemination of these ALPA results will ensure that both funded and non-funded jurisdictions are able to: (1) identify policies and other factors that support or hinder childhood lead poisoning prevention efforts; (2) understand what strategies are being used by funded public health agencies to implement childhood lead poisoning prevention activities; and (3) use this knowledge to develop and apply similar strategies to support the national agenda to eliminate childhood lead poisoning.

CDC will now use one data collection mode, a web survey. Reporting via email will be eliminated. This program management survey has been revised in several ways, including the addition of new answer options and questions to understand usage of the updated blood lead reference value (BLRV). The time per response is the same from the 2021 estimate (47 minutes per response) despite revisions to the survey. This updated estimate is based on recent pilot tests of the revised survey among nine respondents, and includes the time needed to review the ALPA Training Manual.

CDC is requesting OMB approval for a total time burden of 59 hours and a total number of 75 respondents per year. These estimates remain unchanged from the previous PRA clearance.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
State or Local Governments (or their bona fide fiscal agents).	ALPA Web Survey	75	1	47/60	59
Total					59

Jeffrey M. Zirger,

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

[FR Doc. 2022–27508 Filed 12–19–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC); Notice of Charter Renewal

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of charter renewal.

SUMMARY: This gives notice under the Federal Advisory Committee Act of October 6, 1972, that the Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC), Centers for Disease Control and Prevention, Department of Health and Human Services, has been renewed for a 2-year period through November 25, 2024.

FOR FURTHER INFORMATION CONTACT: CAPT Deron Burton, MD, JD, MPH, Acting Designed Federal Officer, Centers for Disease Control and Prevention (CDC)/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC), CDC, HHS, 1600 Clifton Road, NE, Mailstop US8–6, Atlanta, Georgia 30329–4027; Telephone (404) 639–1506; Email: *DBurton@cdc.gov.*

The Director, Strategic Business Initiatives Unit, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Strategic Business Initiatives Unit, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2022–27481 Filed 12–19–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2022–0014]

Record of Decision for the Final Supplemental Environmental Impact Statement for the Roybal Campus 2025 Master Plan; Correction

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: General notice.

SUMMARY: On November 17, 2022, the Centers for Disease Control and Prevention (CDC), within the Department of Health and Human Services (HHS), published a notice in the **Federal Register** announcing the Record of Decision (ROD) for the Final Supplemental Environmental Impact Statement (SEIS) for CDC's Roybal Campus in Atlanta, Georgia. In the Decision section of the notice, the description of the incinerator was incorrect.

FOR FURTHER INFORMATION CONTACT: Thayra Riley, NEPA Coordinator, Office of Safety, Security, and Asset Management, Centers for Disease Control and Prevention, 1600 Clifton

Road NE, Mailstop H20–4, Atlanta, Georgia 30329. Email: *cdc-roybalgaseis@cdc.gov.* Telephone: 770–488–8170.

SUPPLEMENTARY INFORMATION:

Correction

In the Decision section of the **Federal Register** notice of November 17, 2022 (87 FR 69023), center column, the description of the incinerator was labeled as a Hazardous/Medical/Infectious Waste Incinerator. The correct description is a Hospital/Medical/Infectious Waste Incinerator. The correct Decision section to read:

Decision

Based on the Final SEIS, CDC has decided to implement Alternative 1 (Preferred Alternative) as the selected alternative. This Alternative includes the construction and operation of a new Hospital/Medical/Infectious Waste Incinerator in a new laboratory building, the operation of two proposed emergency standby power diesel generators to support that laboratory, and annual testing of the generators. According to the analysis, no potential significant impacts were identified for the selected alternative.

CDC's decision is based on an analysis of the potential impacts of the alternatives considered in the SEIS weighed against CDC's continuing need to fulfill its unique and critical public health mission and its ability to mitigate in whole or in part the adverse impacts. CDC also considered the input from the public and agencies, such as the U.S. Fish and Wildlife Service, Georgia Department of Natural Resources, Georgia Environmental Protection Division, and Georgia Historic Preservation Division.

Availability of the ROD: The ROD is available in the Supplemental Materials tab of the docket found on the Federal eRulemaking Portal at *https://www.regulations.gov,* identified by Docket No. CDC–2022–0014.

Dated: December 15, 2022.

Angela K. Oliver,

Executive Secretary, Centers for Disease Control and Prevention.

[FR Doc. 2022–27584 Filed 12–19–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1774–FN]

Medicare Program; Approval of Request for an Exception to the Prohibition on Expansion of Facility Capacity Under the Hospital Ownership and Rural Provider Exceptions to the Physician Self-Referral Prohibition

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

ACTION: Notice.

SUMMARY: This notice announces our decision to approve the request from Doctors Hospital at Renaissance, Ltd.'s for an exception to the prohibition on expansion of facility capacity.

DATES: The decision announced in this notice is applicable on December 16, 2022.

ADDRESSES: *POH-ExceptionRequests@cms.hhs.gov.*

I. Background

Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law: (1) prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship unless the requirements of an applicable exception are satisfied; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for any improperly referred designated health services. A financial relationship may be an ownership or investment interest in the entity or a compensation arrangement with the entity. The statute establishes a number of specific exceptions and grants the Secretary of the Department of Health and Human Services (the Secretary) the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse.

Section 1877(d) of the Act sets forth exceptions related to ownership or investment interests held by a physician (or an immediate family member of a physician) in an entity that furnishes designated health services. Section 1877(d)(2) of the Act provides an exception for ownership or investment interests in rural providers (the ''rural provider exception''). In order to qualify for the rural provider exception, the designated health services must be furnished in a rural area (as defined in section 1886(d)(2) of the Act) and substantially all the designated health services furnished by the entity must be furnished to individuals residing in a rural area. In addition, in the case where the entity is a hospital, the hospital must meet the requirements of section 1877(i)(1) of the Act no later than September 23, 2011. Section 1877(d)(3) of the Act provides an exception for ownership or investment interests in a hospital located outside of Puerto Rico (the ''whole hospital exception''). In order to qualify for the whole hospital exception, the referring physician must be authorized to perform services at the hospital, the ownership or investment interest must be in the hospital itself (and not merely in a subdivision of the hospital), and the hospital must meet the requirements of section 1877(i)(1) of the Act no later than September 23, 2011.

II. Prohibition on Facility Expansion

Section 6001(a)(3) of the Patient Protection and Affordable Care Act (Affordable Care Act) (Pub. L. 111–148) amended the rural provider and whole hospital exceptions to provide that a hospital may not increase the number of operating rooms, procedure rooms, and beds beyond that for which the hospital was licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of this date, but did have a provider agreement in effect on December 31, 2010, the effective date of such provider agreement) (the hospital's ''baseline number of operating rooms, procedure rooms, and beds''). Thus, since March 23, 2010, a physician-owned hospital that seeks to avail itself of either exception is prohibited from expanding the number of operating rooms, procedure rooms, and beds (''facility capacity'') unless it has been granted an exception to the prohibition by the Secretary.

Section 6001(a)(3) of the Affordable Care Act added new section 1877(i)(3)(A)(i) of the Act, which required the Secretary to establish and implement a process for granting exceptions to the prohibition on expansion of facility capacity for hospitals that qualify as an ''applicable hospital.'' Section 1106 of the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) amended section 1877(i)(3)(A)(i) of the Act to require the Secretary to establish and implement a process for granting exceptions to the prohibition on expansion of facility capacity for hospitals that qualify as either an ''applicable hospital'' or a ''high