are among young people between the ages of 15 and 24. Young people aged 13–24 account for 21% of all new HIV diagnoses in the United States, with most occurring among 20–24-year-olds.

Establishing healthy behaviors during childhood and adolescence is easier and more effective than trying to change unhealthy behaviors during adulthood. One venue that offers valuable opportunities for improving adolescent health is at school. Schools have direct contact with over 50 million students for at least six hours a day over 13 key years of their social, physical, and intellectual development. In addition, schools often have staff with knowledge of critical health risk and protective behaviors and have pre-existing infrastructure that can support a varied set of healthful interventions. This makes schools well-positioned to help reduce adolescents' risk for HIV infection and other STD through sexual health education (SHE), access to sexual health services (SHS), and safe and supportive environments (SSE).

Since 1987, the Division of Adolescent and School Health (DASH) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) of the Centers for Disease Control and Prevention (CDC), has worked to support HIV prevention efforts in the nation's schools. CDC requests OMB approval to collect data over a two-year period from funded agencies under award PS18–1807: Promoting Adolescent Health through School-Based HIV Prevention. Funded agencies are local education agencies (LEAs), also known as school districts. The fundamental purposes of PS18–1807 are to build and strengthen the capacity of LEAs and their priority schools to effectively contribute to the reduction of HIV infection and other STD among adolescents; and the reduction of disparities in HIV infection and other STD experienced by specific adolescent sub-populations. Priority schools are middle and high schools within the funded LEAs in which youth are at risk for HIV infection and other STDs. This funding supports a multi-component, multilevel effort to support youth reaching adulthood in the healthiest possible way.

CDC will use a web-based system to collect data on the approaches that LEAs are using to meet their goals. Approaches include helping LEAs and priority schools deliver SHE emphasizing HIV and other STD prevention; increasing adolescent access to key SHS; and establishing SSEs for students and staff. Given the impact of the COVID–19 pandemic on schools, these data will also be used to help understand which approaches LEAs were able to implement during the pandemic and which approaches presented challenges in this context.

To track LEA progress and evaluate the effectiveness of program activities, CDC will collect data using a mix of process and outcome measures. Process measures to be completed by all LEAs will assess the extent to which planned program activities have been implemented and lead to feasible and sustainable programmatic outcomes. Process measures include items on school health policy and practice assessment and training and technical assistance received from non-governmental partner organizations. Outcome measures, which will be completed by local education agencies, assess whether funded activities at each site are leading to intended outcomes including public health impact of systemic change in schools. These measures drove the development of questionnaires that have been tailored to each LEA's strategies (*i.e.,* SHE, SHS, SSE).

Respondents are the same 25 LEAs that have been funded under PS18–1807. LEAs will continue to complete the questionnaires semi-annually using the Program Evaluation and Reporting System (PERS), an electronic web-based interface specifically designed for this data collection. CDC anticipates that semi-annual information collection will continue after the current OMB approval time frame ends on November 30, 2022. With this extension, additional data collection will be conducted at two time points, November 1, 2022–March 1, 2023, and May 1, 2023–September 1, 2023. The estimated burden per response is approximately 2–26 hours. This estimate includes time for LEAs to gather information at the district and school levels. Annualizing this collection over two years results in an estimated annualized burden of 1,750 hours per year and a total of 3,500 hours for the requested two-year extension across all funded LEAs. There are no costs to respondents other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Local Education Agencies	Funded District Questionnaire	25	2	2
	Priority School Questionnaire	25	2	26
	District Assistance Questionnaire	25	2	7

Jeffrey M. Zirger,

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

[FR Doc. 2022–21216 Filed 9–29–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3430–PN]

Medicare and Medicaid Programs: Application From The Joint Commission (TJC) for Continued Approval of its Psychiatric Hospital Accreditation Program

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

ACTION: Notice with request for comment.

SUMMARY: This proposed notice acknowledges the receipt of an application from The Joint Commission for continued recognition as a national accrediting organization for psychiatric hospitals that wish to participate in the Medicare or Medicaid programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by October 31, 2022.

ADDRESSES: In commenting, refer to file code CMS–3430–PN.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3430–PN, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–3430–PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written ONLY to the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Danielle Adams, (410) 786–8818, Donald Howard, (410) 786–6764, or Lillian Williams, (410) 786–8636.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a psychiatric hospital provided certain requirements are met. Section 1861(f) of the of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a psychiatric hospital. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 482 subpart E specify the minimum conditions that a psychiatric hospital must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for psychiatric hospitals.

Generally, to enter into an agreement, a psychiatric hospital must first be certified by a State Survey Agency as complying with the conditions or requirements set forth in part 482 subpart E of our regulations. Thereafter, the psychiatric hospital is subject to regular surveys by a State Survey Agency to determine whether it continues to meet these requirements. Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met the requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of the Department of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. A national accrediting organization applying for approval of its accreditation program under part 488, subpart A, must provide the Centers for Medicare & Medicaid Services (CMS) with reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at § 488.5. The regulations at § 488.5(e)(2)(i) require accrediting organizations to reapply for continued approval of its accreditation program every 6 years or sooner as determined by CMS.

The Joint Commission's current term of approval for their psychiatric hospital accreditation program expires February 25, 2023.

II. Approval of Deeming Organizations

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of a national accrediting organization's requirements consider, among other factors, the applying accrediting organization's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide us with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of The Joint Commission's request for continued approval of its psychiatric hospital accreditation program. This notice also solicits public comment on whether the Joint Commission's requirements meet or exceed the Medicare conditions of participation (CoPs) for psychiatric hospitals.

III. Evaluation of Deeming Authority Request

The Joint Commission submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its psychiatric hospital accreditation program. This application was determined to be complete on July 30, 2022. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of The Joint Commission will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of The Joint Commission's standards for psychiatric hospitals as compared with CMS' psychiatric hospital CoPs.
- The Joint Commission's survey process to determine the following:

++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

++ The comparability of the Joint Commission's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ The Joint Commission's processes and procedures for monitoring a psychiatric hospital found out of compliance with the Joint Commission's program requirements. These monitoring procedures are used only when the Joint Commission's identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.9(c).

++ The Joint Commission's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ The Joint Commission's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of the Joint Commission's staff and other resources, and its financial viability.

++ The Joint Commission's capacity to adequately fund required surveys.

++ The Joint Commission's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

++ The Joint Commission's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ The Joint Commission's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. 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*).

V. Response to Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

In accordance with the provisions of Executive Order 12866, this regulation 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 on September 8, 2022, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: September 27, 2022.

Lynette Wilson,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2022–21305 Filed 9–28–22; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4200–N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2023

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

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2023. The calendar year 2023 AIC threshold amounts are $180 for ALJ hearings and $1,850 for judicial review.

DATES: This annual adjustment takes effect on January 1, 2023.

FOR FURTHER INFORMATION CONTACT: Liz Hosna, (410) 786–4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act) established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review at $100 and $1,000, respectively, for Medicare Part A and Part B appeals. Additionally, section 1869(b)(1)(E) of the Act provides that beginning in January 2005, the AIC threshold amounts are to be adjusted annually by the percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved and rounded to the nearest multiple of $10. Sections 1852(g)(5) and 1876(c)(5)(B) of the Act apply the AIC adjustment requirement to Medicare Part C/ Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement, pursuant to 42 CFR 417.840. Section 1860D–4(h)(1) of the Act, provides that a Medicare Part D plan sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) of the Act with respect to benefits, including appeals and the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations at § 405.1006(b)(2) require the Secretary of Health and