proposed collection, each proposed extension of an existing collection of information, and each reinstatement of a previously approved information collection before submitting the collection to the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
3. Enhance the quality, utility, and clarity of the information to be collected;
4. Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses; and
5. Assess information collection costs.

Proposed Project

Assessing Knowledge, Attitudes, and Practices (KAPs) of Hispanic/Latina Women of Reproductive Age (WRA) about Folic Acid Fortification and Supplementation—New—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

A contemporary understanding of cultural factors in the decision-making process and how certain populations of women obtain information is needed for Hispanic/Latina women of reproductive age (WRA) to increase their knowledge and intake of folic acid to prevent neural tube defects (NTD).

Previous research highlighted important nuances in potential cultural beliefs regarding folic acid. A study of Spanish-speaking, Hispanic/Latina women in the southwest United States found no cultural barriers to incorporating folic-acid rich foods into their diets; however, focus groups of Mexican-American women within the study found several cultural barriers. These included: misperception of the term folic acid as an illegal substance (as the word ''acid'' is sometimes used to describe the drug LSD); the importance of folic acid in preventing NTDs since their healthcare providers did not talk to them about folic acid; the absence of folic acid in injectable form at the pharmacy; and mistaken beliefs that birth defects are not preventable (resulting from an act of God). Other studies also present contradictory findings suggesting that Spanish-speaking, Mexican-American women have increased awareness of the association between folate and birth defects compared to English-speaking, Mexican-American women. Although several studies have examined beliefs and best practices for promoting folic acid consumption, more research is needed to determine cultural factors in the decision-making process around folic acid intake for Hispanic/Latina WRA.

The objective of this project is to conduct formative research with Hispanic/Latina WRA and leadership from key organizations that serve Hispanic/Latina populations to understand the following: (1) knowledge and awareness about folic acid and fortified food for NTD prevention; (2) practices around consumption of fortified foods as well as traditional food items that may or may not be fortified and supplement use; and (3) appropriate messages and dissemination channels to improve folic acid intake from supplements and folic acid fortified foods among Hispanic/Latina WRA.

This information collection will involve focus groups with Hispanic/Latina WRA. CDC requests OMB approval for an estimated 63 annual burden hours. 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)	Total burden (in hours)
Hispanic/Latina Women of Reproductive Age (WRA)	Knowledge, Attitudes, and Practices (KAPs) of Hispanic/Latina WRA: Focus Group Moderator Guide.	63	1	1	63
Total					63

Jeffrey M. Zirger,

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

[FR Doc. 2022–25400 Filed 11–21–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2022–0116]

CDC Recommendations for Hepatitis C Testing Among Perinatally Exposed Infants and Children—United States, 2023; Request for Comment and Notice of Informational Webinar

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

ACTION: Notice with comment.

SUMMARY: The Centers for Disease Control and Prevention (CDC), in the Department of Health and Human Services (HHS), announces the opening of a docket to obtain comment on proposed new recommendations for perinatal hepatitis C virus (HCV) infection testing to identify infants who may go on to develop chronic hepatitis C. Recommendations include: HCV testing of all perinatally exposed infants at age 2–6 months with a Nucleic Acid Test (NAT) for detection of HCV ribonucleic acid (RNA); and referral of infants with detectable HCV RNA to a healthcare provider with expertise in pediatric hepatitis C management. CDC

also announces an Informational Webinar to explain the public comment process.

DATES: Written comments must be received on or before January 27, 2023.

The Informational Webinar will be held December 6, 2022 from 3–4 p.m. EST.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2022–0116 by either of the methods listed below.

- *Federal eRulemaking Portal: https://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Division of Viral Hepatitis, Centers for Disease Control and Prevention, 1600 Clifton Road NE, Mailstop U12–3, Atlanta, GA 30329, Attn: Docket No. CDC–2022–0116.

Instructions: All submissions received must include the agency name and Docket Number. All relevant comments received will be posted without change to *https://www.regulations.gov,* including any personal information provided. Do not submit comments by email; CDC does not accept comments by email. For access to the docket to read background documents or comments received, go to *https://www.regulations.gov.*

Registration for Informational Webinar: You can register for the webinar at *https://www.zoomgov.com/webinar/register/WN_tDK5btj3QpGcmDzKVjvDbw.* CDC will not accept public comment during this webinar.

FOR FURTHER INFORMATION CONTACT: Lakshmi Panagiotakopoulos, Centers for Disease Control and Prevention, 1600 Clifton Road NE, Mailstop U12–3, Atlanta, GA 30329. Email: *DVHpolicy@cdc.gov.* Telephone: (404) 639–8000.

SUPPLEMENTARY INFORMATION:

Background

Hepatitis C virus (HCV) infection is the most commonly reported blood-borne infection in the United States, causing substantial liver damage and death.[1] During 2017–2020, there were an estimated 2.2 million non-institutionalized adults in the United States living with hepatitis C.[2] Percutaneous exposure (*e.g.,* injection drug use or blood transfusion) is the most efficient mode of HCV transmission, and injection drug use is the primary risk factor for infection.[3] National surveillance data reveal a steady increase in HCV infections in the United States from 2010 through 2020, with rates of acute infections more than quadrupling among reproductive aged persons during this time, corresponding with increases in injection drug use.[4] Approximately 7 percent of perinatally exposed children (*i.e.,* those coming into contact with the virus during pregnancy or delivery) will acquire perinatal HCV infection.[5] Curative direct-acting antiviral (DAA) drugs are an FDA-approved treatment, currently approved for use beginning at 3 years of age. However, many perinatally infected children are not tested or linked to care.[6] [7] [8] [9]

The World Health Organization (WHO)'s global health sector strategies [10] for eliminating viral hepatitis include diagnosing at least 90% of people living with hepatitis C by 2030. In support of this goal, CDC conducted a systematic review of the literature to develop recommendations for testing perinatally exposed infants and children for hepatitis C. Among children born to women with HCV infection, well-child visits in the first 6 months of life are the most frequently attended and provide an opportunity to test in a patient group that is often lost to follow-up. Although treatment is not currently approved for infants and children under 3 years of age, it is important to test exposed infants as close to birth as possible and record a diagnosis in the medical record. HCV-infected infants and children are usually asymptomatic, and it is important to diagnose and treat HCV infection before liver damage occurs. Prior studies have estimated that, in the United States, the total annual burden of HCV infection was about 10 billion U.S. dollars in 2017.[11] Proper identification of perinatally infected children, referral to care for evaluation and monitoring, and curative DAA treatment are critical to achieving the goal of hepatitis C elimination.

As described in the recommendation document found in the Supporting and Related Materials tab of the docket, these recommendations supplement ''CDC Recommendations for Hepatitis C Screening Among Adults—United States, 2020,'' which includes screening during each pregnancy, by recommending the timing and type of HCV test for infants and children born to persons determined to have HCV infection in pregnancy. In addition, this recommendation replaces a prior recommendation for testing perinatally exposed infants and children included in a CDC guideline from 1998,[12] as HCV epidemiology and methods of testing infants and children for HCV infection have evolved.

Public Participation

Interested persons or organizations are invited to participate by submitting written views, recommendations, and data related to any of the proposed recommendations or supporting evidence. In addition, CDC invites comments specifically on the following questions:

- Based on the evidence presented in the full recommendations document (*see* Supporting and Related Materials tab), does the evidence support the proposed recommendations for testing

[1] Centers for Disease Control and Prevention. Viral Hepatitis Surveillance Report—United States, 2020. *https://www.cdc.gov/hepatitis/statistics/2020surveillance/index.htm.* Published September 2022. *See also* Hofmeister, M.G., Rosenthal, E.M., Barker, L.K., Rosenberg, E.S., Barranco, M.A., Hall, E.W., Edlin, B.R., Mermin, J., Ward, J.W. and Ryerson, A.B. (2019), Estimating Prevalence of Hepatitis C Virus Infection in the United States, 2013–2016. Hepatology, 69: 1020–1031. *https://doi.org/10.1002/hep.30297* Rosenberg ES, Rosenthal EM, Hall EW, Barker L, Hofmeister MG, Sullivan PS, Dietz P, Mermin J, Ryerson AB. Prevalence of Hepatitis C Virus Infection in US States and the District of Columbia, 2013 to 2016. JAMA Netw Open. 2018 Dec 7;1(8):e186371. doi: 10.1001/jamanetworkopen.2018.6371. PMID: 30646319; PMCID: PMC6324373.

[2] Thompson WW, Symum H, Sandul A, et al. Vital Signs: Hepatitis C Treatment Among Insured Adults—United States, 2019–2020. MMWR Morb Mortal Wkly Rep 2022;71:1011–1017. DOI: *http://dx.doi.org/10.15585/mmwr.mm7132e1.*

[3] Centers for Disease Control and Prevention. Viral Hepatitis Surveillance Report—United States, 2020. *https://www.cdc.gov/hepatitis/statistics/2020surveillance/index.htm.* Published September 2022.

[4] Centers for Disease Control and Prevention. Viral Hepatitis Surveillance Report—United States, 2020. *https://www.cdc.gov/hepatitis/statistics/2020surveillance/index.htm.* Published September 2022.

[5] Benova, L., et al., Vertical transmission of hepatitis C virus: systematic review and meta-analysis. Clin Infect Dis, 2014. 59(6): p. 765–73.

[6] Towers, C.V. and K.B. Fortner, Infant follow-up postdelivery from a hepatitis C viral load positive mother. J Matern Fetal Neonatal Med, 2019. 32(19): p. 3303–3305.

[7] Lopata, S.M., et al., Hepatitis C Testing Among Perinatally Exposed Infants. Pediatrics, 2020. 145(3).

[8] Hojat, L.S., et al., Using Preventive Health Alerts in the Electronic Health Record Improves Hepatitis C Virus Testing Among Infants Perinatally Exposed to Hepatitis C. Pediatr Infect Dis J, 2020. 39(10): p. 920–924.

[9] Kuncio, D.E., et al., Failure to Test and Identify Perinatally Infected Children Born to Hepatitis C Virus-Infected Women. Clin Infect Dis, 2016. 62(8): p. 980–5.

[10] Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030. Geneva: World Health Organization; 2022. License: CC BY–NC–SA 3.0 IGO. Available at: *https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/strategies/global-health-sector-strategies.*

[11] Stepanova M, Younossi ZM. Economic Burden of Hepatitis C Infection. Clin Liver Dis. 2017 Aug;21(3):579–594. doi: 10.1016/j.cld.2017.03.012. Epub 2017 Apr 22. PMID: 28689595.

[12] Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. Centers for Disease Control and Prevention. MMWR Recomm Rep. 1998 Oct 16;47(RR–19):1–39. PMID: 9790221.

perinatally exposed infants and children for HCV infection? If not, please state the reason why and, if available, provide additional evidence for consideration.

• Are CDC's proposed recommendations (*see* Supporting and Related Materials tab) clearly written? If not, please provide changes to make them clearer.

• If implemented as currently drafted, do you believe the proposed recommendations would result in increased identification and treatment of perinatal HCV infections and reduction in associated health and financial consequences in the United States (*e.g.,* healthcare costs to treat complications of chronic hepatitis C)? If not, please provide an explanation.

Please note that comments received, including attachments and other supporting materials, are part of the public record and are subject to public disclosure. Comments will be posted on *https://www.regulations.gov.* Therefore, do not include any information in your comment or supporting materials that you consider confidential or inappropriate for public disclosure. If you include your name, contact information, or other information that identifies you in the body of your comments, that information will be on public display. CDC will review all submissions and may choose to redact or withhold submissions containing private or proprietary information such as Social Security numbers, medical information, inappropriate language, or duplicate or near duplicate examples of a mass-mail campaign.

Informational Webinar: CDC will host an Informational Webinar on December 6, 2022 from 3:00–4:00 p.m. EST to explain the public comment process. CDC will not accept public comment on the Draft Recommendations during the webinar.

Dated: November 17, 2022.

Angela K. Oliver,

Executive Secretary, Centers for Disease Control and Prevention.

[FR Doc. 2022–25421 Filed 11–21–22; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Submission for OMB Review; Annual Report on Households Assisted by the Low Income Home Energy Assistance Program (OMB #0970–0060)

AGENCY: Office of Community Services (OCS), Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Request for public comment.

SUMMARY: OCS, Division of Energy Assistance, is requesting a substantial change of the Household Report Office of Management and Budget (OMB) #0970–0060, expiration May 31, 2025). Grant recipients complete the Household Report on an annual basis, completing either the Long Form or the Short Form version of the report. Submission of the completed report is one requirement for the Low Income Home Energy Assistance Program (LIHEAP) grant recipients applying for Federal LIHEAP block grant funds. OCS proposes substantive changes, including the addition of reporting requirements for assisted applicants and household member demographic characteristics on the Household Report Long Form and Short Form, and the removal of reporting requirements collecting counts of applicant households by assistance type and poverty interval on the Household Report Long Form.

DATES: *Comments due within 30 days of publication.* OMB must make a decision about the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* One can find this particular information collection by selecting ''Currently under 30-day Review-Open for Public Comments'' or by using the search function. You can also obtain copies of the proposed collection of information by emailing *infocollection@acf.hhs.gov.* Identify all emailed requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: States, the District of Columbia, and the Commonwealth of Puerto Rico are required to complete the Household Report-Long Form on an annual basis. The Long Form collects the following information:

• Assisted households, by type of LIHEAP assistance and funding source;

• Assisted households receiving bill payment assistance, by funding source;

• Assisted households receiving any type of LIHEAP assistance, by funding source;

• Assisted households by poverty interval, type of LIHEAP assistance, and funding source;

• Assisted households, by type of LIHEAP assistance and funding source, having at least one vulnerable member who is at least 60 years or older, disabled, or 5 years old or younger;

• Assisted households receiving any type of LIHEAP assistance or funding source, having at least one member 60 years or older, disabled, or 5 years old or younger.

Tribal grant recipients and other U.S. territory grant recipients are required to complete the Household Report-Short Form on an annual basis. The Short Form collects data only on the number of households, by funding source, receiving heating, cooling, energy crisis, and/or weatherization benefits.

The information reported in the Household Report Long Form and Short Form is being collected for the Department's annual LIHEAP Report to Congress. The data also provides information about the need for LIHEAP funds. Finally, the data are used in the calculation of LIHEAP performance measures under the Government Performance and Results Act of 1993. The data elements will allow the accuracy of measuring LIHEAP targeting performance and LIHEAP cost efficiency.

ACF is proposing changes to the Household Report Long Form and Short Form beginning with FY 2023 reporting. These changes include additional reporting requirements for assisted household and household member demographic characteristics, and the removal of reporting requirements collecting counts of applicant households by assistance type and poverty interval on the Household Report Long Form. The additional reporting requirements include the following:

1. Number of Households by Owner/Renter Status (own, rent with utilities billed separately, rent with utilities in rental fee, other) [This is optional for FY 2023 reporting and required beginning with FY 2024 reporting].

2. Number of Assisted Applicants by Ethnicity. Grant recipients will report on assisted applicants by ethnicity according to standard census categories