ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects (Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995), the Health Resources and Services Administration (HRSA) announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this ICR should be received no later than January 25, 2016.

ADDRESSES: Submit your comments to *paperwork@hrsa.gov* or mail the HRSA Information Collection Clearance Officer, Room 10C–24, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email *paperwork@hrsa.gov* or call the HRSA Information Collection Clearance Officer at (301) 443–1984.

SUPPLEMENTARY INFORMATION: When submitting comments or requesting information, please include the information request collection title for reference. Information Collection Request Title: Rural Network Allied Health Training Program Performance Improvement Measurement System (PIMS). OMB No. 0915–xxxx—New.

Abstract: The Allied Health Training Program will support the development of formal, mature rural health networks that focus on activities that achieve efficiencies, expand access to, coordinate, and improve the quality of essential health care services, and strengthen the rural health care system as a whole. This purpose will be achieved through the recruitment, clinical training, and retention of allied health professionals. This program will further support integrated rural health networks that can partner with local community colleges and other accredited educational institutions (such as vocational and technical colleges) to develop formal clinical training programs.

Need and Proposed Use of the Information: For this program, performance measures were drafted to provide data to the program and to enable HRSA to provide aggregate program data required by Congress under the Government Performance and Results Act of 1993. These measures cover the principal topic areas of interest to the Federal Office of Rural Health Policy including: (a) Access to care; (b) population demographics; (c) staffing; (d) consortium/network; (e) sustainability; and (f) project specific domains. Several measures will be used for this program. All measures will speak to the Federal Office of Rural Health Policy's progress toward meeting the goals set.

Likely Respondents: The respondents are recipients of the Rural Network Allied Health Training Program grant funding.

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. The total annual burden hours estimated for this Information Collection Request are summarized in the table below.

Total Estimated Annualized burden hours:

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Rural Network Allied Health Training Program Performance Improvement Measurement System (PIMS)	10	1	10	3.33	30.33
Total	10	1	10	3.33	30.33

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.

Jackie Painter,

Director, Division of the Executive Secretariat.

[FR Doc. 2015–29967 Filed 11–24–15; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016 Through September 30, 2017

AGENCY: Office of the Secretary, DHHS.

ACTION: Notice.

SUMMARY: The Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and disaster-recovery FMAP adjustments for Fiscal Year 2017 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2016 through September 30, 2017. This notice announces the calculated FMAP rates, in accordance with sections 1101(a)(8) and 1905(b) of the Act, that the U.S. Department of Health and Human Services (HHS) will use in determining the amount of federal matching for state medical assistance (Medicaid), Temporary Assistance for Needy Families (TANF) Contingency Funds, Child Support Enforcement collections, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Foster Care Title IV–E Maintenance payments, and Adoption Assistance payments, and the eFMAP rates for the Children's Health Insurance Program (CHIP) expenditures. Table 1 gives figures for each of the 50 states, the District of Columbia, Puerto

Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. This notice reminds states of available disaster-recovery FMAP adjustments for qualifying states, and adjustments available for states meeting requirements for negative growth in total state personal income. At this time, no states qualify for such adjustments.

This notice also contains the increased eFMAPs for CHIP as authorized under the Patient Protection and Affordable Care Act (Affordable Care Act) for fiscal years 2016 through 2019 (October 1, 2015 through September 30, 2019).

Programs under title XIX of the Act exist in each jurisdiction. Programs under titles I, X, and XIV operate only in Guam and the Virgin Islands. The percentages in this notice apply to state expenditures for most medical assistance and child health assistance, and assistance payments for certain social services. The Act provides separately for federal matching of administrative costs.

Sections 1905(b) and 1101(a)(8)(B) of the Social Security Act (the Act) require the Secretary of HHS to publish the FMAP rates each year. The Secretary calculates the percentages, using formulas in sections 1905(b) and 1101(a)(8), and calculations by the Department of Commerce of average income per person in each state and for the Nation as a whole. The percentages must fall within the upper and lower limits specified in section 1905(b) of the Act. The percentages for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are specified in statute, and thus are not based on the statutory formula that determines the percentages for the 50 states.

Federal Medical Assistance Percentage (FMAP)

Section 1905(b) of the Act specifies the formula for calculating FMAPs as follows:

''Federal medical assistance percentage for any state shall be 100 per centum less the state percentage; and the state percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such state bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent . . .''.

Section 4725(b) of the Balanced Budget Act of 1997 amended section 1905(b) to provide that the FMAP for the District of Columbia for purposes of titles XIX and XXI shall be 70 percent. For the District of Columbia, we note under Table 1 that other rates may apply in certain other programs. In addition, we note the rate that applies for Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands in certain other programs pursuant to section 1118 of the Act. The rates for the States, District of Columbia and the territories are displayed in Table 1, Column 1.

Section 1905(y) of the Act, as added by section 2001 of the Patient Protection and Affordable Care Act of 2010 (''Affordable Care Act''), provides for a significant increase in the FMAP for medical assistance expenditures for individuals determined eligible under the new adult group in the state and who will be considered to be ''newly eligible'' in 2014, as defined in section 1905(y)(2)(A) of the Act. This newly eligible FMAP is 100 percent for Calendar Years 2014, 2015, and 2016, gradually declining to 90 percent in 2020 where it remains indefinitely. In addition, section 1905(z) of the Act, as added by section 10201 of the Affordable Care Act, provides that states that had expanded substantial coverage to low-income parents and nonpregnant adults without children prior to the enactment of the Affordable Care Act, referred to as ''expansion states,'' shall receive an enhanced FMAP that begins in 2014 for medical assistance expenditures for nonpregnant childless adults who may be required to enroll in benchmark coverage. . These provisions are discussed in more detail in the Medicaid Eligibility proposed rule published on August 17, 2011 (76 FR 51172) and the final rule published on March 23, 2012 (77 FR 17143). This notice is not intended to set forth the newly eligible or expansion state FMAP rates.

Other Adjustments to the FMAP

For purposes of Title XIX (Medicaid) of the Social Security Act, the Federal Medical Assistance Percentage (FMAP), defined in section 1905(b) of the Social Security Act, for each state beginning with fiscal year 2006 is subject to an adjustment pursuant to section 614 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111–3. Section 614 of CHIPRA stipulates that a state's FMAP under Title XIX (Medicaid) must be adjusted in two situations.

In the first situation, if a state experiences positive growth in total personal income and an employer in that state has made a significantly disproportionate contribution to a pension or insurance fund, the state's FMAP must be adjusted. Employer pension and insurance fund contributions are significantly disproportionate if the increase in contributions exceeds 25 percent of the increase in total personal income in that state. A **Federal Register** Notice with comment period was issued on June 7, 2010 (75 FR 32182) announcing the methodology for calculating this adjustment; a final notice was issued on October 15, 2010 (75 FR 63480).

A second situation arises if a state experiences negative growth in total personal income. Beginning with Fiscal Year 2006, section 614(b)(3) of CHIPRA specifies that certain employer pension or insurance fund contributions shall be disregarded when computing the per capita income used to calculate the FMAP for states with negative growth in total personal income. In that instance, for the purposes of calculating the FMAP, for a calendar year in which a state's total personal income has declined, the portion of an employer pension and insurance fund contribution that exceeds 125 percent of the amount of the employer contribution in the previous calendar year shall be disregarded.

We request that states follow the same methodology to determine potential FMAP adjustments for negative growth in total personal income that HHS employs to make adjustments to the FMAP for states experiencing significantly disproportionate pension or insurance contributions. See also the information described in the January 21, 2014 **Federal Register** notice (79 FR 3385).

This notice does not contain an FY 2017 adjustment for a major statewide disaster for any state because no state's FMAP decreased by at least three percentage points from FY 2016 to FY 2017.

Enhanced Federal Medical Assistance Percentage (eFMAP) for CHIP

Section 2105(b) of the Act specifies the formula for calculating the eFMAP rates as follows:

The ''enhanced FMAP'', for a state for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the state increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the state, is less than (2) 100 percent; but in no case shall

the enhanced FMAP for a state exceed 85 percent.

In addition, Section 2105(b) of the Social Security Act, as amended by Section 2101 of the Affordable Care Act, increases the eFMAP for states by 23 percentage points:

. . . during the period that begins on October 1, 2015, and ends on September 30, 2019, the enhanced FMAP determined for a state for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent.

The eFMAP rates are used in the Children's Health Insurance Program under Title XXI, and in the Medicaid program for certain children for expenditures for medical assistance described in sections 1905(u)(2) and 1905(u)(3) of the Act. There is no specific requirement to publish the eFMAP rates. We include them in this notice for the convenience of the states, and display both the normal eFMAP rates (Table 1, Column 2) and the Affordable Care Act's increased eFMAP rates (Table 1, Column 3) for comparison.

DATES: *Effective Dates:* The percentages listed in Table 1 will be effective for each of the four quarter-year periods beginning October 1, 2016 and ending September 30, 2017.

FOR FURTHER INFORMATION CONTACT: Thomas Musco or Rose Chu, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, Room 447D, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, (202) 690–6870.

(Catalog of Federal Domestic Assistance Program Nos. 93.558: TANF Contingency Funds; 93.563: Child Support Enforcement; 93.596: Child Care Mandatory and Matching Funds of the Child Care and Development Fund; 93.658: Foster Care Title IV–E; 93.659: Adoption Assistance; 93.769: Ticket-to-Work and Work Incentives Improvement Act (TWWIIA) Demonstrations to Maintain Independence and Employment; 93.778: Medical Assistance Program; 93.767: Children's Health Insurance Program)

Dated: November 18, 2015.

Sylvia M. Burwell,

Secretary.

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2016–SEPTEMBER 30, 2017 (FISCAL YEAR 2017)

State	Federal Medical Assistance percentages	Enhanced Federal Medical Assistance percentages	Enhanced Federal Medical Assistance percentages with ACA 23 PT increase ***
Alabama	70.16	79.11	100.00
Alaska	50.00	65.00	88.00
American Samoa *	55.00	68.50	91.50
Arizona	69.24	78.47	100.00
Arkansas	69.69	78.78	100.00
California	50.00	65.00	88.00
Colorado	50.02	65.01	88.01
Connecticut	50.00	65.00	88.00
Delaware	54.20	67.94	90.94
District of Columbia **	70.00	79.00	100.00
Florida	61.10	72.77	95.77
Georgia	67.89	77.52	100.00
Guam *	55.00	68.50	91.50
Hawaii	54.93	68.45	91.45
Idaho	71.51	80.06	100.00
Illinois	51.30	65.91	88.91
Indiana	66.74	76.72	99.72
Iowa	56.74	69.72	92.72
Kansas	56.21	69.35	92.35
Kentucky	70.46	79.32	100.00
Louisiana	62.28	73.60	96.60
Maine	64.38	75.07	98.07
Maryland	50.00	65.00	88.00
Massachusetts	50.00	65.00	88.00
Michigan	65.15	75.61	98.61
Minnesota	50.00	65.00	88.00
Mississippi	74.63	82.24	100.00
Missouri	63.21	74.25	97.25
Montana	65.56	75.89	98.89
Nebraska	51.85	66.30	89.30
Nevada	64.67	75.27	98.27
New Hampshire	50.00	65.00	88.00
New Jersey	50.00	65.00	88.00
New Mexico	71.13	79.79	100.00
New York	50.00	65.00	88.00
North Carolina	66.88	76.82	99.82
North Dakota	50.00	65.00	88.00
Northern Mariana Islands *	55.00	68.50	91.50
Ohio	62.32	73.62	96.62
Oklahoma	59.94	71.96	94.96
Oregon	64.47	75.13	98.13
Pennsylvania	51.78	66.25	89.25
Puerto Rico *	55.00	68.50	91.50
Rhode Island	51.02	65.71	88.71

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2016–SEPTEMBER 30, 2017 (FISCAL YEAR 2017)—Continued

State	Federal Medical Assistance percentages	Enhanced Federal Medical Assistance percentages	Enhanced Federal Medical Assistance percentages with ACA 23 PT increase ***
South Carolina	71.30	79.91	100.00
South Dakota	54.94	68.46	91.46
Tennessee	64.96	75.47	98.47
Texas	56.18	69.33	92.33
Utah	69.90	78.93	100.00
Vermont	54.46	68.12	91.12
Virgin Islands *	55.00	68.50	91.50
Virginia	50.00	65.00	88.00
Washington	50.00	65.00	88.00
West Virginia	71.80	80.26	100.00
Wisconsin	58.51	70.96	93.96
Wyoming	50.00	65.00	88.00

* For purposes of section 1118 of the Social Security Act, the percentage used under titles I, X, XIV, and XVI will be 75 per centum.

** The values for the District of Columbia in the table were set for the state plan under titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, the percentage for DC is 50.00, unless otherwise specified by law.

*** Section 2101(a) of the Affordable Care Act amended Section 2105(b) of the Social Security Act to increase the enhanced FMAP for states by 23 percentage points, but not to exceed 100 percent, for the period that begins on October 1, 2015 and ends on September 30, 2019 (fiscal years 2016 through 2019).

[FR Doc. 2015–30050 Filed 11–24–15; 8:45 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[OMHA–1502–N]

Medicare Program; Administrative Law Judge Hearing Program for Medicare Claim and Entitlement Appeals; Quarterly Listing of Program Issuances—July Through September 2015

AGENCY: Office of Medicare Hearings and Appeals (OMHA), HHS.

ACTION: Notice.

SUMMARY: This quarterly notice lists the OMHA Case Processing Manual (OCPM) manual instructions that were published from July through September 2015. This manual standardizes the day-to-day procedures for carrying out adjudicative functions, in accordance with applicable statutes, regulations and OMHA directives, and gives OMHA staff direction for processing appeals at the OMHA level of adjudication.

FOR FURTHER INFORMATION CONTACT: Amanda Axeen, by telephone at (571) 777–2705, or by email at *amanda.axeen@hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary of the U.S. Department of Health and Human Services (HHS), administers the nationwide Administrative Law Judge (ALJ) hearing program for Medicare claim, organization and coverage determination, and entitlement appeals under sections 1869, 1155, 1876(c)(5)(B), 1852(g)(5), and 1860D–4(h) of the Social Security Act (the Act). OMHA ensures that Medicare beneficiaries and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicare Advantage Organizations (MAOs) and Medicaid State Agencies, have a fair and impartial forum to address disagreements with Medicare coverage and payment determinations made by Medicare contractors, MAOs, or Part D Plan Sponsors (PDPSs), and determinations related to Medicare eligibility and entitlement, Part B late enrollment penalties, and income-related monthly adjustment amounts (IRMAA) made by the Social Security Administration (SSA).

The Medicare claim, organization and coverage determination appeals processes consist of four levels of administrative review, and a fifth level of review with the Federal district courts after administrative remedies under HHS regulations have been exhausted. The first two levels of review are administered by the Centers for Medicare & Medicaid Services (CMS) and conducted by Medicare contractors for claim appeals, by MAOs and an independent review entity for Part C organization determination appeals, or by PDPSs and an independent review entity for Part D coverage determination appeals. The third level of review is administered by OMHA and conducted by Administrative Law Judges. The fourth level of review is administered by the HHS Departmental Appeals Board (DAB) and conducted by the Medicare Appeals Council. In addition, OMHA and the DAB administer the second and third levels of appeal, respectively, for Medicare eligibility, entitlement, Part B late enrollment penalty, and IRMAA reconsiderations made by SSA; a fourth level of review with the Federal district courts is available after administrative remedies within SSA and HHS have been exhausted.

Sections 1869, 1155, 1876(c)(5)(B), 1852(g)(5), and 1860D–4(h) of the Act are implemented through the regulations at 42 CFR part 405, subparts I and J; part 417, subpart Q; part 422, subpart M; part 423, subparts M and U; and part 478, subpart B. As noted above, OMHA administers the nationwide Administrative Law Judge hearing program in accordance with these statutes and applicable regulations. As part of that effort, OMHA has established the OMHA Case Processing Manual (OCPM). Through the OCPM, the OMHA Chief Administrative Law Judge establishes the day-to-day procedures for carrying out adjudicative functions, in accordance with applicable statutes, regulations and OMHA directives. The OCPM provides direction for processing appeals at the OMHA level of adjudication for Medicare Part A and B claims; Part C organization determinations; Part D coverage determinations; and SSA eligibility and entitlement, Part B late