

receipt of your comment(s), please check <http://www.regulations.gov>, approximately two to three days after submission to verify posting (except allow 30 days for posting of comments submitted by mail).

FOR FURTHER INFORMATION CONTACT: Visit the CECANF Web site at <https://eliminatechildabusefatalities.sites.usa.gov/> or contact Patricia Brincefield, Communications Director, at 202–818–9596, U.S. General Services Administration, 1800 F Street NW., Room 7003D, Washington, DC 20405, Attention: Tom Hodnett (CD) for CECANF.

SUPPLEMENTARY INFORMATION:

Background: CECANF was established to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect.

Agenda: Commission members will continue discussing the work plans of the Commission subcommittees, the information that they have obtained to date, and emerging recommendations.

Attendance at the Meeting: Individuals interested in attending the meeting in person or participating by webinar and teleconference must register in advance. To register to attend in person or by webinar/phone, please go to <http://meetingtomorrow.com/webcast/CECANF> and follow the prompts. Once you register, you will receive a confirmation email with the teleconference number. Detailed meeting minutes will be posted within 90 days of the meeting. Members of the public will not have the opportunity to ask questions or otherwise participate in the meeting.

However, members of the public wishing to comment should follow the steps detailed under the heading **ADDRESSES** in this publication or contact us via the CECANF Web site at <https://eliminatechildabusefatalities.sites.usa.gov/contact-us/>.

Dated: November 9, 2015.

Karen White,
Executive Assistant.

[FR Doc. 2015–29002 Filed 11–13–15; 8:45 am]

BILLING CODE 6820–34–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8060–N]

RIN 0938–AS37

Medicare Program; CY 2016 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

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

ACTION: Notice.

SUMMARY: This annual notice announces Medicare’s Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2016. This premium is paid by enrollees age 65 and over who are not otherwise eligible for benefits under Medicare Part A (hereafter known as the “uninsured aged”) and by certain disabled individuals who have exhausted other entitlement. The monthly Part A premium for the 12 months beginning January 1, 2016, for these individuals will be \$411. The premium for certain other individuals as described in this notice will be \$226.

DATES: *Effective Date:* This notice is effective on January 1, 2016.

FOR FURTHER INFORMATION CONTACT: Clare McFarland, (410) 786–6390.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1818 of the Social Security Act (the Act) provides for voluntary enrollment in the Medicare Hospital Insurance Program (Medicare Part A), subject to payment of a monthly premium, of certain persons aged 65 and older who are uninsured under the Old-Age, Survivors, and Disability Insurance (OASDI) program or the Railroad Retirement Act and do not otherwise meet the requirements for entitlement to Medicare Part A. These “uninsured aged” individuals are uninsured under the OASDI program or the Railroad Retirement Act, because they do not have 40 quarters of coverage under Title II of the Act (or are/were not married to someone who did). (Persons insured under the OASDI program or the Railroad Retirement Act and certain others do not have to pay premiums for Medicare Part A.)

Section 1818A of the Act provides for voluntary enrollment in Medicare Part A, subject to payment of a monthly premium for certain disabled individuals who have exhausted other entitlement. These are individuals who were entitled to coverage due to a

disabling impairment under section 226(b) of the Act, but who are no longer entitled to disability benefits and free Medicare Part A coverage because they have gone back to work and their earnings exceed the statutorily defined “substantial gainful activity” amount (section 223(d)(4) of the Act).

Section 1818A(d)(2) of the Act specifies that the provisions relating to premiums under section 1818(d) through section 1818(f) of the Act for the aged will also apply to certain disabled individuals as described above.

Section 1818(d)(1) of the Act requires us to estimate, on an average per capita basis, the amount to be paid from the Federal Hospital Insurance Trust Fund for services incurred in the upcoming calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A. We must then determine the monthly actuarial rate for the following year (the per capita amount estimated above divided by 12) and publish the dollar amount for the monthly premium in the succeeding CY. If the premium is not a multiple of \$1, the premium is rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not of \$1, it is rounded to the next highest \$1).

Section 13508 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103–66) amended section 1818(d) of the Act to provide for a reduction in the premium amount for certain voluntary enrollees (section 1818 and section 1818A of the Act). The reduction applies to an individual who is eligible to buy into the Medicare Part A program and who, as of the last day of the previous month:

- Had at least 30 quarters of coverage under Title II of the Act;
- Was married, and had been married for the previous 1-year period, to a person who had at least 30 quarters of coverage;
- Had been married to a person for at least 1 year at the time of the person’s death if, at the time of death, the person had at least 30 quarters of coverage; or
- Is divorced from a person and had been married to the person for at least 10 years at the time of the divorce if, at the time of the divorce, the person had at least 30 quarters of coverage.

Section 1818(d)(4)(A) of the Act specifies that the premium that these individuals will pay for CY 2016 will be equal to the premium for uninsured aged enrollees reduced by 45 percent.

II. Monthly Premium Amount for CY 2016

The monthly premium for the uninsured aged and certain disabled individuals who have exhausted other entitlement for the 12 months beginning January 1, 2016, is \$411.

The monthly premium for the individuals eligible under section 1818(d)(4)(B) of the Act, and therefore, subject to the 45 percent reduction in the monthly premium, is \$226.

III. Monthly Premium Rate Calculation

As discussed in section I of this notice, the monthly Medicare Part A premium is equal to the estimated monthly actuarial rate for CY 2016 rounded to the nearest multiple of \$1 and equals one-twelfth of the average per capita amount, which is determined by projecting the number of Medicare Part A enrollees aged 65 years and over as well as the benefits and administrative costs that will be incurred on their behalf.

The steps involved in projecting these future costs to the Federal Hospital Insurance Trust Fund are:

- Establishing the present cost of services furnished to beneficiaries, by type of service, to serve as a projection base;
- Projecting increases in payment amounts for each of the service types; and
- Projecting increases in administrative costs.

We base our projections for CY 2016 on—(1) current historical data; and (2) projection assumptions derived from current law and the Mid-Session Review of the President's Fiscal Year 2016 Budget.

We estimate that in CY 2016, 47,251,107 people aged 65 years and over will be entitled to benefits (without premium payment) and that they will incur about \$233.221 billion in benefits and related administrative costs. Thus, the estimated monthly average per capita amount is \$411.31 and the monthly premium is \$411. Subsequently, the full monthly premium reduced by 45 percent is \$226.

IV. Costs to Beneficiaries

The CY 2016 premium of \$411 is approximately 1 percent higher than the CY 2015 premium of \$407. We estimate that approximately 652,000 enrollees will voluntarily enroll in Medicare Part A, by paying the full premium. Furthermore, the CY 2016 reduced premium of \$226 is approximately 0.9 percent higher than the CY 2015 premium of \$224. We estimate an additional 61,000 enrollees will pay the

reduced premium. Therefore, we estimate that the total aggregate cost to enrollees paying these premiums in CY 2016, compared to the amount that they paid in CY 2015, will be about \$32 million.

V. Waiver of Proposed Notice and Comment Period

We use general notices, rather than notice and comment rulemaking procedures, to make announcements such as this premium notice. In doing so, we acknowledge that, under the Administrative Procedure Act (APA), interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice are excepted from the requirements of notice and comment rulemaking. The agency may also waive notice and comment if there is "good cause," as defined by the statute. We considered publishing a proposed notice to provide a period for public comment. However, under the APA, we may waive that procedure if we find good cause that prior notice and comment are impracticable, unnecessary, or contrary to the public interest.

We are not using notice and comment rulemaking in this notification of Medicare Part A premiums for CY 2016 as that procedure is unnecessary because of the lack of discretion in the statutory formula that is used to calculate the premium and the solely ministerial function that this notice serves. The APA permits agencies to waive notice and comment rulemaking when notice and public comment thereon are unnecessary. On this basis, we waive publication of a proposed notice and a solicitation of public comments.

VI. 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.*).

VII. Regulatory Impact Analysis

A. Statement of Need

Section 1818(d) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) during September of each year to determine and publish the amount to be paid, on an average per capita basis, from the Federal Hospital Insurance Trust Fund for services

incurred in the impending calendar year (CY) (including the associated administrative costs) on behalf of individuals aged 65 and over who will be entitled to benefits under Medicare Part A.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. Part I, Ch. 8).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major notices with economically significant effects (\$100 million or more in any 1 year). As stated in section IV of this notice, we estimate that the overall effect of the changes in the Part A premium will be a cost to voluntary enrollees (section 1818 and section 1818A of the Act) of about \$32 million. As a result, this notice is non-economically significant under section 3(f)(1) of Executive Order 12866 and is not a major action under the Congressional Review Act. In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any 1 year (for details, see the Small Business Administration's Web site at http://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf).

Individuals and states are not included in the definition of a small

entity. As discussed above, this annual notice announces Medicare's Hospital Insurance (Part A) premium for uninsured enrollees in calendar year (CY) 2016. As a result, we are not preparing an analysis for the RFA because the Secretary has determined that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. As discussed above, we are not preparing an analysis for section 1102(b) of the Act, because the Secretary has determined that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately \$144 million. This notice does not impose mandates that will have a consequential effect of \$144 million or more on state, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Since this notice does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

Dated: November 6, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: November 9, 2015

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

[FR Doc. 2015-29176 Filed 11-10-15; 4:15 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS-3427]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (the PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including any of the following subjects: (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.

DATES: Comments must be received by January 15, 2016.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send your comments electronically to <http://www.regulations.gov>. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) that are accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>.

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.

3. Call the Reports Clearance Office at (410) 786-1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786-1326.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS-3427 End Stage Renal Disease Application and Survey and Certification Report

Under the PRA (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires federal agencies to publish a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Information Collection

1. *Type of Information Collection Request:* Reinstatement with change of a previously approved collection; *Title of Information Collection:* End Stage Renal Disease Application and Survey and Certification Report; *Use:* Part I of this form is a facility identification and screening measurement used to initiate the certification and recertification of ESRD facilities. Part II is completed by the Medicare/Medicaid State survey agency to determine facility compliance with ESRD conditions for coverage.