governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.0 million to $35.5 million in any one year. Individuals and states are not included in the definition of a small entity. CMS is not preparing an analysis for the RFA because it has determined, and the Secretary certifies, that this document will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if an action 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, CMS defines a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment purposes and has fewer than 100 beds. CMS is not preparing an analysis for section 1102(b) of the Act because it has determined, and the Secretary certifies, that this document 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 regulatory action whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. In 2015, that threshold is approximately $144 million. This document will have no consequential effect 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 regulatory action (and subsequent final action) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. Because this document does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget reviewed this document.

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

Dated: December 7, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2016–01835 Filed 1–29–16; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3323–N]

Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs; Extension of Comment Period

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

ACTION: Request for information; extension of comment period.

SUMMARY: This document extends the comment period for the December 31, 2015 request for information entitled ''Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs'' (80 FR 81824) (referred to in this document as December 31 RFI). The comment period for the December 31 RFI, which would have ended on February 1, 2016, is extended for 15 days.

DATES: The comment period is extended to February 16, 2016. To be assured consideration, written or electronic comments on the December 31 RFI must be received at one of the addresses provided below no later than February 16, 2016.

ADDRESSES: In commenting on the December 31 RFI, please refer either to file code CMS–3323–NC and comment as indicated in that document (80 FR 81824) or file code CMS–3323–N and comment as provided in this document. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four 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–3323–N, P.O. Box 8013, Baltimore, MD 21244–8013.

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–3323–N, 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 comments 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.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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 Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments. Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through

Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

FOR FURTHER INFORMATION CONTACT: Lisa Marie Gomez, (410) 786–1175.

SUPPLEMENTARY INFORMATION: On December 31, 2015, we published a request for information in the **Federal Register** (80 FR 81824) entitled, ''Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs'' (referred to in this document as ''the December 31 RFI''). That request for information seek public comment regarding several items related to the certification of health information technology (IT), including electronic health records (EHR) products used for reporting to certain CMS quality reporting programs such as, but not limited to, the Hospital Inpatient Quality Reporting (IQR) Program and the Physician Quality Reporting System (PQRS). In addition, it requested feedback on how often to require recertification, the number of clinical quality measures (CQMs) a certified Health IT Module should be required to certify to, and testing of certified Health IT Module(s).

We have received inquiries from stakeholders regarding the 30-day comment period to submit comments regarding the December 31 RFI. The stakeholders stated that they need additional time to respond to the questions posed in the December 31 RFI. Since we requested the public's comments on several options, we believe that it is important to allow ample time for the public to prepare their comments. Therefore, we have decided to extend the comment period for an additional 15 days. This document announces the extension of the public comment period to February 16, 2016.

Dated: January 28, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2016–01937 Filed 2–1–16; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2398–N]

RIN 0983–ZB24

Medicaid Program; Final FY 2013 and Preliminary FY 2015 Disproportionate Share Hospital Allotments, and Final FY 2013 and Preliminary FY 2015 Institutions for Mental Diseases Disproportionate Share Hospital Limits

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

ACTION: Notice.

SUMMARY: This notice announces the final federal share disproportionate share hospital (DSH) allotments for federal fiscal year (FY) 2013 and the preliminary federal share DSH allotments for FY 2015. This notice also announces the final FY 2013 and the preliminary FY 2015 limitations on aggregate DSH payments that states may make to institutions for mental disease and other mental health facilities. In addition, this notice includes background information describing the methodology for determining the amounts of states' FY DSH allotments.

DATES: This notice is effective March 3, 2016. The final allotments and limitations set forth in this notice are effective for the fiscal years specified.

FOR FURTHER INFORMATION CONTACT: Stuart Goldstein, (410) 786–0694 and Richard Cuno, (410) 786–1111.

SUPPLEMENTARY INFORMATION:

I. Background

A. Fiscal Year DSH Allotments

A state's federal fiscal year (FY) disproportionate share hospital (DSH) allotment represents the aggregate limit on the federal share amount of the state's payments to DSH hospitals in the state for the FY. The amount of such allotment is determined in accordance with the provisions of section 1923(f)(3) of the Social Security Act (the Act). Under such provisions, in general a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the Consumer Price Index for all Urban Consumers (CPI–U) for the previous FY.

The Affordable Care Act amended Medicaid DSH provisions, adding section 1923(f)(7) of the Act which would have required reductions to states' FY DSH allotments beginning with FY 2014, the calculation of which was described in the Disproportionate Share Hospital Payment Reduction final rule published in the September 18, 2013 **Federal Register** (78 FR 57293). Under the DSH reduction methodology, first, each state's unreduced FY DSH allotment would have been calculated in accordance with the provisions of section 1923(f) of the Act, excluding section 1923(f)(7) of the Act; then, the reduction amount for each state would have been determined under the provisions of section 1923(f)(7) of the Act and implementing regulations at 42 CFR 447.294; and, finally, the net FY DSH allotment for each state would have been determined by subtracting the DSH reduction amount for the state from its unreduced FY 2014 DSH allotment.

The reductions under section 1923(f)(7) of the Act were most recently delayed and modified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10), enacted on April 16, 2015. The reductions of states' fiscal year DSH allotments under section 1923(f)(7) of the Act that were applicable to FY 2017 were repealed, and are instead scheduled to begin in FY 2018 at modified levels. MACRA also extended DSH allotment reductions through 2025.

Because there is no reduction to DSH allotments for FY 2015 under section 1923(f)(7) of the Act, this notice contains only the state-specific preliminary FY 2015 DSH allotments, as calculated under the statute without application of the reductions that would have otherwise been imposed. This notice also provides information on the calculation of such FY DSH allotments, the calculation of the states' IMD DSH limits, and the amounts of states' preliminary FY 2015 IMD DSH limits.

B. Determination of Fiscal Year DSH Allotments

Generally, in accordance with the methodology specified under section 1923(f)(3) of the Act, a state's FY DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding FY by the percentage change in the CPI–U for the previous FY. Also in accordance with section 1923(f)(3) of the Act, a state's DSH allotment for a FY is subject to the limitation that an increase to a state's DSH allotment for a FY cannot result in the DSH allotment exceeding the greater of the state's DSH allotment for the previous FY or 12 percent of the state's total medical assistance expenditures for the allotment year (this is referred to as the 12 percent limit).

Furthermore, under section 1923(h) of the Act, federal financial participation