community, county, regional, and state levels.

With the continuing shift in the healthcare environment towards provision of value-based care and utilization of reimbursement strategies through Centers for Medicare and Medicaid Services quality reporting programs, the latest competitive Rural Health Care Coordination Program cohort also aligned with this shift. An increased number of sophisticated applicants leveraging increasingly intricate reporting methodologies for quality data collection, utilization and analysis has resulted in an estimate of burden hours more in line with the realities of the health care landscape. In addition, the total number of responses has increased to 10 since the previous Notice of Award. This is due to a new Rural Health Care Coordination Program grant cycle with an increased number of awardees and therefore an increased number of respondents.

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. All measures will speak to HRSA's progress toward meeting the goals set.

Likely Respondents: Recipients of the Rural Health Care Coordination Program 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 ICR 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 Health Care Coordination Grant Program Measures	10	1	10	3.5	35
Total	10		10		35

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.

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2020–26254 Filed 11–27–20; 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, 2021 Through September 30, 2022

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

DATES: The percentages listed in Table 1 will be effective for each of the four quarter-year periods beginning October 1, 2021 and ending September 30, 2022.

FOR FURTHER INFORMATION CONTACT: Ann Conmy, 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.

SUPPLEMENTARY INFORMATION: The Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and disaster-recovery FMAP adjustments for Fiscal Year 2022 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2021 through September 30, 2022. 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, Title IV–E Foster Care Maintenance payments, Adoption Assistance payments and Kinship Guardianship 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 adjustments available for states meeting requirements for disproportionate employer pension or insurance fund contributions and adjustments for disaster recovery. At this time, no state qualifies for such adjustments, and territories are not eligible.

The FY 2022 FMAP rates do not include the 6.2 percentage point increase in the FMAP provided under Section 6008 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116–127) because the increase depends upon states meeting statutory requirements in FFCRA that cannot be assumed. If applied, the temporary 6.2 percentage increase in the FMAP is effective beginning January 1, 2020 and can extend through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services

for COVID–19, including any extensions, terminates.

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 United States (meaning, for this purpose, the fifty states and the District of Columbia). 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 the 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 the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum.

Section 1905(b) further specifies that the FMAP 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. Section 202(c) of the Further Consolidated Appropriations Act, 2020 (Pub. L. 116–94) amends section 1905(b) to increase the FMAP to 76 percent for Puerto Rico and increase the FMAP to 83 percent for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to 83 percent, for the period beginning December 21, 2020, and ending September 30, 2021. 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'') (Pub. L. 111–148), provides for a significant increase in the FMAP for medical assistance expenditures for newly eligible individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act, as added by the Affordable Care Act (the new adult group); ''newly eligible'' is defined in section 1905(y)(2)(A) of the Act. The FMAP for the new adult group 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 offered substantial health coverage to certain low-income parents and nonpregnant, childless adults on the date of enactment of the Affordable Care Act, referred to as ''expansion states,'' shall receive an enhanced FMAP beginning in 2014 for medical assistance expenditures for nonpregnant childless adults who may be required to enroll in benchmark coverage under section 1937 of the Act. These provisions are discussed in more detail in the Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010 proposed rule published on August 17, 2011 (76 FR 51148, 51172) and the final rule published on March 23, 2012 (77 FR 17144, 17194). This notice is not intended to set forth the matching rates for the new adult group as specified in section 1905(y) of the Act or the matching rates for nonpregnant, childless adults in expansion states as specified in section 1905(z) of the Act.

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, can be 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 no growth or positive growth in total personal income and an employer in that state has made a significantly disproportionate contribution to an employer pension or insurance fund, the state's FMAP must be adjusted. The adjustment involves disregarding the significantly disproportionate employer pension or insurance fund contribution in computing the per capita income for the state (but not in computing the per capita income for the United States). Employer pension and insurance fund contributions are significantly disproportionate if the increase in contributions exceeds 25 percent of the total increase in personal income in that state. A **Federal Register** Notice with comment period was published on June 7, 2010 (75 FR 32182) announcing the methodology for calculating this adjustment; a final notice was published on October 15, 2010 (75 FR 63480).

The 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, 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 or insurance fund contribution that exceeds 125 percent of the amount of such contribution in the previous calendar year shall be disregarded in computing the per capita income for the state (but not in computing the per capita income for the United States).

No Federal source of reliable and timely data on pension and insurance contributions by individual employers and states is currently available. We request that states report employer pension or insurance fund contributions to help determine potential FMAP adjustments for states experiencing significantly disproportionate pension or insurance contributions and states experiencing a negative growth in total personal income. See also the information described in the January 21, 2014 **Federal Register** notice (79 FR 3385).

Section 2006 of the Affordable Care Act provides a special adjustment to the FMAP for certain states recovering from a major disaster. This notice does not contain an FY 2022 adjustment for a major statewide disaster for any state (territories are not eligible for FMAP adjustments) because no state had a recent major statewide disaster and had

its FMAP decreased by at least three percentage points from FY 2020 to FY 2021. See information described in the December 22, 2010 **Federal Register** notice (75 FR 80501).

Enhanced Federal Medical Assistance Percentage (eFMAP) for CHIP

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

The eFMAP rates are used in the Children's Health Insurance Program under Title XXI, and in the Medicaid program for expenditures for medical assistance provided to certain children as 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 (Table 1, Column 2).

Section 2705(b) of the Act, as amended by the HEALTHY KIDS Act of 2017, increased the eFMAP by 11.5 percentage points for FY 2021 and is no longer applicable.

(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 24, 2020.

Alex M. Azar II,

Secretary.

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2021–SEPTEMBER 30, 2022

[Fiscal year 2022]

State	Federal Medical Assistance Percentages	Enhanced Federal Medical Assistance Percentages
Alabama	72.37	80.66
Alaska	50.00	65.00
American Samoa*	55.00	68.50
Arizona	70.01	79.01
Arkansas	71.62	80.13
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	57.72	70.40
District of Columbia**	70.00	79.00
Florida	61.03	72.72
Georgia	66.85	76.80
Guam*	55.00	68.50
Hawaii	53.64	67.55
Idaho	70.21	79.15
Illinois	51.09	65.76
Indiana	66.30	76.41
Iowa	62.14	73.50
Kansas	60.16	72.11
Kentucky	72.75	80.93
Louisiana	68.02	77.61
Maine	64.00	74.80
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	65.48	75.84
Minnesota	50.51	65.36
Mississippi	78.31	84.82
Missouri	66.36	76.45
Montana	64.90	75.43
Nebraska	57.80	70.46
Nevada	62.59	73.81
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	73.71	81.60
New York	50.00	65.00
North Carolina	67.65	77.36
North Dakota	53.59	67.51
Northern Mariana Islands*	55.00	68.50
Ohio	64.10	74.87
Oklahoma	68.31	77.82
Oregon	60.22	72.15
Pennsylvania	52.68	66.88
Puerto Rico*	55.00	68.50
Rhode Island	54.88	68.42
South Carolina	70.75	79.53
South Dakota	58.69	71.08
Tennessee	66.36	76.45

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2021–SEPTEMBER 30, 2022—Continued

[Fiscal year 2022]

State	Federal Medical Assistance Percentages	Enhanced Federal Medical Assistance Percentages
Texas	60.80	72.56
Utah	66.83	76.78
Vermont	56.47	69.53
Virgin Islands *	55.00	68.50
Virginia	50.00	65.00
Washington	50.00	65.00
West Virginia	74.68	82.28
Wisconsin	59.88	71.92
Wyoming	50.00	65.00

* 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 for the territories.

** For purposes of section 1905(b) of the Social Security Act, the FMAP for the District of Columbia, for purposes of titles XIX and XXI, shall be 70 percent. 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 disproportionate share hospital (DSH) allotments under those titles. For other purposes, the percentage for DC is 50.00, unless otherwise specified by law.

[FR Doc. 2020–26387 Filed 11–27–20; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Amended Notice of Meeting

Notice is hereby given of a change in the meeting of the Center for Scientific Review Special Emphasis Panel, December 10, 2020, 09:30 a.m. to December 10, 2020, 05:00 p.m., National Institutes of Health, Eunice Kennedy Shriver National Institute of, 6701B Rockledge Drive, Bethesda, MD 20892, which was published in the **Federal Register** on November 16, 2020, 85 FR 73063.

This notice is being amended to change the meeting start time from 10:00 a.m. to 9:30 a.m. The meeting is closed to the public.

Dated: November 24, 2020.

Miguelina Perez,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2020–26370 Filed 11–27–20; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel; Mechanism for Time-Sensitive Drug Abuse Research (R21 Clinical Trial Optional).

Date: December 9, 2020.

Time: 12:00 p.m. to 5:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, National Institute on Drug Abuse, 301 North Stonestreet Avenue, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Sheila Pirooznia, Ph.D., Scientific Review Officer, Division of Extramural Review, Scientific Review Branch, National Institute on Drug Abuse, NIH, 301 North Stonestreet Avenue, MSC 6021, Bethesda, MD 20892, (301) 496–9350, *sheila.pirooznia@nih.gov*.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse and Addiction Research Programs, National Institutes of Health, HHS)

Dated: November 24, 2020.

Tyeshia M. Roberson,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2020–26367 Filed 11–27–20; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel; Small Business: Spine and Vertebral Disc.

Date: December 17, 2020.

Time: 11:00 a.m. to 12:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Rockledge II, 6701 Rockledge Drive, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Aftab A. Ansari, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of