Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Ricker Hamilton, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

TO: Senator James Hamper, Chair
Representative Drew Gattine, Chair
Members, Joint Standing Committee on Appropriations and Financial Affairs

FROM: Ricker Hamilton, Commissioner

DATE: January 3, 2018

SUBJECT: Medicaid Expansion Fiscal Note and Related Information

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Department of Health and Human Services Fiscal Note

As the Legislature works to provide funding for the recently-passed citizen initiative, the Department of Health and Human Services (DHHS) seeks to provide information to assist the Legislature in accurately and realistically understanding the impact of Medicaid expansion. To that end, please see the attached spreadsheet detailing the estimated fiscal impact of Medicaid expansion. When reviewing the fiscal note, please take note of the information below.

Fiscal Amounts

From SFY 2018 through SFY 2023, DHHS estimates a total general fund expenditure of $452,992,279. DHHS expects annual expenditures thereafter to be at least a six percent annual increase additional to the SFY 2023 baseline of $109,049,527. Note that DHHS estimates a one-month lag in claims due to eligibility determination of applications. As a result, DHHS assumes 11 months of claim expenditures for State fiscal year (SFY) 2019, while OFPR assumes 12 months of claim expenditures.

The vast majority of the monetary differences between the DHHS estimate and the estimate produced by OFPR are attributable to four items:

1. **Savings**

   OFPR estimates $27 million in expected savings from transitional populations and reductions in State mental health, substance abuse, prison, family planning, general assistance, and senior prescription drug programs. DHHS agrees with OFPR that expected savings can only

be realized if those currently participating in these services move to MaineCare and others eligible for these services, but not currently participating, are prevented from receiving these services. In absence of that prevention and withholding of services, the Department does not assume savings. In addition, should savings occur, they would not be realized until well after full implementation is complete, would be gradual in nature, and would be directly proportionate to new enrollment. Another area of concern is the assumed savings in the eligibility categories such as the Medically Needy and Pregnant Women. If savings are to be assumed as a result of Medicaid expansion, there must be a literal elimination of State-funded service contracts, resulting in a significant reduction in the services for participants in the above-mentioned programs.

2. Annual Rate Factors

OFPR does not indicate what figures were used for the annual rate factor, the medical consumer price index (med CPI), or the utilization factor. DHHS uses a total annual rate of six percent, comprised of the anticipated med CPI and the utilization rate. The anticipated med CPI average for the time period is developed based on the most recent US Census Bureau calculations and historical averages.

3. Assumptions Regarding the Federal Match

DHHS bases the enhanced Federal Medical Assistance Percentage (FMAP) for children on current federal law, which indicates the Affordable Care Act enhanced level expires at the conclusion of federal fiscal year (FFY) 2019. This results in a level of 75.16 percent for FFY 2020. OFPR assumes a future change to federal law, continuing an enhanced Children's FMAP. We believe it is appropriate to assume current law, given the political dynamic associated with changes to the Affordable Care Act, as well as good accounting practices. In addition, OFPR indicates the use of a 98.07 percent FMAP, the FFY17 level. The Centers for Medicare and Medicaid Services (CMS) recently updated the FMAP, indicating the following levels: 98.04 percent in FFY18; 98.16 percent in FFY19; and 75.16 percent in FFY20 and beyond. Please see the attached Federal Register Notice (Vol. 82, No. 223/Tuesday, November 21, 2017).

4. Assumptions Regarding Participation and Costs

The estimates also differ regarding member count and per member costs. OFPR assumes a slightly higher (approximately 7,000 individuals) level of participation, but a lower per member cost. Subsequent to the development of the OFPR estimate in October 2016, updated data regarding claims and other per member cost inputs has become available. DHHS uses that updated data.

We believe this estimate to be conservative, and these numbers should serve as a baseline estimate. When Maine expanded Medicaid in the early 2000's, enrollment and cost projections were significantly overrun. In recent years, many other states have had similar experiences.

Carried Balances

Over the years, as the MaineCare budget grew from 13 percent of the State general fund budget in the mid 1990's to one-quarter of it today, the massive shortfalls in Medicaid overshadowed other core State priorities and have exacerbated the tax burden in this State. The program grew from 180,000 in the late 1990s to over 354,000 when the current Governor took office, and from a budget of $1.2 billion in 2002 to $2.4 billion in 2011. By 2011, Maine's Medicaid rolls had grown to nearly 30 percent of the State's population. Throughout that period, the State had been unable to pay its bills to hospitals and had resorted to payment pushes from one fiscal year to the next to deal with the multiple and significant financial challenges perpetually confronting DHHS.

DHHS is unquestionably the State's most complex budget to understand, let alone manage. In order to manage, the Department has taken into account all of its anticipated needs, and all of the anticipated resources through a complex, but extremely accurate, forecasting model. While balances that are carried forward can appear to be "free money," every dollar has been accounted for and is necessary to ultimately pay health care providers for the services they render to MaineCare members—whether in this fiscal year or next.

It is imperative that DHHS not operate on a razor-thin margin, as happened in previous decades. Adequately funding the program over the last several years has reaped significant reward, which cannot be jeopardized to temporarily fund a massive expansion of welfare. Most recently, the importance of financial stability at DHHS was demonstrated during the 2017 State government shutdown, when payments to those providing services to Maine's neediest were able to continue, despite the budget impasse.

Any questions regarding specific account balances can be directed to OFPR.

Implementation Timeline

While the citizen initiative lists dates by which implementation is to occur, it is important to note that there are practical considerations. The reality is that in order to buy health care for more than 80,000 people, the State needs the money to pay for it. The effective date discussed above may be different from the actual start date. Implementation cannot occur until the necessary resources have been appropriated, and thus the actual start date will vary based on when the

Legislature successfully appropriates the necessary dollars. A specific example pertains to new hires—the Department cannot begin basic hiring activities until the Legislature authorizes and appropriates for the 103 necessary new positions. Without the positions and an adequate operational structure in place, the massive workload of implementing expansion to 80,000 people will have a detrimental impact on programs Department-wide. The citizen initiative was apparently drafted without regard to the logistics associated with implementation, complicating the designation of specific dates. Factors to consider include the following:

- The current capacity of the Department to hire, find qualified candidates, and conduct training is limited.
- It takes the Office for Family Independence (OFI) approximately six weeks to recruit and hire a typical cohort of new hires (about 10-20 eligibility specialists at a time).
- Following hiring, OFI's in-house training program takes between 14-20 weeks for a cohort to complete.
- The Office of Information Technology will need approximately 26 weeks to complete changes for both eligibility and claims systems, including the Authorization Claims Enrollment System (ACES) and the Maine Integrated Health Management Solutions (MIHMS).

Another variable factor in the timeline is CMS approval of the State Plan Amendment (SPA). CMS has a defined timeline of 90 days after a SPA is submitted to either approve or deny the request. However, the agency also has the ability to take a SPA "off the clock" with requests for additional information. A request for additional information could delay action on the SPA to beyond the 90 days. OFPR assumes that eligibility occurs regardless of CMS SPA approval—an assumption not shared by DHHS.

Conclusion

The mission of the Department of Health and Human Services is to promote safe, healthy, independent lives for all Mainers, while ensuring efficient and effective use of resources for Mainers that need it most. It is vital that the citizen initiative be implemented in a manner that furthers that mission, and avoids harm to Mainers in need of assistance.

Medicaid Expansion - Citizen Referendum 1/9/2018

(estimated effective date 7/1/18, one month claims lag)

0.6434 FY18 Final FMAP
0.6452 FY19 Final FMAP
0.64475 Blended

6.0% Annual rate factor
4.0% CPI Medical
2.0% Utilization factor

OMS FISCAL SUMMARY

Expansion FMAP	
CY15	100%
CY16	100%
CY17	95%
CY18	94%
CY19	93%
CY20 and thereafter	90%

	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
FMAP Rates:						
Expansion Blended FMAP	94.00%	93.50%	91.50%	90.00%	90.00%	90.00%
Other FMAP	64.34%	64.475%	64.52%	64.52%	64.52%	64.52%
Children's FMAP	98.04%	98.13%	80.91%	75.16%	75.16%	75.16%
Childless Adults:	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023
Childless Adults <139% FPL						
MaineCare PMPM estimate		704.25	746.51	791.30	838.77	889.10
Member Count		57,335	57,335	57,335	57,335	57,335
Number of months		11	12	12	12	12
Total Computable	0	444,160,100	513,610,589	544,427,224	577,092,858	611,718,429
Federal Share	0	415,289,694	469,953,689	489,984,502	519,383,572	550,546,586
State Share	0	28,870,407	43,656,900	54,442,722	57,709,286	61,171,843
Parents 100%-138% FPL:						
MaineCare PMPM estimate		342.30	362.84	384.61	407.68	432.15
Member Count		15,817	15,817	15,817	15,817	15,817
Number of months		11	12	12	12	12
Total Computable	0	59,555,022	68,867,262	72,999,297	77,379,255	82,022,010
Federal Share	0	38,398,100	44,433,157	47,099,146	49,925,095	52,920,601
State Share	0	21,156,922	24,434,105	25,900,151	27,454,160	29,101,409
Parents (Woodwork):						
Parents <139% FPL						
MaineCare PMPM estimate		342.30	362.84	384.61	407.68	432.15
Member Count		3,460	3,460	3,460	3,460	3,460
Number of months		11	12	12	12	12
Total Computable	0	13,027,943	15,065,040	15,968,942	16,927,079	17,942,704
Federal Share	0	8,399,766	9,719,964	10,303,161	10,921,351	11,576,633
State Share	0	4,628,177	5,345,076	5,665,781	6,005,728	6,366,071
Children (Woodwork):						
MaineCare PMPM estimate		415.66	440.60	467.04	495.06	524.76
Member Count		5,766	5,766	5,766	5,766	5,766
Number of months		11	12	12	12	12
Total Computable	0	26,363,668	30,485,987	32,315,146	34,254,055	36,309,298
Federal Share	0	25,870,667	24,666,212	24,288,064	25,745,348	27,290,068
State Share	0	493,001	5,819,775	8,027,082	8,508,707	9,019,230
CLAIM SUMMARY						
010-10A-014701-6700	0	55,148,507	79,255,856	94,035,736	99,677,881	105,658,553
013-10A-014701-6700	0	487,958,227	548,773,022	571,674,873	605,975,366	642,333,888
ADMIN SUMMARY (OFI 6 mths)						
010-10A-045301 OFI	1,811,058	3,390,974	3,390,974	3,390,974	3,390,974	3,390,974
014-10A-045301 OFI	2,795,839	5,244,394	5,244,394	5,244,394	5,244,394	5,244,394
010-10A-012901 OIT	449,816					
013-10A-012901 OIT	1,349,448					
TOTAL						
010 - General Fund	**2,260,874**	**58,539,481**	**82,646,831**	**97,426,711**	**103,068,855**	**109,049,527**
013 - Federal Expenditure Funds	1,349,448	487,958,227	548,773,022	571,674,873	605,975,366	642,333,888
014 - Other Special Revenue Fund	2,795,839	5,244,394	5,244,394	5,244,394	5,244,394	5,244,394
GRAND TOTAL	**6,406,161**	**551,742,102**	**636,664,247**	**674,345,978**	**714,288,615**	**756,627,810**

Final November 2017

Enhanced FMAP		ACA
FFY16	73.87%	96.87%
FFY17	75.07%	98.07%
FFY18	75.04%	98.04%
FFY19	75.16%	98.16%
FFY20	75.16%	75.16%
FFY21	75.16%	75.16%
FFY22	75.16%	75.16%

Total Members 82,378

Total FY18 Q4 - FY23
Total GF Impact 452,992,279

health care, increase awareness of the connection between oral health and overall health, prevent disease and promote oral health, and improve health literacy to health providers and patients alike. HRSA developed a core set of oral health clinical competencies for non-dental providers as part of its Integration of Oral Health and Primary Care Practice (IOHPCP) initiative in response to recommendations from two Institute of Medicine (IOM) reports: *Advancing Oral Health in America* and *Improving Access to Oral Health Care for Vulnerable and Underserved Populations.* NNOHA participated in the IOHPCP initiative and in fiscal year (FY) 2012 received supplemental funding (U30CS09745–05–02) to implement a pilot project in safety net settings to inform the impact and effectiveness of oral health core clinical competencies and inter-professional collaboration in primary care settings. The goal of the project was to increase integration of oral health and primary health care. NNOHA published the pilot project results in a user guide entitled, *User's Guide for Implementation of inter-professional oral health core clinical competencies* and continues to provide technical assistance to health centers and training on oral health integration and primary care practice.

The Joint Explanatory Statement to the Consolidated Appropriations Act of FY 2017 encouraged HRSA to allocate $250,000 for demonstration projects to support the implementation of integrating oral health and primary care projects. The projects are to model the core clinical oral health competencies for non-dental providers that HRSA published and initially tested in its 2014 report, *Integration of Oral Health and Primary Care Practice.* In order to achieve this goal, HRSA will provide supplemental funding to the NNOHA to advance and expand the implementation of oral health core clinical competencies in health centers, focusing on services for pregnant women and children. Additionally, these demonstration projects will directly align with four HRSA recommendations for effectively incorporating the competencies into clinical practice as described in the 2014 *Integrating Oral Health and Primary Care Practice* report. This activity is consistent with the current work plan of NNOHA and includes providing training and technical assistance on IOHPCP. NNOHA's primary roles are to coordinate all activities at the planning, implementation, evaluation, and dissemination stages, as well as provide technical assistance and training to participating HCs. NNOHA shall select no fewer than six HCs, which it supports as part of the current HRSA-funded National Training and Technical Assistance Cooperative Agreement Program (U30CS29051). NNOHA will assure that each HC will propose, implement, and track data for an innovative inter-professional oral health project that measurably increases the adoption of the core clinical oral health competencies among non-dental providers in the delivery of care to pregnant women and children.

FOR FURTHER INFORMATION CONTACT: Chinyere Amaefule, Office of Quality Improvement, Division of Strategic Partnerships, Bureau of Primary Health Care, Health Resources and Services Administration, 5600 Fishers Lane, Rockville, Maryland 20857, Phone: (301) 594–4417, Email: *Camaefule@hrsa.gov.*

Grantee/organization name	Grant No.	State	FY 2017 authorized funding level	FY 2017–2018 estimated supplemental amount
National Network of Oral Health Access	U30CS29051	CO	$500,000	$250,000

Dated: November 14, 2017.

George Sigounas,

Administrator.

[FR Doc. 2017–25191 Filed 11–20–17; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2018 Through September 30, 2019

AGENCY: Office of the Secretary, DHHS.

ACTION: Notice.

DATES: The percentages listed in Table 1 will be effective for each of the four quarter-year periods beginning October 1, 2018 and ending September 30, 2019.

FOR FURTHER INFORMATION CONTACT: Caryn Marks 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.

SUPPLEMENTARY INFORMATION: The Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and disaster-recovery FMAP adjustments for Fiscal Year 2019 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2018 through September 30, 2019. 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 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 (PPACA) 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 beginning 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 2019 adjustment for a major statewide disaster for any state (territories are not eligible for FMAP adjustments) because no state's FMAP decreased by at least three percentage points from FY 2018 to FY 2019.

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.

(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 13, 2017.

Eric D. Hargan,

Acting Secretary.

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2018–SEPTEMBER 30, 2019

[Fiscal year 2019]

	Federal medical assistance percentages	Enhanced federal medical assistance percentages	Enhanced federal medical assistance percentages with ACA 23 Pt Inc***
Alabama	71.88	80.32	100.00
Alaska	50.00	65.00	88.00
American Samoa*	55.00	68.50	91.50
Arizona	69.81	78.87	100.00
Arkansas	70.51	79.36	100.00
California	50.00	65.00	88.00
Colorado	50.00	65.00	88.00
Connecticut	50.00	65.00	88.00
Delaware	57.55	70.29	93.29
District of Columbia**	70.00	79.00	100.00
Florida	60.87	72.61	95.61
Georgia	67.62	77.33	100.00
Guam*	55.00	68.50	91.50
Hawaii	53.92	67.74	90.74
Idaho	71.13	79.79	100.00
Illinois	50.31	65.22	88.22
Indiana	65.96	76.17	99.17
Iowa	59.93	71.95	94.95
Kansas	57.10	69.97	92.97
Kentucky	71.67	80.17	100.00
Louisiana	65.00	75.50	98.50
Maine	64.52	75.16	98.16
Maryland	50.00	65.00	88.00
Massachusetts	50.00	65.00	88.00
Michigan	64.45	75.12	98.12
Minnesota	50.00	65.00	88.00
Mississippi	76.39	83.47	100.00
Missouri	65.40	75.78	98.78
Montana	65.54	75.88	98.88
Nebraska	52.58	66.81	89.81
Nevada	64.87	75.41	98.41
New Hampshire	50.00	65.00	88.00
New Jersey	50.00	65.00	88.00
New Mexico	72.26	80.58	100.00
New York	50.00	65.00	88.00
North Carolina	67.16	77.01	100.00
North Dakota	50.00	65.00	88.00
Northern Mariana Islands*	55.00	68.50	91.50
Ohio	63.09	74.16	97.16
Oklahoma	62.38	73.67	96.67
Oregon	62.56	73.79	96.79
Pennsylvania	52.25	66.58	89.58
Puerto Rico*	55.00	68.50	91.50
Rhode Island	52.57	66.80	89.80
South Carolina	71.22	79.85	100.00
South Dakota	56.71	69.70	92.70
Tennessee	65.87	76.11	99.11
Texas	58.19	70.73	93.73
Utah	69.71	78.80	100.00
Vermont	53.89	67.72	90.72
Virgin Islands*	55.00	68.50	91.50
Virginia	50.00	65.00	88.00
Washington	50.00	65.00	88.00
West Virginia	74.34	82.04	100.00
Wisconsin	59.37	71.56	94.56
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. 2017–24953 Filed 11–20–17; 8:45 am]
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Announcement of Meeting of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030

AGENCY: Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice.

SUMMARY: The U.S. Department of Health and Human Services (HHS) announces the next federal advisory committee meeting regarding the development of national health promotion and disease prevention objectives for 2030. This meeting will be held online via webinar and is open to the public. The Committee will discuss the nation's health promotion and disease prevention objectives and will provide recommendations to improve health status and reduce health risks for the nation by the year 2030. The Committee will advise the Secretary on the Healthy People 2030 mission, vision, framework, and organizational structure. The Committee will provide advice regarding criteria for identifying a more focused set of measurable, nationally representative objectives. Pursuant to the Committee's charter, the Committee's advice must assist the Secretary in reducing the number of objectives while ensuring that the selection criteria identifies the most critical public health issues that are high-impact priorities supported by current national data.

DATES: The Committee will meet on December 11, 2017, from 3:00 p.m. to 5:00 p.m. Eastern Time (ET).

ADDRESSES: The meeting will be held online via webinar. To register to attend the meeting, please visit the Healthy People Web site at *http://www.healthypeople.gov.*

FOR FURTHER INFORMATION CONTACT: Emmeline Ochiai, Designated Federal Official, Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion, 1101 Wootton Parkway, Room LL–100, Rockville, MD 20852, (240) 453–8280 (telephone), (240) 453–8281 (fax). Additional information is available on the Healthy People Web site at *http://www.healthypeople.gov.*

SUPPLEMENTARY INFORMATION: The names and biographies of the Committee members are available at *https://www.healthypeople.gov/2020/about/history-development/healthy-people-2030-advisory-committee.*

Purpose of Meeting: Through the Healthy People initiative, HHS leverages scientific insights and lessons from the past decade, along with new knowledge of current data, trends, and innovations, to develop the next iteration of national health promotion and disease prevention objectives. Healthy People provides science-based, 10-year national objectives for promoting health and preventing disease. Since 1979, Healthy People has set and monitored national health objectives that meet a broad range of health needs, encourage collaboration across sectors, guide individuals toward making informed health decisions, and measure the impact of our prevention and health promotion activities. Healthy People 2030 health objectives will reflect assessments of major risks to health and wellness, changing public health priorities, and emerging technologies related to our nation's health preparedness and prevention.

Public Participation at Meeting: Members of the public are invited to join the online Committee meeting. There will be no opportunity for oral public comments during this online Committee meeting. However, written comments are welcome throughout the entire development process of the national health promotion and disease prevention objectives for 2030 and may be emailed to *HP2030@hhs.gov.*

To join the Committee meeting, individuals must pre-register at the Healthy People Web site at *http://www.healthypeople.gov.* Participation in the meeting is limited. Registrations will be accepted until maximum webinar capacity is reached, and must be completed by 9:00 a.m. ET on December 11, 2017. A waiting list will be maintained should registrations exceed capacity, and those individuals will be contacted as additional space for the meeting becomes available. Registration questions may be directed to *HealthyPeople@norc.org.*

Authority: 42 U.S.C. 300u and 42 U.S.C. 217a. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 is governed by provisions of the Federal Advisory Committee Act (FACA), Public Law 92–463, as amended (5 U.S.C., App.) which sets forth standards for the formation and use of federal advisory committees.

Dated: November 14, 2017.

Don Wright,

Deputy Assistant Secretary for Health, (Disease Prevention and Health Promotion).

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2017–0125]

Information Collection Request to Office of Management and Budget; OMB Control Number: 1625–0121

AGENCY: Coast Guard, DHS.

ACTION: Sixty-day notice requesting comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the U.S. Coast Guard intends to submit an Information Collection Request (ICR) to the Office of Management and Budget (OMB), Office of Information and Regulatory Affairs (OIRA), requesting an extension of its approval for the following collection of information: 1625–0121, United States Coast Guard Academy Introduction Mission Program Application and Supplemental Forms; without change. Our ICR describes the information we seek to collect from the public. Before submitting this ICR to OIRA, the Coast Guard is inviting comments as described below.

DATES: Comments must reach the Coast Guard on or before January 22, 2018.

ADDRESSES: You may submit comments identified by Coast Guard docket number [USCG–2017–0125] to the Coast Guard using the Federal eRulemaking Portal at *http://www.regulations.gov.* See the "Public participation and request for comments" portion of the **SUPPLEMENTARY INFORMATION** section for