40 CFR part 60, appendix A into the SIP because this allows for use of an EPA test method when specified in a permit issued in Article 15. Method 22 can be used for a variety of purposes, including determination of fugitive (non-stack) emissions and visible emissions from stationary sources (stacks) depending on the applicable emission standards [4] and State permit requirements.

IV. What action is the EPA taking?

For the reasons expressed in III.A and III.B, the EPA is proposing to approve the following revisions, shown in Table 1, to the State's Air Pollution Control rules.

TABLE 1—LIST OF NORTH DAKOTA REVISIONS THAT THE EPA IS PROPOSING TO APPROVE

Revised sections in January 28, 2013 and April 22, 2014 submissions proposed for approval
January 28, 2013 submittal: 33–15–14–02.5.a
April 22, 2014 submittal: 33–15–03–05.2

V. Incorporation by Reference

In this rule, the EPA is proposing to include in a final EPA rule regulatory text that includes incorporation by reference. In accordance with requirements of 1 CFR 51.5, the EPA is proposing to incorporate by reference North Dakota Administrative Code as described in section IV. of this preamble. The EPA has made, and will continue to make, these materials generally available through *www.regulations.gov* and/or at the EPA Region 8 Office (please contact the person identified in the ''For Further Information Contact'' section of this preamble for more information).

VI. Statutory and Executive Orders Review

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable federal regulations (42 U.S.C. 7410(k), 40 CFR 52.02(a)). Thus, in reviewing SIP submissions, the EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this proposed action merely approves some state law as meeting federal requirements; this proposed action does not impose additional requirements beyond those imposed by state law. For that reason, this proposed action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and,
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

The SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications and will not impose substantial direct costs on tribal governments or preempt tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Incorporation by reference, Intergovernmental relations, Greenhouse gases, Lead, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: July 13, 2017.

Debra H. Thomas,

Acting Regional Administrator, Region 8.

[FR Doc. 2017–15978 Filed 7–27–17; 8:45 am]

BILLING CODE 6560–50–P

[4] U.S. EPA Question and Answer Document. *EPA Method 22—Visual Determination of Fugitive Emissions. https://www3.epa.gov/ttn/atw/area/method22qa.doc.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2394–P]

RIN 0938–AS63

Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

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

ACTION: Proposed rule.

SUMMARY: The Affordable Care Act requires aggregate reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments annually beginning with fiscal year (FY) 2018. This proposed rule delineates a methodology to implement the annual allotment reductions.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 28, 2017.

ADDRESSES: In commenting, please refer to file code CMS–2394–P. 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–2394–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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–2394–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

[*Note:* This zip code for express mail or courier delivery only. This zip code specifies the agency's physical location.]

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

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. [*Note:* This zip code for express mail or courier delivery only. This zip code specifies the agency's physical location.]

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 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.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

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

SUPPLEMENTARY INFORMATION:

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.

I. Executive Summary

A. Purpose

Section 2551 of the Affordable Care Act amended section 1923(f) of the Social Security Act (the Act) by setting forth aggregate reductions to state Medicaid disproportionate share hospital (DSH) allotments annually from fiscal year (FY) 2014 through FY 2020. Subsequent legislation delayed the start of these reductions until FY 2018. These reductions will run through FY 2025. This proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement annual Medicaid allotment reductions identified in the statute. This rule proposes a DHRM that accounts for relevant data that was unavailable to CMS during prior rulemaking for DSH allotment reductions originally set to take place for FY 2014 and FY 2015.

B. Summary of the Major Provisions

The statute as amended by the Affordable Care Act directs the Secretary to implement the annual DSH allotment reductions using a DHRM. This rule proposes to amend 42 CFR part 447 by establishing the DHRM, which incorporates factors identified in the statute.

C. Impacts

Taking the statutorily specified factors into account for each state, the proposed DHRM would generate a state-specific DSH allotment reduction amount for each fiscal year specified in statute. The total of all DSH allotment reduction amounts in a specific year would equal the aggregate annual reduction amount identified in statute for that same year. To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount would be applied to the unreduced DSH allotment amount for its respective state.

II. Background

A. Introduction

In anticipation of lower uninsured rates and lower levels of hospital uncompensated care, the Affordable Care Act modified the amounts of funding available to states under the Medicaid program to address the situation of hospitals that serve a disproportionate share of low income patients and therefore may have uncompensated care costs. Under sections 1902(a)(13)(A)(iv) and 1923 of the Act, states are required to make payments to qualifying ''disproportionate share'' hospitals (DSH payments). Section 2551 of the Affordable Care Act amended section 1923(f) of the Act, by adding paragraph (7), to provide for aggregate reductions in federal funding under the Medicaid program for such DSH payments for the 50 states and the District of Columbia. DSH allotments are not provided for the five U.S. territories.

Section 1923(f)(7)(A)(i) of the Act requires that the Secretary of Health and Human Services (the Secretary) implement the aggregate reductions in federal funding for DSH payments through reductions in annual state allotments of federal funding for DSH payments (state DSH allotments), and accompanying reductions in payments to each state. Since 1998, the amount of federal funding for DSH payments for each state has been limited to an annual state DSH allotment in accordance with section 1923(f) of the Act. The addition of section 1923(f)(7) of the Act requires the use of a DHRM to determine the percentage reduction in annual state DSH allotments to achieve the required aggregate annual reduction in federal DSH funding. The statutory reductions apply to all states and the District of Columbia except the State of Tennessee. Under section 1923(f)(6)(A)(vi) of the Act, notwithstanding any other provision of subsection 1923(f), or any other provision of law, the DSH allotment for Tennessee is established at $53.1 million per year for FY 2015 through FY 2025. Therefore, Tennessee's DSH allotment is not subject to reduction under section 1923(f)(7) of the Act. For purposes of this rule, references to the reduction for ''each state'' means ''each state subject to a DSH allotment reduction'' (the 50 states and the District of Columbia, except Tennessee).

Section 1923(f)(7)(B) of the Act establishes the following factors that must be considered in the development of the DHRM. The methodology must:

- Impose a smaller percentage reduction on low DSH States;
- Impose the largest percentage reductions on:

++ States that have the lowest percentages of uninsured individuals during the most recent year for which such data are available;

++ States that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients;

++ States that do not target their DSH payments on hospitals with high levels of uncompensated care; and

• Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

We describe in section II.B. of this proposed rule, the principles we intend to apply when calculating the annual DSH allotment reduction amounts for each state through the DHRM.

B. Legislative History and Overview

The Omnibus Budget Reconciliation Act of 1981 (OBRA'81) (Pub. L. 97–35, enacted on August 13, 1981) amended section 1902(a)(13) of the Act to require that Medicaid payment rates for hospitals take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs. Over the more than 35 years since this requirement was first enacted, the Congress has set forth in section 1923 of the Act payment targets and limits to implement the requirement and to ensure greater oversight, transparency, and targeting of funding to hospitals.

To qualify as a DSH under section 1923(b) of the Act, a hospital must meet two minimum qualifying criteria in section 1923(d) of the Act. The first criterion is that the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid individuals. This criterion does not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age or hospitals that do not offer nonemergency obstetric services to the general public as of December 22, 1987. The second criterion is that the hospital has a Medicaid inpatient utilization rate (MIUR) of at least 1 percent.

Under section 1923(b) of the Act, a hospital meeting the minimum qualifying criteria in section 1923(d) of the Act is deemed as a DSH if the hospital's MIUR is at least one standard deviation above the mean MIUR in the state for hospitals receiving Medicaid payments, or if the hospital's low-income utilization rate exceeds 25 percent. States have the option to define DSHs under the state plan using alternative qualifying criteria as long as the qualifying methodology comports with the deeming requirements of section 1923(b) of the Act. Subject to certain federal payment limits, states are afforded flexibility in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act.

Section 1923(f) of the Act limits federal financial participation (FFP) for total statewide DSH payments made to eligible hospitals in each federal FY to the amount specified in an annual DSH allotment for each state. Although there have been some special rules for calculating DSH allotments for particular years or sets of years, section 1923(f)(3) of the Act establishes a general rule that state DSH allotments are calculated on an annual basis in an amount equal to the DSH allotment for the preceding FY increased by the percentage change in the consumer price index for all urban consumers for the previous FY. The annual allotment, after the consumer price index increase, is limited to the greater of the DSH allotment for the previous year or 12 percent of the total amount of Medicaid expenditures under the state plan during the FY. Allotment amounts were originally established in the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 based on each state's historical DSH spending.

Section 1923(g) of the Act also limits DSH payments by imposing a hospital-specific limit on DSH payments. Specifically, a DSH payment must not exceed a hospital's uncompensated care costs for that year (*i.e.* it must not exceed the costs of providing inpatient hospital and outpatient hospital services to Medicaid patients and the uninsured, minus payments received by the hospital by or on the behalf of those patients). FFP is not available for DSH payments that exceed the hospital-specific limit.

The statute, as amended by the Affordable Care Act, required annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. However, subsequent legislation extended the reductions, modified the amount of the reductions, and delayed the start of the reductions until FY 2018. The most recent related amendments to the statute were through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10, enacted April 16, 2015). Currently, the aggregate annual reduction amounts set to begin in FY 2018 are specified in section 1923(f)(7)(A)(ii) of the Act:

- $2,000,000,000 for FY 2018.
- $3,000,000,000 for FY 2019.
- $4,000,000,000 for FY 2020.
- $5,000,000,000 for FY 2021.
- $6,000,000,000 for FY 2022.
- $7,000,000,000 for FY 2023.
- $8,000,000,000 for FY 2024.
- $8,000,000,000 for FY 2025.

To implement these annual reductions, the statute requires that the Secretary reduce annual state DSH allotments, and payments to states, based on a DHRM specified in section 1923(f)(7)(B) of the Act. The proposed DHRM relies on statutorily identified factors collectively to determine a state-specific DSH allotment reduction amount to be applied to the allotment that is calculated under section 1923(f) of the Act prior to the reductions under section 1923(f)(7) of the Act.

In the May 15, 2013 **Federal Register** (78 FR 28551), we published the ''Medicaid Program; State Disproportionate Share Hospital Allotment Reductions'' proposed rule. The rule proposed a DHRM that relied on the statutory factors and solicited comments regarding whether state decisions to extend Medicaid coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act should be accounted for in the reduction methodology. We received several comments in support of accounting for Medicaid coverage expansion and numerous comments in opposition.

In the September 18, 2013 **Federal Register** (78 FR 57293), we published the ''Medicaid Program; State Disproportionate Share Hospital Allotment Reductions'' final rule (herein referred to as the ''2013 DSH allotment reduction final rule''). In the 2013 DSH allotment reduction final rule, we decided to finalize a DHRM that would be in place only for FY 2014 and FY 2015 to allow time for revaluation of the methodology with improved and more recent data and information about the impact of the Affordable Care Act on levels of coverage and uncompensated care. As a result of our reevaluation, we are now proposing to modify the DHRM factor weights and to use improved data sources where possible, as discussed in this proposed rule.

C. DHRM Data Sources

The statute establishes parameters regarding data and data sources for specific factors in the development of the DHRM. We are proposing to utilize for the DHRM, wherever possible, data sources and metrics that are consistent with the statute, transparent, and readily available to CMS, states, and the public, such as: DSH Medicaid Inpatient Utilization Rate (MIUR) data; Medicaid DSH data reported as required by section 1923(j) of the Act; United States Census Bureau data; existing state DSH allotments; and Form CMS–64 Medicaid Budget and Expenditure System (MBES) data. We are proposing to utilize the most recent year available for all data

sources and are proposing to align data sources whenever possible. Selected data sources are discussed in greater detail below.

1. MIUR Data

To ensure that all hospitals are properly deemed disproportionate share in accordance with section 1923(b) of the Act, states must determine the mean MIUR for hospitals receiving Medicaid payments in the state and the value of one standard deviation above the mean. States are currently required to provide this data to CMS annually under § 447.294(d) (CMS–R–266, Office of Management and Budget (OMB) 0938–0746). We will utilize MIUR data from the year that corresponds to the DSH audit SPRY used in the calculation of each state's DSH allotment reductions.

2. Medicaid DSH Audit and Reporting Data

We are also proposing to rely on data derived from Medicaid DSH audit (CMS–R–266, OMB 0938–0746) and reporting data (CMS–R–266, OMB 0938–0746). The data is reported by states as required by section 1923(j) of the Act and the ''Medicaid Disproportionate Share Hospital Payments'' final rule published on December 19, 2008 (73 FR 77904) (and herein referred to as the 2008 DSH audit final rule) requiring state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the hospital-specific DSH limit imposed at section 1923(g) of the Act. This is the only comprehensive data source for DSH hospitals that identifies hospital-specific DSH payments and uncompensated care costs in a manner consistent with Medicaid DSH program requirements.[1]

To date, we have received rich, comprehensive audit and reporting data from each state that makes Medicaid DSH payments. To facilitate the provision of high quality data, we provided explicit parameters in the 2008 DSH audit final rule and associated policy guidance for calculating and reporting data elements. As the data elements are based on hospital costs reports and are subject to audit, the data elements are not due to CMS until the end of the calendar year 3 years following the end of each state plan rate year (SPRY). Additionally, state submitted audit and reporting data is subject to detailed CMS review to ensure quality and accuracy and requires significant resources to compile and prepare for use in the proposed DHRM. This means that the data used for the methodology may not be the most recently submitted data, but instead the most recent data available to us in usable form. For FY 2018 we anticipate utilizing SPRY 2013 DSH audit and reporting data, which was due from states to CMS on December 31, 2016. We considered utilizing alternative uncompensated cost data and Medicaid utilization data from sources such as the Medicare Form CMS–2552 (OMB 0938–0050). The DSH audit and reporting data, however, remains the only comprehensive reported data available that is consistent with Medicaid program requirements.

3. United States Census Bureau Data

As required by the statute, the DHRM must impose the largest percentage DSH allotment reductions on the states that have the lowest percentages of uninsured individuals. Although other sources of this information could be considered for this purpose, the statute explicitly refers to the use of data from the Census Bureau for determining the percentage of uninsured for each state. As with the 2013 DSH allotment reduction final rule, we identified and considered two Census Bureau data sources for this purpose: The American Community Survey (ACS); and the Annual Social and Economic Supplement to the Current Population Survey (CPS). In consultation with the Census Bureau, we are proposing to use the data from the ACS for the following reasons. First, the ACS is the largest household survey in the United States; in that regard, the annual sample size for the ACS is over 30 times larger than that for the CPS—about 3 million for the ACS versus 100 thousand for the CPS. The ACS is conducted continuously each month throughout the year, with the sample for each month being roughly 1/12th of the annual total, while the CPS is conducted in the first 4 months following the end of the survey year.

Finally, although the definition of uninsured and insured status is the same for the ACS and the CPS, the CPS considers the respondents as uninsured if they are uninsured at any time during the year whereas the ACS makes this determination based on whether the respondent has coverage at the time of the interview, which are conducted at various times throughout the year. For these reasons, and with the recommendation of the Census Bureau, we determined that the ACS is the appropriate source for establishing the percentage of uninsured for each state for purpose of the proposed DHRM.

III. Provisions of the Proposed Rule

This proposed rule proposes to amend 42 CFR 447.294 by establishing the DHRM for FY 2018 and subsequent fiscal years, which incorporates factors identified in the statute. We are proposing in § 447.294(a) and (e) to remove language referring to specific federal fiscal years (FY 2014 and FY 2015) when calculating state annual DSH allotment reductions.

We are proposing in § 447.294(b) to add the definition of ''Total hospital cost.''

We are proposing in § 447.294(d) to clarify state data submission requirements by simplifying the language and removing language related to the submission of data for previous state plan rate years (SPRY) already provided to CMS.

We are also proposing to revise § 447.294(e)(3)(i) to clarify that the total Medicaid service expenditures used in the calculation of the Low DSH adjustment factor (LDF) must be for the applicable year. We are proposing to revise § 447.294(e)(5)(i) through (iii) to adjust the weighting of statutorily defined factors.

In addition, we are proposing in § 447.294(f) to update the paragraph to remove references to specific fiscal years.

A. DHRM Overview

The statute requires aggregate annual reduction amounts to be implemented through a DHRM designed by the Secretary consistent with statutorily-established factors. Taking these factors into account for each state, the proposed DHRM would generate a state-specific DSH allotment reduction amount for the specified fiscal years for all states and the District of Columbia with the exception of Tennessee whose DSH allotment is defined in section 1923(f)(6)(A)(vi) of the Act to be $53.1 million, notwithstanding DSH allotment reductions in section 1923(f)(7), for each FY from 2015 through 2025. The total of all DSH allotment reduction amounts would equal the aggregate annual reduction amounts identified in statute for each fiscal year. To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount would be applied to the unreduced DSH allotment amount for its respective state.

We would calculate an unreduced DSH allotment for each state prior to the beginning of each FY, as we do currently. This unreduced allotment is

[1] CMS published a final rule on April 3, 2017 (82 FR 16114) revising the text of 42 CFR 447.299(c)(1). Effective June 2, 2017, the rule amended paragraph (c)(1) to clarify that uncompensated care costs are calculated using total cost of care for Medicaid inpatient and outpatient services, net of third-party payments.

determined by calculating the allotment in section 1923(f) of the Act prior to the application of the DHRM under section 1923(f)(7) of the Act. The unreduced allotment would serve as the base amount for each state to which the state-specific DSH allotment reduction amount would apply annually. In this proposed rule, we are utilizing estimated unreduced DSH allotments for FY 2017 for illustrative purposes. Please note that this illustrative estimate may rely on different data than what is proposed to be used when calculating annual DSH allotment reductions for FY 2018. Specifically, we anticipate that more recent data will be available when calculating the final allotment reductions. For purposes of this illustrative example, we have utilized the most recent available data to CMS.

We propose to apply the DHRM to the unreduced DSH allotment amount on an annual basis for the fiscal years specified in statute. Under the DHRM, we consider the factors identified in the statute to determine each state's annual state-specific DSH allotment reduction amount.

The proposed DHRM utilizes the best available data at the time of calculation and would not recalculate reductions based on revised or late DSH audit reports, MIUR data, or other relevant data. The DHRM would also rely on a series of interacting calculations that result in the identification of state-specific reduction amounts that, when summed, equal the aggregate DSH allotment reduction amount identified by the statute for each applicable year. The proposed DHRM accomplishes this through the following summarized steps:

(1) Separate states into two overall groups, non-low DSH states and low DSH states, to give effect to the statutory low-DSH criterion. (States falling into each category are listed in Table 1.)

(2) Proportionately allocate aggregate DSH funding reductions to each of these two state groups based on each state group's proportion of the total national unreduced DSH allotment amount.

(3) Apply a low DSH adjustment percentage to adjust the non-low DSH and low DSH state groups' DSH funding reduction amount. This step maintains the combined aggregate DSH funding reduction for the low DSH and non-low DSH state groups by distributing a portion of the unadjusted low DSH state DSH funding reduction amount across the non-low DSH state group, as described in greater detail below.

(4) Divide each state group's DSH allotment reduction amount among three statutorily identified factors, the Uninsured Percentage Factor (UPF), the High Level of Uncompensated Care Factor (HUF), and the High Volume of Medicaid Inpatients Factor (HMF). We are proposing to assign a 50 percent weight to the UPF and a 50 percent combined weight for the two DSH payment targeting factors (a 25 percent weight for the HUF, and a 25 percent weight for the HMF). This approach would assign equal weights based on the statutory structure under which the UPF is presented separately, in section 1923(f)(7)(B)(i)(I) of the Act, while the HMF and HUF are grouped together in section 1923(f)(7)(B)(i)(II) of the Act, at items (aa) and (bb). Additionally, compared to the approach taken in the 2013 DSH allotment reduction final rule, this weight assignment would place greater emphasis on the UPF to:

- Reduce the impact of the DSH allotment reduction for states with greater DSH need due to high uninsurance rates.
- Give greater weight to more recent data, since the UPF data relies on more recent data than the HUF and HMF.

We considered various alternative weight assignments prior to proposing equal weights to the requirement at section 1923(f)(7)(B)(i)(I) of the Act and to the combined requirements at section 1923(f)(7)(B)(i)(II) of the Act. We have decided upon the 50 percent weight to the UPF and a 50 percent combined weight for the two DSH payment targeting factors in order to reduce the impact of the DSH allotment reductions for states with high uninsurance rates, place a greater weight to more recent data, and reflect how these factors are specified in statute.

(5) Limit the reduction to be applied to each state's total unreduced DSH allotment to 90 percent of its original unreduced allotment. Any excess reduction amounts called for under the DHRM which are limited by this reduction cap will be factored back into the reduction model and be redistributed among the remaining states that do not exceed the reduction cap based on the proportion of each remaining state's allotment reduction amount to the aggregate allotment reduction amount for its respective state group. This operation would be performed separately for each state group such that, for example, an excess reduction amount attributable to a low DSH state would be reapportioned only among other low DSH states and would not be reapportioned among any states in the non-low DSH state group. By limiting the overall amount by which each state's allotment may be decreased, we propose to preserve at least 10 percent of each state's unreduced DSH allotment, thereby allowing all states to continue to making DSH payments. Placing limits on the reductions applied to each state's original unreduced allotments is a new proposal that was not considered in the 2013 DSH allotment reduction final rule. In view of the then-required aggregate DSH allotment reduction amounts and the DHRM under the 2013 DSH allotment reduction final rule, no state was in jeopardy of having its entire DSH allotment eliminated for FY 2014 or FY 2015 at the time that rule was promulgated. However, with the larger reduction amounts currently scheduled for FYs 2018 through 2025 under the statute, which are as high as $8 billion annually, states may experience the elimination of their entire DSH allotment without the inclusion of a reduction cap methodology in the DHRM. As such, we are soliciting comments on alternative methodologies that would limit the allotment reduction amount that states may receive through the DHRM, specifically on how excess reduction amounts are factored back into the reduction model and on what to use as the maximum reduction percentage. Although we did consider different reduction cap percentages, we believe the proposed 10 percent reduction cap strikes a balance between ensuring reduction amounts are determined based on the statutory DHRM factors and ensuring states maintain the ability to make [an appreciable amount of] DSH payments. Higher reduction caps would cause the reductions to be evenly distributed among all states, instead of being based on the statutory DHRM factors. No cap might result in the complete elimination of some states' DSH allotments and lower caps might result in states with an insignificant amount of DSH allotment with which to make DSH payments.

(6) For each state group, determine state-specific DSH allotment reduction amounts relating to the UPF. To accomplish this, we will compare each state's uninsurance rate to the uninsurance rates of all states in relation to each state's unreduced allotment in proportion to its respective state group's total allotment in order to calculate each state's reduction. As required by statute, states with *lowest* uninsurance rates will receive *largest* percentage DSH reductions.

(7) For each state group, determine state-specific DSH allotment reduction amounts relating to the HUF. By utilizing the most recently available Medicaid DSH audit and reporting data, we will determine the mean uncompensated care level for each state in order to determine the total payments each state makes to non-high

uncompensated care level hospitals. We will then determine the HUF by dividing the total of each state's total payments made to non-high uncompensated care level hospitals by the total payments made non-high uncompensated care level hospitals for its respective state group.

(8) For each state group, determine state-specific DSH allotment reduction amounts relating to the HMF. Again, by utilizing the most recently available Medicaid DSH audit and reporting data, we will determine the mean MIUR for each state in order to determine the amount of DSH payments each state makes to non-high Medicaid volume hospitals. We will then determine the HMF by dividing each state's total payments made to non-high volume Medicaid hospitals by the total payments made non-high volume Medicaid hospitals for its respective state group.

(9) Apply a section 1115 Budget Neutrality Factor for each qualifying state. To apply this factor, we will not reduce any portion of a state's DSH allotment which was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 of the Act as of July 31, 2009. We will assign any qualifying states an average percentage reduction amount within its respective state group for diverted DSH allotment amounts that are not related to a coverage expansion in effect as of July 31, 2009 and for which the state does not have complete and/or relevant DSH payment data .

(10) Identify the state-specific DSH allotment reduction amount.

(11) Subtract each state's state-specific DSH allotment reduction amount from each state's unreduced DSH allotment to determine the state's available DSH allotment for the applicable year.

The manner in which each of the five factors are considered and calculated in the proposed DHRM is described in greater detail below.

The proposed DHRM recognizes the variations in DSH allotments among states and the application of the methodology generates a lesser impact on low DSH states. The DHRM is designed to determine DSH reductions in an equitable manner by grouping similar states into groups for purposes of applying the statutory reduction factors. Reductions assigned through the HMF and HUF would lessen the impact on states that have targeted DSH payments to hospitals that have high volumes of Medicaid inpatients and to hospitals that have high levels of uncompensated care, respectively, while incentivizing payment targeting for future DSH payments. As specified in statute, the DHRM would also take into account the extent to which the DSH allotment for a state was included in part or in whole in the budget neutrality calculation for a coverage expansion approved under section 1115 of the Act as of July 31, 2009 by excluding from DSH allotment reduction the amount of DSH that qualifying states continue to divert specifically for coverage expansion in the budget neutrality calculation. Any amount of DSH diverted for other purposes under the demonstration would still be subject to reduction by automatically assigning qualifying states an average percentage reduction amount within its respective state group for factors for which the state does not have complete and/or relevant DSH payment data.

B. Low DSH Adjustment Factor (LDF)

Section 1923(f)(7)(B)(ii) of the Act requires the DHRM to impose a smaller percentage reduction on ''low DSH states'' that meet the criterion described in section 1923(f)(5)(B) of the Act. To qualify as a low DSH state, total expenditures under the state plan for DSH payments for FY 2000, as reported to us as of August 31, 2003, had to have been greater than zero but less than 3 percent of the state's total Medicaid state plan expenditures during the FY. Historically, low DSH states (identified in Table 1) have received lower DSH allotments relative to their total Medicaid expenditures than non-low DSH states.

To meet the statutory requirement to impose a smaller percentage reduction on low DSH states, the DHRM would create two state groups (low DSH states and non-low DSH states), then would apply the LDF when allocating reduction amounts to each state group. The LDF is calculated and applied as follows:

(1) Separate states into two groups, non-low DSH states and low DSH states.

(2) Divide each state's unreduced preliminary DSH allotment for the year for which the reduction is calculated by estimated Medicaid service expenditures for that same year. Currently, we create a preliminary DSH allotment based on the estimates available in August of the prior year and we issue a final DSH allotment once the federal FY ends.

(3) For each state group, calculate the non-weighted mean of the value calculated in step 2 for states in the group.

(4) Divide the average calculated in step 3 for the low DSH state group by the average calculated in step 3 for the non-low DSH state group.

(5) Convert this number to a percentage. This percentage is the LDF.

(6) Multiply the proportionately allocated DSH funding reductions for the low-DSH state group by the LDF percentage to determine the aggregate DSH reduction amount that would be distributed across the low DSH state group.

(7) Subtract the aggregate DSH reduction amount determined in step 6 from the proportionately allocated DSH funding reduction for the low-DSH state group, and add the remainder to the aggregate DSH reduction amount that would be distributed across the non-low DSH state group.

We considered using various alternative proportional relationships to establish the LDF, including the proportion of each state group's annual Medicaid DSH expenditures to total Medicaid expenditures. However, we believe that this may benefit non-low DSH states that are unable to or otherwise do not spend their existing DSH allotment amount. Therefore, we are proposing to calculate the LDF based on the proportion of each state group's DSH allotments to total Medicaid expenditures.

C. Factor 2—Uninsured Percentage Factor (UPF)

The second factor considered in the proposed DHRM is the UPF identified at section 1923(f)(7)(B)(i)(I) of the Act, which requires that the DHRM impose the largest percentage DSH allotment reductions on states that have the lowest percentages of uninsured individuals. The statute also requires that the percentage of uninsured individuals is determined on the basis of data from the Census Bureau, audited hospital cost reports, and other information likely to yield accurate data, during the most recent year for which such data are available.

To determine the percentage of uninsured individuals in each state, the proposed DHRM relies on the total population and uninsured population as identified in the most recent ''1-year estimates'' data available from the ACS conducted by the Census Bureau. The Census Bureau generates ACS ''1-year estimates'' data annually based on a point-in-time survey of approximately 3 million individuals. For purposes of the proposed DHRM, we would utilize the most recent ACS data available at the time of the calculation of the annual DSH allotment reduction amounts.

The UPF, as applied through the proposed DHRM, has the effect of imposing the lowest relative DSH

allotment reductions on states that have the highest percentage of uninsured individuals. The UPF would mitigate the DSH reduction for states with the highest percentage of uninsured individuals.

The proposed UPF is determined separately for each state group as follows:

(1) *Uninsured Value*—Using United States Census Bureau data, calculate each state's uninsured value by dividing the total state population by the uninsured in the state. (This is different than the percentage rate of uninsurance; the rate of uninsurance can be obtained by dividing 100 by this number.)

(2) *Uninsured Allocation Component*—Determine the relative uninsured value for each state compared to other states in the state group by dividing the value in step one by the state group total of step one values. The result should be a percentage, and the total of the percentages for all states in the state group should total 100 percent.

(3) *Allocation Weighting Factor*—To ensure that larger and smaller states are given fair weight in the final UPF, divide each state's preliminary unreduced DSH allotment by the sum of all unreduced preliminary DSH allotments in the respective state group to obtain allocation weighting factor, expressed as a percentage. The sum of all weighting factors should equal 100 percent. Then, take this percentage for each state and multiply it by the state's uninsured allocation component determined in step 2. The result is the allocation weighting factor.

(4) *UPF*—For each state group, divide each state's allocation weighting factor by the sum of all allocation weighting factors. The resulting percentage is the UPF.

We would determine the UPF portion of the proposed aggregate DSH allotment reduction allocation for each state by multiplying the state's UPF by the aggregate DSH allotment reduction allocated to the UPF factor for the respective state group. As with the prior factor, we propose to utilize preliminary DSH allotment estimates to develop the DSH reduction factors.

D. Factor 3—High Volume of Medicaid Inpatients Factor (HMF)

The third factor considered in the proposed DHRM is the High Volume of Medicaid Inpatients Factor (HMF) identified at section 1923(f)(7)(B)(i)(II)(aa) of the Act, which requires that the DHRM impose the largest percentage DSH allotment reductions on states that do not target DSH payments to hospitals with high volumes of Medicaid inpatients. For purposes of the DHRM, the statute defines hospitals with high volumes of Medicaid patients as those defined in section 1923(b)(1)(A) of the Act. These hospitals must meet minimum qualifying requirements at section 1923(d) of the Act and have an MIUR that is at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state. Every hospital that meets that definition is deemed a disproportionate share hospital and is statutorily required to receive a DSH payment.

States that have been, and continue to, target a large percentage of their DSH payments to hospitals that are federally deemed as a DSH based on their MIUR would receive the lowest reduction amounts relative to their total spending. States that target the largest amounts of DSH payments to hospitals that are not federally deemed based on MIUR would receive the largest reduction amounts under this factor. The current DSH allotment amounts are unrelated to the amounts of MIUR-deemed hospitals and their DSH-eligible uncompensated care costs. By basing the HMF reduction on the amounts that states do not target to hospitals with high volumes of Medicaid inpatients as described below in section (4), this proposed methodology incentivizes states to target DSH payments to such hospitals.

To ensure that all deemed disproportionate share hospitals receive a required DSH payment, states are already required to determine the mean MIUR for hospitals receiving Medicaid payments in the state and the value of one standard deviation above the mean. This rule proposes to rely on MIUR information for use in the DHRM that CMS collects from states on an annual basis under § 447.294(d). When a state or states do not submit this required MIUR information timely, for purposes of this factor, we would assume that the state(s) have the highest value of one standard deviation above the mean reported among all other states that did submit this information timely.

The calculation of the HMF would rely on extant data that should be readily available to states. The following data elements are used in the proposed HMF calculation: The preliminary unreduced DSH allotment for each state; the DSH hospital payment amount reported for each DSH in accordance with § 447.299(c)(17); the MIUR for each DSH reported in accordance with § 447.299(c)(3); and the value of one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state reported separately.

The proposed HMF is a state-specific percentage that would be calculated separately for each state group (low DSH and non-low DSH) as follows:

(1) For each state, classify each DSH that has an MIUR at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state as a High Medicaid Volume hospital.

(2) For each state, determine the amount of DSH payments to non-High Medicaid Volume DSH hospitals. This data element should come from the most recently submitted and accepted DSH audit template.

(3) For each state, determine a percentage by dividing the state's total DSH payments made to non-High Medicaid Volume hospitals by the aggregate amount of DSH payments made to non-High Medicaid Volume hospitals for the entire state group. The result of step 3 is the HMF.

(4) Determine each state's HMF reduction amount by applying the HMF percentage to the aggregate reduction amount allocated to this factor for each state group.

As a result of this methodology, there are a number of interactions that may occur for states among DSH payment methodologies, DSH allotments, and DSH allotment reductions. Most of these scenarios work in concert with this factor's established reduction relationship. For example, if a state paid out its entire DSH allotment to hospitals with high volumes of Medicaid inpatients, it would receive no reduction associated with this factor because all DSH payments were made only to hospitals that qualify as high volume. The results of this scenario would be consistent with the methodology because the state is incentivized to target DSH payments to high Medicaid volume hospitals.

Another example is a state that makes DSH payments up to the hospital-specific DSH limit to all hospitals with high Medicaid volume but also uses its remaining allotment to make DSH payments to hospitals that do not qualify as high volume. In this example, the state would receive a reduction under this factor based on the amount of DSH payments it made to non-high Medicaid volume hospitals. Though the state targeted DSH payments to hospitals with high Medicaid volume, the existing size of its DSH allotment permitted it to make DSH payments to hospitals that did not meet the statutory definition of high Medicaid volume. In that situation, this allotment reduction would effectively reduce a state's existing DSH allotment to the extent that the allotment exceeded the

maximum amount that the state could pay to hospitals that are high Medicaid volume. The resulting HMF reduction would be greater for states with DSH allotments large enough to pay significant amounts to non-high Medicaid volume hospitals. This ensures that states target DSH payments to high Medicaid volume hospitals and distribute the reductions in such a way as to promote the ability of all states to provide DSH funds to high Medicaid volume hospitals.

We seek comments on the proposed DHRM with respect to whether the proposed implementation of this factor is expected to be effective in tying the level of DSH reductions to the targeting of DSH payments to high Medicaid volume hospitals.

E. Factor 4—High Level of Uncompensated Care Factor (HUF)

The fourth factor considered in the DHRM is the HUF identified at section 1923(f)(7)(B)(i)(II)(bb) of the Act, which requires that the DHRM impose the largest percentage DSH allotment reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care. We are proposing to rely on the existing statutory definition of uncompensated care cost used in determining the hospital-specific limit on FFP for Medicaid DSH payments.

As defined in section 1923(g)(1) of the Act, the state must calculate for each hospital, for each FY, the difference between the costs incurred by that hospital for furnishing inpatient hospital and outpatient hospital services during the applicable state FY to Medicaid individuals and individuals who have no health insurance or other source of third party coverage for the inpatient hospital and outpatient hospital services they receive, less all applicable revenues received for these hospital services. This difference, if any, between incurred inpatient hospital and outpatient hospital costs and associated revenues is considered a hospital's uncompensated care costs, or hospital-specific DSH limit.

For purposes of this rule, we are proposing to rely on this definition of uncompensated care costs for the calculation of the HUF, as reported by states on the most recent available Medicaid DSH audit and reporting data. For the proposed DHRM, hospitals with high levels of uncompensated care costs are defined based on a comparison with other Medicaid DSH hospitals in their state. Any hospital that exceeds the mean ratio of uncompensated care costs to total Medicaid and uninsured inpatient and outpatient hospital service costs within its state is considered a hospital with a high level of uncompensated care. This data is consistent with the existing Medicaid DSH program definition of uncompensated care and is readily available to states and CMS.

The following data elements would be used in the HUF calculation:

- The preliminary unreduced DSH allotment for each state;
- DSH hospital payment amounts reported for each DSH in accordance with § 447.299(c)(17);
- Uncompensated care cost amounts reported for each DSH in accordance with § 447.299(c)(16);
- Total Medicaid cost amounts reported for each DSH in accordance with § 447.299(c)(10); and
- Total uninsured cost amounts reported for each DSH in accordance with § 447.299(c)(14).
- Total hospital cost amounts reported for each DSH in accordance with § 447.299(c)(20).

The statute also requires that uncompensated care costs used in this factor of the DHRM exclude bad debt. The proposed rule relies on the uncompensated care cost data derived from Medicaid DSH audit and reporting required by section 1923(f) of the Act and implementing regulations. This uncompensated care data excludes bad debt, including unpaid co-pays and deductibles, associated with individuals with a source of third party coverage for the service received during the year.

The HUF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as follows:

(1) Determine each disproportionate share hospital's uncompensated care level by dividing its uncompensated care cost by total hospital cost. This data element would come from the most recently submitted and accepted Medicaid DSH audit and associated reporting.

(2) For each state, calculate the weighted mean uncompensated care level.

(3) Identify all hospitals that meet or exceed the mean uncompensated care level as high uncompensated care level hospitals. We are also considering identifying a metric higher than the mean for purposes of identifying hospitals as high uncompensated care level hospitals and are specifically soliciting comments on alternative methodologies.

(4) For each state, determine the total amount of DSH payments to non-high uncompensated care level hospitals.

(5) For each state, determine a percentage by dividing the state's total DSH payments made to non-high uncompensated care level hospitals by the aggregate amount of DSH payments made to non-high uncompensated care level hospitals for the entire state group. The result would be the HUF.

(6) Determine each state's HUF reduction amount by applying the HUF percentage to the aggregate reduction amount allocated to this factor for each state group.

In previous rulemaking, we identified some potential scenarios where the interactions may have been inconsistent with the intent of this methodology. Under the 2013 DSH allotment reduction final rule, it was possible for a hospital not to have been considered to have a higher level of uncompensated care even though it provided a higher percentage of services to Medicaid and uninsured individuals and had greater total qualifying uncompensated care costs than another hospital that did qualify as having a high level of uncompensated care. This was due to the previous formula determining the level of uncompensated care by dividing uncompensated care by the sum of total Medicaid costs and total uninsured costs. We propose to resolve this problem discussed in earlier rulemaking by determining the level of uncompensated care by dividing uncompensated care costs by total hospital costs.

We seek comments on the proposed DHRM with respect to whether the proposed implementation of this factor is expected to be effective in tying the level of DSH reductions to the targeting of DSH payments to hospitals with high levels of uncompensated care. We believe that the proposed methodology, in using the mean uncompensated care cost level as the measure to identify hospitals with high levels of uncompensated care, captures the best balance in tying the level of DSH reductions to the targeting of DSH payments to such high level uncompensated care hospitals. Understanding potential data limitations and that the proposed methodology does not precisely distinguish how states direct DSH payments among hospitals that are identified as at or above the mean uncompensated care level, we are specifically soliciting comments on alternative methodologies regarding state targeting of DSH payments to hospitals with high levels of uncompensated care.

F. Factor 5—Section 1115 Budget Neutrality Factor (BNF)

The statute requires that we take into account the extent to which a state's

DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 demonstration authority as of July 31, 2009. These states possess full annual DSH allotments as calculated under section 1923(f) of the Act. Under an approved section 1115 demonstration, however, some states have limited authority to make DSH payments under section 1923 of the Act because all or a portion of their DSH allotment was included in the budget neutrality calculation for a coverage expansion under an approved section 1115 demonstration or to fund uncompensated care pools and/or safety net care pools. For applicable states, DSH payments under section 1923 of the Act are limited to the DSH allotment calculated under section 1923(f) of the Act less the allotment amount included in such a budget neutrality calculation. If a state's entire DSH allotment is included in such a budget neutrality calculation, it would have no available DSH funds with which to make DSH payments under section 1923 of the Act for the period of the demonstration.

Consistent with the statute, for states that include DSH allotment in budget neutrality calculations for coverage expansion under an approved section 1115 demonstration as of July 31, 2009, we propose to exclude from the DSH allotment reduction, for the HMF and the HUF factors, the amount of DSH allotment that each state currently continues to divert specifically for coverage expansion in the budget neutrality calculation. DSH allotment amounts included in budget neutrality calculations for non-coverage expansion purposes under approved demonstrations would still be subject to reduction. Uncompensated care pools and safety net care pools are considered non-coverage expansion purposes for the budget neutrality factor. For section 1115 demonstrations not approved as of July 31, 2009, any DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, under a later approval would also be subject to reduction.

We are proposing to determine for each reduction year if any portion of a state's DSH allotment qualifies for consideration under this factor. To qualify annually, CMS and the state would have to have included the state's DSH allotment in the budget neutrality calculation for a coverage expansion that was approved under section 1115 of the Act as of July 31, 2009, and the coverage expansion would have to still exist in the approved section 1115 demonstration at the time that reduction amounts are calculated for each FY. If a state had an amount for coverage expansion approved under a section 1115 of the Act as of July 31, 2009 but subsequently reduced this amount, the approved amount remaining under the section 1115 would not be subject to reduction.

The proposed DHRM would take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a demonstration approved under section 1115 of the Act as of July 31, 2009 by excluding from reduction under the HMF and HUF amounts diverted specifically for a coverage expansion and automatically assigning qualifying states an average reduction amount (that is, the average HUF and HMF of the state's respective state group) for any DSH allotment diverted for non-coverage expansion purposes and any amounts diverted for coverage expansion if the section 1115 demonstration was not approved as of July 31, 2009. DSH allotment reductions relating to two DHRM factors (the HUF and the HMF) are determined based on how states target DSH payments to certain hospitals. Since states that diverted all or a portion of their DSH allotments would have limited or no relevant data for these two factors, we would be unable to evaluate how they spent the diverted portion of their DSH allotment for these targeting criteria. Accordingly, for diversion amounts subject to reduction, we are proposing to maintain the HUF and HMF formula for DSH payments for which qualifying states would have available data. Because we would not have DSH payment data for DSH allotment amounts diverted for non-coverage expansion (or for coverage expansions not approved as of July 31, 2009), we are proposing to assign average HUF and HMF reduction percentages for the portion of the DSH allotment that a state diverted for non-coverage expansion (or for coverage expansions not approved as of July 31, 2009) that it was consequently unable to use to target payments to disproportionate share hospitals. Instead of assigning the average percentage reduction to non-qualifying amounts, we considered using alternative percentages higher or lower than the average. However, these alternative percentages might provide an unintended benefit or penalty to these states for DSH diversions approved under section 1115 of the Act. We are seeking comment regarding the use of different percentages for the reductions to diversion amounts that do not qualify under the BNF and regarding alternative BNF methodologies that may provide preferable alternatives.

G. Illustration of DSH Health Reform Methodology (DHRM)

Table 1 and the values contained therein are provided only for purposes of illustrating the application of the DHRM and the associated DSH reduction factors described in this proposed rule to determine each state's DSH allotment reduction.

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TABLE 1: FY 2017 DSH HEALTH REFORM METHODOLOGY

*FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY							
		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		50.00%	25.00%	25.00%	100.00%		
	Total Reg. DSH Reduction:	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$12,463,721	$6,231,860	$6,231,860	$24,927,441		
27.83%	TOTAL:	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000		
A	B	C	D	E	F	G	H
STATE	Unreduced FY 2017 DSH Allotment (Estimate)	Reduction Based on UPF Uninsured Factor	Reduction Based on HMF High Volume Factor	Reduction Based On HUF High Level Factor	Total Reduction C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment F/B	FY 2017 Reduced Allotment B - F
Alabama	$337,648,430	$24,336,783	$22,311,475	$12,205,968	$58,854,226	17.43%	$278,794,204
Arizona	$111,176,922	$7,137,605	$3,547,314	$540,535	$11,225,454	10.10%	$99,951,468
California	$1,203,730,377	$84,684,522	$27,524,140	$41,213,794	$153,422,456	12.75%	$1,050,307,921
Colorado	$101,569,041	$8,631,358	$7,177,442	$2,752,327	$18,561,127	18.27%	$83,007,914
Connecticut	$219,608,734	$27,749,875	$8,953,379	$12,499,484	$49,202,738	22.40%	$170,405,996
District of Columbia	$67,255,174	$11,161,638	$948,482	$4,788,317	$16,898,437	25.13%	$50,356,737
Florida	$219,608,734	$11,604,440	$7,724,576	$14,761,318	$34,090,334	15.52%	$185,518,400
Georgia	$295,099,237	$16,322,138	$9,642,846	$10,330,646	$36,295,629	12.30%	$258,803,608

*FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY							
		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		50.00%	25.00%	25.00%	100.00%		
	Total Reg. DSH Reduction:	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$12,463,721	$6,231,860	$6,231,860	$24,927,441		
27.83%	TOTAL:	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000		
A	B	C	D	E	F	G	H
Illinois	$236,079,390	$21,211,561	$21,228,808	$2,226,180	$44,666,550	18.92%	$191,412,840
Indiana	$234,706,837	$17,212,117	$7,854,285	$2,660,409	$27,726,811	11.81%	$206,980,026
Kansas	$45,294,302	$3,871,800	$3,187,693	$1,866,967	$8,926,460	19.71%	$36,367,842
Kentucky	$159,216,333	$16,485,287	$7,021,414	$6,556,338	$30,063,039	18.88%	$129,153,294
Louisiana	$752,888,159	$44,629,718	$8,761,366	$28,576,335	$81,967,418	10.89%	$670,920,741
Maine	$115,294,586	$9,949,588	$1,191,719	$1,053,779	$12,195,085	10.58%	$103,099,501
Maryland	$83,725,829	$9,314,506	$3,064,435	$2,498,384	$14,877,325	17.77%	$68,848,504
Massachusetts	$334,903,321	$89,406,469	$8,587,673	$7,322,652	$105,316,795	31.45%	$229,586,526
Michigan	$290,981,574	$29,838,010	$17,552,322	$19,346,010	$66,736,341	22.93%	$224,245,233
Mississippi	$167,451,660	$10,119,288	$4,755,050	$2,557,905	$17,432,243	10.41%	$150,019,417
Missouri	$520,198,191	$39,063,452	$29,634,901	$23,891,614	$92,589,967	17.80%	$427,608,224
Nevada	$50,784,519	$2,924,122	$436,562	$544,246	$3,904,930	7.69%	$46,879,589
New Hampshire	$175,795,169	$16,765,244	$2,912,141	$2,025,265	$21,702,651	12.35%	$154,092,518
New Jersey	$706,865,615	$56,618,281	$44,292,058	$52,834,997	$153,745,336	21.75%	$553,120,279
New York	$1,763,732,651	$177,505,591	$78,224,710	$73,714,317	$329,444,617	18.68%	$1,434,288,034
North Carolina	$323,922,884	$21,676,870	$14,090,407	$20,538,422	$56,305,699	17.38%	$267,617,185

*FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY							
		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		50.00%	25.00%	25.00%	100.00%		
	Total Reg. DSH Reduction:	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$12,463,721	$6,231,860	$6,231,860	$24,927,441		
27.83%	TOTAL:	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000		
A	B	C	D	E	F	G	H
Ohio	$446,080,243	$46,702,161	$25,434,391	$29,795,707	$101,932,258	22.85%	$344,147,985
Pennsylvania	$616,277,012	$63,782,334	$32,922,465	$24,331,996	$121,036,794	19.64%	$495,240,218
Rhode Island	$71,372,839	$8,426,370	$6,425,719	$1,860,620	$16,712,709	23.42%	$54,660,130
South Carolina	$359,609,303	$23,233,999	$22,965,009	$23,842,222	$70,041,229	19.48%	$289,568,074
Tennessee*	$0	$0	$0	$0	$0	0.00%	$0
Texas	$1,050,004,264	$48,245,203	$50,044,327	$49,773,279	$148,062,808	14.10%	$901,941,456
Vermont	$24,705,984	$4,369,886	$1,875,609	$775,093	$7,020,587	28.42%	$17,685,397
Virginia	$96,196,942	$7,735,598	$122,311	$3,188,924	$11,046,833	11.48%	$85,150,109
Washington	$203,138,079	$19,249,651	$12,038,303	$10,449,879	$41,737,833	20.55%	$161,400,246
West Virginia	$74,117,949	$7,570,819	$1,314,810	$2,444,211	$11,329,840	15.29%	$62,788,109
Total Regular DSH States	$11,459,040,284	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559	17.24%	$9,483,967,725
LOW DSH STATES							
Alaska	$22,366,812	$258,424	$851,319	$136,279	$1,246,022	5.57%	$21,120,790
Arkansas	$47,367,170	$799,743	$33,070	$1,146,287	$1,979,100	4.18%	$45,388,070
Delaware	$9,940,805	$254,209	$205,569	$94,226	$554,005	5.57%	$9,386,800

*FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY							
		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		50.00%	25.00%	25.00%	100.00%		
	Total Reg. DSH Reduction:	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$12,463,721	$6,231,860	$6,231,860	$24,927,441		
27.83%	TOTAL:	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000		
A	B	C	D	E	F	G	H
Hawaii	$10,701,306	$403,540	$326,243	$78,866	$808,649	7.56%	$9,892,657
Idaho	$18,049,095	$264,628	$49,829	$87,268	$401,724	2.23%	$17,647,371
Iowa	$43,242,210	$1,394,059	$115,140	$1,361,179	$2,870,379	6.64%	$40,371,831
Minnesota	$82,011,647	$2,774,292	$218,017	$565,875	$3,558,184	4.34%	$78,453,463
Montana	$12,463,647	$174,295	$522,983	$208,536	$905,813	7.27%	$11,557,834
Nebraska	$31,072,684	$638,999	$157,417	$641,315	$1,437,730	4.63%	$29,634,954
New Mexico	$22,366,812	$306,213	$136,653	$45,268	$488,134	2.18%	$21,878,678
North Dakota	$10,488,492	$265,499	$54,018	$11,994	$331,511	3.16%	$10,156,981
Oklahoma	$39,763,220	$514,542	$1,587,344	$446,030	$2,547,915	6.41%	$37,215,305
Oregon	$49,704,028	$1,015,201	$788,620	$931,845	$2,735,666	5.50%	$46,968,362
South Dakota	$12,127,506	$245,843	$18,050	$24,036	$287,929	2.37%	$11,839,577
Utah	$21,541,402	$341,688	$1,159,479	$446,117	$1,947,284	9.04%	$19,594,118
Wisconsin	$103,801,167	$2,808,415	$436	$1,298	$2,810,149	2.71%	$100,991,018
Wyoming	$248,521	$4,131	$7,674	$5,441	$17,245	6.94%	$231,276
Total Low DSH States	$537,256,524	$12,463,721	$6,231,860	$6,231,860	$24,927,441	4.64%	$512,329,083

*FOR ILLUSTRATION PURPOSES ONLY - FY 2017 DSH HEALTH REFORM METHODOLOGY							
		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation					
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL		
		50.00%	25.00%	25.00%	100.00%		
	Total Reg. DSH Reduction:	$987,536,279	$493,768,140	$493,768,140	$1,975,072,559		
LOW DSH Adj. Factor	Total Low DSH Reduction:	$12,463,721	$6,231,860	$6,231,860	$24,927,441		
27.83%	TOTAL:	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000		
A	B	C	D	E	F	G	H
National Total	$11,996,296,808	$1,000,000,000	$500,000,000	$500,000,000	$2,000,000,000	16.67%	$9,996,296,808

*Under section 1923(f)(6)(A)(vi) of the Act the DSH allotment for Tennessee is established at $53.1 million per year for FY 2015 through FY 2025. Therefore, Tennessee is not subject to reductions under section 1923(f)(7) of the Act.

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IV. Collection of Information Requirements

Beginning with each state's Medicaid state plan for rate year 2005, each state must submit to CMS (at the same time as it submits the completed DSH audit as required under § 455.304) the data specified under § 447.299 for each DSH hospital to which the state made a DSH payment. While the reported information will allow CMS to verify the appropriateness of such payments, the reporting requirements and burden are currently approved by OMB under control number 0938–0746 (CMS–R–266). Importantly, this rule does not propose any new/revised information collection requirements or burden pertaining to § 447.299.

Although mentioned earlier in this preamble, this rule does not propose any new/revised SPA or auditing requirements or burden nor any new/revised information collection requirements or burden associated with CMS–64 (control number 0938–1265) or CMS–2552 (control number 0938–0050).

Since this rule does not propose any new or revised information collection requirements or burden, it need not be reviewed by OMB under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Statement of Need

The Affordable Care Act amended the Act by requiring aggregate reductions to state Medicaid DSH allotments annually from FY 2014 through FY 2020. Subsequent legislation extended the reductions, modified the amount of the reductions, and delayed the start of the reductions until FY 2018. The most recent related amendments to the statute were through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10, enacted April 16, 2015). This proposed rule delineates the DHRM to implement the annual reductions for FY 2018 through FY 2025.

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 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), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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). This rule has been designated an ''economically significant'' rule measured by the $100 million threshold, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a Regulatory Impact Analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) 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 2017, that threshold is approximately $148 million. This final rule would not mandate any requirements for state, local, or tribal governments, nor would it affect private sector costs.

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 rule does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

The RFA requires agencies to analyze options for regulatory relief of small entities, and to prepare an Initial Regulatory Flexibility Analysis (IRFA), for proposed rules that would have a ''significant economic 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. Individuals and states are not included in the definition of a small entity.

We are not preparing an IRFA because we have determined, and the Secretary certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities (including hospitals and providers) because states still have considerable flexibility to determine DSH state plan payment methodologies.

In addition, section 1102(b) of the 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 603 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. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues 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 regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

Executive Order 13175 directs agencies to consult with Tribal officials prior to the formal promulgation of regulations having tribal implications. This proposed rule has tribal implications, and in accordance with E.O. 13175 and the CMS Tribal Consultation Policy (December, 2015), CMS will consult with Tribal officials prior to the formal promulgation of this regulation.

C. Anticipated Effects

1. Effects on State Medicaid Programs

We anticipate, effective for FY 2018, that the proposed DSH allotment reductions would have a direct effect on the ability for some or all states to

maintain state-wide Medicaid DSH payments at FY 2017 levels. Federal share DSH allotments, which are published by CMS in an annual **Federal Register** notice, limit the amount of federal financial participation (FFP) in the aggregate that states can pay annually in DSH payments to hospitals. This proposed rule would reduce state DSH allotment amounts, and therefore, would limit the states' ability to make DSH payments and claim FFP for DSH payments at FY 2017 levels. By statute, the rule would reduce state DSH allotments by $43,000,000,000 for FY 2018 through FY 2025. We anticipate that the rule would reduce total federal financial participation claimed by states by similar amounts, although it may not equal the exact amount of the allotment reductions. Due to the complexity of the interaction among the proposed DHRM methodology, state DSH allotments, DHRM data, future state DSH payment levels and methodologies for these years, we cannot provide a specific estimate of the total federal financial impact for each year.

The proposed rule utilizes a DHRM that would mitigate the negative impact on states that continue to have high percentages of uninsured and are targeting DSH payments to hospitals that have a high volume of Medicaid patients and to hospitals with high levels of uncompensated care.

2. Effects on Providers

We anticipate that the final rule would affect certain providers through the reduction of state DSH payments. We cannot, however, estimate the impact on individual providers or groups of providers. This proposed rule would not affect the considerable flexibility afforded states in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statutes and regulations. States would retain the ability to preserve existing DSH payment methodologies or to propose modified methodologies by submitting state plan amendments to us. Some states may determine that implementing a proportional reduction in DSH payments for all qualifying hospitals is the preferred method to account for the reduced allotment. Alternatively, states could determine that the best action is to propose a methodology that would direct DSH payments reductions to hospitals that do not have high Medicaid volume and do not have high levels of uncompensated care. Regardless, the rule would incentivize states to target DSH payments to hospitals that are most in need of Medicaid DSH funding based on their serving a high volume of Medicaid inpatients and having a high level of uncompensated care.

This proposed rule also does not affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act. This hospital-specific limit requires that Medicaid DSH payments to a qualifying hospital not exceed the costs incurred by that hospital for providing inpatient and outpatient hospital services furnished during the year to Medicaid patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year, less applicable revenues for those services.

Although this rule would reduce state DSH allotments, the management of the reduced allotments still largely remains with the states. Given that states would retain the same flexibility to design DSH payment methodologies under the state plan and that individual hospital-specific DSH payment limits would not be affected, we cannot predict whether and how states would exercise their flexibility in setting DSH payments to account for their reduced DSH allotment and how this would affect individual providers or specific groups of providers.

D. Alternatives Considered

The statute specifies the annual DSH allotment reduction amounts. Therefore, we were unable to consider alternative reduction amounts. However, we did consider various methodological alternatives to the DHRM throughout each individual section in detail. These proposed alternatives relate to various weight assignments to reduction factors identified in the statute, utilizing various alternative data sources for uncompensated cost and uninsured data, and proposing a reduction cap methodology in order to limit the reduction amount to be applied to each state's total unreduced DSH allotment.

E. Accounting Statement and Table

As required by OMB Circular A–4 (available at *www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this proposed rule.

TABLE 2—ACCOUNTING STATEMENT

Category	Estimates	Units		
		Year dollar	Discount rate %	Period covered
Transfers				
Annualized Reductions in Disproportionate Share Hospital Allotment (in millions)	−5,049.1 −5,232.5	2017 2017	7 3	2018–2025 2018–2025
From Whom to Whom	Federal Government to the States due to assumed reduced number of uninsured and uncompensated care.			

F. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. Section 2(a) of Executive Order 13771 requires an agency, unless prohibited by law, to identify at least two existing regulations to be repealed when the agency publicly proposes for notice and comment, or otherwise promulgates, a new regulation. In furtherance of this requirement, section 2(c) of Executive Order 13771 requires that the new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations. OMB's implementation guidance, issued on April 5, 2017, explains that ''Federal spending regulatory actions that cause only income transfers between taxpayers and

program beneficiaries (for example, regulations associated with . . . Medicare spending) are considered 'transfer rules' and are not covered by E.O. 13771 . . . . However . . . such regulatory actions may impose requirements apart from transfers. . . In those cases, the actions would need to be offset to the extent they impose more than de minimis costs. Examples of ancillary requirements that may require offsets include new reporting or recordkeeping requirements.'' It has been determined that this proposed rule is a transfer rule that does not impose more than de minimis costs as described previously and thus is not a regulatory action for the purposes of E.O. 13771.

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

List of Subjects in 42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 447—PAYMENTS FOR SERVICES

■ 1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

■ 2. Section 447.294 is amended by—
■ a. Revising the section heading;
■ b. Revising paragraph (a);
■ c. Amending paragraph (b) by adding the definition of ''Total hospital cost''; and
■ d. Revising paragraphs (d), (e) introductory text, (e)(3)(i) and (5)(i) through (iii), and (f).

The revisions and addition reads as follows:

§ 447.294 Medicaid disproportionate share hospital (DSH) allotment reductions.

* * * * *

(a) *Basis and purpose.* This section sets forth the DSH health reform methodology (DHRM) for calculating State-specific annual DSH allotment reductions as required under section 1923(f) of the Act.

(b) * * *

Total hospital cost means the total annual costs incurred by a hospital for furnishing inpatient and outpatient hospital services.

* * * * *

(d) *State data submission requirements.* States are required to submit the mean MIUR, determined in accordance with section 1923(b)(1)(A) of the Act, for all hospitals receiving Medicaid payments in the State and the value of one standard deviation above such mean. The State must provide this data to CMS by June 30 of each year. To determine which state plan rate year's data the state must submit, subtract 3 years from the calendar year in which the data is due.

(e) *DHRM methodology.* Section 1923(f)(7) of the Act requires aggregate annual reduction amounts as specified in paragraph (f) of this section to be reduced through the DHRM. The DHRM is calculated on an annual basis based on the most recent data available to CMS at the time of the calculation. The DHRM is determined as follows:

* * * * *

(3) * * *

(i) Dividing each State's preliminary unreduced DSH allotment by their respective total estimated Medicaid service expenditures for the applicable fiscal year.

* * * * *

(5) * * *

(i) UPF—50 percent.

(ii) HMF—25 percent.

(iii) HUF—25 percent.

* * * * *

(f) *Annual DSH allotment reduction application.* For each fiscal year identified in section 1923(f)(7)(A)(ii) of the Act, CMS will subtract the State-specific DSH allotment amount determined in paragraph (e)(14) of this section from that State's final unreduced DSH allotment. This amount is the State's final DSH allotment for the fiscal year.

May 26, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2017.

Thomas Price,

Secretary, Department of Health and Human Services.

[FR Doc. 2017–15962 Filed 7–27–17; 8:45 am]

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