

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.
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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).

[FR Doc. 2017-25192 Filed 11-20-17; 8:45 am]

BILLING CODE 4150-32-P

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