

bounded on the west by the Inner Harbor west bulkhead, located at Baltimore, MD. All coordinates refer to datum NAD 1983.

(c) *Regulations.* The general safety zone regulations found in 33 CFR part 165, subpart C apply to the safety zone created by this section.

(1) All persons are required to comply with the general regulations governing safety zones found in 33 CFR 165.23.

(2) Entry into or remaining in this safety zone is prohibited unless authorized by the Coast Guard Captain of the Port Maryland-National Capital Region. All vessels underway within this safety zone at the time it is implemented are to depart the zone.

(3) Persons desiring to transit the area of the safety zone shall obtain authorization from the Captain of the Port Maryland-National Capital Region or designated representative. To request permission to transit the area, the Captain of the Port Maryland-National Capital Region and or designated representatives can be contacted at telephone number 410-576-2693 or on marine band radio VHF-FM channel 16 (156.8 MHz). The Coast Guard vessels enforcing this section can be contacted on marine band radio VHF-FM channel 16 (156.8 MHz). Upon being hailed by a U.S. Coast Guard vessel, or other Federal, State, or local agency vessel, by siren, radio, flashing light, or other means, the operator of a vessel shall proceed as directed. If permission is granted to enter the safety zone, all persons and vessels shall comply with the instructions of the Captain of the Port Maryland-National Capital Region or designated representative and proceed as directed while within the zone.

(4) *Enforcement officials.* The U.S. Coast Guard may be assisted in the patrol and enforcement of the zone by Federal, State, and local agencies.

(d) *Enforcement period.* This section will be enforced from 11 p.m. on April 8, 2017, until 1 a.m. on April 9, 2017, and if necessary due to inclement weather, from 11 p.m. on April 9, 2017, until 1 a.m. on April 10, 2017.

Dated: March 28, 2017.

L.P. Harrison, Jr.,

Captain, U.S. Coast Guard, Captain of the Port Maryland-National Capital Region.

[FR Doc. 2017-06451 Filed 3-31-17; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG-2015-1081]

Safety Zones; Annual Events Requiring Safety Zones in the Captain of the Port Lake Michigan Zone—Start of the Chicago to Mackinac Race

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce a safety zone for the Start of the Chicago to Mackinac Race on a portion of Lake Michigan on July 15, 2017. This action is intended to ensure the safety of life on the navigable waterway immediately before, during, and after this event. During the enforcement period listed below, no vessel may transit this safety zone without approval from the Captain of the Port Lake Michigan or a designated representative.

DATES: The regulations in 33 CFR 165.929 will be enforced for the location listed in item (e)(45) in Table 165.929 from 10 a.m. until 4 p.m. on July 15, 2017.

FOR FURTHER INFORMATION CONTACT: If you have questions about this notice of enforcement, call or email LT Lindsay Cook, Waterways Management Division, Marine Safety Unit Chicago, at 630-986-2155, email address *D09-DG-MSUChicago-Waterways@uscg.mil*.

SUPPLEMENTARY INFORMATION: The Coast Guard will enforce the Safety Zone; Start of the Chicago to Mackinac Race listed as item (e)(45) in Table 165.929 of 33 CFR 165.929. Section 165.929 lists many annual events requiring safety zones in the Captain of the Port Lake Michigan zone. This safety zone encompasses all waters of Lake Michigan in the vicinity of the Navy Pier at Chicago IL, within a rectangle that is approximately 1500 by 900 yards. The rectangle is bounded by the coordinates beginning at 41°53.252' N., 087°35.430' W.; then south to 41°52.812' N., 087°35.430' W.; then east to 41°52.817' N., 087°34.433' W.; then north to 41°53.250' N., 087°34.433' W.; then west, back to point of origin. This safety zone will be enforced on July 15, 2017, from 10 a.m. until 4 p.m.

All vessels must obtain permission from the Captain of the Port Lake Michigan, or his or her designated on-scene representative to enter, move within, or exit this safety zone during the enforcement times listed in this

notice of enforcement. Requests must be made in advance and approved by the Captain of the Port before transits will be authorized. Approvals will be granted on a case-by-case basis. Vessels and persons granted permission to enter the safety zone shall obey all lawful orders or directions of the Captain of the Port Lake Michigan, or his or her on-scene representative.

This notice of enforcement is issued under authority of 33 CFR 165.929, Safety Zones; Annual events requiring safety zones in the Captain of the Port Lake Michigan zone, and 5 U.S.C. 552(a). The Coast Guard will provide the maritime community with advance notification of this enforcement period via Broadcast Notice to Mariners and Local Notice to Mariners. The Captain of the Port Lake Michigan or a designated on-scene representative may be contacted via VHF Channel 16 during the event.

Dated: March 27, 2017.

A.B. Cocanour,

Captain, U.S. Coast Guard, Captain of the Port Lake Michigan.

[FR Doc. 2017-06496 Filed 3-31-17; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2399-F]

RIN 0938-AS92

Medicaid Program; Disproportionate Share Hospital Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs

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

ACTION: Final rule.

SUMMARY: This final rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under section 1923(g)(1)(A) of the Social Security Act (Act), and the application of such limitation in the annual DSH audits required under section 1923(j) of the Act, by clarifying that the hospital-specific DSH limit is based only on uncompensated care costs. Specifically, this rule makes explicit in the text of the regulation, an existing interpretation that uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments made to hospitals by or on

behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals. As a result, the hospital-specific limit calculation will reflect only the costs for Medicaid eligible individuals for which the hospital has not received payment from any source.

DATES: These regulations are effective on June 2, 2017.

FOR FURTHER INFORMATION CONTACT: Wendy Harrison, (410) 786-2075.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative History

Title XIX of the Act authorizes the Secretary of the Department of Health and Human Services (the Secretary) to provide grants to states to help finance programs furnishing medical assistance (state Medicaid programs) to specified groups of eligible individuals in accordance with an approved state plan. “Medical Assistance” is defined at section 1905(a) of the Act as payment for part or all of the cost of a list of specified care for eligible individuals. Section 1902(a)(13)(A)(iv) of the Act requires that payment rates for hospitals take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to payments for such disproportionate share hospitals (DSH) payments. These specific statutory requirements include aggregate state level limits, hospital-specific limits, qualification requirements, and auditing requirements.

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 disproportionate share hospital (DSH). 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 fiscal year (FY) to the amount specified in an annual DSH allotment for each state. These allotments essentially establish a finite pool of available federal DSH funds that states use to pay the federal

portion of payments to all qualifying hospitals in each state. As states often use most or all of their federal DSH allotment, in practice, if one hospital gets more DSH funding, other DSH-eligible hospitals in the state may get less.

B. Hospital-Specific DSH Limit

Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), which was signed into law on August 10, 1993, added section 1923(g) of the Act, limiting Medicaid DSH payments during a year to a qualifying hospital to the amount of uncompensated care costs for that same year. The Congress enacted the hospital-specific limit on DSH payments in response to reports that some hospitals received DSH payment adjustments that exceeded “the net costs, and in some instances the total costs, of operating the facilities.” (H.R. Rep. No. 103-111, at 211-12 (1993), reprinted in 1993 U.S.C.C.A.N. 278, 538-39.) Such excess payments were inconsistent with the purpose of the Medicaid DSH payment, which is to ameliorate the real economic burden faced by hospitals that treat a disproportionate share of low-income patients and to ensure continued access to care for Medicaid patients. Accordingly, Congress imposed a hospital-specific limit that restricts Medicaid DSH payments to qualifying hospitals to the costs incurred by the hospital of providing inpatient and outpatient hospital services during the year to Medicaid eligible patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year, net of Medicaid payments (other than Medicaid DSH) and payments by uninsured patients. The statute states that the costs of providing services are “as determined by the Secretary,” and as further explained below, the Secretary has determined that “costs,” as it is used in the statute, are costs net of third-party payments received for those services, including, but not limited to, payments by Medicare and private insurance. As a result, the hospital-specific limit will reflect only the amount of uncompensated care costs for that same year.

Congress revisited the DSH payment requirements in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173, enacted on December 8, 2003). The MMA added section 1923(j) to the Act, which requires states to report specified information about their DSH payments, including independent, certified audits that, among other

elements, are required to review compliance with the hospital-specific limits under section 1923(g)(1)(A) of the Act. Significantly, section 1923(j)(2)(C) of the Act provides a gloss on section 1923(g)(1)(A), by specifying that the audits must verify that only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection [1923(g) of the Act] are included in the calculation of the hospital-specific limits under such subsection. Until the establishment of an audit requirement, there was no standardization among the states as to how the hospital-specific limit was calculated. In the late 1990’s and early 2000’s the Government Accountability Office (GAO) and the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued a series of reports focusing on the hospital-specific DSH limit. Among other findings, the GAO and OIG reports identified multiple instances where states included unallowable costs or did not account for costs net of applicable payments when determining the hospital-specific limits. These reviews and audits led to the enactment, as part of the MMA, of the audit requirements at section 1923(j) of the Act. Section 1923(j) of the Act not only required that we issue standardized audit methods and procedures, it also provided clarity on how the hospital-specific limit should be applied. Specifically, section 1923(j)(2)(C) of the Act provides that only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals (described in section 1923(g)(1)(A) of the Act) are included in the calculation of the hospital-specific limits under section 1923(g)(1)(A) of the Act. This provision makes clear that Congress intended that the hospital-specific limit at section 1923(g)(1) of the Act only includes uncompensated care costs. And it also makes clear that FFP is not available for DSH payments that exceed a hospital’s hospital-specific limit. In passing OBRA 93 and the hospital-specific DSH limit, Congress contemplated that hospitals with “large numbers of privately insured patients through which to offset their operating losses on the uninsured” may not warrant Medicaid DSH payments (H. Rep. 103-111, p. 211).

C. The 2008 DSH Final Rule and Subsequent Policy Guidance

Section 1001 of the MMA required annual state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the DSH

limit imposed at section 1923(g) of the Act.

In the August 26, 2005, **Federal Register** we published the “Medicaid Program; Disproportionate Share Hospital Payments” proposed rule (70 FR 50262) to implement the annual DSH audit and reporting requirements established or amended by the MMA. During the public comment period, one commenter requested clarification regarding the treatment of individuals dually eligible for Medicaid and Medicare for purposes of calculating the hospital-specific DSH limit. We responded to this comment in the “Medicaid Disproportionate Share Hospital Payments” final rule (73 FR 77904) (herein referred to as the 2008 DSH final rule) published in the December 19, 2008 **Federal Register**. As section 1923(g) of the Act limits DSH payments on a hospital-specific basis to “uncompensated costs,” the response to the comment clarified that all costs and payments associated with individuals dually eligible for Medicare and Medicaid, including Medicare payments received by the hospital on behalf of the patients, must be included in the calculation of the hospital-specific DSH limit. In other words, the extent to which a hospital receives Medicare payments for services rendered to Medicaid eligible patients must be accounted for in determining uncompensated care costs for those services.

We also indicated in the 2008 DSH final rule that to be considered an inpatient or outpatient hospital service for purposes of Medicaid DSH, a service must meet the federal and state definitions of an inpatient hospital service or outpatient hospital service and must be included in the state’s definition of an inpatient hospital service or outpatient hospital service under the approved state plan and paid under the state plan as an inpatient hospital or outpatient hospital service. While a state may have some flexibility to define the scope of inpatient or outpatient hospital services covered by the state plan, a state must use consistent definitions. Hospitals may engage in any number of activities, or may furnish practitioner, nursing facility, or other services to patients that are not within the scope of inpatient hospital services or outpatient hospital services and are not paid as such. These services are not considered inpatient or outpatient hospital services for purposes of calculating the Medicaid hospital-specific DSH limit.

Following the publication of the 2008 DSH final rule, we received numerous questions from interested parties

regarding the treatment of costs and payments associated with dual eligible and Medicaid eligible individuals who also have a source of third party coverage (for example, coverage from a private insurance company) for purposes of calculating uncompensated care costs. We posted additional policy guidance titled “*Additional Information on the DSH Reporting and Audit Requirements*” on the Medicaid Web site at <https://www.medicaid.gov/medicaid/financing-and-reimbursement/dsh/> making it clear that all costs and payments associated with dual eligible and individuals with a source of third party coverage must be included in calculating the hospital-specific DSH limit, as section 1923(g) of the Act limits DSH payments to “uncompensated costs.” This additional guidance was based upon the policy articulated in the 2008 DSH final rule and was consistent with subregulatory guidance issued to all state Medicaid directors on August 16, 2002.

In the August 16, 2002, letter to state Medicaid directors, we directed that when a state calculates the uninsured costs and the Medicaid shortfall for the OBRA 93 uncompensated care cost limits, it must reflect a hospital’s costs of providing services to Medicaid patients and the uninsured, net of Medicaid payments (except DSH) made under the state plan and net of third party payments. Medicaid payments include, but are not limited to, regular Medicaid fee-for-service rate payments, any supplemental or enhanced payments, and Medicaid managed care organization payments. The guidance also stated that not recognizing these payments would overstate a hospital’s amount of uninsured costs and Medicaid shortfall, thus inflating the OBRA 93 uncompensated care cost limits for that particular hospital. As state DSH payments are limited to an annual federal allotment, this policy is necessary to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients.

Prior to the 2008 DSH final rule, some states and hospitals were excluding both costs and payments associated with Medicaid eligible individuals with third party coverage, including Medicare, when calculating hospital-specific DSH limits (or were including costs while not including payments). Excluding both costs and payments associated with Medicaid eligible individuals is not consistent with the statutory requirement that we include the costs of all individuals “eligible for medical assistance,” which means those individuals eligible for Medicaid.

Including costs (while not including payments) led to the artificial inflation of uncompensated care costs and, correspondingly, of hospital-specific DSH limits and permitted some hospitals to be paid based on the same costs by two payers—once by Medicare or other third party payer and once by Medicaid. The clarification included in the 2008 DSH final rule and subsequent subregulatory guidance promotes fiscal integrity and equitable distribution of DSH payments among hospitals by preventing payment to DSH hospitals based on costs that are covered by Medicare or a private insurer. It also promotes program integrity by ensuring that hospitals receive Medicaid DSH payments only up to the actual uncompensated care costs incurred in providing inpatient and outpatient hospital services to Medicaid eligible individuals or individuals with no health insurance or other source of third party coverage.

Given the timing of the final rule and audit requirements, we recognized that there could have been a retroactive impact on some states and hospitals if the requirements had been imposed immediately. To ensure that states and hospitals did not experience any immediate adverse fiscal impact due to the publication of the DSH audit and reporting final rule and to foster development and refinement of auditing techniques, we included a transition period in the final rule. During this transition period, states were not required to repay FFP associated with Medicaid DSH overpayments identified through the annual DSH audits. The final rule allowed for a 3-year period between the close of the state plan rate year and when the final audit was due to us, which meant that audits for state plan rate year 2008 were not due to us until December 31, 2011. Recognizing that states would be auditing state plan rate years that closed prior to publication of the final rule, we stated in the final rule that there would be no financial implications until the audits for state plan rate year 2011 were due to us on December 31, 2014. This allowed states and hospitals to adjust to the audit requirements and make adjustments as necessary. This resulted in a transition period for the audits associated with state plan rate years 2005 through 2010.

The 2008 DSH final rule also reiterated our policy that costs and payments are treated on an aggregate, hospital-specific basis. In that rule, we explicitly acknowledge that there will be instances where Medicaid payments will be greater than the costs of treating Medicaid eligible patients. But because

those payments reduce the overall uncompensated costs of treating Medicaid eligible patients, we required that all Medicaid payments be included in the hospital-specific limit calculation, and explained that any “excess” payments will be applied against the uncompensated care costs that result from the uninsured calculation. This position is codified in § 455.304(d)(4). Specifically, for purposes of the hospital-specific limit calculation, any Medicaid payments, including but not limited to regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments, made to a disproportionate share hospital for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs for these services, are applied against the total uncompensated care costs of furnishing inpatient and outpatient hospital services to individuals with no source of third party coverage for such services.

The same principle applies to payments received from third party payers that exceed the cost of the service provided to a particular Medicaid eligible individual. All third party payments (including, but not limited to, payments by Medicare and private insurance) must be included in the calculation of uncompensated care costs for purposes of determining the hospital-specific DSH limit, regardless of what the Medicaid incurred cost is for treating the Medicaid eligible individual. For example, if a hospital treats two Medicaid eligible patients at a cost of \$2,000 and receives a \$500 payment from a third party for each individual and a \$100 payment from Medicaid for each individual, the total uncompensated care cost to the hospital is \$800, regardless of whether the payments received for one patient exceeded the cost of providing the service to that individual.

Subsequent to both the 2008 DSH final rule and the 2010 guidance, multiple states, hospitals, and other stakeholders expressed concern regarding this policy and requested clarification. In addition to requests for clarification, some states challenged this policy. We have disapproved one state plan amendment (SPA) proposing to exclude from the hospital-specific limit calculation the portion of a Medicare payment that exceeds the cost of providing a service to a dual eligible and one state plan amendment SPA proposing to exclude the portion of a third party commercial payment that exceeds the cost of providing a service

to a Medicaid eligible individual with private insurance coverage. Additionally, some hospitals, and one state government agency, have sued regarding the treatment of third party payers in calculating uncompensated care costs.

In light of the statutory requirement limiting DSH payments on a hospital-specific basis to uncompensated care costs, it is inconsistent with the statute to assist hospitals with costs that have already been compensated by third party payments. This final rule is designed to reiterate the policy and make explicit within the terms of the regulation that all costs and payments associated with dual eligible and individuals with a source of third party coverage must be included in calculating the hospital-specific DSH limit. This policy is necessary to ensure that only actual uncompensated care costs are included in the Medicaid hospital-specific DSH limit. And, because state DSH payments are limited to an annual federal allotment, this policy is also necessary to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients.

In a simplified example, consider a state that has only two hospitals. The first hospital treated only patients who were either uninsured or eligible for Medicaid, and received no payments other than from Medicaid. The hospital-specific limit for this hospital would be equal to the hospital’s total costs of treating its patients through inpatient hospital or outpatient hospital services minus the non-DSH Medicaid payments. The second hospital, on the other hand, treated only patients who were either uninsured or dually eligible for Medicaid and Medicare, and received no payments other than from Medicaid and Medicare. Under 1902(a)(13)(A)(iv) of the Act, the “situation” of the second hospital that receives comparatively generous payments from Medicare for the dual eligible is relevantly different than the “situation” of the first hospital that has not received such payments. Our policy—that Medicare and other third party payments must be taken into account when determining a hospital’s costs for the purpose of calculating Medicaid DSH payments—ensures that the DSH payment reflects the real economic burden of hospitals that treat a disproportionate share of low-income patients (that is, the “situation” of the hospitals). Turning back to the example, the hospital-specific limit for the second hospital must take into account both the Medicaid and Medicare payments. If the hospital-specific limit did not take into

account the Medicare payments, the second hospital would be able to receive DSH dollars in excess of its uncompensated care costs. As federal DSH funding is limited by the state-wide DSH allotment, the excess DSH payments to the second hospital may be at the expense of the first hospital, which could otherwise receive these DSH dollars.

II. Summary of Proposed Provisions

We proposed to clarify the hospital-specific limitation on Medicaid DSH payments under section 1923(g)(1)(A) of the Act and annual DSH audit requirements under section 1923(j) of the Act. Specifically, this rule proposes to modify the terms of the current regulation to make it explicit that “costs” for purposes of calculating hospital-specific DSH limits are costs net of third-party payments received.

At § 447.299 we proposed to clarify the definition of “Total cost of care for Medicaid IP/OP services” to specify that the total annual costs of inpatient hospital and outpatient hospital (IP/OP) services must account for all third party payments, including, but not limited to payments by Medicare and private insurance.

III. Analysis of and Responses to Public Comments

We received 161 timely comments from state Medicaid agencies, provider associations, providers, and other interested parties, in response to the publication of the Disproportionate Share Hospital Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs proposed rule. During our review of these comments, we identified 10 general comment areas, in which we received multiple comments, from multiple respondents. We also received 9 specific comments that did not fit into the general comment areas. Those comments and our responses are included below.

A. Proposed Rule Is Consistent With the Statute

Comment: Many commenters suggested that CMS’ interpretation of the hospital-specific limit is inconsistent with the statutory language under section 1923(g)(1)(A) of the Social Security Act, or that CMS’ interpretation is not required under section 1923(j) of the Act.

Response: We disagree with these commenters. The statute limits Medicaid DSH payments to the amount of uncompensated care costs for that same year. Specifically, the statute limits the DSH payment to the costs

incurred by the hospital of providing inpatient and outpatient hospital services during the year to Medicaid eligible patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year, net of Medicaid payments (other than Medicaid DSH) and payments by uninsured patients. The statute states that the costs of providing services are “as determined by the Secretary”; such language gives us the discretion to take Medicare and other third party payments into account when determining a hospital’s costs for the purpose of calculating Medicaid DSH payments. As a result, the hospital-specific limit calculation reflects only the costs for Medicaid eligible individuals for which the hospital has not received payment from any source.

Even though the 2008 regulation did not expressly mention Medicare and third party payments, this policy is necessary to facilitate the Congressional directive of section 1923 of the Act in general, and the hospital-specific limit in particular, of limiting the DSH payment to a hospital’s uncompensated care costs. Moreover, we have been clear in our longstanding policy and in the 2008 rule that all third party payments must be taken into account when calculating the hospital-specific limit. This policy was also articulated in subsequent implementation guidance.

B. Uninsured and Dual Eligible Patients

Comment: A number of commenters suggested that the policy reflected in the proposed rule should not apply to dual eligible patients for which there has not been a Medicaid claim generated or a Medicaid payment received on behalf of the dually eligible individual, noting that children who qualify for Medicaid often have Medicaid as their secondary coverage. According to the commenters, by including private insurance payments for services never billed to Medicaid, hospitals serving a high number of children with complex medical conditions may become ineligible for DSH funds, even though they have substantial losses for Medicaid-paid admissions and for the uninsured.

Response: The statutory language refers to those “eligible for medical assistance,” which means those individuals eligible for Medicaid benefits. The statutory language does not condition eligibility on whether the cost of the service was claimed, or if a Medicaid payment was received. Therefore, all costs and payments associated with Medicaid eligible individuals must be included in the

hospital-specific limit calculation, regardless of whether Medicaid made a payment.

Moreover, the commenters’ belief—that under our longstanding policy, a hospital may receive a DSH payment up to the hospital-specific limit and nevertheless incur “substantial losses” for treating Medicaid eligible and uninsured individuals—is incorrect. In the situation where a hospital receives a DSH payment up to the hospital-specific limit, a hospital will have received payments equal to the cost of providing inpatient and outpatient hospital services to Medicaid eligible and the uninsured (from Medicaid, Medicaid DSH, and from other payers). Rather, it appears that the commenters are suggesting that the hospital-specific limit calculation should take into account the cost of services that are not paid for as inpatient or outpatient services or costs that are not paid for by Medicaid at all. Ancillary programs and services that hospitals provide to patients may be laudable, but they are not paid for by Medicaid because they are not costs associated with furnishing inpatient and outpatient hospital services to Medicaid eligible and uninsured individuals. To the extent a hospital has actual uncompensated care costs for furnishing such hospital services, the hospital will be eligible to receive a DSH payment in accordance with the statute and regulation. Under our interpretation of the statute, the hospital-specific limit ensures that a hospital’s eligible uncompensated care costs may be compensated but that Medicaid DSH payments will not double pay for costs that have already been compensated. Accordingly, we believe our approach best fulfills the purpose of the DSH statute.

Comment: A few of the commenters suggested that CMS needs to reconsider how they determine a patient is uninsured, suggesting, for example, that the one-time determination of an individual’s status as having third-party coverage should be reconsidered. The commenters also suggested that CMS should allow an inpatient hospital service to be reevaluated at the point that a benefit limit or dollar limit is reached, or benefits are otherwise exhausted, in which case the individual may be treated as uninsured for that portion of the stay.

Response: We thank the commenters for this comment, but it is outside the scope of this rule. This rule does not address how a patient is determined to be “uninsured”. Rather, the rule is clarifying existing policy on the calculation of Medicaid uncompensated

care costs for the purposes of making Medicaid DSH payments.

C. Effective Date

Comment: Multiple commenters suggested that, if the proposed rule is finalized, CMS should only impose this policy prospectively and should provide an adequate transition period to allow states to change their payment methodologies.

Response: This rule is providing clarification to existing policy, therefore there is no issue of retroactivity, nor a need for a transition period. Under the 2008 regulation, states were provided a 5-year transition period, from 2005 through 2010. Given previous rulemaking and implementing guidance, we do not believe it is necessary to afford an additional transition period.

D. No Increased Burden to States or Hospitals

Comment: Many commenters suggested that the regulation will impose a great burden on all involved, which outweighs any incremental benefit in transparency and accountability, and diverts scarce financial and human resources away from providing and paying for care to beneficiaries.

Response: We disagree with the commenters and believe that taking into account all third party payments associated with a Medicaid eligible individual better facilitates the Congressional directive of section 1923 of the Act in general, and the hospital-specific limit in particular. Medicaid DSH payments are limited to an annual federal allotment. As states often use most or all of their federal DSH allotment, in practice, if one hospital gets more DSH funding, other DSH-eligible hospitals in the state may get less. This policy ensures that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients. This rule does not reflect a change in policy and the language of this final rule accurately reflects existing policy.

E. Pending Litigation

Comment: Multiple commenters suggested that in light of the pending litigation, CMS should withdraw the proposed rule, refrain from enforcing its subregulatory guidance, and await the outcome of that litigation.

Response: This final rule is a clarification of the existing policy and as such it is not necessary to wait for the outcome of the pending litigation. We believe that our interpretation—that all third party payments should be taken into account—better facilitates the

Congressional directive of section 1923 of the Act in general, and the hospital-specific limit in particular, by limiting the DSH payment to a hospital's uncompensated care costs.

F. Additional Costs Affecting Medicaid

Comment: A number of commenters stated that the proposed rule would ensure consistency in how Medicaid shortfall is calculated and provide a more complete measure of the financial impact of these patients on hospital finances. These commenters suggested including certain costs of physicians and clinic services provided by hospitals in the calculation of "uncompensated care costs." The commenters also suggested including provider contributions toward the non-federal share of DSH payments through health care related taxes and other mechanisms, which affect their net Medicaid payments.

Response: We agree with the commenters that the rule as proposed would ensure consistency in how Medicaid uncompensated care costs are calculated and provide a more complete measure of the financial impact of Medicaid eligible patients on DSH hospitals. The proposed rule did not address whether certain costs of physicians and clinic services provided by hospitals and provider contributions toward the non-federal share of DSH payments should be included for purposes of calculating the hospital-specific limit. Therefore, this rule only addresses the scope of inpatient and outpatient hospital costs that can be included for Medicaid DSH purposes.

G. Policy Clarification

Comment: Many commenters suggested that CMS withdraw the proposed rule because it is not a clarification of existing policy, but rather a substantive rule that is changing the current policy.

Response: We disagree. This rule does not reflect a change and the language of this final rule accurately reflects existing policy. This policy has also been articulated in the 2008 DSH final rule, as well as implementing guidance.

H. Rule Poses No Financial Impact

Comment: A few commenters suggested that the proposed rule would redistribute billions of dollars, therefore the rule will be considered as having an economically significant impact on hospitals. The commenters requested that CMS make all records available, including data and reports, used in drafting the proposed rule and publish a regulatory impact analysis for the rule.

Response: Not recognizing third party payments associated with Medicaid eligible individuals would overstate a hospital's uncompensated care costs, thus inappropriately inflating the hospital-specific limit. Providing clarification to the existing policy ensures that the limited Medicaid DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients. The regulatory impact of this final rule is specifically addressed in the regulatory impact section.

I. Appropriate Allocation of DSH Funds

Comment: Multiple commenters suggested that the proposed rule is most harmful to children's hospitals and safety net hospitals, such as Medicare-dependent hospitals, rural facilities, critical access hospitals, sole community hospitals, and Indian Health Service (IHS) areas, which are the very hospitals that the Medicaid DSH program was developed to help.

Response: The policy reflected in the proposed rule does not disproportionately harm children's hospitals and safety net hospitals. We believe this rule ensures the appropriate allocation of Medicaid DSH dollars to those hospitals that have a true financial shortfall related to serving Medicaid eligible individuals. The intent of this rule is to provide clarification to the statutory requirements and ensure Medicaid DSH dollars are available to offset costs that are truly uncompensated.

J. Applying the Rule

Comment: A few commenters suggested that CMS should withdraw the proposed rule because, if finalized, this rule cannot be enforced, applied or implemented uniformly across all states.

Response: This rule ensures that existing interpretive policy is explicitly reflected in our regulatory text. This policy is currently being enforced, applied and implemented uniformly across all states, except in limited instances where we have suspended enforcement of the existing policy in light of court orders. We appreciate the commenters' concern but are finalizing the rule as proposed.

In addition to the comments we discussed above, we received 9 comments that did not fit into the 10 general comment areas. Those additional 9 comments, along with our responses, are included below.

Comment: One commenter suggested that comments received through the rulemaking process cannot be considered meaningful consultation within the scope of Executive Order

13175 and CMS' own tribal consultation policy, which states that tribal consultation must take place prior to the rulemaking process.

Response: Executive Order 13175 and our own tribal consultation policy state that to the extent practicable and permitted by law, no agency shall issue any regulation that will significantly affect Indian Tribes, without prior consultation with tribal officials. The rule as proposed would not have a significant impact on Indian Tribes because the language of this rule accurately reflects existing policy that is currently being enforced, applied and implemented uniformly across all states, except in limited instances where we have suspended enforcement of the existing policy in light of court orders. Further, this policy has been previously articulated in the 2008 DSH final rule. During the development of the 2008 DSH final rule, the agency held the required tribal consultation.

Comment: One commenter wanted to reiterate concerns raised in comments submitted on CMS-1655-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long-Term Care Hospital Payment System and Proposed Policy Changes and Fiscal Year 2017 rates, et al. The Medicare DSH payment is a percentage add-on to the standard diagnosis-related group (DRG) payment (excluding new technology add-on payments and outlier payments). Effective October 1, 2013 the methodology for calculating Medicare DSH payments was revised so that eligible hospitals are paid 25 percent of the DSH payment under the previous methodology, and the remaining 75 percent is an uncompensated care payment allocated from a prospectively determined estimate of dollars. Medicare allocates these dollars based on the ratio of a hospital's uncompensated care costs to the uncompensated care costs of all hospitals eligible for Medicare DSH. We proposed to define uncompensated care costs as the costs of charity care and non-Medicare bad debt and to incorporate Worksheet S-10 data over a 3-year period beginning in FY 2018, where insured low income day data (which we have been using as a proxy for uncompensated care costs) will be averaged with uncompensated care cost data.

Response: This rule does not impact the formula for calculating Medicare DSH payments. Medicaid and Medicare DSH operate under two different statutory authorities and this final rule only addresses the Medicaid DSH calculation. As such, Medicaid

uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for all payments received by hospitals by or on behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals.

Comment: One commenter stated that adherence to Medicare reasonable costs principles and methods in the DSH program is clearly emphasized throughout the law, the rules and other CMS guidance, and that FAQ 33 violates these principles, many of which are foundational to the earliest days of the Medicare and Medicaid program. According to the commenter, CMS stated in FAQ 21 that the same methods used in preparing the Medicare 2552–96 cost report should be applied in determining costs to be used in calculating the hospital-specific DSH limits, and that Medicare reasonable cost principles do not allow for other patients to bear the cost of care provided to program beneficiaries.

Response: In the Additional Information on the DSH Reporting and Audit Requirements, Part I, FAQ 33, we clarified that “days, costs, and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. As Medicaid should be the payer of last resort, hospitals should also offset both Medicaid and third-party revenue associated with the Medicaid eligible day against the costs for that day to determine any uncompensated amount.” We disagree that this violates Medicare cost principles or general methods in the CMS–2552 cost report. Since the costs of these services are included in the hospital-specific DSH limit calculation, revenue associated with those same services must be applied as offsets to arrive at net costs to the hospital for the services. In the CMS–2552 settlement worksheets, payments received for program services, including payment from non-program sources, are offset against costs of program services (or program payment amount) to arrive at net program payment. Furthermore, we disagree that this application results in other patients bearing the cost of care provided to program beneficiaries. The clarification in the cited FAQ and in this rule continues to allow the hospital-specific DSH limit to recognize a hospital’s uncompensated care costs for Medicaid services (including those Medicaid services for which there is Medicare or third party payment) and uninsured services.

Comment: One commenter suggested that CMS and states should leverage the same coordination of benefits processes employed by state Medicaid programs, which would capture resource and cost efficiencies as well as economies of scale. According to the commenter, CMS and states must mandate that providers of DSH services submit individual claims transactions through MMIS so that Medicaid will be able to look for instances where the uninsured individual has access to other health insurance that can be billed as primary. The commenter suggested that these recommendations are in line with GAO and MACPAC recommendations.

Response: While we understand the importance of ensuring accurate accounting of payments, this rule is not related to coordination of benefits or claims transactions. We always encourage state efforts to assist uninsured individuals in exploring avenues to obtain health care coverage. Also, Medicaid DSH is not an individual service payment, rather it is a payment in recognition of costs that certain hospitals incur for serving Medicaid and uninsured individuals.

Comment: One commenter referenced a State Medicaid Plan, approved by CMS from 2004 to 2013, which set forth the hospital-specific Medicaid DSH limit calculation in detail and made no mention of private health insurance or Medicare payments made on behalf of Medicaid eligible patients as separate offsets.

Response: The approved state plan in question did not go into sufficient detail to address the policy at issue here. The state plan language provided assurances that the state was abiding by statutory requirements, but did not delve into the details of the hospital-specific limit. We anticipate that the state in question will comply with applicable statutory and regulatory requirements in implementing its state plan, and that the independent DSH audit will determine if it did so.

Comment: One commenter requested clarification that the proposed rule in no way affects the qualifying criteria for a hospital being deemed DSH, and that it only applies to limit the financial benefit associated with such determination.

Response: This final rule does not address deeming qualifications for hospitals for Medicaid DSH purposes. Determining how a hospital qualifies as a DSH is not within the scope of this rule.

Comment: One commenter asked that we address whether the source of private insurance must come from private health insurance owned by the

Medicaid beneficiary or whether it can come from a policy otherwise identifying the Medicaid beneficiary and paying the hospital for hospital services furnished to the beneficiary.

Response: This rule clarifies existing policy that uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments received by hospitals by or on behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals. Therefore, those payments received by or on behalf of Medicaid eligible individuals from private health insurance, regardless of whether the policy is owned by or otherwise covers some or all of the costs of hospital services furnished to the Medicaid beneficiary, must be accounted for.

Comment: One commenter encouraged CMS to permit a hospital to carry net uncompensated care cost forward for one year, in the event that the following year a DSH qualified hospital realized an extraordinary third party liability (TPL) recovery year, resulting in the hospital exceeding its hospital-specific limit.

Response: This rule does not address how uncompensated care costs are attributed for accounting purposes. The final rule from 2008 lays out the detailed requirements for how costs should be audited and reported, and those requirements do not permit a hospital to carry net uncompensated care cost forward for one year, in the event that the following year a DSH qualified hospital realized an extraordinary TPL recovery year.

Comment: One commenter suggested CMS consider the Medicaid provider tax with this rule, stating that the Medicaid provider tax on the state’s hospitals is currently only using 28 percent of the tax money to benefit the hospitals by funding the Medicaid DSH allotment. According to the commenter, this rule could have many of these hospitals paying this provider tax without receiving anything back in the form of DSH payments to help offset the cost.

Response: This rule does not address how states utilize revenues generated by health-care related taxes. While we realize that many states impose health care-related taxes to generate non-federal share for Medicaid payments, there is no requirement that the revenues be used to fund payments back to the same provider class. States have flexibility in how they utilize the revenues so long as there are no hold harmless violations.

IV. Provisions of the Final Rule

We are finalizing the provisions as proposed.

V. Collection of Information Requirements

This rule does not impose any new or revised information collection requirements or burden. It does not impact currently approved reporting, auditing, or state plan requirements or associated burden estimates. Consequently, this rule is not subject to the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

VI. Regulatory Impact Statement

A. Statement of Need

This final rule will ensure that only the uncompensated care costs for covered services provided to Medicaid eligible individuals are included in the calculation of the hospital-specific DSH limit, as required by section 1923(g) of the Act.

B. Overall Impact

We have examined the impacts 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 (Pub. L. 96–354 enacted on September 19, 1980) (RFA), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4 enacted on March 22, 1995) (UMRA), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

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). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by

another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a “significant regulatory action” under E.O. 12866, nor a “major rule” under the Congressional Review Act.

The RFA requires agencies to analyze options for regulatory relief for small entities, and to prepare a final regulatory flexibility analysis if a rule is found to have a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than \$7.5 million to \$38.5 million in any 1 year).

We are not preparing a final regulatory flexibility analysis because we have determined, and the Secretary certifies, that this final rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if 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 604 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 final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (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. Currently, that threshold is approximately \$146

million. Since this rule would not mandate spending costs on state, local, or tribal governments in the aggregate, or by the private sector over the threshold of \$146 million or more in any 1 year, the requirements of the UMRA are not applicable.

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.

C. Anticipated Effects

1. Effects on State Medicaid Programs

Because this is not a change in policy, we do not anticipate that this final rule will have significant financial effects on state Medicaid programs. This rule will only make explicit within the terms of the regulation that “costs” for purposes of section 1923(g) of the Act are costs net of third-party payments.

2. Effects on Other Providers

Because this is not a change in policy, we do not anticipate that this final rule will have significant financial effects on other providers. This rule would only make explicit within the regulation that “costs” for purposes of section 1923(g) of the Act are costs net of amounts that have been paid by third parties and will ensure a more equitable distribution of Medicaid DSH payments within each state.

D. Alternatives Considered

We considered not proposing this rule. However, numerous states and other stakeholders have requested clarification regarding this requirement. Accordingly, we are proposing to make explicit within the terms of our regulation our existing policy that implements sections (g) and (j) of the Act, in part.

Additionally, we considered issuing additional policy guidance through subregulatory means, such as a letter to all state Medicaid directors. However, we anticipate that modifying the regulatory text of 42 CFR part 447 is as clear and comprehensive as possible on this issue, avoiding any need for future clarification.

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 amends 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 447.299 is amended by revising paragraph (c)(10) to read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

(10) *Total Cost of Care for Medicaid IP/OP Services.* The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals. The total annual costs are determined on a hospital-specific basis, not a service-specific basis. For purposes of this section, costs—

(i) Are defined as costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance.

(ii) Must capture the total burden on the hospital of treating Medicaid eligible patients prior to payment by Medicaid. Thus, costs must be determined in the aggregate and not by estimating the cost of individual patients. For example, if a hospital treats two Medicaid eligible patients at a cost of \$2,000 and receives a \$500 payment from a third party for each individual, the total cost to the hospital for purposes of this section is \$1,000, regardless of whether the third party payment received for one patient exceeds the cost of providing the service to that individual.

* * * * *

Dated: March 24, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: March 28, 2017.

Thomas E. Price,

Secretary, Department of Health and Human Services.

[FR Doc. 2017-06538 Filed 3-30-17; 4:15 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF HOMELAND SECURITY**Federal Emergency Management Agency****44 CFR Part 64**

[Docket ID FEMA-2016-0002; Internal Agency Docket No. FEMA-8473]

Suspension of Community Eligibility

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: This rule identifies communities where the sale of flood insurance has been authorized under the National Flood Insurance Program (NFIP) that are scheduled for suspension on the effective dates listed within this rule because of noncompliance with the floodplain management requirements of the program. If the Federal Emergency Management Agency (FEMA) receives documentation that the community has adopted the required floodplain management measures prior to the effective suspension date given in this rule, the suspension will not occur and a notice of this will be provided by publication in the **Federal Register** on a subsequent date. Also, information identifying the current participation status of a community can be obtained from FEMA's Community Status Book (CSB). The CSB is available at <https://www.fema.gov/national-flood-insurance-program-community-status-book>.

DATES: The effective date of each community's scheduled suspension is the third date ("Susp.") listed in the third column of the following tables.

FOR FURTHER INFORMATION CONTACT: If you want to determine whether a particular community was suspended on the suspension date or for further information, contact Patricia Suber, Federal Insurance and Mitigation Administration, Federal Emergency Management Agency, 400 C Street SW., Washington, DC 20472, (202) 646-4149.

SUPPLEMENTARY INFORMATION: The NFIP enables property owners to purchase Federal flood insurance that is not otherwise generally available from private insurers. In return, communities agree to adopt and administer local floodplain management measures aimed at protecting lives and new construction from future flooding. Section 1315 of the National Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits the sale of NFIP flood insurance unless an appropriate public

body adopts adequate floodplain management measures with effective enforcement measures. The communities listed in this document no longer meet that statutory requirement for compliance with program regulations, 44 CFR part 59. Accordingly, the communities will be suspended on the effective date in the third column. As of that date, flood insurance will no longer be available in the community. We recognize that some of these communities may adopt and submit the required documentation of legally enforceable floodplain management measures after this rule is published but prior to the actual suspension date. These communities will not be suspended and will continue to be eligible for the sale of NFIP flood insurance. A notice withdrawing the suspension of such communities will be published in the **Federal Register**.

In addition, FEMA publishes a Flood Insurance Rate Map (FIRM) that identifies the Special Flood Hazard Areas (SFHAs) in these communities. The date of the FIRM, if one has been published, is indicated in the fourth column of the table. No direct Federal financial assistance (except assistance pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act not in connection with a flood) may be provided for construction or acquisition of buildings in identified SFHAs for communities not participating in the NFIP and identified for more than a year on FEMA's initial FIRM for the community as having flood-prone areas (section 202(a) of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4106(a), as amended). This prohibition against certain types of Federal assistance becomes effective for the communities listed on the date shown in the last column. The Administrator finds that notice and public comment procedures under 5 U.S.C. 553(b), are impracticable and unnecessary because communities listed in this final rule have been adequately notified.

Each community receives 6-month, 90-day, and 30-day notification letters addressed to the Chief Executive Officer stating that the community will be suspended unless the required floodplain management measures are met prior to the effective suspension date. Since these notifications were made, this final rule may take effect within less than 30 days.

National Environmental Policy Act. FEMA has determined that the community suspension(s) included in this rule is a non-discretionary action and therefore the National