Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Robin Moseley, M.A.T., Designated Federal Officer, OID, CDC, 1600 Clifton Road NE., Mailstop D10, Atlanta, Georgia 30333, Telephone: (404) 639–4461.

The Director, Management Analysis and Services Office has been delegated the authority to sign Federal Register notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2014–17739 Filed 7–28–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Request for Nominations of Candidates To Serve on the Advisory Committee to the Director, Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is soliciting nominations for possible membership on the Advisory Committee to the Director, Centers for Disease Control and Prevention (ACD, CDC). This committee consists of 15 experts in fields related to health policy, public health, global health, preparedness, preventive medicine, the faith-based and community-based sector, and allied fields who are selected by the Secretary of the U.S. Department of Health and Human Services (HHS). The committee advises the HHS Secretary and the CDC Director concerning policy and broad strategies that will enable CDC to fulfill its mission of protecting health through health promotion, prevention, and preparedness. The committee recommends ways to prioritize CDC's activities, improve results, and address health disparities. It also provides guidance to help CDC work more effectively with its various private and public sector constituents to make health protection a practical reality.

Nominations are being sought for individuals who have expertise and qualifications necessary to contribute to the accomplishment of the committee's mission. Nominees will be selected by the HHS Secretary or designee from authorities knowledgeable in the fields of public health as well as from the general public. Members may be invited to serve for terms of up to four years.

The U.S. Department of Health and Human Services policy stipulates that committee membership shall be balanced in terms of professional training and background, points of view represented, and the committee's function. In addition to a broad range of expertise, consideration is given to a broad representation of geographic areas within the U.S., with diverse representation of both genders, ethnic and racial minorities, lesbian, gay, bisexual, and transgender and persons with disabilities. Nominees must be U.S. citizens, and cannot be full-time employees of the U.S. Government.

Candidates should submit the following items:

- Current *curriculum vitae,* including complete contact information (name, affiliation, mailing address, telephone number, email address);
- A letter of recommendation stating the qualifications of the candidate.

Nomination materials must be postmarked by August 31, 2014, and sent to: Gayle Hickman, Office of the Chief of Staff, Centers for Disease Control and Prevention, 1600 Clifton Road, NE., Mailstop D14, Atlanta, Georgia 30333, telephone (404) 639–7158.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both the Centers for Disease Control and Prevention, and the Agency for Toxic Substances and Disease Registry.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. 2014–17736 Filed 7–28–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval; Louisiana Medicaid State Plan Amendments (SPAs) 13–23, 13–25 and 13–28

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

ACTION: Notice of Hearing: Reconsideration of Disapproval.

SUMMARY: This notice announces an administrative hearing to be held on September 9, 2014, at the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Division of Medicaid & Children's Health, Dallas Regional Office, 1301 Young Street, Room #801, 8th Floor Dallas, Texas 75202 to reconsider CMS' decision to disapprove Louisiana's Medicaid SPAs 13–23, 13–25 and 13–28.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by August 13, 2014.

FOR FURTHER INFORMATION CONTACT: Benjamin R. Cohen, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244, Telephone: (410) 786–3169.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS' decision to disapprove the Louisiana Medicaid SPAs 13–23, 13–25 and 13–28. CMS received Louisiana SPAs 13–23 and 13–25 on June 27, 2013, and 13–28 on July 12, 2013 with proposed effective dates of June 24, 2013 and October 1, 2013, respectively. The amendments propose to provide for supplemental Medicaid inpatient hospital payments and disproportionate share hospital (DSH) payments to private hospitals participating in public-private partnerships. These SPAs were disapproved on May 2, 2014.

The issues to be considered at the hearing are:

- Whether the state established that Louisiana SPAs 13–23, 13–25 and 13–28 comply with section 1903(w) of the Social Security Act (the Act) which generally provides that state expenditures are not allowable to the extent that the state receives certain provider-related donations and taxes As set forth in implementing regulations at 42 Code of the **Federal Register** (CFR) 433.54, expenditures are not allowable, and federal financial participation (FFP) is not available, to the extent that the state receives provider-related donations and there is a ''hold harmless arrangement'' under which providers (or the provider class) could be effectively repaid for a provider-related tax or donation through any direct or indirect payment, offset, or waiver.

○ Specifically, at issue is whether (1) the state established that certain payments from providers to the state (characterized by the state as advance lease payments) were not provider donations, when the state did not document such payments to be consistent with ordinary market business practices for leasing property;

(2) whether the state established that the supplemental and DSH payments made under the SPAs were not linked to Cooperative Endeavor Agreements that provide, among other things, for of the advance lease payments from privately owned hospitals that are at issue when such agreements were entered into with entities qualifying for increased Medicaid payments under the SPA; and (3) whether the state established that there was no hold harmless arrangement despite the apparent return of donated funds back to the private hospitals in the form of increased Medicaid payments.

As noted in this statement of the issues set forth above, the burden is on the state to demonstrate that the ''advance lease payments'' were not a donation, were not linked to Medicaid payments, and that there is no hold harmless arrangement. CMS is authorized under section 1902(b) of the Act, as implemented by 42 CFR Part 430, Subpart B, to approve state plan amendments only based on a determination that the amendments comply with the requirements of relevant federal statutes and regulations and can serve as a basis for FFP.

- Whether Louisiana SPAs 13–23, 13–25 and 13–28 comply with the requirements of 1902(a)(2) and 1902(a)(4) of the Act which requires that the state plan provide for the non-federal share of expenditures under the state plan, from either state or local funding. Because the SPAs at issue propose to claim for FFP without adjustment to reflect unallowable expenditures resulting from the provider related donation and hold harmless arrangement discussed above, they would result in a non-federal share that would be insufficient to meet the requirements of section 1902(a)(2). Moreover, section 1902(a)(4) of the Act requires that the state plan comply with methods of administration as are found necessary by the Secretary for the proper and efficient operation of the plan. Among the implementing regulations for section 1902(a)(4) of the Act is the requirement at 42 CFR 430.10 that a state plan contain all information necessary for CMS to determine that the plan can be approved to serve as a basis for FFP in the state program. Because the state has not established that the supplemental payments are not part of a hold harmless arrangement that would result in a reduction in FFP, the state has not established that the SPAs are consistent with section 1902(a)(4) and the implementing regulations at 42 CFR 430.10.
- Whether the state has established that the supplemental payments set forth in Louisiana SPA 13–23, 13–25, and 13.28 are consistent with the statutory requirement at section 1902(a)(30)(A) of the Act that payments must be ''consistent with efficiency, economy, and quality of care''.
- Whether Louisiana SPAs 13–23, 13–25 and 13–28 comport with the broad principles of the federal-state partnership embodied in section 1903(a) of the Act, because they indicate circumstances in which the federal government would pay more than its share of the net expenditures, after accounting for claimed expenditures that are effectively repaid by the provider-related donations.

Section 1116 of the Act and federal regulations at 42 CFR Part 430, establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to Louisiana announcing an administrative hearing to reconsider the disapproval of its SPAs reads as follows:

Ms. J. Ruth Kennedy, Medicaid Director, Department of Health and Hospitals, 628 North 4th Street, P.O. Box 91030, Baton Rouge, LA 70821–9030.

Dear Ms. Kennedy: I am responding to your request for reconsideration of the decision to disapprove Louisiana State Plan Amendments (SPAs) 13–23, 13–25 and 13–28. The Centers for Medicare & Medicaid Services (CMS) received SPAs 13–23 and 13–25 on June 27, 2013, and 13–28 on July 12, 2013 with proposed effective dates of June 24, 2013 and October 1, 2013, respectively. The amendments propose to provide for supplemental Medicaid inpatient hospital payments and disproportionate share hospital (DSH) payments to private hospitals participating in public-private partnerships. These SPAs were disapproved on May 2, 2014.

I am scheduling a hearing on your request for reconsideration to be held on September 9, 2014, at the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Division of Medicaid & Children's Health, Dallas Regional Office, 1301 Young Street, Room #801, Dallas, Texas 75202. The issues to be considered at the hearing are:

- Whether the state established that Louisiana SPAs 13–23, 13–25 and 13–28 comply with section 1903(w) of the Social Security Act (the Act) which generally provides that state expenditures are not allowable to the extent that the state receives provider-related donations and taxes. As set forth in implementing regulations at 42 Code of the Federal Register (CFR) 433.54, expenditures are not allowable, and federal financial participation (FFP) is not available, to the extent that the state receives provider-related donations and there is a ''hold harmless arrangement'' under which providers (or the provider class) could be effectively repaid for a provider-related tax or donation through any direct or indirect payment, offset, or waiver.
  - Specifically, at issue is whether (1) the state established that certain payments from providers to the state (characterized by the state as advance lease payments) were not provider donations, when the state did not document such payments to be consistent with ordinary market business practices for leasing property; (2) whether the state established that the supplemental and DSH payments made under the SPAs were not linked to Cooperative Endeavor Agreements that provide, among other things, for the advance lease payments from privately owned hospitals that are at issue when such agreements were entered into with entities qualifying for increased Medicaid payments under the SPAs; and (3) whether the state established that there was no hold harmless arrangement despite the apparent return of donated funds back to the private hospitals in the form of increased Medicaid payments.
  - As noted in this statement of the issues set forth above, the burden is on the state to demonstrate that the ''advance lease payments'' were not a donation, were not linked to Medicaid payments, and that there is no hold harmless arrangement. CMS is authorized under section 1902(b) of the Act, as implemented by 42 CFR Part 430, Subpart B, to approve state plan

amendments only based on a determination that the amendments comply the requirements of relevant federal statutes and regulations and can serve as a basis for FFP.

• Whether Louisiana SPAs 13–23, 13–25 and 13–28 comply with the requirements of 1902(a)(2) and 1902(a)(4) of the Act which requires that the state plan provide for the non-federal share of expenditures under the state plan, from either state or local funding. Because the SPAs at issue propose to claim for FFP without adjustment to reflect unallowable expenditures resulting from the provider related donation and hold harmless arrangement discussed above, they would result in a non-federal share that would be insufficient to meet the requirements of section 1902(a)(2). Moreover, section 1902(a)(4) of the Act requires that the state plan comply with methods of administration as are found necessary by the Secretary for the proper and efficient operation of the plan. Among the implementing regulations for section 1902(a)(4) of the Act is the requirement at 42 CFR 430.10 that a state plan contain all information necessary for CMS to determine that the plan can be approved to serve as a basis for FFP in the state program. Because the state has not established that the supplemental payments are not part of a hold harmless arrangement that would result in a reduction in FFP, t the state has not established that the SPAs are consistent with section 1902(a)(4) and the implementing regulations at 42 CFR 430.10.

• Whether the state has established that the supplemental payments set forth in Louisiana SPAs 13–23, 13–25, and 13–28 are consistent with the statutory requirement at section 1902(a)(30)(A) of the Act that payments must be ''consistent with efficiency, economy, and quality of care''.

• Whether Louisiana SPAs 13–23, 13–25 and 13–28 comport with the broad principles of the federal-state partnership embodied in section 1903(a) of the Act, because they indicate circumstances in which the federal government would pay more than its share of the net expenditures, after accounting for claimed expenditures that are effectively repaid by the provider-related donations.

If the hearing date is not acceptable, I would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786 3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the state at the hearing.

Sincerely,

Marilyn Tavenner

cc: Benjamin R. Cohen

Section 1116 of the Social Security Act (42 U.S.C. section 1316; 42 CFR section 430.18)

(Catalog of Federal Domestic Assistance program No. 13.714, Medicaid Assistance Program.)

Dated: July 23, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2014–17871 Filed 7–28–14; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6057–N]

Medicare Program; Expanded Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration

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

ACTION: Notice.

SUMMARY: This notice announces the expansion of the Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration to 12 additional states.

DATES: This expanded demonstration begins on October 1, 2014.

FOR FURTHER INFORMATION CONTACT: Doris M. Jackson, (410) 786–4459.

Questions regarding the Medicare Prior Authorization for Power Mobility Device Demonstration should be sent to *pademo@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(a)(1)(J)), authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program. On September 1, 2012, we implemented the Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration that would operate for a period of 3 years (September 1, 2012 through August 31, 2015). The demonstration was initially implemented in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas. These states were selected for the demonstrations based upon their history of having high levels of improper payments and incidents of fraud related to PMDs. The objective of the demonstration is to develop improved methods for the investigation and prosecution of fraud in order to protect the Medicare Trust Fund from fraudulent actions and any resulting improper payments. This demonstration is providing the agency with valuable data through which the agency, working with its partners, can develop new avenues for combating the submission of fraudulent claims to the Medicare program for PMDs and improving methods for the investigation and prosecution of PMD fraud. We will share demonstration data within the agency, with our contractors, and with law enforcement partners for further analysis and investigation. We believe that data evidencing changes in physician ordering and supplier billing practices that coincide with this demonstration could provide investigators and law enforcement with important information for determining how and where to focus their investigations concerning fraud in the provision of PMDs. For instance, results from this demonstration could potentially indicate collaboration between ordering physicians and suppliers in submitting fraudulent claims for PMDs. This data could assist investigators and law enforcement in targeting their investigations in this area. Additionally, changes in billing practices that result from this demonstration could provide specific leads for investigators and law enforcement personnel. For instance, where a supplier that frequently submitted claims prior to the demonstration stops submitting claims during the demonstration, law enforcement may determine it prudent to investigate that supplier.

Data we will analyze will include the following:

• Suppliers who no longer bill or have a significant decrease in billing.

• Physicians/treating practitioners with a high volume of submissions.

• Codes that show a dramatic increase in use.

Based on preliminary data collected, spending per month on PMDs in the