

Summary reports, status reports, reports of the Office of Inspector General, and reports of actions taken pursuant to authority delegated by the Board of Directors.

#### Discussion Agenda

Memorandum and resolution re: Final Rule: Credit Risk Retention.

Briefing re: Update of Projected Deposit Insurance Fund Losses, Income, and Reserve Ratios for the Restoration Plan.

In calling the meeting, the Board determined, on motion of Vice Chairman Thomas M. Hoenig, seconded by Director Richard Cordray (Director, Consumer Financial Protection Bureau), concurred in by Director Thomas J. Curry (Comptroller of the Currency), Director Jeremiah O. Norton (Appointive), and Chairman Martin J. Gruenberg, that Corporation business required its consideration of the matters on less than seven days' notice to the public; and that no earlier notice of the meeting than that previously provided on October 16, 2014, was practicable.

The meeting was held in the Board Room temporarily located on the fourth floor of the FDIC Building located at 550 17th Street NW., Washington, DC.

Dated: October 21, 2014.

Federal Deposit Insurance Corporation.

**Robert E. Feldman,**

*Executive Secretary.*

[FR Doc. 2014-25340 Filed 10-21-14; 4:15 pm]

**BILLING CODE 6714-01-P**

#### FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

##### Sunshine Act Notice: Cancellation of Meeting Notice

October 20, 2014.

The following Commission meeting has been cancelled. No earlier announcement of the cancellation was possible.

**TIME AND DATE:** 2:00 p.m., Wednesday, October 22, 2014.

**PLACE:** The Richard V. Backley Hearing Room, Room 511N, 1331 Pennsylvania Avenue NW., Washington, DC 20004 (entry from F Street entrance).

**STATUS:** Open.

**MATTERS TO BE CONSIDERED:** The Commission will consider and act upon the following in open session: *Secretary of Labor v. DQ Fire and Explosion Consultants*, Docket Nos. WEVA 2011-952-R, et al. (Issues include whether the Administrative Law Judge erred in ruling that the violation of the order in question was the result of high negligence.)

Any person attending this meeting who requires special accessibility features and/or auxiliary aids, such as sign language interpreters, must inform the Commission in advance of those needs. Subject to 29 CFR 2706.150(a)(3) and 2706.160(d).

**CONTACT PERSON FOR MORE INFORMATION:** Emogene Johnson (202) 434-9935/(202) 708-9300 for TDD Relay/1-800-877-8339 for toll free.

**Emogene Johnson,**

*Administrative Assistant.*

[FR Doc. 2014-25379 Filed 10-21-14; 4:15 pm]

**BILLING CODE 6735-01-P**

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

##### Medicare Program; Appellant Forum Regarding the Administrative Law Judge Hearing Program for Medicare Claim Appeals

**AGENCY:** Office of Medicare Hearings and Appeals (OMHA), HHS.

**ACTION:** Notice of Meeting.

**SUMMARY:** This notice announces the second Office of Medicare Hearings and Appeals (OMHA) Medicare Appellant Forum. The purpose of this event is to provide updates to OMHA appellants on the status of OMHA operations and to relay information on a number of OMHA and CMS initiatives designed to reduce the backlog in the processing of Medicare appeals at the OMHA level and lower levels of the administrative appeals process.

##### DATES:

**Meeting Date:** The OMHA Medicare Appellant Forum announced in this notice will be held on Wednesday, October 29, 2014.

The OMHA Medicare Appellant Forum will begin at 10:00 a.m. Eastern Standard Time (EST) and check-in will begin at 9:00 a.m. EST. It is anticipated the Forum will last until 3:00 p.m. EST.

**Deadline for Registration of Attendees and Requests for Special**

**Accommodation:** The deadline to register to attend the OMHA Medicare Appellant Forum and request a special accommodation, as provided for in the American's with Disabilities Act, is 5:00 p.m. EST, Friday, October 24, 2014.

**ADDRESSES: Meeting Location:** The OMHA Medicare Appellant Forum will be held in the Cohen Auditorium of the Wilbur J. Cohen building located at 330 Independence Ave. SW., Washington, DC 20024.

A toll-free phone line and/or webcasting will be provided. Information on these options will be

posted at a later date on the OMHA Web site; <http://www.hhs.gov/omha/index.html>.

**Registration and Special Accommodations:** Individuals wishing to attend the OMHA Medicare Appellant Forum must register by following the on-line registration instructions located in section III of this notice or by contacting staff listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Individuals who need special accommodations should contact staff listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

**FOR FURTHER INFORMATION CONTACT:** Renée Johnson, (703) 235-8269, [renee.johnson@hhs.gov](mailto:renee.johnson@hhs.gov). Alternatively, you may forward your requests via email to [OSOMHAAppealantForum@hhs.gov](mailto:OSOMHAAppealantForum@hhs.gov); please indicate "Request for information" or "Request for special accommodation" in the subject line.

##### SUPPLEMENTARY INFORMATION:

##### I. Background

The Office of Medicare Hearings and Appeals (OMHA), a staff division within the Office of the Secretary of the U.S. Department of Health and Human Services (HHS), administers the nationwide Administrative Law Judge hearing program for Medicare claim, organization and coverage determination, and entitlement appeals under sections 1869, 1155, 1876(c)(5)(B), 1852(g)(5), and 1860D-4(h) of the Social Security Act. OMHA ensures that Medicare beneficiaries and the providers and suppliers that furnish items or services to Medicare beneficiaries, as well as Medicare Advantage Organizations (MAOs) and Medicaid State Agencies, have a fair and impartial forum to address disagreements with Medicare coverage and payment determinations made by Medicare contractors, MAOs, or Part D Plan Sponsors (PDPs), and determinations related to Medicare eligibility and entitlement, and income-related premium surcharges made by the Social Security Administration (SSA).

The Medicare claim appeal process consists of four levels of administrative review within HHS, and a fifth level of review with the Federal courts after administrative remedies within HHS have been exhausted. The first two levels of review are administered by the Centers for Medicare & Medicaid Services (CMS) and conducted by Medicare contractors for Part A and Part B claim appeals, by MAOs and an independent review entity for Part C organization determination appeals, or

by PDPSs and an independent review entity Part D coverage determination appeals. The third level of review is administered by OMHA and conducted by Administrative Law Judges. The fourth level of review is administered by the HHS Departmental Appeals Board (DAB) and conducted by the Medicare Appeals Council. In addition, OMHA and the DAB administer the second and third levels of appeal, respectively, for Medicare eligibility, entitlement and premium surcharge reconsiderations made by SSA; a fourth level of review with the Federal courts is available after administrative remedies within HHS have been exhausted.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554), which added section 1869(d)(1)(A) of the Social Security Act, provides for an Administrative Law Judge to conduct a hearing and render a decision within 90 days of a timely filed request for hearing. Section 1869(d)(3) of the Social Security Act states that, if an ALJ does not render a decision by the end of the specified timeframe, the appellant may request review by the Departmental Appeals Board. Likewise, if the Departmental Appeals Board does not render a decision by the end of the specified timeframe, the appellant may seek judicial review. OMHA was established in July 2005 pursuant to section 931 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173), which required the transfer of responsibility for the Administrative Law Judge hearing level of the Medicare claim and entitlement appeals process from SSA to HHS. OMHA was expected to improve service to appellants and reduce the average 368-day waiting time for a hearing decision that appellants experienced with SSA.

OMHA serves a broad sector of the public, including Medicare providers, suppliers, and MAOs, and Medicare beneficiaries, who are often elderly or disabled and among the nation's most vulnerable populations. OMHA currently administers its program in five field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; the Mid-Atlantic Field Office in Arlington, Virginia; and the recently established field office in Kansas City, Missouri. OMHA uses video-teleconferencing (VTC), telephone conferencing, and in-person formats to provide appellants with hearings.

At the time OMHA was established, it was envisioned that OMHA would receive the claim and entitlement

appeals workload from the Medicare Part A and Part B programs, and organization determination appeals from the Medicare Advantage (Part C) program, as well as coverage determination appeals from the Medicare Prescription Drug (Part D) program and appeals of Income Related Monthly Adjustment Amount (IRMAA) premium surcharges assessed by SSA. With this mix of work at the expected levels, OMHA was able to meet the 90-day adjudication time frame.

However, in recent years, OMHA has experienced a significant and sustained increase in appeals workload that has compromised its ability to meet the 90-day adjudication time frame. In addition to the expanding Medicare beneficiary population and increased utilization of services across that population, the increase in appeals workload has resulted from a number of changes in the Medicare claim review and appeals processes in recent years, including:

- Medicaid State Agency (MSA) appeals of Medicare coverage denials for beneficiaries dually enrolled in both Medicare and Medicaid. These appeals were previously addressed through a demonstration project that employed an alternative dispute resolution process to determine whether the Medicare or Medicaid program would pay for care furnished to the dually enrolled beneficiaries. The demonstration project ended in 2010, and the MSA appeals entered the standard administrative appeals process, increasing appeals workloads throughout the Medicare claim appeal process, including at OMHA.

- The Fee-for-Service Recovery Audit (RA) program (also known as the Recovery Audit Contractor (RAC) program), which was made permanent by section 302 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432). Appeals from the RA program began to enter the administrative appeals process at the CMS contractor levels in fiscal year 2011. In fiscal year 2012, OMHA began receiving hearing requests arising from the RA program that exceeded projections.

- CMS has implemented a number of changes to enhance its monitoring of payment accuracy in the Medicare Part A and Part B programs, which have increased denial rates and likely contributed to increased appeals. For example, based on recommendations from the HHS Office of Inspector General (OIG), in 2009, CMS tightened its methodologies related to how it calculates the Medicare payment error rate, with a view towards improving provider claims documentation and compliance with Medicare's billing,

coverage, and medical necessity requirements. In addition, Medicare Administrative Contractors (MACs) initiated a series of focused medical review initiatives, which increased the overall number of denied claims. CMS also initiated efforts to eliminate payment error and fraud based on Executive Order 13520 and the Improper Payments Elimination and Recovery Act of 2010 (Pub. L. 111-204), resulting in additional denied claims and the identification of overpayments.

With the increase in overall claim denials, the administrative appeals process has experienced an overall increase in appeal requests. At OMHA, the greater than anticipated workload increase resulted in a backlog of appeals (that is, appeals that cannot be heard and decided within the adjudication time frame) starting in fiscal year 2012, with a 42% increase from fiscal year 2011 in the number of claims appealed to OMHA. In fiscal year 2013, the number of claims appealed to OMHA more than doubled from fiscal year 2012, with a 123% increase, further contributing to the backlog of cases and resulting in a substantial increase in the adjudication time frame. The increase in appealed claims from the RA program was particularly high in fiscal year 2013, with a 506% increase in appealed RA program claims over fiscal year 2012, versus a 77% increase in appealed claims not related to the RA program during that same period of time.

In 2013, CMS issued an Administrator Ruling (published on March 18, 2013, 78 FR 16614) and finalized new rules (published on August 19, 2013, 78 FR 50495) designed to clarify criteria for new (fiscal year 2014) Medicare Part A inpatient hospital admissions, which comprised the disputed issues in a majority of RA program appeals, and to clarify policies at issue in appeals of inpatient claim denials under the existing rules. In addition, CMS expanded the scope of alternative Part B services that could be billed if a Part A inpatient admission was denied and, as part of the ruling, for a limited time allowed hospitals to submit Part B claims for those services beyond the one-year claim filing deadline. Separately, CMS also suspended most RA program audits of Part A inpatient hospital admissions under the new inpatient admission criteria (commonly referred to as the two-midnight rule), which was effective for inpatient claims with admission dates on and after October 1, 2013, in order to offer providers time to become educated on the two-midnight rule. The suspension of audits for new admissions was extended for claims with dates of

admission through March 31, 2015, pursuant to section 111 of the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93). CMS is also making improvements to the RA program that are designed to increase the accuracy of Recovery Audit determinations and to reduce the burden on providers as well as the number of payment denials that providers and suppliers appeal.

OMHA also took measures to mitigate the effects of the workload increase at the Administrative Law Judge level. One of the immediate measures taken was to ensure that the comparatively small numbers of beneficiary-initiated appeals were prioritized. For the remaining cases, OMHA has deferred assignments of new requests for hearing until an adjudicator becomes available, which allows appeals to be assigned more efficiently on a first in/first out basis as an Administrative Law Judge's case docket is able to accommodate additional workload. Nevertheless, OMHA Administrative Law Judges continue to conduct hearings on their pending workloads and have nearly doubled their productivity from Fiscal Year 2009 to Fiscal Year 2013.

On February 12, 2014, OMHA hosted a Medicare Appellant Forum (see OMHA's Notice of Meeting, published on January 3, 2014, 79 FR 393). The Medicare Appellant Forum was conducted to provide the appellant community with an update on the status of OMHA operations; relay information on a number of OMHA initiatives designed to mitigate the backlog in the processing of Medicare appeals at the Administrative Law Judge level; and provide information on measures that appellants could take to make the administrative appeals process work more efficiently at the Administrative Law Judge level. In addition, CMS and the DAB participated in the forum and shared information on operations at their respective appeals levels. As conveyed at the Medicare Appellant Forum, HHS is committed to addressing the challenges facing the Medicare claim and entitlement appeals process, and is continuing to explore potential initiatives to address the workload increase and reduce the backlog of appeals.

Since the Medicare Appellant Forum, OMHA has implemented two pilot programs to provide appellants with meaningful options to address claims pending at the Administrative Law Judge level of appeal, in addition to the existing right to escalate a request for hearing when the adjudication time frame is not met. OMHA is providing appellants with an option to use statistical sampling during the

Administrative Law Judge hearing process, which enables appellants to obtain a decision on large numbers of appealed claims based on a sampling of those claims. OMHA is also providing appellants with an option for settlement conference facilitation, which provides appellants with an independent OMHA facilitator to discuss potential settlement of claims with authorized settlement officials through an alternate dispute resolution process. Additional information on these two pilots can be found on OMHA's Web site, <http://www.hhs.gov/omha>.

OMHA also continues to pursue new case processing efficiencies and an electronic case adjudication processing environment (ECAPE) to bring further efficiencies to the appeals process.

In addition to these initiatives, on August 29, 2014, CMS announced that for claims denied based on inappropriate inpatient status for dates of admission prior to October 1, 2013, CMS is offering an administrative agreement to acute care hospitals and critical access hospitals willing to withdraw pending appeals in exchange for partial payment (68 percent) of the denied inpatient claim (for details regarding the option, see <http://go.cms.gov/InpatientHospitalReview>). In the CMS Ruling 1455–R (published March 18, 2013) and the Fiscal Year 2014 Hospital Inpatient Prospective Payment System Final Rule (published August 22, 2013), CMS clarified the inpatient admission policy for Medicare Part A payment and permitted hospitals to rebill an expanded scope of medically necessary Part B services under Part B. For appeals involving a date of admission prior to October 1, 2013, the hospitals are permitted to rebill under Part B after they have ended or exhausted their Part A inpatient appeals. However, only a limited number of hospitals have participated in the rebilling option. This new CMS administrative agreement option is an alternative to that rebilling process, and, for those hospitals that elect this option, alleviates the administrative burden of current appeals on both the provider and Medicare.

The first OMHA Medicare Appellant Forum, held in February 2014, focused on informing the appellant community of the extent of the current workload challenges and potential initiatives to address those challenges. This second OMHA Medicare Appellant Forum will address new initiatives, OMHA processes and procedures to achieve meaningful backlog reduction strategies and process efficiencies, and current workload status.

## II. Medicare Claim Appeal Appellant Forum and Conference Calling/Webinar Information

### A. Format of the OMHA Medicare Appellant Forum

As noted in section I of this notice, OMHA is conducting this outreach to appellants in the Medicare claim appeals process to provide updates on initiatives to mitigate a backlog in processing Medicare appeals at the OMHA level. Information regarding the OMHA Medicare Appellant Forum can be found on the OMHA Web site at: <http://www.hhs.gov/omha/index.html>.

The majority of the forum will be reserved for presentations about OMHA and CMS initiatives, a presentation from the HHS Departmental Appeals Board, and processes and policy presentations. The time for each presentation will be approximately 30 to 60 minutes and will be based on the material being addressed in the presentation.

Questions and comments from in-person attendees will be solicited at the end of each planned session specific to the presentation, and during a separate question and answer session as time permits. In addition, questions related to the OMHA level of the Medicare claim appeals process will also be accepted on an attendee's registration for potential response during the appropriate presentation.

### B. Conference Call, Live Streaming, and Webinar Information

For participants who cannot attend the OMHA Medicare Appellant Forum in person, there will be the option to attend via teleconference and there may be an option to view the conference via webcasting. Information on the availability of these capabilities will be posted on the OMHA Web site at: <http://www.hhs.gov/omha/index.html>. Please continue to check the Web site for updates on this upcoming event.

Disclaimer: We cannot guarantee reliability of webcasting.

## III. Registration Instructions

The OMHA Headquarters Office is coordinating attendee registration for the OMHA Medicare Appellant Forum. While there is no registration fee, individuals planning to attend the forum must register to attend. In-person participation is limited to two (2) representatives from each organization. Additional individuals may participate by telephone conference or, if available, by webcasting. Information on participation by telephone conference or webcasting will be posted on the OMHA Web site at: <http://www.hhs.gov/omha/index.html>. Registration may be

completed online at the following web address: <http://www.hhs.gov/omha/index.html>. Seating capacity for in-person attendees is limited to the first 400 registrants.

After completing the registration, online registrants will receive a confirmation email which they should bring with them to the meeting. If unable to register online, please register by sending an email to [OSOMHAAppealantForum@hhs.gov](mailto:OSOMHAAppealantForum@hhs.gov). Please include first and last name, title, organization, address, office telephone number, and email address. If seating capacity has been reached, a notification will be sent that the meeting has reached capacity.

#### IV. Security, Building, and Parking Guidelines

Because the OMHA Medicare Appellant Forum will be conducted on Federal property, for security reasons, any persons wishing to attend these meetings must register by the date specified in the **DATES** section of this notice. Please allow sufficient time to go through the security checkpoints. It is suggested that you arrive at the Wilbur J. Cohen building, located at 330 Independence Ave. SW., Washington, DC 20024, no later than 9:30 a.m. EST if you are attending the forum in person.

Security measures include the following:

- Present of photographic identification to the Federal Protective Service or Guard Service personnel.
- Passing through a metal detector and inspection of items brought into the building. We note that all items brought to the Cohen Building, whether personal or for the purpose of demonstration or to support a demonstration, are subject to inspection. We cannot assume responsibility for coordinating the receipt, transfer, transport, storage, set-up, safety, or timely arrival of any personal belongings or items used for demonstration or to support a demonstration.

**Note:** Individuals who are not registered in advance will not be permitted to enter the building and will be unable to attend the forum in person.

Attendees must enter the Cohen Building thru the C Street entrance and proceed to the registration desk. All visitors must be escorted in areas other than the auditorium area and access to the restrooms on the same level in the building. Seating capacity is limited to the first 400 registrants.

Parking in Federal buildings is not available for this event. In addition, street side and commercial parking is extremely limited in the downtown

area. Attendees are advised to use Metro-rail to either the Federal Center SW station (Blue/Orange line) or the L'Enfant Plaza station (Yellow/Green or Blue/Orange lines). The Wilbur J. Cohen building is approximately 1½ blocks from each of these Metro-rail stops. (Catalog of Federal Domestic Assistance Program No. 93.770, Medicare—Prescription Drug Coverage; Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 9, 2014.

**Nancy J. Griswold,**

*Chief Administrative Law Judge, Office of Medicare Hearings and Appeals.*

[FR Doc. 2014-24637 Filed 10-22-14; 8:45 am]

**BILLING CODE 4150-46-P**

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

##### Renewal of Charters for Certain Federal Advisory Committees

**AGENCY:** Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

**ACTION:** Notice.

**SUMMARY:** As stipulated by the Federal Advisory Committee Act, as amended (5 U.S.C. App), the U.S. Department of Health and Human Services (HHS) is hereby announcing that the charters have been renewed for the following federal advisory committees for which the Office of the Assistant Secretary for Health provides management support: Chronic Fatigue Syndrome Advisory Committee (CFSAC); President's Council on Fitness, Sports, and Nutrition (PCFSN); Secretary's Advisory Committee on Human Research Protections (SACHRP); and Advisory Committee on Blood and Tissue Safety and Availability (ACB TSA). Functioning as federal advisory committees, these committees are governed by the provisions of the Federal Advisory Committee Act (FACA). Under FACA, it is stipulated that the charter for a federal advisory committee must be renewed every two years in order for the committee to continue to operate.

**FOR FURTHER INFORMATION CONTACT:** Olga B. Nelson, Committee Management Officer, Office of the Assistant Secretary for Health; U.S. Department of Health and Human Services; 200 Independence Avenue SW., Room 714B; Washington, DC 20201; (202) 690-5205.

**SUPPLEMENTARY INFORMATION:** CFSAC was established on September 5, 2002 as a discretionary federal advisory

committee. The Committee provides science-based advice and recommendations to the Secretary of Health and Human Services, through the Assistant Secretary for Health, on a broad range of issues and topics pertaining to myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), including (1) the current state of knowledge and research and the relevant gaps in knowledge and research about the epidemiology, etiologies, biomarkers, and risk factors relating to ME/CFS, and identifying potential opportunities in these areas; (2) impact and implications of current and proposed diagnosis and treatment methods for ME/CFS; (3) development and implementation of programs to inform the public, health care professionals, and the biomedical, academic, and research communities about ME/CFS advances; and (4) partnering to improve the quality of life of ME/CFS patients.

There was one amendment proposed and approved for the new charter. The charter has been amended to change all references to chronic fatigue syndrome (CFS) to include the myalgic encephalomyelitis (ME). This amendment to the charter was proposed to satisfy a recommendation previously made by CFSAC. During the October 2010 meeting, the Committee had recommended that the Department should “adopt [use of] the term ME/CFS across all HHS programs. After the recommendation was made, the Committee elected to use ME/CFS when discussing this health condition. Amending the charter to reflect the use of ME/CFS demonstrates that the Department supports the Committee's recommendation.

On September 5, 2014, the Secretary of Health and Human Services approved for the CFSAC charter with the proposed amendment to be renewed. The new charter has been made effective; the charter was filed with the appropriate Congressional committees and the Library of Congress on September 5, 2014. Renewal of the CFSAC charter provides authorization for the Committee to continue to operate until September 5, 2016. A copy of the Committee charter is available on the CFSAC Web site at <http://www.hhs.gov/advcomcfs>.

The PCFSN is a non-discretionary federal advisory committee. The PCFSN was established under Executive Order 13545, dated June 22, 2010. This authorizing directive was issued to amend the purpose, function, and name of the Council, which formerly operated as the President's Council on Physical Fitness and Sports (PCPFS). The scope