

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Final Effect of Designation of a Class of Employees for Addition to the Special Exposure Cohort**

**AGENCY:** National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention, Department of Health and Human Services (HHS).

**ACTION:** Notice.

**SUMMARY:** HHS gives notice concerning the final effect of the HHS decision to designate a class of employees from the Sandia National Laboratories-Livermore in Livermore, California, as an addition to the Special Exposure Cohort (SEC) under the Energy Employees Occupational Illness Compensation Program Act of 2000.

**FOR FURTHER INFORMATION CONTACT:** Stuart L. Hinnefeld, Director, Division of Compensation Analysis and Support, NIOSH, 4676 Columbia Parkway, MS C-46, Cincinnati, OH 45226, Telephone 877-222-7570. Information requests can also be submitted by email to [DCAS@CDC.GOV](mailto:DCAS@CDC.GOV).

**SUPPLEMENTARY INFORMATION:**

**Authority:** 42 U.S.C. 7384q(b). 42 U.S.C. 7384l(14)(C).

On December 12, 2013, as provided for under the Secretary of HHS designated the following class of employees as an addition to the SEC:

All employees of the Department of Energy, its predecessor agencies, and its contractors and subcontractors who worked in any area at Sandia National Laboratories-Livermore in Livermore, California, from October 1, 1957, through December 31, 1994, for a number of work days aggregating at least 250 work days, occurring either solely under this employment or in combination with work days within the parameters established for one or more other classes of employees included in the Special Exposure Cohort.

This designation became effective on January 11, 2014. Hence, beginning on January 11, 2014, members of this class of employees, defined as reported in this notice, became members of the SEC.

**John Howard,**

*Director, National Institute for Occupational Safety and Health.*

[FR Doc. 2014-00933 Filed 1-17-14; 8:45 am]

**BILLING CODE 4163-19-P**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014 Through September 30, 2015**

**AGENCY:** Office of the Secretary, DHHS.  
**ACTION:** Notice.

**SUMMARY:** The Federal Medical Assistance Percentages (FMAP), Enhanced Federal Medical Assistance Percentages (eFMAP), and disaster-recovery FMAP adjustments for Fiscal Year 2015 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2014 through September 30, 2015. This notice announces the calculated FMAP and eFMAP rates that the U.S. Department of Health and Human Services (HHS) will use in determining the amount of federal matching for state medical assistance (Medicaid) and Children's Health Insurance Program (CHIP) expenditures, Temporary Assistance for Needy Families (TANF) Contingency Funds, Child Support Enforcement collections, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Foster Care Title IV-E Maintenance payments, and Adoption Assistance payments. Table 1 gives figures for each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. This notice also announces the disaster-recovery FMAP adjustments for qualifying States for FY 2015 that the U.S. Department of Health and Human Services (HHS) will use in determining the amount of federal matching for state medical assistance (Medicaid) and title IV-E Foster Care, Adoption Assistance and Guardianship Assistance programs.

Programs under title XIX of the Act exist in each jurisdiction. Programs under titles I, X, and XIV operate only in Guam and the Virgin Islands, while a program under title XVI (Aid to the Aged, Blind, or Disabled) operates only in Puerto Rico. The percentages in this notice apply to state expenditures for most medical assistance and child health assistance, and assistance payments for certain social services. The Act provides separately for federal matching of administrative costs.

Sections 1905(b) and 1101(a)(8)(B) of the Social Security Act (the Act) require the Secretary of HHS to publish the

FMAP rates each year. The Secretary calculates the percentages, using formulas in sections 1905(b) and 1101(a)(8), and calculations by the Department of Commerce of average income per person in each State and for the Nation as a whole. The percentages must fall within the upper and lower limits given in section 1905(b) of the Act. The percentages for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are specified in statute, and thus are not based on the statutory formula that determines the percentages for the 50 States.

Section 1905(b) of the Act specifies the formula for calculating FMAPs as follows:

"Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 55 percent. . . ."

Section 4725(b) of the Balanced Budget Act of 1997 amended section 1905(b) to provide that the FMAP for the District of Columbia for purposes of titles XIX and XXI shall be 70 percent. For the District of Columbia, we note under Table 1 that other rates may apply in certain other programs. In addition, we note the rate that applies for Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands in certain other programs pursuant to section 1118 of the Act.

Section 1905(y) of the Act, as added by section 2001 of the Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act"), provides for a significant increase in the Federal Medical Assistance Percentage (FMAP) for medical expenditures for individuals determined eligible under the new adult group in the State and who will be considered to be "newly eligible" in 2014, as defined in section 1905(y)(2)(A) of the Act. The FMAP for these newly eligible individuals will be 100 percent for Calendar Years 2014, 2015, and 2016, gradually declining to 90 percent in 2020 where it remains indefinitely. In addition, section 1905(z) of the Act, as added by section 10201 of the Affordable Care Act, provides that

States that had expanded substantial coverage to low-income parents and nonpregnant adults without children prior to the enactment of the Affordable Care Act, referred to as “expansion States,” shall receive an enhanced FMAP that begins in 2014 for nonpregnant childless adults who may be required to enroll in benchmark coverage. These provisions are discussed in more detail in the Medicaid Eligibility proposed rule published on August 17, 2011 (76 FR 51172) and the final rule published on March 23, 2012 (77 FR 17143).

For purposes of Title XIX (Medicaid) of the Social Security Act, the Federal Medical Assistance Percentage (FMAP), defined in section 1905(b) of the Social Security Act, for each State beginning with fiscal year 2006 is subject to an adjustment pursuant to section 614 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111–3. Section 614 of CHIPRA stipulates that a State’s FMAP under Title XIX (Medicaid) must be adjusted in two situations.

In the first situation, if a State experiences positive growth in total personal income and an employer in that State has made a significantly disproportionate contribution to a pension or insurance fund, the State’s FMAP must be adjusted. Employer pension and insurance fund contributions are significantly disproportionate if the increase in contributions exceeds 25 percent of the increase in total personal income in that State. A **Federal Register** Notice with comment period was issued on June 7, 2010 announcing the methodology for calculating this adjustment; a final notice was issued on October 15, 2010.<sup>1 2</sup>

<sup>1</sup> As required by section 614(b)(2), the personal income data set originally used to calculate FMAP rates shall also be used for making this adjustment to the FMAP rates. The required adjustment is a recalculation of the FMAP rate disregarding any significantly disproportionate employer pension or insurance fund contribution in computing the State per capita income, but not disregarding such contributions in computing the United States per capita income used in the FMAP calculation. Section 614(c) provides that in no case shall a State have its FMAP reduced because of the application of this disregard.

<sup>2</sup> A change in BEA’s method for reporting defined benefit pension plans should mitigate the reporting, and therefore the need for this adjustment in the future. In 2013, BEA changed its method for reporting defined benefit pension plans as part of personal income by changing from a cash accounting basis to an accrual accounting basis. This change will tend to have steadier estimates than the more volatile cash contributions made by employers. (McCulla, Stephanie H., Holdren, Alyssa E., and Smith, Shelly. “Improved Estimates of the National Income and Product Accounts.” Survey of Current Business, September 2013 (page 14)).

A second situation arises if a State experiences negative growth in total personal income. Beginning with Fiscal Year 2006, section 614(b)(3) of CHIPRA specifies that certain employer pension or insurance fund contributions shall be disregarded when computing the per capita income used to calculate the FMAP for States with negative growth in total personal income. In that instance, for the purposes of calculating the FMAP, for a calendar year in which a State’s total personal income has declined, the portion of an employer pension and insurance fund contribution that exceeds 125 percent of the amount of the employer contribution in the previous calendar year shall be disregarded. The statutory formula for calculating the FMAP is based on the ratio of the State’s per capita income to the per capita income of the entire United States. Employer pension or insurance fund contributions increase State personal income and, by operation of the statutory formula, could result in lower FMAPs than would be the case if those contributions were disregarded.

We request that States follow the same methodology to determine potential FMAP adjustments for negative growth in total personal income that HHS employs to adjust the FMAP for States experiencing significantly disproportionate pension or insurance contributions. For a State experiencing negative growth in total personal income, if that State believes that an individual employer has made a pension or insurance fund contribution that may qualify for an FMAP adjustment for negative growth, the State should provide data on that individual employer contribution to HHS. The State may submit official audited financial statements for the employer for the year of the contribution and the prior year or other evidence that the increase in the employer’s contribution is likely to exceed 125 percent of the employer’s contribution in the previous year in the State.

The deadline for submitting 2005 through 2012 employer contributions, and the associated prior year contributions, will be the end of FY 2014 (September 30, 2014). The deadline for submitting 2013 and future employer contributions, and the associated prior year contributions, will be the end of the second fiscal year following the end of the employer’s annual fiscal statement that includes the employer contributions.

After a State submits written notification that such a contribution or contributions occurred, HHS will verify

the State’s data. As part of this verification process, HHS will search the Security Exchange Commission (SEC) filings or the Internal Revenue Service (IRS) 5500 Annual Return/Report of Employee Benefit Plan database to find the employer’s contributions for the relevant two-year period. If HHS is unable to verify the State’s submitted data, no FMAP adjustment will be made.

This notice does not contain an FY 2015 adjustment for a major statewide disaster for any State because no State’s FMAP decreased by at least three percentage points from FY 2014 to FY 2015.

Section 2105(b) of the Act specifies the formula for calculating the eFMAP rates as follows:

The “enhanced FMAP”, for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

The eFMAP rates are used in the Children’s Health Insurance Program under Title XXI, and in the Medicaid program for certain children for expenditures for medical assistance described in sections 1905(u)(2) and 1905(u)(3) of the Act. There is no specific requirement to publish the eFMAP rates. We include them in this notice for the convenience of the States.

**DATES: Effective Dates:** The percentages listed in Table 1 will be effective for each of the four quarter-year periods beginning October 1, 2014 and ending September 30, 2015.

**FOR FURTHER INFORMATION CONTACT:** Thomas Musco or Rose Chu, Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, Room 447D—Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201, (202) 690–6870.

(Catalog of Federal Domestic Assistance Program Nos. 93.558: TANF Contingency Funds; 93.563: Child Support Enforcement; 93.596: Child Care Mandatory and Matching Funds of the Child Care and Development Fund; 93.658: Foster Care Title IV–E; 93.659: Adoption Assistance; 93.769: Ticket-to-Work and Work Incentives Improvement Act (TWWIIA) Demonstrations to Maintain Independence and Employment; 93.778: Medical Assistance Program; 93.767: Children’s Health Insurance Program).

Dated: December 18, 2013.

**Kathleen Sebelius,**  
Secretary.

TABLE 1—FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES,  
EFFECTIVE OCTOBER 1, 2014—SEPTEMBER 30, 2015  
[Fiscal Year 2015]

State	Federal medical assistance percentages	Enhanced federal medical assistance percentages
Alabama	68.99	78.29
Alaska	50.00	65.00
American Samoa *	55.00	68.50
Arizona	68.46	77.92
Arkansas	70.88	79.62
California	50.00	65.00
Colorado	51.01	65.71
Connecticut	50.00	65.00
Delaware	53.63	67.54
District of Columbia **	70.00	79.00
Florida	59.72	71.80
Georgia	66.94	76.86
Guam *	55.00	68.50
Hawaii	52.23	66.56
Idaho	71.75	80.23
Illinois	50.76	65.53
Indiana	66.52	76.56
Iowa	55.54	68.88
Kansas	56.63	69.64
Kentucky	69.94	78.96
Louisiana	62.05	73.44
Maine	61.88	73.32
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	65.54	75.88
Minnesota	50.00	65.00
Mississippi	73.58	81.51
Missouri	63.45	74.42
Montana	65.90	76.13
Nebraska	53.27	67.29
Nevada	64.36	75.05
New Hampshire	50.00	65.00
New Jersey	50.00	65.00
New Mexico	69.65	78.76
New York	50.00	65.00
North Carolina	65.88	76.12
North Dakota	50.00	65.00
Northern Mariana Islands *	55.00	68.50
Ohio	62.64	73.85
Oklahoma	62.30	73.61
Oregon	64.06	74.84
Pennsylvania	51.82	66.27
Puerto Rico *	55.00	68.50
Rhode Island	50.00	65.00
South Carolina	70.64	79.45
South Dakota	51.64	66.15
Tennessee	64.99	75.49
Texas	58.05	70.64
Utah	70.56	79.39
Vermont	54.01	67.81
Virgin Islands *	55.00	68.50
Virginia	50.00	65.00
Washington	50.03	65.02
West Virginia	71.35	79.95
Wisconsin	58.27	70.79
Wyoming	50.00	65.00

\* For purposes of section 1118 of the Social Security Act, the percentage used under titles I, X, XIV, and XVI will be 75 per centum.

\*\* The values for the District of Columbia in the table were set for the state plan under titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, the percentage for D.C is 50.00, unless otherwise specified by law.

[FR Doc. 2014-00931 Filed 1-17-14; 8:45 am]

BILLING CODE 4150-05-P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Advisory Council on Alzheimer's Research, Care, and Services; Meeting

**AGENCY:** Assistant Secretary for Planning and Evaluation, HHS.

**ACTION:** Notice of meeting.

**SUMMARY:** This notice announces the public meeting of the Advisory Council on Alzheimer's Research, Care, and Services (Advisory Council). The Advisory Council on Alzheimer's Research, Care, and Services provides advice on how to prevent or reduce the burden of Alzheimer's disease and related dementias on people with the disease and their caregivers. During the February meeting, the Advisory Council will hear presentations from the three subcommittees (Research, Clinical Care, and Long-Term Services and Supports), which will inform the 2014 recommendations. The Advisory Council will discuss the G8 Dementia Summit that was held on December 11, 2013.

**DATES:** The meeting will be held on February 3, 2013 from 9:30 a.m. to 4:30 p.m. EDT.

**ADDRESSES:** The meeting will be held in Room 800 in the Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

*Comments:* Time is allocated on the agenda to hear public comments. In lieu of oral comments, formal written comments may be submitted for the record to Helen Lamont, Ph.D., OASPE, 200 Independence Avenue SW., Room 424E, Washington, DC 20201. Comments may also be sent to [napa@hhs.gov](mailto:napa@hhs.gov). Those submitting written comments should identify themselves and any relevant organizational affiliations.

**FOR FURTHER INFORMATION CONTACT:** Helen Lamont, Ph.D. (202) 690-7996, [helen.lamont@hhs.gov](mailto:helen.lamont@hhs.gov). Note: Seating may be limited. Those wishing to attend the meeting must send an email to [napa@hhs.gov](mailto:napa@hhs.gov) and put "February 3 meeting attendance" in the Subject line by Friday, January 24, so that their names may be put on a list of expected attendees and forwarded to the security officers at the Department of Health and Human Services. Any interested member of the public who is a non-U.S. citizen should include this information at the time of registration to ensure that the appropriate security procedure to gain entry to the building is carried out.

Although the meeting is open to the public, procedures governing security and the entrance to Federal buildings may change without notice. If you wish to make a public comment, you must note that within your email.

**SUPPLEMENTARY INFORMATION:** Notice of these meetings is given under the Federal Advisory Committee Act (5 U.S.C. App. 2, section 10(a)(1) and (a)(2)). Topics of the Meeting: The Advisory Council will hear presentations from the three subcommittees (Research, Clinical Care, and Long-Term Services and Supports), which will inform the 2014 recommendations. The Advisory Council will discuss the G8 Dementia Summit that was held on December 11, 2013.

**Procedure and Agenda:** This meeting is open to the public. Please allow 30 minutes to go through security and walk to the meeting room. The meeting will also be webcast at [www.hhs.gov/live](http://www.hhs.gov/live).

**Authority:** 42 U.S.C. 11225; Section 2(e)(3) of the National Alzheimer's Project Act. The panel is governed by provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees.

Dated: January 2, 2014.

**Donald Moulds,**

*Acting Assistant Secretary for Planning and Evaluation.*

[FR Doc. 2014-01083 Filed 1-17-14; 8:45 am]

BILLING CODE P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Food and Drug Administration

[Docket No. FDA-2014-N-0001]

#### Microbiology Devices Panel of the Medical Devices Advisory Committee; Notice of Meeting

**AGENCY:** Food and Drug Administration, HHS.

**ACTION:** Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

*Name of Committee:* Microbiology Devices Panel of the Medical Devices Advisory Committee.

*General Function of the Committee:* To provide advice and recommendations to the Agency on FDA's regulatory issues.

*Date and Time:* The meeting will be held on March 12, 2014, from 8 a.m. to 6 p.m.

*Location:* College Park Holiday Inn, Ballroom, 10000 Baltimore Ave., College Park, MD 20740; 301-345-6700.

*Contact Person:* Shanika Craig, Center for Devices and Radiological Health, Food and Drug Administration, 10903 New Hampshire Ave., Silver Spring, MD 20993, [Shanika.Craig@fda.hhs.gov](mailto:Shanika.Craig@fda.hhs.gov), 301-796-6639, or FDA Advisory Committee Information Line, 1-800-741-8138 (301-443-0572 in the Washington, DC area). A notice in the **Federal Register** about last minute modifications that impact a previously announced advisory committee meeting cannot always be published quickly enough to provide timely notice. Therefore, you should always check the Agency's Web site at <http://www.fda.gov/AdvisoryCommittees/default.htm> and scroll down to the appropriate advisory committee meeting link, or call the advisory committee information line to learn about possible modifications before coming to the meeting.

*Agenda:* On March 12, 2014, the committee will discuss, make recommendations, and vote on a premarket approval application for a new indication for the cobas Human Papillomavirus (HPV) Test, sponsored by Roche Molecular Systems, Inc. The cobas HPV Test is a qualitative in vitro test for the detection of HPV that is currently approved for use in conjunction with cervical cytology. Roche is seeking a claim whereby the cobas HPV Test can be used as a first-line primary cervical screening test. The test utilizes amplification of target DNA by the polymerase chain reaction and nucleic acid hybridization for the detection of 14 high risk (HR) HPV types in a single analysis. The test specifically identifies types HPV 16 and HPV 18 while concurrently detecting the rest of the high risk types (31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68). Per the proposed indication, women who test negative for high risk HPV types by the cobas HPV Test would be followed up in accordance with the physician's assessment of screening and medical history, other risk factors, and professional guidelines. Women who test positive for HPV genotypes 16 and/or 18 by the cobas HPV Test would be referred to colposcopy. Women who test high risk HPV positive and 16/18 negative by the cobas HPV Test (12 other HR HPV positive) would be evaluated by cervical cytology to determine the need for referral to colposcopy.

FDA intends to make background material available to the public no later than 2 business days before the meeting. If FDA is unable to post the background