Dated: June 9, 2008.

Elaine L. Baker,

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

[FR Doc. E8–13493 Filed 6–13–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Medicaid Program; Notice of Single-Source Grant Award to the States of Louisiana and Mississippi for the Grant Entitled ''Deficit Reduction Act-Hurricane Katrina Healthcare Related Provider Stabilization''

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

ACTION: Notice of Single-Source Non-Competitive Supplemental Awards.

Funding Amount: $19,100,000.

Period of Performance: June 9, 2008–September 30, 2009.

CFDA: 93.776.

Authority: Section 6201(a)(4) of the Deficit Reduction Act of 2005 (DRA)

Purpose: The Secretary has authorized an additional $19.1 million in supplemental grant funds to be made available to the States of Louisiana and Mississippi. Based on the share of total Medicare inpatient payments made to each State's eligible general acute care hospitals and inpatient psychiatric facilities (IPFs) located in the Federal Emergency Management Agency (FEMA) designated counties/parishes in calendar year 2006 (the latest and most complete year of Medicare billing data available to us), funding is being allocated in the following proportions: 53 percent to Louisiana ($10,143,671) and 47 percent to Mississippi ($8,956,329).

Since its inception, the Provider Stabilization Grant (PSG) program has been used to fund State payments to general acute care hospitals, skilled nursing facilities, IPFs, and community mental health centers in impacted communities that may face financial pressures because of changing wage rates that are not yet reflected in Medicare prospective payment system (PPS) payment methodologies. For this third round of PSG funding, CMS determined that these supplemental grant funds would be used by the States to make payments to only those Medicare participating inpatient PPS (IPPS) hospitals and IPFs that are currently paid under a Medicare PPS and that are the most significantly, negatively impacted (financial or otherwise) related to Hurricane Katrina.

Although the States had significant discretion in determining the payment distribution methodology, the methodology had to clearly reflect the basis upon which the State would determine ''negative impact'' and then how each provider would receive an appropriate share of the funds. Grant funds may not be distributed to IPPS hospitals and IPFs that are not in operation or that are outside of the FEMA Hurricane Katrina designated counties/parishes for individual and public assistance. The States' payment methodologies were to specify the relevant time periods and any other factors that would be considered in distributing available grant funds according to the principles specified above, and were subject to approval by CMS.

The States were also allowed to choose to use a portion of the funds (not to exceed 20% of the grant) to address immediate, unmet, health care infrastructure needs that objective data indicate was caused as a direct result of Hurricane Katrina and or its subsequent flooding. This optional provision was also subject to CMS approval.

Under the authority of section 6201(a)(4) of the Deficit Reduction Act of 2005, the Secretary, Department of Health and Human Services, has invoked his authority to restore health care in impacted communities affected by Hurricane Katrina by offering this unique funding opportunity to enable States to make payments to assist general acute care hospitals and IPFs that are paid under a Medicare PPS, with the financial pressures that may result from changing wage rates in those impacted communities. Louisiana and Mississippi are the only States with knowledge and ability to administer a grant designed to affect impacted communities in their own respective States. For the reasons cited above, the Secretary has directed CMS to offer supplemental single-source awards to the States of Louisiana and Mississippi.

FOR FURTHER INFORMATION CONTACT: Wendy J. Alexander, Ph.D., Health Insurance Specialist, Finance Systems and Budget Group, Centers for Medicaid and State Operations, Centers for Medicare & Medicaid Services, Mail Stop S3–13–15, 7500 Security Boulevard, Baltimore, MD 21244, (410) 786–5245.

Authority: Section 6201(a)(4) of the Deficit Reduction Act of 2005 (DRA).

Dated: June 10, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E8–13525 Filed 6–13–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2008–N–0132]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; State Petitions for Exemption From Preemption

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by July 16, 2008.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–6974, or e-mailed to *baguilar@omb.eop.gov*. All comments should be identified with the OMB control number 0910–0277. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: Jonna Capezzuto, Office of the Chief Information Officer (HFA–250), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–4659.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

State Petitions for Exemption From Preemption—21 CFR 100.1(d) (OMB Control No. 0910–0277)—Extension

Under section 403A(b) of the Federal Food, Drug, and Cosmetic Act (the act) (21 U.S.C. 343–1(b)), States may petition FDA for exemption from Federal preemption of State food labeling and standard of identity requirements.

Section 100.1(d) (21 CFR 100.1(d)) sets forth the information a State is required to submit in such a petition. The information required under § 100.1(d) enables FDA to determine whether the State food labeling or standard of identity requirement satisfies the criteria of section 403A(b) of the act for granting exemption from Federal preemption.

In the **Federal Register** of March 4, 2008 (73 FR 11648), FDA published a 60-day notice requesting public comment on the information collection provisions. No comments were received.

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

21 CFR Section	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
100.1(d)	1	1	1	40	40

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

The reporting burden for § 100.1(d) is minimal because petitions for exemption from preemption are seldom submitted by States. In the last 3 years, FDA has not received any new petitions for exemption from preemption; therefore, the agency estimates that one or fewer petitions will be submitted annually. Although FDA has not received any new petitions for exemption from preemption in the last 3 years, it believes these information collection provisions should be extended to provide for the potential future need of a State or local government to petition for an exemption from preemption under the provisions of section 403(A) of the act.

Dated: June 10, 2008.

Jeffrey Shuren,

Associate Commissioner for Policy and Planning.

[FR Doc. E8–13522 Filed 6–13–08; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Recruitment of Sites for Assignment of Corps Personnel

AGENCY: Health Resources and Services Administration (HRSA), HHS.

ACTION: General notice.

SUMMARY: The Health Resources and Services Administration (HRSA) announces that the listing of entities, and their Health Professional Shortage Area (HPSA) scores, that will receive priority for the assignment of National Health Service Corps (NHSC) personnel (Corps Personnel, Corps members) for the period July 1, 2008, through June 30, 2009, is posted on the NHSC Web site at *http://nhsc.bhpr.hrsa.gov/jobs/index.asp.* This list specifies which entities are eligible to receive assignment of Corps members who are participating in the NHSC Scholarship Program, the NHSC Loan Repayment Program, and Corps members who have become Corps members other than pursuant to contractual obligations under the Scholarship or Loan Repayment Programs. Please note that not all vacancies associated with sites on this list will be for Corps members, but could be for individuals serving an obligation to the NHSC through the Private Practice Option.

Eligible HPSAs and Entities

To be eligible to receive assignment of Corps personnel, entities must: (1) Have a current HPSA designation by the Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration; (2) not deny requested health care services, or discriminate in the provision of services to an individual because the individual is unable to pay for the services or because payment for the services would be made under Medicare, Medicaid, or the State Children's Health Insurance Program; (3) enter into an agreement with the State agency that administers Medicaid, accept payment under Medicare and the State Children's Health Insurance Program, see all patients regardless of their ability to pay, and use and post a discounted fee plan; and (4) be determined by the Secretary to have (a) A need and demand for health manpower in the area; (b) appropriately and efficiently used Corps members assigned to the entity in the past; (c) general community support for the assignment of Corps members; (d) made unsuccessful efforts to recruit; and (e) a reasonable prospect for sound fiscal management by the entity with respect to Corps members assigned there. Priority in approving applications for assignment of Corps members goes to sites that (1) Provide primary medical care, mental health, and/or oral health services to a primary medical care, mental health, or dental HPSA of greatest shortage, respectively; (2) are part of a system of care that provides a continuum of services, including comprehensive primary health care and appropriate referrals or arrangements for secondary and tertiary care; (3) have a documented record of sound fiscal management; and (4) will experience a negative impact on its capacity to provide primary health services if a Corps members is not assigned to the entity.

Entities that receive assignment of Corps personnel must assure that (1) the position will permit the full scope of practice and that the clinician meets the credentialing requirements of the State and site; and (2) the Corps member assigned to the entity is engaged in full-time clinical practice at the approved service location for a minimum of 40 hours per week with at least 32 hours per week in the ambulatory care setting. Obstetricians/gynecologists, certified nurse midwives (CNMs), and family practitioners who practice obstetrics on a regular basis, are required to engage in a minimum of 21 hours per week of outpatient clinical practice. The remaining hours, making up the minimum 40-hour per week total, include delivery and other clinical hospital-based duties. For all Corps personnel, time spent on-call does not count toward the 40 hours per week. In addition, sites receiving assignment of Corps personnel are expected to (1) Report to the NHSC all absences, including those in excess of the authorized number of days (up to 35 work days or 280 hours per contract year); (2) report to the NHSC any change in the status of an NHSC clinician at the site; (3) provide the time and leave records, schedules, and any related personnel documents for NHSC assignees (including documentation, if applicable, of the reason(s) for the termination of an NHSC clinician's employment at the site prior to his or her obligated service end date); and (4) submit a Uniform Data System (UDS) report. The UDS allows the site to assess the age, sex, race/ethnicity of, and provider encounter records for, its user population. The UDS reports are site specific. Providers fulfilling NHSC commitments are assigned to a specific