*Place:* Hilton Washington Embassy Row, Ambassador Room, 2015 Massachusetts Avenue, NW., Washington, DC 20036, Telephone: (202) 939–4124.

*Status:* Open to the public, limited only by the space available. Those who wish to attend are encouraged to register with the contact person listed below. If you will require a sign language interpretator, or have other special needs, please notify the contact person by 4:30 E.S.T. on December 1, 2008.

*Purpose:* The Interagency Committee on Smoking and Health advises the Secretary, Department of Health and Human Services, and the Assistant Secretary for Health in the (a) coordination of all research and education programs and other activities within the Department and with other federal, state, local and private agencies and (b) establishment and maintenance of liaison with appropriate private entities, federal agencies, and state and local public health agencies with respect to smoking and health activities.

*Matters to be Discussed:* The agenda will focus on ''Nicotine Addiction.'' Agenda items are subject to change as priorities dictate.

*Contact Person for More Information:* Ms. Monica L. Swann, Management and Program Analyst, Office on Smoking and Health, Centers for Disease Control and Prevention, 4770 Buford Highway, M/S K50, Atlanta, GA 30341, (770) 488–5278. 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 CDC and the Agency for Toxic Substances and Disease Registry.

Dated: October 15, 2008.

**Elaine L. Baker,**

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

[FR Doc. E8–25122 Filed 10–21–08; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

**[Document Identifier: CMS–R–137]**

### Agency Information Collection Activities: Proposed Collection; Comment Request

**AGENCY:** Centers for Medicare & Medicaid Services, Department of Health and Human Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Internal Revenue Service (IRS)/Social Security Administration (SSA)/Centers for Medicare and Medicaid Services (CMS) Data Match and Supporting Regulations in 42 CFR 411.20–491.206 *Use:* Medicare Secondary Payer (MSP) is essentially the same concept known in the private insurance industry as coordination of benefits; it refers to those situations where Medicare assumes a secondary payer role to certain types of private insurance for covered services provided to a Medicare beneficiary.

Congress sought to reduce the losses to the Medicare program by requiring in 42 U.S.C. 1395y(b)(5) that the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS perform an annual data match (the IRS/SSA/CMS Data Match, or ''Data Match'' for short). CMS uses the information obtained through Data Match to contact employers concerning possible application of the MSP provisions by requesting information about specifically identified employees (either a Medicare beneficiary or the working spouse of a Medicare beneficiary). This statutory data match and employer information collection activity enhances CMS's ability to identify both past and present MSP situations. *Form Number:* CMS–R–137 (OMB# 0938–0763); *Frequency:* Annually; *Affected Public:* Business or other for-profit, not-for-profit institutions, Farms, State, Local or Tribal Governments; *Number of Respondents:* 326,597; *Total Annual Responses:* 326,597; *Total Annual Hours:* 1,900,795.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.hhs.gov/PaperworkReductionActof1995*, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *December 22, 2008:*

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: *October 10, 2008.*

**Michelle Shortt,**

*Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.*

[FR Doc. E8–25201 Filed 10–21–08; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

### Centers for Medicare & Medicaid Services

### Notice of Hearing: Reconsideration of Disapproval of Arkansas State Plan Amendment (SPA) 07–024

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

**ACTION:** Notice of hearing.

**SUMMARY:** This notice announces an administrative hearing to be held on December 9, 2008, at the CMS Dallas Regional Office, 1301 Young Street, Suite 833, Room 1196, Dallas, Texas 75202, to reconsider CMS' decision to disapprove Arkansas SPA 07–024.

**CLOSING DATE:** Requests to participate in the hearing as a party must be received by the presiding officer by November 6, 2008.

**FOR FURTHER INFORMATION CONTACT:** Benjamin 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 Arkansas SPA 07–024 which was submitted on

January 18, 2008, and disapproved on August 19, 2008.

Under this SPA, the State would increase the dispensing fee from $5.51 to $8.68 for brand name prescription drugs. The dispensing fee for generic drugs would increase to $11.68, an increase from $5.51 for drugs with a maximum allowable cost (MAC) limit and from $7.51 for drugs without a MAC limit. The dispensing fee for generic drugs would be further increased to $12.68 if there is a 2.3 percent increase in the proportion of total claims dispensed as generic drugs. CMS was unable to approve this SPA because it does not comply with section 1902(a)(30)(A) of the Social Security Act (the Act) and the longstanding requirements of Federal regulations (previously codified at 42 CFR 447.331 and at 42 CFR 447.332), which specify that the State must have a reasonable dispensing fee.

Section 1902(a)(30)(A) of the Act requires that States have methods and procedures to assure that payment rates are consistent with efficiency, economy, and quality of care. Section 1902(a)(30)(A) and longstanding requirements of Federal regulations (previously codified at 42 CFR 447.331 and 42 CFR 447.332) provide that payments for drugs are to be based on the ingredient cost of the drug and a reasonable dispensing fee.

In support of its proposal, the State submitted survey findings dated February 2, 2007, performed by MENTORx that show the median dispensing cost is $9.25 for all pharmacies with a spread of $4.44 between the 20th percentile value ($7.45) and the 80th percentile value ($11.89). The study looked at the difference in dispensing costs between independent and chain pharmacies, but not between brand and generic drugs.

The hearing will involve the following issues:

- The MENTORx survey failed to present supporting evidence for the State's determination of separate dispensing fees for brand and generic prescriptions and the State has failed to provide us with sufficient evidence to demonstrate that the separate dispensing fee for brand name and generic prescription drugs is reasonable.
- MENTORx recommended the 80th percentile ($11.89) be used as the dispensing fee for all prescriptions. While the State did not follow this recommendation, it did not adequately explain why it chose the dispensing fee for brand name drugs based on the 40th percentile value ($8.68) and the initial dispensing fee for generics based slightly below the 80th percentile value ($11.89). The State's current dispensing fee of $5.51 is one of the highest in the Nation among State Medicaid programs. The proposed dispensing fee for generic drugs would be the highest in the Nation among State Medicaid programs and would be the largest variance in dispensing fees between brand and generic drugs. Accordingly, the State failed to adequately explain why a dispensing fee slightly below the 80th percentile value would not result in most pharmacies being overpaid to dispense generic drugs. Therefore, CMS did not believe that the State demonstrated why this is reasonable.
- Despite the fact that the generic dispensing fee was set at the maximum cost in the survey, the State did not adequately explain why it would further increase the generic fee above the 80th percentile to $12.68. While the State claimed that increasing the dispensing fee would be budget neutral based on a 2.3 percent increase in the proportion of total claims dispensed as generic drugs, it did not explain why a further incentive from the current $2 differential to a $4 differential was reasonable.
- In response to our formal concerns, the State indicated that data do not exist to differentiate dispensing cost of brand versus generic drugs. The State indicated that the intent of the proposed dispensing fee is to encourage the use of less costly generics, and thus avoid the higher ingredient reimbursement of a brand. However, the State failed to consider the ingredient cost of drugs as well as the cost of dispensing, to ensure that both are being paid appropriately. To increase the dispensing fee without considering the ingredient cost payment so that it accurately estimates acquisition cost results in an overall payment that is inconsistent with the requirement of the statute that payments be consistent with efficiency and economy.

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 Arkansas announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Mr. Breck Hopkins, Chief Counsel, Arkansas Department of Human Services, P.O. Box 1437, Slot S–260, Little Rock, AR 72203–1437.

Dear Mr. Hopkins: I am responding to your request for reconsideration of the decision to disapprove the Arkansas State plan amendment (SPA) 07–024, which was submitted on January 18, 2008, and disapproved on August 19, 2008.

Under this SPA, the State proposed to increase the dispensing fee from $5.51 to $8.68 for brand name prescription drugs. The dispensing fee for generic drugs would increase to $11.68, an increase from $5.51 for drugs with a maximum allowable cost (MAC) limit and from $7.51 for drugs without a MAC limit. The dispensing fee for generic drugs would be further increased to $12.68 if there is a 2.3 percent increase in the proportion of total claims dispensed as generic drugs. I was unable to approve this SPA because it does not comply with section 1902(a)(30)(A) of the Social Security Act (the Act) and the longstanding requirements of Federal regulations (previously codified at 42 CFR 447.331 and at 42 CFR 447.332), which specify that the State must have a reasonable dispensing fee.

Section 1902(a)(30)(A) of the Act requires that States have methods and procedures to assure that payment rates are consistent with efficiency, economy, and quality of care. Section 1902(a)(30)(A) and longstanding requirements of Federal regulations (previously codified at 42 CFR 447.331 and 42 CFR 447.332) provide that payments for drugs are to be based on the ingredient cost of the drug and a reasonable dispensing fee.

In support of its proposal, the State submitted survey findings dated February 2, 2007, performed by MENTORx that show the median dispensing cost is $9.25 for all pharmacies with a spread of $4.44 between the 20th percentile value ($7.45) and the 80th percentile value ($11.89). The study looked at the difference in dispensing costs between independent and chain pharmacies, but not between brand and generic drugs.

The hearing will involve the following issues:

- The MENTORx survey failed to present supporting evidence for the State's determination of separate dispensing fees for brand and generic prescriptions and the State has failed to provide us with sufficient evidence to demonstrate that the separate dispensing fee for brand name and generic prescription drugs is reasonable.
- MENTORx recommended the 80th percentile ($11.89) be used as the dispensing

fee for all prescriptions. While the State did not follow this recommendation, it did not adequately explain why it chose the dispensing fee for brand name drugs based on the 40th percentile value ($8.68) and the initial dispensing fee for generics based slightly below the 80th percentile value ($11.89). The State's current dispensing fee of $5.51 is one of the highest in the Nation among State Medicaid programs. The proposed dispensing fee for generic drugs would be the highest in the Nation among State Medicaid programs and would be the largest variance in dispensing fees between brand and generic drugs. Accordingly, the State failed to adequately explain why a dispensing fee slightly below the 80th percentile value would not result in most pharmacies being overpaid to dispense generic drugs. Therefore, we do not believe that the State has demonstrated why this is reasonable.

• Despite the fact that the generic dispensing fee was set at the maximum cost in the survey, the State did not adequately explain why it would further increase the generic fee above the 80th percentile to $12.68. While the State claimed that increasing the dispensing fee would be budget neutral based on a 2.3 percent increase in the proportion of total claims dispensed as generic drugs, it did not explain why a further incentive from the current $2 differential to a $4 differential was reasonable.

• In response to our formal concerns, the State indicated that data do not exist to differentiate dispensing cost of brand versus generic drugs. The State indicated that the intent of the proposed dispensing fee is to encourage the use of less costly generics, and thus avoid the higher ingredient reimbursement of a brand. However, the State failed to consider the ingredient cost of drugs as well as the cost of dispensing, to ensure that both are being paid appropriately. To increase the dispensing fee without considering the ingredient cost payment so that it accurately estimates acquisition cost results in an overall payment that is inconsistent with the requirement of the statute that payments be consistent with efficiency and economy.

I am scheduling a hearing on your request for reconsideration to be held on December 9, 2008, at the CMS Dallas Regional Office, 1301 Young Street, Suite 833, Room 1196, Dallas, Texas 75202, in order to reconsider the decision to disapprove SPA 07–024. If this date is not acceptable, we 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 Cohen as the presiding officer. If these arrangements present any problems, please contact the presiding officer at (410) 786–3169. In order to facilitate any communication which may be necessary between the parties 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,
Kerry Weems,
*Acting Administrator.*

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

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

Dated: October 16, 2008.

**Kerry Weems,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

[FR Doc. E8–25196 Filed 10–22–08; 8:45 am]

**BILLING CODE 4120–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Administration for Children and Families

### Submission for OMB Review; Comment Request

*Title:* Annual Statistical Report on Children in Foster Homes and Children in Families Receiving Payment in Excess of the Poverty Income Level from a State Program Funded Under Part A of Title IV of the Social Security Act.

*OMB No.:* 0970–0004.

*Description:* The Department of Health and Human Services is required to collect these data under section 1124 of Title I of the Elementary and Secondary Education Act, as amended by Public Law 103–382. The data are used by the U.S. Department of Education for allocation of funds for programs to aid disadvantaged elementary and secondary students. Respondents include various components of State Human Service agencies.

*Respondents:* The 52 respondents include the 50 States, the District of Columbia, and Puerto Rico.

ANNUAL BURDEN ESTIMATES

| Instrument | Number of respondents | Number of responses per respondent | Average burden hours per response | Total burden hours |
|---|---|---|---|---|
| Annual Statistical Report on Children in Foster Homes and Children Receiving Payments in Excess of the Poverty Level From a State Program Funded Under Part A of Title IV of the Social Security Act | 52 | 1 | 264.35 | 13,746.20 |

*Estimated Total Annual Burden Hours:* 13,746.20.

*Additional Information:* Copies of the proposed collection may be obtained by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACE Reports Clearance Officer. All requests should be identified by the title of the information collection. E-mail address: *infocollection@acf.hhs.gov.*

*OMB Comment:* OMB is required to make a decision concerning the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. Written comments and recommendations for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, Fax: 202–395–6974, Attn: Desk Officer for the Administration for Children and Families.

Date: October 15, 2008.

**Janean Chambers,**

*Reports Clearance Officer.*

[FR Doc. E8–25038 Filed 10–21–08; 8:45 am]

**BILLING CODE 4184–01–M**

## DEPARTMENT OF HOMELAND SECURITY

### U.S. Citizenship and Immigration Services

### Agency Information Collection Activities: Form I–539, Extension of an Existing Information Collection; Comment Request

**ACTION:** 30-Day Notice of Information Collection Under Review: Form I–539, Application to Extend/Change Nonimmigrant Status; OMB Control No. 1615–0003.