Import Cynomolgus, African Green, or Rhesus Monkeys into the United States'', for another three years. This data collection is currently approved under OMB Control No. 0920–0263. There are no revisions proposed to the currently approved information collection request.

A registered importer must request a special permit to import Cynomolgus, African Green, or Rhesus monkeys. To receive a special permit to import nonhuman primates, the importer must submit a written plan to the Director of CDC which specifies steps that will be taken to prevent exposure of persons and animals during the entire importation and quarantine process for the arriving nonhuman primates.

Under the special permit arrangement, registered importers must submit a plan to CDC for importation and quarantine if they wish to import the specific monkeys covered. The plan must address disease prevention procedures to be carried out in every step of the chain of custody of such monkeys, from embarkation in the country of origin to release from quarantine. Information such as species, origin and intended use for monkeys, transit information, isolation and quarantine procedures, and procedures for testing of quarantined animals is necessary for CDC to make public health decisions. This information enables CDC to evaluate compliance with the standards and to determine whether the measures being taken are adequate to prevent exposure of persons and animals during importation. CDC will monitor at least 2 shipments to be assured that the provisions of a special permit plan are being followed by a new permit holder. CDC will assure that adequate disease control practices are being used by new permit holders before the special permit is extended to cover the receipt of additional shipments under the same plan for a period of 180 days, and may be renewed upon request. This extension eliminates the burden on importers to repeatedly report identical information, requiring submission only of specific shipment itineraries and information on changes to the plan which require approval.

Respondents are commercial or not-for-profit importers of nonhuman primates. The burden represents full disclosure of information and itinerary/change information, respectively. There are no costs to respondents except for their time to complete the requisition process. The annualized burden for this data collection is 13 hours.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden
Businesses (limited permit)	5	2	30/60	5
Businesses (extended permit)	1	3	10/60	5
Organizations (limited permit)	3	2	30/60	3
Organizations (extended permit)	12	2	10/60	4
Total				13

Dated: November 29, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E7–23634 Filed 12–5–07; 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 of New York State Children's Health Insurance Program (SCHIP) State Child Health Plan Amendment (SPA) #10

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

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on January 16, 2008, at the CMS New York Regional Office, 38–110A, 26 Federal Plaza, New York, New York 10278, to reconsider CMS' decision to disapprove New York SCHIP SPA #10.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by December 21, 2007.

FOR FURTHER INFORMATION CONTACT: Kathleen Scully-Hayes, Presiding Officer, CMS, Lord Baltimore Drive, Mail Stop LB–23–20, Baltimore, Maryland 21244, Telephone: (410) 786–2055.

SUPPLEMENTARY INFORMATION: This notice announces an administrative hearing to reconsider CMS' decision to disapprove New York SCHIP SPA #10 which was submitted on April 12, 2007, with additional information submitted on May 9, 2007, and August 27, 2007, and disapproved on September 7, 2007.

This SPA would have increased the financial eligibility standard for the State's separate SCHIP from the current effective family income eligibility level at or below 250 percent of the Federal poverty level (FPL) to an effective family income eligibility level at or below 400 percent of the FPL. The SPA also would have imposed a 6-month waiting period from the date of last insurance coverage for children with family incomes above 250 percent of the FPL, with certain listed exceptions.

The CMS disapproved the SPA because it would result in a child health plan that did not comport with the requirements of sections 2101(a), 2102(a), and 2102(b)(3)(C) of the Social Security Act (the Act). These requirements provide that funding must be used to provide coverage to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage, that the State plan includes effective outreach procedures to enroll all eligible uninsured children, and that the coverage made available does not merely substitute for private coverage. This disapproval is also consistent with the August 17, 2007, letter to State Health Officials clarifying how CMS believes these existing statutory requirements should be applied by all States expanding SCHIP effective eligibility levels above 250 percent of the FPL.

The following will be at issue at the hearing:

- Whether the State has demonstrated that SPA #10 is consistent with the requirement in section 2101(a) of the Act for effective and efficient program operation. SPA #10 would require that the State devote limited SCHIP funding to children with higher effective family incomes when the program has not enrolled substantially all of the core

population of targeted low-income children with family incomes below 200 percent of the FPL;

• Whether New York has demonstrated that SPA #10 is consistent with the requirements in section 2102(a) to identify and enroll all uncovered children who are eligible to participate in public health insurance programs, to ensure that the SCHIP program is coordinated with those efforts, and to have effective outreach procedures;

• Whether the State has met the requirements to have reasonable procedures in place to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans, consistent with section 2102(b)(3)(C) of the Act, as implemented by 42 CFR 457.805. For family income eligibility levels higher than 250 percent of the FPL, the preamble to that regulatory provision indicated that States would need to have specific procedures in place, and later the August 17, 2007, State Health Officials' Letter further articulated the procedures that CMS would consider reasonable. SPA #10 did not include those specific procedures (including a period of uninsurance of at least 1 year, and cost sharing comparable to competing private plans subject to the overall 5 percent family cap).

Section 1116 of the Act and Federal regulations at 42 CFR 457.204 and 42 CFR part 430, subpart D, 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 New York announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Ms. Deborah Bachrach, Deputy Commissioner, Office of Health Insurance Programs, State of New York, Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

Dear Ms. Bachrach:

I am responding to your request for reconsideration of the decision to disapprove the New York State Children's Health Insurance Program (SCHIP) State Child Health Plan Amendment (SPA) #10, which was submitted on April 12, 2007, with additional information submitted on May 9, 2007, and August 27, 2007, and disapproved on September 7, 2007.

This SPA would have increased the financial eligibility standard for the State's separate SCHIP from the current effective family income eligibility level at or below 250 percent of the Federal poverty level (FPL) to an effective family income eligibility level at or below 400 percent of the FPL. The SPA also would have imposed a 6-month waiting period from the date of last insurance coverage for children with family incomes above 250 percent of the FPL, with certain listed exceptions.

The Centers for Medicare & Medicaid Services (CMS) disapproved the SPA because it would result in a child health plan that did not comport with the requirements of sections 2101(a), 2102(a), and 2102(b)(3)(C) of the Social Security Act (the Act). These requirements provide that funding must be used to provide coverage to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage, that the State plan includes effective outreach procedures to enroll all eligible uninsured children, and that the coverage made available does not merely substitute for private coverage. This disapproval is also consistent with the August 17, 2007, letter to State Health Officials clarifying how CMS believes these existing statutory requirements should be applied by all States expanding SCHIP effective eligibility levels above 250 percent of the FPL.

The following will be at issue at the hearing:

• Whether the State has demonstrated that SPA #10 is consistent with the requirement in section 2101(a) of the Act for effective and efficient program operation. SPA #10 would require that the State devote limited SCHIP funding to children with higher effective family incomes when the program has not enrolled substantially all of the core population of targeted low-income children with family incomes below 200 percent of the FPL;

• Whether New York has demonstrated that SPA #10 is consistent with the requirements in section 2102(a) to identify and enroll all uncovered children who are eligible to participate in public health insurance programs, to ensure that the SCHIP program is coordinated with those efforts, and to have effective outreach procedures;

• Whether the State has met the requirements to have reasonable procedures in place to ensure that health benefits coverage provided under the State plan do not substitute for coverage provided under group health plans, consistent with section 2102(b)(3)(C) of the Act, as implemented by Federal regulations at 42 CFR 457.805. For family income eligibility levels higher than 250 percent of the FPL, the preamble to that regulatory provision indicated that States would need to have specific procedures in place, and later the August 17, 2007, State Health Officials' Letter further articulated the procedures that CMS would consider reasonable. SPA #10 did not include those specific procedures (including a period of uninsurance of at least 1 year, and cost sharing comparable to competing private plans subject to the overall 5 percent family cap).

I am scheduling a hearing on your request for reconsideration to be held on January 16, 2008, at the CMS New York Regional Office, 38–110A, 26 Federal Plaza, New York, New York 10278, to reconsider the decision to disapprove SCHIP SPA #10. 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, Subpart D.

I am designating Ms. Kathleen Scully-Hayes as the presiding officer. If these arrangements present any problems, please contact the presiding officer at (410) 786–2055. 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 457.203)

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

Dated: November 30, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E7–23734 Filed 12–5–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Office of Community Services

AGENCY: Office of Community Services, ACF, DHHS.

ACTION: Notice of cancellation of standing program announcement for the Assets for Independence (AFI) Program (HHS–2005–ACF–OCS–EI–0053).

CFDA#: 93.602.

Legislative Authority: The Assets for Independence Act (Title IV of the