allowable state expenditures on medical assistance.

• Section 1903(w)(6)(A) of the Act, which allows states to use funds derived from state or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under section 1903 of the Act.

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 in the **Federal Register** 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 state Medicaid agency of additional issues that will be considered at the hearing, we will also publish that notice in the **Federal Register**.

Any interested 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 or moved, the presiding officer will notify all participants.

The notice to South Carolina announcing an administrative hearing to reconsider the disapproval of its SPAs reads as follows:

Joshua D. Baker,

Director, South Carolina Department of Health and Human Services, Post Office Box 8206, Columbia, SC 29202–8206.

Dear Mr. Baker:

I am responding to the request for reconsideration (dated September 5, 2019) of the decision to disapprove South Carolina's state plan amendments (SPAs) 16–0012–A, 17–0006–A, and 18–0011–A, which we received on September 6, 2019. South Carolina SPAs 16–0012–A, 17–0006–A, and 18–0011–A were submitted to the Centers for Medicare & Medicaid Services (CMS) on December 21, 2016, June 28, 2017, and June 29, 2018, respectively, and disapproved on July 9, 2019. I am scheduling a hearing on the request for reconsideration to be held on November 20, 2019 at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303–8909.

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786–3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the presiding officer to indicate acceptability of the hearing date and location that has been established and provide names of the individuals who will represent the State at the hearing. If the hearing date or location is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties and may designate another location, with due regard for the convenience and necessity of the parties and their representatives. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR part 430.

These SPAs requested CMS approval to add new eligible physicians associated with Greenville Memorial Hospital and Palmetto Health Richland (since merged into a single entity, Prisma Health) to the current physician teaching supplemental payment methodology. Specifically, SPAs 16–0012–A, 17–0006–A, and 18–0011–A proposed to use intergovernmental transfers from the Greenville Health Authority to the state Medicaid Agency as the non-federal share of the proposed payments.[1] The source of the transfers would be from the ''Setoff Debt Collection Program,'' which garnishes state individual income tax refunds to satisfy medical debt liabilities for services furnished by certain providers, rather than state or local tax revenue as required by Section 1903(w)(6)(A) of the Social Security Act (the Act). The revenue collected from the Setoff Debt Collection Program is derived from previously uncollected patient revenue.

The issues to be considered at the hearing are whether South Carolina SPAs 16–0012–A, 17–0006–A, and 18–0011–A are inconsistent with the requirements of:

• Section 1902(a)(2) of the Act, which provides that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

• Sections 1903(a) and 1905(b) of the Act, which provide that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.

• Section 1903(w)(6)(A) of the Act, which allows States to use funds derived from State or local taxes, which are then transferred from units of government to the Medicaid Agency, as the non-federal share of Medicaid payments unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under section 1903 of the Act.

In the event that CMS and the State come to agreement on resolution of the issues that formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Seema Verma,

Administrator.

cc: Benjamin R. Cohen.

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 4, 2019.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2019–22319 Filed 10–8–19; 4:15 pm]

BILLING CODE 4120–01–P

[1] As reflected in the July 9, 2019 disapproval letter, CMS did not examine, or reach a conclusion with respect to, whether the Greenville Health Authority is a unit of government eligible to make an intergovernmental transfer.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

[OMB No. 0915–0307—Extension]

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; Ryan White HIV/AIDS Program Core Medical Services Waiver Application Requirements

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA has submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period.

DATES: Comments on this ICR should be received no later than November 12, 2019.

ADDRESSES: Submit your comments, including the Information Collection Request Title, to the desk officer for HRSA, either by email to *OIRA_submission@omb.eop.gov* or by fax to 202–395–5806.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email Lisa Wright-Solomon, the HRSA Information Collection Clearance Officer at *paperwork@hrsa.gov* or call (301) 443–1984.

SUPPLEMENTARY INFORMATION:

Information Collection Request Title: Ryan White HIV/AIDS Program Core Medical Services Waiver Application Requirements, OMB No. 0915–0307—Extension.

Abstract: Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009, also known as the Ryan White HIV/AIDS Program (RWHAP), requires that grant recipients expend funds on core medical services including antiretroviral drugs for individuals with HIV who are eligible under the statute. In addition, after reserving statutory permissible amounts for administrative and clinical quality management costs from the total award amount, at least 75 percent of the remainder is to be expended on core medical services.[1] For a grant recipient under the RWHAP Parts A, B, or C to be exempted from this requirement, a waiver must be requested from HRSA for review and approval in accordance with statute.

On October 25, 2013, HRSA published revised standards for core medical services waiver requests in the **Federal Register** (78 FR 63990). These revised standards allow grant recipients flexibility to adjust resource allocation based on the current situation in their local environments. These standards ensure that grant recipients receiving waivers demonstrate the availability of core medical services, including antiretroviral drugs, for persons with HIV served under the HRSA RWHAP. The core medical services waiver request process applies to RWHAP grant applicants and recipients under Parts A, B, and C of Title XXVI of the PHS Act. Core medical services waivers are effective for a 1-year period. Grant applicants may submit a waiver request before, or with the annual grant application, and grant recipients can submit up to four months after the grant award has been made.

A 60-day notice was published in the **Federal Register** on August 15, 2019, vol. 84, No. 158; pp. 41726–27. There were no public comments.

Need and Proposed Use of the Information: HRSA uses the documentation submitted in core medical services waiver requests to determine if the grant applicant or recipient meets the statutory requirements for waiver eligibility including: (1) No waiting lists for AIDS Drug Assistance Program services; and (2) evidence of core medical services availability within the grant recipient's jurisdiction, state, or service area to all persons with HIV identified and eligible under Title XXVI of the PHS Act.[2]

Likely Respondents: Ryan White HIV/AIDS Program Parts A, B, and C grant applicants and recipients.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this ICR are summarized in the table below.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Waiver Request	20	1	20	5.5	110
Total	20		20		110

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2019–22274 Filed 10–10–19; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of General Medical Sciences Special Emphasis Panel Review of NIGMS Support of Competitive Research (SCORE) Award Applications.

Date: November 8, 2019.

Time: 12:00 p.m. to 3:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of General Medical Sciences, Natcher Building, 45 Center Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Rebecca H. Johnson, Ph.D., Scientific Review Officer, Office of Scientific Review, National Institute of General Medical Sciences, National Institutes of Health, Natcher Building, Room 3AN18C, 45 Center Drive, Bethesda, MD 20892, (301) 594–2771, *johnsonrh@nigms.nih.gov.*

Name of Committee: National Institute of General Medical Sciences Special Emphasis Panel, Review of Limited Competition: NIGMS Legacy Community-Wide Scientific Resources (R24) Applications.

Date: November 13, 2019.

Time: 1:00 p.m. to 4:00 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of General Medical Sciences, Natcher Building, 45 Center Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Rebecca H. Johnson, Ph.D., Scientific Review Officer, Office of Scientific Review, National Institute of General Medical Sciences, National Institutes of Health, Natcher Building, Room 3AN18C, 45 Center Drive, Bethesda, MD 20892, (301) 594–2771 *johnsonrh@nigms.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical

[1] Sections 2604(c)(1), 2612(b)(1), and 2651(c)(1) of the PHS Act.

[2] Sections 2604(c)(2), 2612(b)(2), and 2651(c)(2) of the PHS Act.