exclusive dealing by Pfizer. Prescription pharmaceutical customers (*e.g.,* insurance companies) set up bid processes for purchasing pharmaceutical products on a product-by-product (or category-by-category) basis and have generally resisted efforts by large pharmaceutical companies to bundle products across categories, unless the bundle is in the customer's best interest. We found no evidence that this acquisition would undermine customers' ability to prevent anticompetitive bundling. As a result, we conclude that the addition of the Wyeth portfolio of products to Pfizer's portfolio is not likely to enhance the merged entity's ability to engage in anticompetitive bundling, especially because the combined portfolio would contain few blockbuster drugs.

Staff also investigated whether the acquisition would create a patent thicket by virtue of the breadth of the combined companies' patent portfolio. A merger-created patent thicket could reduce or eliminate competition in human pharmaceutical products by enabling the combined firm to prevent other pharmaceutical companies from developing products through the enforcement of intellectual property rights. After evaluating the parties' respective patent portfolios in a number of areas where both firms are active, including, most notably, Alzheimer's disease, the evidence showed that the combination of the intellectual property of Pfizer with that of Wyeth would not pose any greater barrier to entry to third-party companies than the intellectual property held by the companies individually.

Finally, staff evaluated whether the transaction would decrease basic research or the pace of innovation in pharmaceutical markets by eliminating a leader in pharmaceutical research and development; changing the incentives of companies performing pharmaceutical research and development; or reducing the number of potential research, marketing, or funding partners. Pharmaceutical research and development is a dynamic field with multiple participants including both large and small traditional pharmaceutical companies, specialty pharmaceutical companies, biotechnology companies, and contract research organizations. The evidence does not indicate that the combination raises antitrust concerns in these respects.

Even within the discrete product areas where both Pfizer and Wyeth are actively pursuing research and development, such as treatments for Alzheimer's disease, we conclude that the transaction is not likely to affect competition in basic research or innovation. Within Alzheimer's disease specifically, fundamental information about the disease, including its cause, how to diagnose it prior to the appearance of symptoms, and when intervention must occur to modify the disease, is still unknown. There is no scientific consensus about the most promising track for the treatment of Alzheimer's disease. As a result, it is a dynamic area of drug development, and the many companies working in this disease area are pursuing many different pathways with compounds that can have different effects and risk factors.

Although Pfizer and Wyeth are two of the most active companies pursuing research and development activities in the Alzheimer's disease area, it is unlikely that the combination of the Pfizer and Wyeth's Alzheimer's disease pipelines will diminish the incentives of Pfizer or any other company to compete in the research and development of Alzheimer's disease treatments. Further, the combination of Pfizer and Wyeth is not likely to affect the ability of other companies to continue to develop and ultimately introduce new products to treat Alzheimer's disease.

The Commission's extensive investigation and commitment of resources in this matter reflects its dedication to ensuring that pharmaceutical markets are competitive and that consumers have access to innovative and affordable medications. Although the Commission, based on the evidence gathered, determined that this transaction did not raise anticompetitive concerns in the markets for human pharmaceuticals, the Commission remains dedicated to ensuring that pharmaceutical markets are competitive. We will closely monitor these markets and continue to evaluate future transactions under the framework explained here to determine their effect on competition in the health care market, and, where appropriate, take action to ensure that any merger or acquisition does not undermine the pharmaceutical industry's competitiveness.

By direction of the Commission, Commissioner Harbour and Commissioner Kovacic recused.

Donald S. Clark,

Secretary.

[FR Doc. E9–28336 Filed 11–25–09; 8:45 am]

BILLING CODE 6750–01–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, 2010 through September 30, 2011

AGENCY: Office of the Secretary, DHHS.

ACTION: Notice.

SUMMARY: The Federal Medical Assistance Percentages (FMAP) and Enhanced Federal Medical Assistance Percentages (eFMAP) for Fiscal Year 2011 have been calculated pursuant to the Social Security Act (the Act). These percentages will be effective from October 1, 2010 through September 30, 2011. 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. The table 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.

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 services and medical insurance services, 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 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)(B), 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 50 per centum.

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 the table of FMAPs 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 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 will be effective for each of the four quarter-year periods beginning October 1, 2010 and ending September 30, 2011.

FOR FURTHER INFORMATION CONTACT: Carrie Shelton, 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: November 20, 2009.

Kathleen Sebelius,

Secretary.

FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2010–SEPTEMBER 30, 2011

[Fiscal year 2011]

State	Federal medical assistance percentages	Enhanced federal medical assistance percentages
Alabama	68.54	77.98
Alaska	50.00	65.00
American Samoa *	50.00	65.00
Arizona	65.85	76.10
Arkansas	71.37	79.96
California	50.00	65.00
Colorado	50.00	65.00
Connecticut	50.00	65.00
Delaware	53.15	67.21
District of Columbia **	70.00	79.00
Florida	55.45	68.82
Georgia	65.33	75.73
Guam *	50.00	65.00
Hawaii	51.79	66.25
Idaho	68.85	78.20
Illinois	50.20	65.14
Indiana	66.52	76.56
Iowa	62.63	73.84
Kansas	59.05	71.34
Kentucky	71.49	80.04
Louisiana	63.61	74.53
Maine	63.80	74.66
Maryland	50.00	65.00
Massachusetts	50.00	65.00
Michigan	65.79	76.05
Minnesota	50.00	65.00
Mississippi	74.73	82.31
Missouri	63.29	74.30
Montana	66.81	76.77
Nebraska	58.44	70.91
Nevada	51.61	66.13
New Hampshire	50.00	65.00
New Jersey	50.00	65.00

FEDERAL MEDICAL ASSISTANCE PERCENTAGES AND ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, EFFECTIVE OCTOBER 1, 2010–SEPTEMBER 30, 2011—Continued

[Fiscal year 2011]

State	Federal medical assistance percentages	Enhanced federal medical assistance percentages
New Mexico	69.78	78.85
New York	50.00	65.00
North Carolina	64.71	75.30
North Dakota	60.35	72.25
Northern Mariana Islands *	50.00	65.00
Ohio	63.69	74.58
Oklahoma	64.94	75.46
Oregon	62.85	74.00
Pennsylvania	55.64	68.95
Puerto Rico *	50.00	65.00
Rhode Island	52.97	67.08
South Carolina	70.04	79.03
South Dakota	61.25	72.88
Tennessee	65.85	76.10
Texas	60.56	72.39
Utah	71.13	79.79
Vermont	58.71	71.10
Virgin Islands *	50.00	65.00
Virginia	50.00	65.00
Washington	50.00	65.00
West Virginia	73.24	81.27
Wisconsin	60.16	72.11
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 75.00 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 DC is 50.00 per centum, unless otherwise specified by law.

[FR Doc. E9–28438 Filed 11–25–09; 8:45 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Toxicology Program (NTP); NTP Interagency Center for the Evaluation of Alternative Toxicological Methods (NICEATM); Evaluation of In Vitro Estrogen Receptor Transcriptional Activation and In Vitro Cell Proliferation Assays for Endocrine Disruptor Chemical Screening: Request for Nominations for an Independent Expert Peer Review Panel and Submission of Relevant In Vitro and In Vivo Data

AGENCY: National Institute of Environmental Health Sciences (NIEHS), National Institutes of Health (NIH).

ACTION: Request nominations for an independent expert panel and submission of relevant data.

SUMMARY: NICEATM, in collaboration with the Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM), is planning to convene an independent scientific peer review panel (hereafter, Panel) to assess the validation status of an *in vitro* stably-transfected estrogen receptor (ER) transcriptional activation (TA) Assay (LUMI–CELL® ER assay) and an *in vitro* cell proliferation assay (CertiChem MCF–7 Cell Proliferation assay) for their usefulness and limitations in determining whether and to what extent chemicals can interact with estrogen receptors *in vitro.*

Validated assays that can detect the interaction of chemicals with specific hormone receptors including the ER are included in the U.S. Environmental Protection Agency (EPA) Endocrine Disruptor Screening Program (EDSP) (*http://www.epa.gov/endo/pubs/assayvalidation/status.htm*). The two assays that will undergo peer review are currently undergoing validation studies to determine their usefulness and limitations for the EDSP. Any other existing data from these two assays are requested to ensure that all available relevant data are considered by the Panel. Data from other existing *in vitro* and *in vivo* assays for the 78 reference substances used for the validation studies (available at *http://iccvam.niehs.nih.gov/docs/endo_docs/EDAddendFinal.pdf*) are requested for use in characterizing the expected *in vitro* and *in vivo* activity of these 78 reference substances. At this time NICEATM requests:

- Nominations of expert scientists for consideration as potential Panel members.
- Submission of existing data from the LUMI–CELL® ER and the CertiChem MCF–7 Cell Proliferation assays.
- Submission of data from *in vivo* or other *in vitro* assessments for the 78 reference substances recommended by ICCVAM for the validation of *in vitro* ER and AR binding and TA test methods (available at *http://iccvam.niehs.nih.gov/docs/endo_docs/EDAddendFinal.pdf*).

DATES: Submit nominations and data by January 11, 2010. Data submitted after this date will be considered in the evaluation, where feasible.

ADDRESSES: Submit nominations and data electronically by e-mail to *niceatm@niehs.nih.gov,* or via the NICEATM–ICCVAM Web site at *http://iccvam.niehs.nih.gov/contact/FR_pubcomment.htm.* Nominations and data may also be sent by mail or fax to Dr. William S. Stokes, Director, NICEATM, NIEHS, P.O. Box 12233, Mail Stop: K2–16, Research Triangle Park, NC 27709, (telephone) 919–541–2384, (fax) 919–541–0947, (e-mail). Courier address: NIEHS, NICEATM, 530 Davis Drive, Room 2034, Morrisville, NC 27560.