Dated: January 27, 1997.

Georgi Jones,

Director, Office of Policy and External Affairs, Agency for Toxic Substances and Disease Registry.

[FR Doc. 97–2383 Filed 1–30–97; 8:45 am]

BILLING CODE 4163–70–P

Centers for Disease Control and Prevention

Citizens Advisory Committee on Public Health Service Activities and Research at Department of Energy (DOE) Sites: Fernald Health Effects Subcommittee

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Agency for Toxic Substances and Disease Registry (ATSDR) and the Centers for Disease Control and Prevention (CDC) announce the following meeting.

Name: Citizens Advisory Committee on Public Health Service Activities and Research at DOE Sites: Fernald Health Effects Subcommittee.

Times and Dates: 1 p.m.–9 p.m., February 12, 1997. 8:30 a.m.–5 p.m., February 13, 1997.

Place: The Plantation, 9660 Dry Fork Road, Harrison, Ohio 45020, telephone 513/367–5610.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 50 people.

Background: Under a Memorandum of Understanding (MOU) signed in December 1990 with DOE, the Department of Health and Human Services (HHS) has been given the responsibility and resources for conducting analytic epidemiologic investigations of residents of communities in the vicinity of DOE facilities, workers at DOE facilities, and other persons potentially exposed to radiation or to potential hazards from non-nuclear energy production use. HHS delegated program responsibility to CDC.

In addition, an MOU was signed in October 1990 and renewed in November 1992 between ATSDR and DOE. The MOU delineates the responsibilities and procedures for ATSDR's public health activities at DOE sites required under sections 104, 105, 107, and 120 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA or ''Superfund''). These activities include health consultation and public health assessments at DOE sites listed on, or proposed for, the Superfund National Priorities List and at sites that are the subject of petitions from the public; and other health-related activities such as epidemiologic studies, health surveillance, exposure and disease registries, health education, substance-specific applied research, emergency response, and preparation of toxicological profiles.

Purpose: This subcommittee is charged with providing advice and recommendations to the Director, CDC, and the Administrator, ATSDR, regarding community, American Indian Tribes, and labor concerns pertaining to CDC's and ATSDR's public health activities and research at this DOE site. The purpose of this meeting is to provide a forum for community, and labor interaction and serve as a vehicle for community concern to be expressed as advice and recommendations to CDC and ATSDR.

Matters to be Discussed: Agenda items include: Presentations from the National Center for Environmental Health (NCEH) regarding current activities; the National Institute for Occupational Safety and Health and ATSDR will provide updates on the progress of current studies.

Agenda items are subject to change as priorities dictate.

An unavoidable administrative delay prevented meeting the 15-day publication requirement.

Contact Persons for More Information: Steven A. Adams, or Nadine Dickerson, Radiation Studies Branch, Division of Environmental Hazards and Health, NCEH, CDC, 4770 Buford Highway, NE, (M/S F–35), Atlanta, Georgia 30341–3724, telephone 770/488–7040, FAX 770/488–7044.

Dated: January 28, 1997.

Carolyn J. Russell,

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

[FR Doc. 97–2573 Filed 1–30–97; 8:45 am]

BILLING CODE 4163–18–P

Health Care Financing Administration

[HCFA R–143]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, has submitted to the Office of Management and Budget (OMB) the following proposal for the collection of information. Interested persons are invited to send comments regarding the 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. HCFA–R–143 *Type of Information Collection Request:* Reinstatement, without change, of previously approved collection for which approval has expired; *Title of Information Collection:* Analysis of Malpractice Premium Data; *Form No.:* HCFA–R–143; *Use:* The Omnibus Reconciliation Act of 1989 section 1848 (e) (Pub. L. 101–239) requires the Secretary of Health and Human Services (HHS) to develop and update geographic adjustment factors for existing payment localities used in calculating the Medicare Economic Index in setting the Medicare physician fee schedule update; *Frequency:* Annually; *Affected Public:* State, local or tribal govt., business or other for-profit, or not-for-profit institutions; *Number of Respondents:* 50; *Total Annual Responses:* 50; *Total Annual Hours:* 150.

To obtain copies of the supporting statement for the proposed paperwork collections referenced above, E-mail your request, including your address and phone number, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: January 24, 1997.

Edwin J. Glatzel

Director, Management Analysis and Planning Staff, Office of Financial and Human Resources, Health Care Financing Administration.

[FR Doc. 97–2363 Filed 1–30–97; 8:45 am]

BILLING CODE 4120–03–P

[MB–104–N]

Medicaid Program; Preliminary Limitations on Aggregate Payments to Disproportionate Share Hospitals: Federal Fiscal Year 1997

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice announces the preliminary Federal fiscal year (FFY) 1997 national target and individual State allotments for Medicaid payment adjustments made to hospitals that serve a disproportionate number of Medicaid recipients and low-income patients with special needs. We are publishing this notice in accordance with the provisions of section 1923(f)(1)(C) of the Social Security Act and implementing regulations at 42 CFR 447.297 through 447.299. The preliminary FFY 1997

State DSH allotments published in this notice will be superseded by the final FFY 1997 DSH allotments that we intend to publish in the Federal Register about April 1997.

EFFECTIVE DATE: The preliminary DSH payment adjustment expenditure limits included in this notice apply to Medicaid DSH payment adjustments for FFY 1997.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1902(a)(13)(A) of the Social Security Act (the Act) requires States to ensure that their Medicaid payment rates include payment adjustments for Medicaid-participating hospitals that serve a large number of Medicaid recipients and other low-income individuals with special needs (referred to as disproportionate share hospitals (DSH)). The DSH payment adjustments are calculated on the basis of formulas specified in section 1923 of the Act.

Section 1923(f) of the Act and implementing Medicaid regulations at 42 CFR 447.297 through 447.299 require us to estimate and publish in the Federal Register a national aggregate target and each State's allotment for DSH payments for each Federal fiscal year (FFY). The implementing regulations provide that the national DSH payment limit for a FFY specified in the Act is a target rather than an absolute cap when determining the amount that can be allocated for DSH payments. The national DSH payment target is 12 percent of the total amount of medical assistance expenditures (excluding total administrative costs) that are projected to be made under approved Medicaid State plans during the FFY. (Note: Whenever the phrases ''total medical assistance expenditures'' or ''total administrative costs'' are used in this notice, they mean both the State and Federal share of expenditures or costs.)

In addition to the national DSH payment target, there is a specific State DSH limit for each State for each FFY. The State DSH limit is a specified amount of DSH payment adjustments applicable to a FFY above which FFP will not be available. This is called the ''State DSH allotment.''

Each State's DSH allotment for FFY 1997 is calculated by first determining whether the State is a ''high-DSH State'' or a ''low-DSH State.'' This is determined by using the State's ''base allotment.'' A State's base allotment is the greater of the following amounts: (1) the total amount of the State's actual and projected DSH payment adjustments made under the State's approved State plan applicable to FFY 1992, as adjusted by HCFA; or (2) $1,000,000.

A State whose base allotment exceeds 12 percent of the State's total medical assistance expenditures (excluding administrative costs) projected to be made in FFY 1997 is referred to as a ''high-DSH State'' for FFY 1997. The FFY 1997 State DSH allotment for a high-DSH State is limited to the State's base allotment.

A State whose base allotment is equal to or less than 12 percent of the State's total medical assistance expenditures (excluding administrative costs) projected to be made in FFY 1997 is referred to as a ''low-DSH State.'' The FFY 1997 State DSH allotment for a low-DSH State is equal to the State's DSH allotment for FFY 1996 increased by growth amounts and supplemental amounts, if any. However, the FFY 1997 DSH allotment for a low-DSH State cannot exceed 12 percent of the State's total medical assistance expenditures for FFY 1997 (excluding administrative costs).

The growth amount for FFY 1997 is equal to the projected percentage increase (the growth factor) in a low-DSH State's total Medicaid program expenditures between FFY 1996 and FFY 1997 multiplied by the State's final DSH allotment for FFY 1996. Because the national DSH payment limit is considered a target, low-DSH States whose programs grow from one year to the next can receive a growth amount that would not be permitted if the national DSH payment limit was viewed as an absolute cap.

There is no growth factor and no growth amount for any low-DSH State whose Medicaid program does not grow (that is, stayed the same or declined) between FFY 1996 and FFY 1997. Furthermore, because a low-DSH State's FFY 1996 DSH allotment cannot exceed 12 percent of the State's total medical assistance expenditures, it is possible for its FFY 1997 DSH allotment to be lower than its FFY 1996 DSH allotment. This occurs when the State experiences a decrease in its program expenditures between years and its prior FFY DSH allotment is greater than 12 percent of the total projected medical assistance expenditures for the current FFY. For FFY 1997, no State has a State DSH allotment that is lower than its final FFY 1996 State DSH allotment.

For the first time since we began publishing the DSH allotments, there are State supplemental amounts available for redistribution to low-DSH States for FFY 1997. Under section 1923(f)(3) of the Act and implementing regulations at 42 CFR 447.298(e), the State supplemental amount, if any, is equal to a low-DSH State's relative share of a pool of funds (the redistribution pool). The redistribution pool is equal to the national 12-percent DSH payment target reduced by the sum of the total of the base allotments for high-DSH States, the total of the State DSH allotments for the previous FFY for low-DSH States, and the total of the low-DSH State growth amounts. Since the projected FFY 1997 national 12-percent DSH payment target is greater than the sum of these amounts, there is a redistribution pool and supplemental amounts are available for low-DSH States for FFY 1997.

In accordance with section 1923(f)(3) of the Act and 42 CFR 447.298(e), we determine each low-DSH State's supplemental amount by determining the State's relative share of the national redistribution pool on the basis of the State's total medical assistance expenditures for FFY 1997 compared to the sum of the medical assistance expenditures for the year for all low-DSH States. However, we will not provide any low-DSH State with a supplemental amount that would result in the State's total DSH allotment exceeding 12 percent of the State's projected medical assistance expenditures. Any supplemental amounts that cannot be allocated to a low-DSH State because of this limitation will be reallocated to other low-DSH States whose allotment does not exceed this 12-percent limit.

As prescribed in the law and regulations, no State's DSH allotment will be below a minimum of $1,000,000.

As an exception to the above requirements, under section 1923(f)(1)(A)(i)(II) of the Act and regulations at 42 CFR 447.296(b)(5) and 447.298(f), a State may make DSH payments for a FFY in accordance with the minimum payment adjustments required by Medicare methodology described in section 1923(c)(1) of the Act. The preliminary FFY 1997 State DSH allotments for the District of Columbia, Iowa, and Nebraska have been determined in accordance with this exception.

We are publishing in this notice the preliminary FFY 1997 national DSH payment target and State DSH allotments based on the best available data we received to date from the States, as adjusted by HCFA. These data are taken from each State's FFY 1996 and FFY 1997 projected Medicaid expenditures as reported on the August 15, 1996 Medicaid Budget Report (Form

HCFA–37) submission. All data are adjusted as necessary.

II. Calculations of the Preliminary FFY 1997 DSH Limits

The total of the preliminary State DSH allotments for FFY 1997 is equal to the sum of the base allotments for all high-DSH States, the FFY 1996 State DSH allotments for all low-DSH States, the growth amounts for all low-DSH States, and the supplemental amounts for all low-DSH States. A State-by-State breakdown is presented in section III of this notice.

We classified States as high-DSH or low-DSH States. If a State's base allotment exceeded 12 percent of its total unadjusted medical assistance expenditures (excluding administrative costs) projected to be made under the State's approved plan under title XIX of the Act in FFY 1997, we classified that State as a ''high-DSH'' State. If a State's base allotment was 12 percent or less of its total unadjusted medical assistance expenditures projected to be made under the State's approved plan under title XIX of the Act in FFY 1997, we classified that State as a ''low-DSH'' State. Based on this classification, there are 37 low-DSH States and 13 high-DSH States for FFY 1997.

Using the most recent data from the States' August 1996 budget projections (Form HCFA–37), we estimate the States' FFY 1997 national total medical assistance expenditures to be $171,499,434,000. Thus, the overall preliminary FFY 1997 national DSH payment target is $20,579,932,000 (12 percent of $171,499,434,000).

In the preliminary FFY 1997 State DSH allotments, we provide a total of $977,126,000 ($522,321,000 Federal share) in growth amounts for the 37 low-DSH States. The growth factor percentage for each of the low-DSH States was determined by calculating the Medicaid program growth percentage for each low-DSH State between FFY 1996 and FFY 1997. To compute this percentage, we first ascertained each low-DSH State's total FFY 1996 projected medical assistance and administrative expenditures as reported on the State's August 15, 1996 Form HCFA–37. Next, we compared those expenditures to each low-DSH State's total estimated unadjusted FFY 1997 medical assistance and administrative expenditures, also as reported to HCFA on the State's August 15, 1996 Form HCFA–37 through the ''cutoff'' date of September 10, 1996. The cutoff date is the date through which the State's budget estimates reported on the August 15, 1996 Form HCFA–37 are accepted and applied in preparing the State's Medicaid grant award for the upcoming quarter (in this case, October through December 1996). The growth factor is the percentage increase in the projected expenditures from FFY 1996 to FFY 1997.

The growth factor percentage for each State was multiplied by the low-DSH State's final FFY 1996 DSH allotment amount to establish the State's preliminary growth amount for FFY 1997.

Since the preliminary FFY 1997 national DSH payment target of $20,579,932,000 is greater than $20,444,198,000, representing the sum of the total of the base allotments for high-DSH States ($7,375,265,000), the total of the State DSH allotments for the previous FFY for low-DSH States ($12,091,807,000), and the growth amounts for low DSH States ($977,126,000), there is a preliminary FFY 1997 redistribution pool in the amount of the excess ($135,734,000). The supplemental amount for each low-DSH State is the low-DSH State's relative share of the redistribution pool, determined by allocating the redistribution pool on the basis of the low-DSH State's medical assistance expenditures compared to the national total medical assistance expenditures for low-DSH States.

The low-DSH State's growth amount and supplemental amounts are added to the low-DSH State's final FFY 1996 DSH allotment amount to establish the preliminary total low-DSH State DSH allotment for FFY 1997. If a low-DSH State's growth amount, when added to its final FFY 1996 DSH allotment amount, exceeds 12 percent of its FFY 1997 estimated medical assistance expenditures, the State only receives a partial growth amount that, when added to its final FFY 1996 allotment, limits its total State DSH allotment for FFY 1997 to 12 percent of its estimated FFY 1997 medical assistance expenditures. For this reason, seven of the low-DSH States received partial growth amounts, and two low-DSH States received no growth amounts. Similarly, a low-DSH State's supplemental amounts are limited by the State's 12-percent limit.

Also, in accordance with the minimum payment adjustments required by Medicare methodology, the preliminary FFY 1997 State DSH allotments for the District of Columbia, Iowa, and Nebraska are $63,461,000, $19,575,000, and $14,550,000, respectively.

In summary, the total of all preliminary State DSH allotments for FFY 1997 is $20,579,932,000 ($11,615,775,000 Federal share). This total is composed of the high-DSH States' base allotments ($7,375,265,000), the low-DSH States' prior FFY's final State DSH allotments ($12,091,807,000), plus growth amounts for all low-DSH States ($977,126,000), plus supplemental amounts for low-DSH States ($135,734,000). The total of all preliminary FFY 1997 State DSH allotments is 12 percent of the total medical assistance expenditures (excluding administrative costs) projected to be made by these States in FFY 1997. That is, the total of all preliminary DSH allotments for FFY 1997, including supplemental amounts, is equal to the FFY 1997 national 12 percent DSH payment target amount of $20,579,932,000.

Each State should monitor and make any necessary adjustments to its DSH spending during FFY 1997 to ensure that its actual FFY 1997 DSH payment adjustment expenditures do not exceed its State DSH allotment for FFY 1997 published in this notice. As the ongoing reconciliation between actual FFY 1997 DSH payment adjustment expenditures and the FFY 1997 DSH allotments takes place, each State should amend its plan as may be necessary to make any adjustments to its FFY 1997 DSH payment adjustment expenditure patterns so that the State will not exceed its FFY 1997 DSH allotment.

The FFY 1997 reconciliation of DSH allotments to actual expenditures will take place on an ongoing basis as States file expenditure reports with HCFA for DSH payment adjustment expenditures applicable to FFY 1997. Additional DSH payment adjustment expenditures made in succeeding FFYs that are applicable to FFY 1997 will continue to be reconciled with each State's FFY 1997 DSH allotment as additional expenditure reports are submitted to ensure that the FFY 1997 DSH allotment is not exceeded. As a result, any DSH payment adjustment expenditures for FFY 1997 in excess of the FFY 1997 DSH allotment will be disallowed, and therefore, subject to the normal Medicaid disallowance procedures.

III. Preliminary FFY 1997 DSH Allotments

Key to Chart

Column and Description

Column A = Name of State.

Column B = High or Low DSH State Designation for FFY 1997. ''High'' indicates the State is a high-DSH State and ''Low'' indicates the State is a low-DSH State.

Column C = Final FFY 1996 DSH Allotments for All States. These were published in the Federal Register on September 23, 1996 (61 FR 49781).

Column D = Base Allotments for High-DSH States. The base allotment is the greater of the high-DSH State's FFY 1992 allowable DSH payment adjustment expenditures applicable to FFY 1992, or $1,000,000. ''NA, LOW DSH'' entries in this column refer to low-DSH States.

Column E = Growth Amounts for Low-DSH States. The growth amount is an increase in a low-DSH State's final FFY 1996 DSH allotment to the extent that the State's Medicaid program grew between FFY 1996 and FFY 1997. ''NA, HIGH DSH'' entries in this column refer to high-DSH States, which receive no growth. ''NONE, NO GROWTH'' entries in this column refer to low-DSH States whose Medicaid program had no increase or a decrease from FFY 1996 to FFY 1997.

Column F = Supplemental Amounts for Low-DSH States. The supplemental amount is the low-DSH State's relative share of the national redistribution pool. ''NA, HIGH DSH'' entries in this column refer to high-DSH States, which do not receive supplemental amounts. ''NONE, LOW AT 12%'' entries in this column refer to low-DSH States which do not receive any supplemental amounts because their DSH allotments are already at the State specific 12 percent limit.

Column G = Preliminary FFY 1997 State DSH Allotments. For a high-DSH State, this is equal to the base allotment from column D. For a low-DSH State, this is equal to the final State DSH allotment for FFY 1996 from column C plus, if any, the growth amount from column E and the supplemental amount from column F.

PRELIMINARY FEDERAL FISCAL YEAR 1997 DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS UNDER PUBLIC LAW 102–234 AMOUNTS ARE STATE AND FEDERAL SHARES

[Dollars Are in Thousands (000)]

A	B	C	D	E	F	G
State	FFY 1997 High or low DSH state designation	Final FFY 1996 DSH allotments for all states	Base allotments for high DSH states	Growth amounts for low DSH states (1)	Supplemental pool distribution for low DSH states	Preliminary FFY 1997 state DSH allotments
AL	HIGH	$417,458	$417,458	NA, HIGH DSH	NA, HIGH DSH	$417,458
AK	LOW	21,700	NA, LOW DSH	$1,949	$699	24,348
AR	LOW	3,605	NA, LOW DSH	$163	$2,636	6,403
CA	LOW	2,191,451	NA, LOW DSH	$10,852	NONE, LOW AT 12%	2,202,303
CO	HIGH	302,014	$302,014	NA, HIGH DSH	NA, HIGH DSH	302,014
CT	HIGH	408,933	$408,933	NA, HIGH DSH	NA, HIGH DSH	408,933
DE	LOW	8,613	NA, LOW DSH	$434	$833	9,880
DC (2)	LOW	61,854	NA, LOW DSH	NONE, NO GROWTH	$1,606	63,461
FL	LOW	340,018	NA, LOW DSH	$27,934	$12,930	380,882
GA	LOW	426,717	NA, LOW DSH	$21,751	$7,557	456,025
HI	LOW	82,686	NA, LOW DSH	$4,738	$1,513	88,937
ID	LOW	2,382	NA, LOW DSH	$259	$787	3,428
IL	LOW	542,225	NA, LOW DSH	$43,695	$13,925	599,845
IN	LOW	342,139	NA, LOW DSH	$4,762	NONE, LOW AT 12%	346,900
IA (2)	LOW	15,735	NA, LOW DSH	$1,275	$2,564	19,575
KS	HIGH	188,935	$188,935	NA, HIGH DSH	NA, HIGH DSH	188,935
KY	LOW	284,863	NA, LOW DSH	$10,668	NONE, LOW AT 12%	295,531
LA	HIGH	1,217,636	$1,217,636	NA, HIGH DSH	NA, HIGH DSH	1,217,636
ME	HIGH	165,317	165,317	NA, HIGH DSH	NA, HIGH DSH	165,317
MD	LOW	150,952	NA, LOW DSH	$18,103	$5,632	174,688
MA	LOW	575,289	NA, LOW DSH	$10,734	NONE, LOW AT 12%	586,023
MI	LOW	686,478	NA, LOW DSH	$35,623	NONE, LOW AT 12%	722,101
MN	LOW	63,890	NA, LOW DSH	$4,821	$6,254	74,965
MS	LOW	200,912	NA, LOW DSH	$19,357	NONE, LOW AT 12%	220,269
MO	HIGH	731,894	$731,894	NA, HIGH DSH	NA, HIGH DSH	731,894
MT	LOW	1,417	NA, LOW DSH	$75	$797	2,289
NE (2)	LOW	12,031	NA, LOW DSH	$997	$1,522	14,550
NV	HIGH	73,560	$73,560	NA, HIGH DSH	NA, HIGH DSH	73,560
NH	HIGH	392,006	$392,006	NA, HIGH DSH	NA, HIGH DSH	392,006
NJ	HIGH	1,094,113	$1,094,113	NA, HIGH DSH	NA, HIGH DSH	1,094,113
NM	LOW	20,272	NA, LOW DSH	$1,965	$2,030	24,267
NY	LOW	3,047,528	NA, LOW DSH	$523,632	$21,922	3,593,082
NC	LOW	458,975	NA, LOW DSH	$74,792	$9,632	543,399
ND	LOW	1,262	NA, LOW DSH	$67	$651	1,981
OH	LOW	651,596	NA, LOW DSH	$62,471	$13,872	727,939
OK	LOW	25,021	NA, LOW DSH	$542	$2,348	27,912
OR	LOW	33,118	NA, LOW DSH	$946	$3,011	37,074
PA	LOW	967,407	NA, LOW DSH	$49,593	NONE, LOW AT 12%	1,017,000
RI	LOW	111,480	NA, LOW DSH	$2,354	$894	114,728
SC	HIGH	439,759	$439,759	NA, HIGH DSH	NA, HIGH DSH	439,759
SD	LOW	1,555	NA, LOW DSH	$178	$726	2,459
TN	HIGH	430,611	$430,611	NA, HIGH DSH	NA, HIGH DSH	430,611
TX	HIGH	1,513,029	$1,513,029	NA, HIGH DSH	NA, HIGH DSH	1,513,029
UT	LOW	6,307	NA, LOW DSH	$369	$1,278	7,955
VT	LOW	31,740	NA, LOW DSH	$3,375	$796	35,911
VA	LOW	222,005	NA, LOW DSH	$16,713	$4,753	243,471
WA	LOW	352,800	NA, LOW DSH	$21,117	$6,387	380,304

PRELIMINARY FEDERAL FISCAL YEAR 1997 DISPROPORTIONATE SHARE HOSPITAL ALLOTMENTS UNDER PUBLIC LAW 102–234 AMOUNTS ARE STATE AND FEDERAL SHARES—Continued

[Dollars Are in Thousands (000)]

A	B	C	D	E	F	G
State	FFY 1997 High or low DSH state designation	Final FFY 1996 DSH allotments for all states	Base allotments for high DSH states	Growth amounts for low DSH states (1)	Supplemental pool distribution for low DSH states	Preliminary FFY 1997 state DSH allotments
WV	LOW	132,415	NA, LOW DSH	NONE, NO GROWTH	$2,600	135,015
WI	LOW	11,746	NA, LOW DSH	$726	$5,204	17,676
WY	LOW	1,623	NA, LOW DSH	$97	$376	2,096
TOTAL		19,467,072	$7,375,265	$977,126	$135,734	20,579,932

Notes:
(1) THERE WERE 2 LOW DSH STATES WITH NO GROWTH AND 7 LOW DSH STATES WITH PARTIAL GROWTH UP TO 12% OF FFY 97 MAP.
(2) ALLOTMENT BASED UPON MINIMUM PAYMENT ADJUSTMENT AMOUNT.

IV. Regulatory Impact Statement

The Regulatory Flexibility Act, 5 U.S.C. 601 through 612, requires a regulatory flexibility analysis for every rule subject to proposed rulemaking procedures under the Administrative Procedure Act, 5 U.S.C. 552, unless we certify that the rule will not have a significant economic impact on a substantial number of small entities. For purposes of a RFA, States and individuals are not considered small entities. However, providers are considered small entities. Additionally, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a notice may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We do not believe that this notice will have a significant economic impact on a substantial number of small entities because it reflects no new policies or procedures, and should have an overall positive impact on payments to DSHs by informing States of the extent to which DSH payments may be increased without violating statutory limitations. This notice sets forth no changes in our regulations; rather, it reflects the DSH allotments for each State as determined in accordance with 42 CFR 447.297 through 447.299.

We have discussed the method of calculating the preliminary FFY 1997 national DSH payment target and the preliminary FFY 1997 individual State DSH allotments in the previous sections of this preamble. These calculations should have a positive impact on payments to DSHs. Allotments will not be reduced for high-DSH States since we interpret the 12-percent limit as a target. Low-DSH States'' allotments are equal to their prior FFY DSH allotments plus their growth and supplemental amounts, if any.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

(Catalog of Federal Assistance Program No. 93.778, Medical Assistance Program)

Dated: November 21, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: December 20, 1996.

Donna E. Shalala,

Secretary.

[FR Doc. 97–2381 Filed 1–30–97; 8:45 am]

BILLING CODE 4120–01–P

National Institutes of Health

Proposed Collection; Comment Request; Research and Research Training Grant Applications and Related Forms

SUMMARY: In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, for opportunity for public comment on proposed data collection projects, the Office of Extramural Research, the National Institutes of Health (NIH) will publish periodic summaries of proposed projects to be submitted to the Office of Management and Budget (OMB) for review and approval.

PROPOSED COLLECTION: *Title:* Research and Research Training Grant Applications and Related Forms. *Type of Information Collection Request:* Revision, OMB 0925–0001, Expiration Date 9/30/97. *Form Numbers:* PHS 398, 2590, 2271, 3734 and HHS 568. *Need and Use of Information Collection:* The application is used by applicants to request Federal assistance for research and research-related training. The other related forms are used for trainee appointment, final invention reporting, and to relinquish rights to a research grant. *Frequency of Response:* Applicants may submit applications for published receipt dates. If awarded, annual progress is reported and trainees may be appointed or reappointed. *Affected Public:* Individuals or Households; Business or other for-profit; Not-for-profit institutions; Federal Government; and State, Local or Tribal Government. *Type of Respondents:* Adult scientific professionals. The annual reporting burden is as follows: *Estimated Number of Respondents:* 111,182; *Estimated Number of Responses per Respondent:* 1.05; *Average Burden Hours Per Response:* 19.63; and *Estimated total Annual Burden Hours Requested:* 2,291,676. The estimated annualized cost to respondents in $80,127,861 (Using a $35 physician/professor/clerical/trainee/administration staff average hourly wage rate.) There are no Capital Costs to report. There are no Operating or Maintenance Costs to report.

REQUEST FOR COMMENTS: Written comments and/or suggestions from the public and affected agencies are invited on one or more the following points: (1) Whether the proposed collection of information is necessary for the proper performance of the function of the agency, including whether the information will have practical utility; (2) The accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) Ways to enhance the quality, utility, and clarity of the information to be collected; and (4)