request by an individual who is considering the purchase of a hearing aid, the dispenser is required to provide a copy of the User Instructional Brochure for that model hearing aid or the name and address or telephone number of the manufacturer or distributor from whom a User Instructional Brochure for the hearing aid may be obtained. Under conditions of sale of hearing aid devices, manufacturers or distributors shall provide sufficient copies of the User Instructional Brochure to sellers for distribution to users and prospective users and provide a copy of the User Instructional Brochure to any health care professional, user, or prospective user who requests a copy in writing. The regulations also require that the patient provide a written statement that he or she has undergone a medical evaluation within the previous 6 months before the hearing aid is dispensed, although informed adults may waive the medical evaluation requirement by signing a written statement. Finally, the regulation requires that the dispenser retain for 3 years copies of all physician statements or any waivers of medical evaluations.

The information obtained through this collection of information is used by FDA to ensure that hearing aids are sold and used in a way consistent with the public health.

The information contained in the User Instructional Brochure is intended not only for the hearing aid user but also for the physician, audiologist, and dispenser. The data is used by these health care professionals to evaluate the suitability of a hearing aid, to permit proper fitting of it, and to facilitate repairs. The data also permits the comparison of the performance characteristics of various hearing aids. Noncompliance could result in a substantial risk to the hearing impaired because the physician, audiologist, or dispenser would not have sufficient data to match the aid to the needs of the user.

The respondents to this collection of information are hearing aid manufacturers, distributors, dispensers, health professionals, or other for profit organizations.

In 1993, FDA conducted an audit of hearing aid dispensers in four FDA districts to determine the level of compliance with existing hearing aid requirements. The estimates relating to § 801.421(a)(1) and (a)(2) in the reporting and recordkeeping burden tables below are based on information obtained in this audit. This audit revealed that medical evaluations were obtained in 32 percent of the sales and signed waivers were obtained in 60 percent of the sales.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN

21 CFR Section	No. of Respondents	Annual Frequency per Respondents	Total Annual Responses	Hours per Response	Total Hours
801.420	40	5	200	40	8,000
801.421(a)(1)	9,900	52	514,800	0.10	51,480
801.421(a)(2)	19,900	97	960,300	0.30	288,090
801.421(b)	9,900	162	1,600,000	0.30	480,000
801.421(c)	9,940	5	49,700	0.17	8,449
Total Burden Hours					836,019

There are no capital costs or operating and maintenance costs associated with this collection of information.

TABLE 2.—ESTIMATED ANNUAL RECORDKEEPING BURDEN

21 CFR Section	No. of Recordkeepers	Annual Frequency per Recordkeeping	Total Annual Records	Hours per Recordkeeper	Total Hours
801.421(d)	9,900	162	1,600,000	0.25	400,000
Total					400,000

There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: September 8, 1997.

William K. Hubbard,

Associate Commissioner for Policy Coordination.

[FR Doc. 97–24348 Filed 9–12–97; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[MB–110–N]

RIN: 0938–AH93

Medicaid Program; Final 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 final 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 final FFY 1997 State disproportionate share hospital (DSH) allotments published in this notice supersede the preliminary FFY 1997 DSH allotments that were published in the **Federal Register** on January 31, 1997.

EFFECTIVE DATE: The final 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). 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 payment limit for each State for each FFY. The State DSH payment 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 1997 DSH allotment cannot exceed 12 percent of the State's total medical assistance expenditures for FFY 1997, it is possible for its FFY 1997 DSH allotment to be lower than its FFY 1996 DSH allotment. This occurs when the State's prior FFY DSH allotment is greater than 12 percent of the total projected medical assistance expenditures for the current FFY. For FFY 1997, this is the case for the States of California and Hawaii. For the State of California, even though the State projected Medicaid program growth from FFY 1996 to FFY 1997, its FFY 1996 DSH allotment was greater than its FFY 1997 12 percent limit. For the State of Hawaii, the State projected a decrease in its FFY 1997 medical assistance expenditures such that its FFY 1997 12 percent limit was lower than its FFY 1996 DSH allotment.

When we published the preliminary State DSH allotments for FFY 1997 in the **Federal Register** on January 31, 1997, for the first time since we began publishing the DSH allotments, there were State supplemental amounts available for redistribution to low-DSH States for FFY 1997. However, in the final FFY 1997 State DSH allotments published in this notice, there are no State supplemental amounts. This is due to changes in the States' estimated expenditures for FFY 1997, and from the use of the actual Medicaid expenditures for FFY 1996 in these final allotments from those used in determining the preliminary FFY 1997 State DSH allotments.

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. However, in determining the final FFY 1997 State DSH allotments published in this notice, the projected FFY 1997 national 12-percent DSH payment target is less than the sum of these amounts. Therefore, there is no redistribution pool and no supplemental amounts 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, if available, 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 final 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 final 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 actual Medicaid expenditures for FFY 1996 as reported on the States' quarterly expenditure report Form HCFA–64 submissions and the FFY 1997 projected Medicaid expenditures as reported on the February 15, 1997 Medicaid Budget Report (Form HCFA–37) submission. All data are adjusted as necessary.

II. Calculations of the Final FFY 1997 DSH Limits

The total of the final 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 (including any adjustments required because of the 12 percent limitation), 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' February 1997 budget projections (Form HCFA–37), we estimate the States' FFY 1997 national total medical assistance expenditures to be $169,259,338,000. Thus, the overall final FFY 1997 national DSH payment target is $20,311,121,000 (12 percent of $169,259,338,000).

In the final FFY 1997 State DSH allotments, we provide a total of $873,722,000 ($461,188,000 Federal share) in growth amounts for 35 of the 37 low-DSH States. The FFY 1997 growth amounts for low-DSH States are determined by multiplying the low-DSH States' final FFY 1996 State DSH allotments by the growth factor percentage for those States. The growth factor percentage for each of the low-DSH States is determined by calculating the States' percentage change in Medicaid program expenditures (including administrative expenditures) between FFY 1996 and FFY 1997. To compute this percentage, we first ascertained each low-DSH State's total FFY 1996 actual medical assistance and administrative expenditures as reported on the State's four quarterly Medicaid expenditure reports (Form HCFA–64) for FFY 1996. Next, we compared those expenditures to each low-DSH State's total estimated unadjusted FFY 1997 medical assistance and administrative expenditures, as reported to HCFA on the State's February 15, 1997 Form HCFA–37 through the ''cutoff'' date of March 26, 1997. The cutoff date is the date through which the State's budget estimates reported on the February 15, 1997 Form HCFA–37 are accepted and applied in preparing the State's Medicaid grant award for the upcoming quarter (in this case, April through June 1997).

No final FFY 1997 redistribution pool is available, since the final FFY 1997 national DSH payment target of $20,311,121,000 is less than $20,335,510,000, 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 ($873,722,000) and the negative adjustment for the States of California and Hawaii due to the 12 percent limitation requirement ($3,003,000 and $2,281,000, respectively). That is, this sum exceeds the national target by $24,390,000.

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.

A low-DSH State's growth amount and supplemental amounts, if any, are added to the low-DSH State's final FFY 1996 DSH allotment amount to establish the final total low-DSH State's DSH allotment for FFY 1997. If a low-DSH State's growth amount and supplemental amount (if any), when added to its final FFY 1996 DSH allotment amount, exceed 12 percent of its FFY 1997 estimated medical assistance expenditures, the State can only receive 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. Eleven of the low-DSH States were affected by the 12 percent limitation requirement. Nine of these low-DSH States received partial growth amounts, and two low-DSH States' (California and Hawaii) final FFY 1997 State DSH allotment are lower than their final FFY 1996 State DSH allotments.

Also, in accordance with the minimum payment adjustments required by Medicare methodology, the final FFY 1997 State DSH allotments for the District of Columbia, Iowa, and Nebraska are $79,920,000, $16,910,000, and $13,366,000, respectively.

In summary, the total of all final State DSH allotments for FFY 1997 is $20,335,510,000 ($11,475,206,000 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), and the growth amounts for all low-DSH States ($873,722,000), and the negative adjustment for the States of California and Hawaii due to the 12 percent limitation requirement ($3,003,000 and $2,281,000, respectively), plus supplemental amounts for low-DSH States ($0). The total of all final FFY 1997 State DSH allotments is 12.0 percent of the total medical assistance expenditures (excluding administrative costs) projected to be made by these States in FFY 1997.

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. Final FFY 1997 DSH Allotments

Key to Chart:

Column	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 =	Final 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.

BILLING CODE 4120–01–P

FINAL 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	FINAL 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	$4,249	$0	$25,948
AR	LOW	$3,605	NA, LOW DSH	$155	$0	$3,760
CA	LOW	$2,191,451	NA, LOW DSH	NONE, NO GROWTH	$0	$2,188,448
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	$258	$0	$8,871
DC (2)	LOW	$61,854	NA, LOW DSH	$18,065	$0	$79,920
FL	LOW	$340,018	NA, LOW DSH	$25,775	$0	$365,793
GA	LOW	$426,717	NA, LOW DSH	$253	$0	$426,970
HI	LOW	$82,686	NA, LOW DSH	NONE, NO GROWTH	$0	$80,405
ID	LOW	$2,382	NA, LOW DSH	$169	$0	$2,552
IL	LOW	$542,225	NA, LOW DSH	$64,415	$0	$606,640
IN	LOW	$342,139	NA, LOW DSH	$13,707	$0	$355,845
IA (2)	LOW	$15,735	NA, LOW DSH	$1,175	$0	$16,910
KS	HIGH	$188,935	$188,935	NA, HIGH DSH	NA, HIGH DSH	$188,935
KY	LOW	$284,863	NA, LOW DSH	$24,360	$0	$309,223
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	$18,284	$0	$169,236
MA	LOW	$575,289	NA, LOW DSH	$21,762	$0	$597,051
MI	LOW	$686,478	NA, LOW DSH	$7,354	$0	$693,832
MN	LOW	$63,890	NA, LOW DSH	$6,927	$0	$70,817
MS	LOW	$200,912	NA, LOW DSH	$15,708	$0	$216,620
MO	HIGH	$731,894	$731,894	NA, HIGH DSH	NA, HIGH DSH	$731,894
MT	LOW	$1,417	NA, LOW DSH	$61	$0	$1,478
NE (2)	LOW	$12,031	NA, LOW DSH	$1,335	$0	$13,366
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	$2,535	$0	$22,807
NY	LOW	$3,047,528	NA, LOW DSH	$478,982	$0	$3,526,510
NC	LOW	$458,975	NA, LOW DSH	$27,533	$0	$486,508
ND	LOW	$1,262	NA, LOW DSH	$35	$0	$1,297
OH	LOW	$651,596	NA, LOW DSH	$30,797	$0	$682,393
OK	LOW	$25,021	NA, LOW DSH	$727	$0	$25,748
OR	LOW	$33,118	NA, LOW DSH	$1,601	$0	$34,718
PA	LOW	$967,407	NA, LOW DSH	$65,413	$0	$1,032,820
RI	LOW	$111,480	NA, LOW DSH	$2,934	$0	$114,414
SC	HIGH	$439,759	$439,759	NA, HIGH DSH	NA, HIGH DSH	$439,759
SD	LOW	$1,555	NA, LOW DSH	$56	$0	$1,612
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	$221	$0	$6,528
VT	LOW	$31,740	NA, LOW DSH	$2,230	$0	$33,970
VA	LOW	$222,005	NA, LOW DSH	$20,480	$0	$242,484
WA	LOW	$352,800	NA, LOW DSH	$11,533	$0	$364,333
WV	LOW	$132,415	NA, LOW DSH	$3,153	$0	$135,568
WI	LOW	$11,746	NA, LOW DSH	$1,197	$0	$12,943
WY	LOW	$1,623	NA, LOW DSH	$281	$0	$1,904
TOTAL		$19,467,072	$7,375,265	$873,722	$0	$20,335,510

NOTES:

(1) THERE ARE 2 LOW DSH STATES WITH FFY 1997 ALLOTMENTS LESS THAN THEIR FFY 1996 ALLOTMENTS DUE TO THE 12 PERCENT LIMIT AND 9 LOW DSH STATES WITH PARTIAL GROWTH UP TO 12 PERCENT OF FFY 97 MAP

(2) ALLOTMENT BASED UPON MINIMUM PAYMENT ADJUSTMENT AMOUNT

BILLING CODE 4120–01–C

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 disproportionate share hospitals 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 disproportionate share hospitals. 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: June 5, 1997.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: July 24, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 97–24281 Filed 9–12–97; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Public Law 104–13), the Health Resources and Services Administration (HRSA) will publish periodic summaries of proposed projects being developed for submission to OMB under the Paperwork Reduction Act of 1995. To request more information on the proposed project or to obtain a copy of the data collection plans, call the HRSA Reports Clearance Officer on (301) 443–1129.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Uniform Data System (OMB No. 0915–0193)—Extension and Revision—This is a request for extension and revision of a reporting system, the Uniform Data System (UDS), that consolidated and replaced annual reporting requirements for the cluster of primary care grantees funded by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). The UDS includes reporting requirements for grantees of the following primary care programs: Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Outreach and Primary Health Services for Homeless Children and Public Housing Primary Care. Authorizing Legislation is found in Public Law 104–299, Health Center Consolidation Act of 1996, enacting Section 330 of the Public Health Service Act.

The Bureau of Primary Health Care collects data on its programs to ensure compliance with legislative mandates and to report to Congress and policy makers on program accomplishments. To meet these objectives, BPHC requires a core set of information collected annually that is appropriate for monitoring and evaluating performance and reporting on annual trends. The UDS includes two components: the Universal Report, completed by all grantees, provides data on services, staffing, and financing; and the Grant Report, completed by grantees funded under the Homeless or Public Housing Program as well as one of the other programs, provides data on characteristics of users whose services fall within the scope of the Homeless or Public Housing Program grant. The first UDS reports were collected March 31, 1997 and analysis of data indicates that several revisions should be made. Program officials have noted that additional information needs to be collected which was included in previous reporting systems but was deleted from the UDS. Grantees will be asked to provide information on the charges, collections, bad debt write off and contractual disallowances by payor sources (Medicaid, Medicare, self pay and private insurance). Existing UDS forms are being reviewed to determine how the revenue/income reporting can be modified to accommodate these changes. Additional revisions will include annotating the forms to indicate which lines are subtotals and the lines to which they sum.

The proposed changes are not expected to add significantly to the reporting burden. Estimates of annualized reporting burden are as follows:

Type of report	Number of respondents	Hours per response	Total burden hours
Universal Report	694	24	16,656
Grant Report	88	16	1,408