## Centers for Disease Control and Prevention

### Technical Advisory Committee for Diabetes Translation and Community Control Programs; Meeting

In accordance wtih section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following committee meeting.

Name: Technical Advisory Committee for Diabetes Translation and Community Control Programs.

Time and Date: 8:30 a.m.-4:30 p.m., Monday, January 30, 1995.

Place: Rhodes Building, 4th Floor Conference Room, 3005 Chamblee-Tucker Road, Atlanta, Georgia 30341, telephone 404/488–5000. (Exit Chamblee-Tucker Road off I–85).

Status: Open to the public, limited only by the space available.

Purpose: This committee is charged with advising the Director, CDC, regarding priorities and feasible goals for translation activities and community control programs designed to reduce risk factors, morbidity, and mortality from diabetes and its complications. The committee advises regarding policies, strategies, goals and objectives, and priorities; identifies research advances and technologies ready for translation into widespread community practice; recommends public health strategies to be implemented through community interventions; advises on operational research and outcome evaluation methodologies; identifies research issues for further clinical investigation; and advises regarding the coordination of programs with Federal, voluntary, and private resources involved in the provisions of services to people with diabetes.

Matters to be Discussed: Committee members will discuss CDC's role in primary prevention, the National Diabetes Education Program, screening issues, the Regenstreif Conference, Policy and economic activities, and the status of the Diabetes Control Programs and health communication.

Agenda items are subject to change as priorities dictate.

Contact Person For More Information: Cheryl Shaw, Program Specialist, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC, 4770 Buford Highway, NE, (K–10), Atlanta, Georgia 30341–3724, telephone 404/488–5004.

Dated: January 9, 1995.

**William H. Gimson,**

*Acting Associate Director for Policy Coordination, Centers for Disease Control and Prevention (CDC).*

[FR Doc. 95–886 Filed 1–12–95; 8:45 am]

BILLING CODE 4163–18–M

### Poverty-Associated Mental Retardation Prevention Technical Assistance Workshop; Meeting

The National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC), announces the following meeting.

Name: Poverty-Associated Mental Retardation (PAMR) Prevention Technical Assistance Workshop for Planning Grant Recipients.

Time and Date: 8:30 a.m.–4:30 p.m., January 30, 1995.

Place: Swissotel Atlanta, 3391 Peachtree Road, NE, Atlanta, Georgia 30326.

Status: Open to the public limited only by the space available.

Purpose: The primary purpose of this workshop is to provide technical assistance to recipients of CDC grants as they plan programs to prevent PAMR. The workshop is not designed to provide general information on mental retardation or on prevention of PAMR.

Supplementary Information: The workshop will convene a group of recipients of CDC PAMR Planning Grants.

Seven of every 1,000 ten-year old children suffer from mild mental retardation, and three of every 1,000 suffer from more serious mental retardation. Poor children, especially those whose mothers have less than a high school education, are at risk for cognitive delay of as much as one standard deviation of IQ (15 points) at age three. Studies such as the Infant Health and Development Program and the Carolina Abecedarian Project have proven that an intensive early health and development intervention can prevent or reduce as much as two-thirds of PAMR. CDC is actively involved in research and planning to help States develop a community-based program to prevent PAMR.

Contact Person for Additional Information: Edward A. Brann, M.D., Chief, Mental Retardation Prevention Section, Developmental Disabilities Branch, Division of Birth Defects and Developmental Disabilities, NCEH, CDC, Mailstop F–15, 4770 Buford Highway, NE, Atlanta, Georgia 30341–3724, telephone 404/488–7400.

Dated: January 6, 1995.

**William H. Gimson,**

*Acting Associate Director for Policy Coordination, Centers for Disease Control and Prevention (CDC).*

[FR Doc. 95–883 Filed 1–12–95; 8:45 am]

BILLING CODE 4163–18–M

## Food and Drug Administration

**[Docket No. 94F–0455]**

### American Science and Engineering, Inc.; Filing of Food Additive Petition

**AGENCY:** Food and Drug Administration, HHS.

**ACTION:** Notice.

**SUMMARY:** The Food and Drug Administration (FDA) is announcing that American Science and Engineering, Inc., has filed a petition proposing that the food additive regulations be amended to provide for the safe use of X-radiation, produced by the operation of X-ray tubes at energy levels of 500,000 electron volts (500 keV) or lower, to inspect cargo containers that may contain food.

**DATES:** Written comments on the petitioner's environmental assessment by February 13, 1995.

**ADDRESSES:** Submit written comments to the Dockets Management Branch (HFA–305), Food and Drug Administration, rm. 1–23, 12420 Parklawn Dr., Rockville, MD 20857.

**FOR FURTHER INFORMATION CONTACT:** Patricia A. Hansen, Center for Food Safety and Applied Nutrition (HFS–206), Food and Drug Administration, 200 C St. SW., Washington, DC 20204, 202–418–3098.

**SUPPLEMENTARY INFORMATION:** Under the Federal Food, Drug, and Cosmetic Act (sec. 409(b)(5) (21 U.S.C. 348(b)(5))), notice is given that a food additive petition (FAP 5M4438) has been filed by American Science and Engineering Inc., 40 Erie St., Cambridge, MA 02139–4286. The petition proposes to amend the food additive regulations in § 179.21 *Sources of radiation used for inspection of food, for inspection of packaged food, and for controlling food processing* (21 CFR 179.21) to provide for the safe use of X-radiation, produced by the operation of X-ray tubes at energy levels of 500 keV or lower, to inspect cargo containers that may contain food.

The potential environmental impact of this action is being reviewed. To encourage public participation consistent with regulations promulgated under the National Environmental Policy Act (40 CFR 1501.4(b)), the agency is placing the environmental assessment submitted with the petition that is the subject of this notice on display at the Dockets Management Branch (address above) for public review and comment. Interested persons may, on or before February 13, 1995, submit to the Dockets Management Branch (address above) written comments. Two copies of any comments are to be submitted, except that individuals may submit one copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday. FDA will also place on public display any amendments to, or comments on, the

petitioner's environmental assessment without further announcement in the **Federal Register**. If, based on its review, the agency finds that an environmental impact statement is not required and this petition results in a regulation, the notice of availability of the agency's finding of no significant impact and the evidence supporting that finding will be published with the regulation in the **Federal Register** in accordance with 21 CFR 25.40(c).

Dated: January 6, 1995.

**Alan M. Rulis,**

*Acting Director, Office of Premarket Approval, Center for Food Safety and Applied Nutrition.*

[FR Doc. 95–897 Filed 1–13–95; 8:45 am]

BILLING CODE 4160–01–F

## Health Care Financing Administration

**[MB–089–N]**

**RIN 0938–AG61**

## Medicaid Program; Limitations on Aggregate Payments to Disproportionate Share Hospitals: Federal Fiscal Year 1995

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

**ACTION:** Notice.

**SUMMARY:** This notice announces the preliminary Federal fiscal year (FFY) 1995 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 (the Act) and implementing regulations at 42 CFR 447.297 through 447.299. The preliminary FFY 1995 State DSH allotments published in this notice will be superseded by final FFY 1995 DSH allotments to be published in the **Federal Register** by April 1, 1995.

**EFFECTIVE DATE:** The preliminary DSH payment adjustment expenditure limits included in this notice apply to Medicaid DSH payment adjustments that are applicable to FFY 1995.

**FOR FURTHER INFORMATION CONTACT:** Richard Strauss, (410) 966–2019.

**SUPPLEMENTARY INFORMATION:**

### I. Background

Section 1923(f) of the Social Security Act (the Act) and implementing Medicaid regulations at 42 CFR 447.297 through 447.299 require us to estimate and publish in the **Federal Register** the national target and each State's allotment for disproportionate hospital share (DSH) payments for each Federal fiscal year (FFY). DSH payments are payment adjustments made to Medicaid-participating hospitals that serve a large number of Medicaid recipients and other low-income individuals with special needs. Preliminary amounts must be published by October 1 of each FFY and final amounts by April 1 of each FFY.

The implementing regulations provide that the national aggregate DSH limit for a FFY is a target rather than an absolute cap when determining the amount that can be allocated for DSH payments. The national DSH 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 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 1995 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: (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 1995 is referred to as a ''high-DSH State.'' The FFY 1995 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 1995 is referred to as a ''low-DSH State.'' The FFY 1995 State DSH allotment for a low-DSH State is equal to the State's DSH allotment for FFY 1994 increased by growth amounts and supplemental amounts, if any. However, the FFY 1995 DSH allotment for a low-DSH State cannot exceed 12 percent of the State's total medical assistance expenditures for FFY 1995 (excluding administrative costs).

The growth amount for FFY 1995 is equal to the projected percentage increase (the growth factor) in a low-DSH State's total Medicaid program expenditures between FFY 1994 and FFY 1995 multiplied by the State's final DSH allotment for 1994. Because the national DSH limit is considered a target, a low-DSH State whose program grows from one year to the next can receive a growth amount that would not be permitted if the national 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 fiscal years FFY 1994 and FFY 1995. Furthermore, because a low-DSH State's FFY 1995 DSH allotment cannot exceed 12 percent of the State's total medical assistance expenditures, it is possible for its FFY 1995 DSH allotment to be lower than its FFY 1994 DSH allotment. This situation 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. This situation did not occur for FFY 1995. Consequently, there are no States with preliminary FFY 1995 State DSH allotments that are lower than the final FFY 1994 State DSH allotments.

There is no supplemental amount available for redistribution for FFY 1995. The supplemental amount, if any, is equal to a low-DSH State's proportional share of a pool of funds (the redistribution pool). The redistribution pool is equal to the national 12-percent DSH target reduced by 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 sum of these amounts is above the projected FFY 1995 national 12 percent DSH target, there is no redistribution pool and, therefore, no supplemental amounts for FFY 1995.

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

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