recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Wendy Taylor, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: January 23, 2001.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards.

[FR Doc. 01–3231 Filed 2–7–01; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Availability of Funds for Grants for the Community Access Program

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice of availability of funds.

SUMMARY: The Health Resources and Services Administration (HRSA) announces the availability of up to $40 million to assist communities and their safety net providers in developing integrated health care delivery systems that serve the uninsured and underinsured with greater efficiency and improved quality of care. This funding is part of the $125 million appropriated for the Community Access Program (CAP) under the FY 2001 HHS Appropriations Act, of which $8.4 million is allocated for special projects and Agency-wide programmatic investments. For those applications that were approved, but not funded in FY 2000, approximately $56 million will be made available pending the results of their validation site visits. The remaining $20 million will be made available later in the fiscal year in the form of grants to new communities or in the form of supplemental/expansion awards to FY 2000 grantees.

In FY 2000, DHHS provided about $23 million in funding for 23 communities for infrastructure development. In FY 2001, HRSA will provide grants to about 50 more communities which were approved but not funded in the FY 2000 application cycle. FY 2001 funding will also be used to support up to 40 additional communities to further their development of integrated delivery systems for the uninsured and underinsured. Grants will vary in size, based on the scope of the project and the size of the service area, and will be for one year.

Through this program, HRSA will support infrastructure development in communities that have already begun to reorganize and integrate their health care delivery systems. Funding described in this notice is not intended to support those communities that have not yet begun the planning and development of necessary organizational structure.

This program shares some of the same goals of the W.K. Kellogg Foundation's Community Voices Program and the Robert Wood Johnson Foundation's Communities in Charge Program. These foundations have also funded communities to develop integrated health care delivery systems for the uninsured, and CAP intends to build on the learning from their experiences.

DATES: The timeline for application submission, review, and award is as follows:

January 26, 2001: Application kits and additional guidance will be available through the HRSA Grants Application Center (GAC).

February 12–16, 2001: There will be a series of six pre-application workshops conducted across the country:

Nashville, TN—February 12, 2001
New Orleans, LA—February 12, 2001
Minneapolis, MN—February 14, 2001
Denver, CO—February 14, 2001
Philadelphia, PA—February 16, 2001
San Francisco, CA—February 16, 2001

May 7, 2001: Applications due to HRSA Grants Application Center.

June 11–22, 2001: Applications reviewed.

July/August 2001: Site visits to selected applicants.

September 2001: Grant awards announced.

ADDRESSES: To receive a complete application kit (i.e., application instructions, necessary forms, and application review criteria), contact the HRSA Grants Application Center at: HRSA GAC, 1815 N. Fort Myer Drive, Suite 300, Arlington, VA 22209, Phone: 1–877–HRSA–123, Fax: 1–877-HRSA–345, E-Mail: *hrsagac@hrsa.gov*.

FOR FURTHER INFORMATION CONTACT: For further information, contact the Community Access Program Office: Community Access Program Office, Health Resources and Services Administration, Parklawn Building, Suite 11–25, 5600 Fishers Lane, Rockville, MD 20857, Phone: (301) 443–0536, Fax: (301) 443–0248.

SUPPLEMENTARY INFORMATION: In 1999, 42.6 million people in the United States did not have health insurance. Of these, 24.2 million were employed—19 million worked full time and 5.2 million worked part time.

The uninsured and underinsured often have complex medical needs, remain outside organized systems of care, and have insufficient resources to obtain care. They may defer care or not receive needed services, and they are about half as likely to receive a routine check-up as insured adults. The uninsured and underinsured also rely heavily on expensive emergency rooms, and because they lack a routine source of care, they often do not receive needed follow-up services.

Many of the uninsured and underinsured rely on the nation's institutions, systems, and individual health professionals that provide a significant volume of health care services without regard for ability to pay. In many communities, these providers are struggling to care for the increasing numbers of uninsured and underinsured individuals. They face many challenges such as an uneven distribution of the burden of uncompensated care, the fragmentation of services for the uninsured, insufficient numbers of certain types of providers, reduced Medicaid revenues due to the market forces of Medicaid managed care, and a growing need for mental health and substance abuse services.

While integration among these providers is critical to serve the uninsured and underinsured with greater efficiency and to improve quality of care, many of these providers are so pressured by basic caregiving tasks, they need assistance to coordinate their efforts with other providers and to develop integrated community-based systems of care.

The Community Access Program

Program Purpose: The purpose of this program is to assist communities and consortia of health care providers to develop the infrastructure necessary to fully develop or strengthen integrated systems of care that coordinate health services for the uninsured and underinsured.

Program Goal: The coordination of services through the CAP grant will allow the uninsured and underinsured to receive efficient and higher quality care and gain entry into a comprehensive system of care. The system will be characterized by effective collaboration, information sharing, and clinical and financial coordination among all levels of care in the community network. The system will be committed to continuous performance

improvement, implementation of best practices, staff development, and real-time feedback of outcomes of care. Care management (e.g., case, disease) will be applied across the continuum for those with chronic illnesses, high-risk individuals, and high utilizers. The system will also strive to provide universal access to the target population and to improve the health status of the community population.

This vision requires a re-thinking of the relationships, priorities, and desired outcomes for local or regional care delivery. It means adopting the philosophy that care for the ill and injured occurs within the context of a comprehensive system design of population health improvement.

The community being served should be actively involved in the system design. Broad understanding, mutual learning between providers and community, and participation in priority setting and governance by the community are essential components of this vision. This will assure sustainability of the system.

Program Description

We are seeking to fund a variety of program models in communities that have an established track record for building partnerships and that have completed the basic planning necessary to implement a coordinated system of care. The successful applicant will design a project that builds upon its current capacities and strengths; brings the major players in the political and health delivery systems to the table; uses the federal funds available to plan a transition to an expanded and innovative approach that will ultimately be competitive within its own market; and will sustain the delivery of services and funding after these federal grants expire. The successful applicant will work with its county board, city council, state legislature, and state health programs to assure the coordination and efficient use of all available resources to achieve program goals.

There is no one successful model that we are trying to replicate. Rather, there are many models that already exist and that each community may draw from in creating a project to address its own needs.

In surveying innovative community approaches to the provision of safety net services, we have come across communities that have:

- Coordinated the provision of care through public hospitals, public health departments, and community health centers;
- Linked hospital and clinic services through state of the art data systems which allow transitions between Medicaid, uninsured, and insured status for low income populations;
- Combined the development of managed care networks for the indigent funded through local tax increases and the redirection of funds towards the care network and away from the support of tertiary care at public hospitals;
- Created networks to allocate uncompensated ambulatory care loads among physicians and redistribute caseloads to private providers; and
- Linked behavioral and acute care services.

We are looking for applicants with clear goals, an operational plan for meeting those goals, a history of commitment to serving indigent populations, and a track record which indicates likely success. Innovative proposals for sustaining the service delivery component of projects could include use of local or state taxing authorities, use of tobacco settlement funds, and creative partnerships with the provider and business communities. Applications will be judged from the perspective of whether the financing proposed is realistic—given state and community resources—and appropriate to the project proposed. It is our intent to fund those applicants that either serve a target population that is distinct from the target population of other applicants or current CAP grantees, or propose distinct strategies that are coordinated and complimentary to those applicants or CAP grantees that have overlapping target populations.

Funded projects will address several common elements:

Community Need: Funded communities will have high or increasing rates of uninsured and underinsured and will have identified specific organizational needs within existing delivery systems. A ''community'' for the purpose of this program may be based on geography or a population group (e.g., the homeless) as defined by the people in the community.

Collaboration Among Safety Net Providers: Funded communities will build upon current investments in communities for serving these populations and include the safety net providers who have traditionally provided services without regard to the ability to pay. The coalition should be built upon formal arrangements among the partners that define the extent of the commitment and involvement in policy development and decision-making from each partner.

Comprehensive Services: Funded communities will include all partners necessary to assure access to a full range of services, including mental health and substance abuse treatment. It is anticipated that the health services (prevention, primary, and specialty) provided by Federally-supported programs that are present in the community will be part of this coalition of providers.

Coordination with Public Insurance Programs: Funded communities will demonstrate coordination (e.g., memoranda of agreements) with state programs to ensure that eligible beneficiaries are enrolled in public insurance programs (e.g., SCHIP, Medicaid).

Community Involvement: Funded communities will have strong community support for these efforts, which provide a broad foundation of assistance to the provider community undertaking this project. Management and governance structures should be in place that assure accountability to funders and define the community role in setting policy. The community involvement in the development, implementation, and governance of the project should be evident. This should include the leadership within the appropriate legislative and executive bodies, providers identified above, health plans and payers, community leaders and consumers.

Sustainability: Funded communities will have a plan for long-term sustainability. There should be evidence that the program is capable of leveraging other sources of funds and integrating current funding sources in a way to assure long-term sustainability of the project.

Eligible Applicants

To encourage the development of different models, this program seeks a variety of applicants representing all types of communities. Applicants which receive funding may be large health care systems or small organizations. Applications are encouraged from large urban areas, small rural communities, and tribal organizations.

Applications may be submitted by public and private non-profit entities that demonstrate a commitment to and experience with providing a continuum of care to uninsured individuals. Each applicant must represent a community-wide coalition that is committed to the project and includes safety net providers (where they exist) who have traditionally provided care to the community's uninsured and underinsured regardless of ability to pay. The community-wide coalition

must consist of partners from all levels of care (i.e., primary, secondary, tertiary) and partners which represent a range of services (e.g., mental health and substance abuse treatment, maternal and child health, oral health, HIV/AIDS care).

Examples of eligible applicants which may apply on behalf of the community-wide coalition include but are not limited to:

- A consortium or network of providers (e.g., public and charitable hospitals; community, migrant, homeless, public housing, and school-based health centers; rural health clinics; free health clinics; teaching hospitals and academic institutions)
- Local government agencies (e.g., local public health departments with service delivery components)
- Tribal governments
- Managed care plans or other payers (e.g., HMOs)
- Agencies of State government, multi-state health systems, or other groups may submit applications on behalf of multiple communities if they demonstrate the ability to coordinate community health care delivery systems and bring resources to the community.

Current CAP grantees are not eligible to apply for this funding.

Funding Criteria

Review criteria that will be used to evaluate applications include:

- Evidence of progress towards integration prior to application for funding
- Evidence that the target population has a high or increasing rate of uninsurance
- Evidence of established partnerships among a broad-based community consortium
- Appropriateness and quality of clinical services to be provided
- Commitments from local government agencies, public and private health care providers, community leaders
- Demonstration of existing and sustainable public and private funding sources
- Accountable management plan and reasonableness of the budget
- Commitment to self evaluation and participation in a national evaluation

Program Expectations

Funding through this initiative may be used to support a variety of projects that would improve access to all levels of care for the uninsured and underinsured through coordinated systmes of care. Each community should design a project that best addresses the needs of the uninsured and underinsured, and the providers in their community.

Examples of activities that could be supported with this funding include:

- Offering a comprehensive delivery system for the uninsured and underinsured through a network of safety net providers. [Single registration, eligibility systems]
- Integrating preventive, mental health, substance abuse, HIV/AIDS, and maternal and child health services within the system. [Block grant funded services, other DHHS programs, state and local programs]
- Developing a shared information system among the community's safety net providers. [Tracking, case management, medical records, financial records]
- Developing and incorporating shared clinical protocols, quality improvement systems, utilization management systems, and error prevention systems.
- Sharing core management functions. [Finance, purchasing, appointment systems]
- Coordinating and strengthening priority services to specific targeted patient groups.
- Developing affordable pharmaceutical services.

Applicants will be expected to budget for travel to two grantee meetings and to meet interim and final reporting requirements as directed by the Community Access Program.

Use of Grant Funds

Funding provided through this program may NOT be used to substitute for or duplicate funds currently supporting similar activities. Grant funds may support costs such as:

- Project staff salaries
- Consultant support
- Management information systems (e.g., hardware and software)
- Project-related travel
- Other direct expenses necessary for the integration of administrative, clinical, information system, or financial functions
- Program evaluation activities

With appropriate justification on why funds are needed to support the following costs, up to a total of 15 percent of grant funds may be used for the following:

- Alteration or renovation of facilities
- Development of additional primary care sites
- Service expansions or direct patient care

Grant funds may NOT be used for:

- Construction
- Reserve requirements for state insurance licensure

Expected Results

The integration and coordination of services among a community's safety net providers are expected to result in:

- A system of care that provides coordinated care to the target population.
- Increased access to primary care resulting in a reduction in hospital admissions for ambulatory sensitive conditions among the uninsured and underinsured.
- Elimination of unnecessary, duplicate functions in service delivery and administrative functions, resulting in savings to reinvest in the system.
- Increased numbers of low-income uninsured people with access to a full range of health services.

Dated: January 31, 2001.

Claude Earl Fox,

Administrator.

[FR Doc. 01–3251 Filed 2–7–01; 8:45 am]

BILLING CODE 4160–15–U

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Notice of Receipt of Applications for Permit

Endangered Species

The following applicants have applied for a permit to conduct certain activities with endangered species. This notice is provided pursuant to Section 10(c) of the Endangered Species Act of 1973, *as amended* (16 U.S.C. 1531, *et seq.*). Written data or comments should be submitted to the Director, U.S. Fish and Wildlife Service, Division of Management Authority, 4401 North Fairfax Drive, Room 700, Arlington, Virginia 22203 and must be received by the Director within 30 days of the date of this publication.

PRT–038203

Applicant: E. Benjamin Nelson, Omaha, NE.

The applicant requests a permit to import the sport-hunted trophy of one male bontebok *(Damaliscus pygargus dorcas)* culled from a captive herd maintained under the management program of the Republic of South Africa, for the purpose of enhancement of the survival of the species.

PRT–038338

Applicant: Neil A. Chamberlain, Linwood, MI.

The applicant requests a permit to import the sport-hunted trophy of one