Ave., suite 850, Silver Spring, MD 20910, 301–495–1591, FAX 301–495–9410.

For other information: William Freas, Scientific Advisors and Consultants Staff (HFM–21), Food and Drug Administration, 1401 Rockville Pike, Rockville, MD 20852–1448, 301–827–0314, FAX 301–827–0294.

SUPPLEMENTARY INFORMATION: The purpose of this meeting is to present and discuss the available scientific evidence and experience relating to: Characterization of cell substrates for the presence of viruses, evaluation of virus removal and inactivation, and other issues relating to viral characterization. The symposium will discuss in detail topics related to the viral safety of biological products, including topics relevant to an ICH international guideline on viral testing and validation that is presently under development.

Plenary sessions will be held on the mornings of June 14, 15, and 16, 1995. Concurrent technical breakout sessions will be held on the afternoons of June 14 and 15, l995.

Dated: May 9, 1995.

William B. Schultz,

Deputy Commissioner for Policy.

[FR Doc. 95–11828 Filed 5–12–95; 8:45 am]

BILLING CODE 4160–01–F

Office of the Secretary

Grants and Cooperative Agreements; Availability, etc.: Managed Care Impact on People With Significant Physical and Mental Disabilities

AGENCY: Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS).

ACTION: Request for applications to conduct research to better understand the impact of managed care on people with significant physical and mental disabilities. Projects will analyze existing data sets to explore issues of utilization, access, quality, costs and outcomes for people with disabilities in managed care systems. In addition, where possible proposed applications shall capitalize on linking state and local data sets containing data on functioning and health status for disabled individuals to utilization and cost data. For purposes of applications requested under this announcement, ''individuals with disabilities'' includes those under the age of 64 with ongoing conditions or chronic illnesses of such severity that they result in a need for extra or specialized health services or assistance with daily living tasks. Specific groups of disabled individuals included in this definition are children and working aged adults 18–65 with physical disabilities, mental retardation, developmental disabilities and persistent mental illness.

SUMMARY: The primary goal of this grant announcement is to support research which employs the analysis of existing data and experience to inform policies related to disability and managed health care. Data sets which permit the Department to compare the service use, expenditures and outcomes of children and working age adults (18–64) with disabilities in managed care with similar persons in the fee-for-service system or that allow for an assessment of utilization and costs prior to and following managed care enrollment are of particular interest. Such data sets could include information from: Medicaid management information systems; community provider networks including community health centers; private insurers and health plans; employers; social security records; hospital records and other accessible data sets which contain relevant analytical variables. These projects are intended to foster new analyses of existing data sources by encouraging the use of data sets from states, local areas, or facilities in order to address issues of quality, cost, access and outcomes. We estimate that the scope and level of effort will require from 12 to 24 months to accomplish.

DATES: The closing date for submitting applications under this announcement is July 14, 1995.

ADDRESSES: Send application to Grants Officer, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, ASPE/IO, 200 Independence Avenue, SW., Room 405F, Hubert H. Humphrey Building, Washington, DC 20201. Attention: Albert A. Cutino, Grants Officer.

FOR FURTHER INFORMATION CONTACT: Application Instructions and Forms should be requested from and submitted to: Grants Officer, Department of Health and Human Services, ASPE/IO, 200 Independence Avenue, SW., Room 405F, Hubert H. Humphrey Building, Washington, DC 20201, Telephone: (202) 690–8794. Requests for Forms will be accepted and responded to up to 30 days prior to closing date of receipt of Applications. Technical questions should be directed to Andreas Frank or Kevin Hennessy, ASPE/IO, Telephone (202) 690–6443 or (202) 690–7272. Questions also may be faxed to (202) 401–7733. Written technical questions should be addressed to Dr. Hennessy or Mr. Frank at the above address. (Application submissions may not be faxed.)

ELIGIBLE APPLICANTS: The Department seeks applications from universities, post-secondary degree granting entities, managed care organizations, private employers and insurers, and other independent researchers. (For-profit organizations are advised that no grant funds may be paid as profit to any recipient of a grant or subgrant.) Profit is any amount in excess of allowable direct and indirect costs of the grantee.

SUPPLEMENTARY INFORMATION:

Part I

Legislative Authority

This cooperative agreement is authorized by Section 1110 of the Social Security Act (42 U.S.C. 1310) and awards will be made from funds appropriated under Public Law 103–112 (DHHS Appropriations Act for FY 1995).

Project History and Purpose

Rising health care expenditures have attracted considerable attention and concern over the past decade. Of particular concern to state and federal governments, Medicaid spending had increased from $41 billion in 1985 to $138 billion by 1994. In an effort to control spiraling Medicaid costs, states are increasingly turning to managed care, with estimates that approximately 25% of current Medicaid recipients are covered by a form of managed care, although participation remains concentrated in a relatively few states. With the demise of national health care reform this trend is expected to accelerate.

Over 93% of Medicaid payments are now made on a fee-for-service basis. Why is such a small proportion of Medicaid payments affected by the movement to managed care? An important reason is that about 70% of Medicaid expenditures goes to support the health care of the disabled and for long term care—neither of which is included in state managed care arrangements to any great extent.

Although research on the impact of managed care is still relatively new, studies of the public sector suggest that costs savings can be achieved without significant compromising quality. To beleaguered states trying to find ways to tame their Medicaid budget, the desire to incorporate their disabled and long term care populations under managed care is understandable.

In theory, managed care should have significant potential for improving services to people with disabilities including: (1) Increased flexibility to design treatment programs tailored to their special needs; (2) more resources for preventative services and care management/coordination; and (3) lower out-of-pocket burdens. However, people with disabilities are concerned that overemphasis on cost reduction may overshadow the potentially positive benefits of managed care. They worry that the financial incentives resulting from a capitation system will result in reduced access to needed services, and that those providers with specialized expertise in disability may be discouraged from participating in managed care arrangements.

State interest in incorporating disabled persons into Medicaid managed care systems—either through 1915(b) or 1115 waiver authorities—has grown dramatically in recent years. Currently, Oregon, Florida, Tennessee and Arizona have approved 1115 waivers that enroll one or more segments of their disabled population into managed care. Another 16 states have received freedom of choice waivers (1915b) under which they have mandated enrollment of certain segments of the SSI disabled population into managed care. However, most of these 1915(b) efforts involve primary care cases management (PCCM) rather than capitation and the assumption of financial risk.

The greatest momentum toward managed care remains in the private sector. Among employer-based plans, and rapid increase in enrollment in managed care plans is well documented. Along with this general trend is a series of developments which directly links private sector managed care arrangements to populations with special needs e.g., the development of subacute care in hospitals and skilled nursing facilities; the development of contracts between providers of rehabilitation services and employer-based health plans; new forms of home health care for high risk populations, carve-outs for managed behavioral health services (including alcohol and substance abuse services).

In short, the movement toward managed care in the public and private sectors is an important and continuing trend that is likely to have a significant impact on people with disabilities. Yet the development of a knowledge base that is available to state and federal policy makers, insurers and health plans, and consumers to facilitate informed decision-making about managed care and disability has barely begun. A variety of critical questions demand answers. For example:

- How well does managed care serve people with disabilities in comparison to the fee-for-service system?
- What health care and related services do people with disabilities need?
- How should quality and effectiveness of care for people with disabilities be measured?
- How can financial incentives be created for health plans to adequately serve people with disabilities?
- How can capitation payments be developed which reflect the service use patterns of disabled populations?
- What are the most effective ways of managing the care of special needs populations?

It is essential that careful attention is directed to adequately addressing these and other important questions, especially at a time in which federal, state, and private insurers have strong incentives to enroll disabled populations into managed care.

To develop information which evaluates the impact of managed care on persons with disabilities and supports the development of approaches which efficiently and effectively respond to their needs, the Office of the Assistant Secretary for Planning and Evaluation has developed a broad-based research plan. This plan includes the following components:

1. Studies which track the service use, cost and outcomes of non-elderly SSI recipients enrolled in managed care under state-wide Medicaid 1115 health reform demonstrations.

2. Studies of the experiences of disabled populations enrolled in large, privately insured, employer-based managed care plans.

3. Studies which document the best practices of innovative public and private managed care plans that serve people with disabilities.

4. A program of grants to encourage experts in a variety of settings to identify and analyze existing data sets which can inform the development of managed care policies and practices which are responsive to special needs populations.

This grant announcement encompasses the fourth component of the above research strategy.

Available Funds

1. The Assistant Secretary has available $800,000 for awards in the $50,000 to $150,000 range.

2. We will consider application over $150,000, but should be submitted as a separate additional application(s).

3. Nothing in this application should be construed as committing the Assistant Secretary to dividing available funds among all qualified applicants or to make any award. The selection of the final awards will be determined by the Assistant Secretary on the basis of the availability of funds, the criteria in Part III of this announcement, and coverage of the Policy Research Area(s) in Part II of this announcement.

Period of Performance

Award(s) pursuant to this announcement will be made on or about September 1, 1995.

Part II. Policy Research Areas

Research conducted under grants awarded through this announcement should be addressed to research questions related to a combination of the following topics: (a) defining and measuring disability in health care system, (b) analyzing the impact of managed care on access to health care services, service use patterns and expenditures, (c) assessing the impact of managed care on individual outcomes and other quality indicators, (d) financing and reimbursement incentives which encourage/impede participation in managed care, and (e) organization of the delivery system for disabled populations enrolled in managed care.

A. Definition and Measurement of Disability

In principle, the movement of both Medicaid programs and large employers to managed care delivery systems affords an opportunity to study the impact of managed care on large numbers of disabled individuals. The difficulty is in determining ways to identify such persons so that their experience can be tracked and compared to others without disabilities and with similarly disabled persons in the fee-for-service system. Further complicating this problem is the often large variation in service use patterns of people with similar disabling conditions.

The goals of this research area are to encourage exploration of alternative approaches to defining and measuring disability and to examine the results of these measures in health care settings. ASPE is particularly interested in the health care experience of children and working age adults with significant disability including persons with physical disabilities, the MR/DD population, and persons with serious mental illness. Questions of interest include:

- What measures or indicators can be used to group people with disabilities in ways that are clinically meaningful? How can these measures be applied to

managed care settings? What are the strengths and limitations of such measures and how does this effect their potential usefulness?

- What conditions, health care consumption patterns or other indicators are particularly good markers of severe disability in working age adults and in children?
- How do managed care providers identify high-risk people with special care needs who may require intensive care management?
- What do we know about the prevalence and participation of various groups of disabled persons in both public and private managed care arrangements? What are the characteristics of enrollees vs. those enrolled in fee-for-service, including the nature and severity of their conditions?

B. Impact on Access, Service Use, and Expenditures

Some aspects of managed care have the potential to be more advantageous than traditional fee-for-service arrangements for people with disabilities. Managed care plans can ensure providers more discretion than the traditional fee-for-service system in allocating resources. Theoretically, the ability to access a more comprehensive range of services and providers can enhance continuity of care, coordination, and appropriateness of services provided. However, many aspects of managed care are potentially disadvantageous to people with disabilities. The major concern is that more emphasis on cost savings will translate into greater risk for less care or inappropriate care for the most vulnerable populations.

Cost-effectiveness remains a critical feature of managed care in that it claims to achieve measurable cost savings for people with disabilities through better care management and the substitution of lower for higher cost services. Unfortunately, there are few data to inform either public payers or health plans about whether such cost savings can be realized. Within this issue area, the following types of questions are pertinent:

Access and Service Use

- What types of health benefits and related services do people with disabilities receive in current managed care systems? What variables best explain variation in service use? How does service use vary among the most prevalent disabling conditions? by indicators of functioning?
- How does managed care affect health service utilization patterns when compared to fee-for-service? To what extent do people with disabilities enrolled in managed care systems have improved access to benefits, services and/or more flexible services delivery patterns?
- Is there any evidence of substitution of certain services as a result of managed care practices (e.g. preventive care and rehabilitation for other services such as in-patient care and emergency room services)?
- To what extent do managed care plans favor physician and hospital services over home health care and rehabilitation services?
- How does access to services by disabled enrollees in managed care vary by payment source, type of managed care plan and severity of disabling condition?

Public and Private Health Care Expenditures

- What are the health care expenditures of people with disabilities in managed care arrangements and how do they compare to the fee-for-service system? How do these expenditures vary according to source of payment, disabling condition, level of functioning/need, date of onset of disabling condition?
- What factors most contribute to the costs of health care for the disabled? Which are most susceptible to modification?
- Are there cost savings associated with managed care use for disabled persons and how are they achieved? Are some types of managed care plans more effective than others in realizing cost savings?
- What impact does managed care have on total, out of pocket and per capita expenditures for disabled populations, and how does this vary among different disabled groups (i.e., mentally ill, mentally retarded/ developmentally disabled, physically disabled, children, adults)?
- How do different cost sharing arrangements under managed care impact on access and utilization for people with disabilities?
- Is there any evidence that managed care plans serving people with disabilities in either the public or private sector shift costs to open ended payment systems such as Medicaid institutional and community based services and programs, state funded programs and community hospitals?
- How do financing sources such as private insurance, Medicaid, workman's compensation and short-term disability insurance interest with one another in financing services for disabled populations enrolled in managed care?

C. Quality and Outcomes

A fundamental question for the disability community and for state and federal policy makers is whether managed health care provides quality services and produces satisfactory outcomes for people with special health care needs. To address this question requires an understanding of what the basic health care needs of the disabled actually are and what services in what amounts are more or less effective in meeting these needs.

Of particular importance in addressing the above issue is finding outcome measures which can be applied to populations whose characteristics and needs are quite distinct from one another. For example, the needs of people with physical disabilities are likely to be markedly different than persons with chronic mental illness. One approach to this issue is to examine the impact of health services on the functioning of people with chronic health care conditions. Questions in this research area include:

Quality

- What disability-specific performance measures do managed care plans employ to assess how well they are doing with special needs populations, and what are the results of applying these measures? Are there satisfaction measures that specifically address the concerns of disabled individuals, and how do they compare to measurement of satisfaction in non-disabled populations?
- How do states monitor the performance of managed care arrangements in which they enroll significant numbers of disabled persons and how does such monitoring affect the quality of services for disabled beneficiaries?

Outcomes of Disabled in Managed Care

- What measures are the most useful in predicting outcomes for people with disabilities in managed care? To what extent should they be condition specific or specific to a particular disabled category? Can these outcomes be linked to the presence/absence of specific services and treatments? If so, what measures of performance are created and how well do managed care plans rate on such measures? To what extent can their performance be compared with the fee-for-service system?
- What impact does managed care have on level of functioning of persons with disabilities? Is this a good measure of quality of care received?
- How does managed care plans compare to fee-for-service plans

compare in areas of mortality and morbidity, enrollment and disenrollment, and satisfaction, for comparably-disabled populations? Are some types of managed care plans better performers than others (e.g., specialized programs vs. plans where the disabled are a small subset of enrollees, PPOs vs. HMOs)? Are sub-populations of the disabled community better or worse off under managed care (i.e. children with functional impairments, adults with cognitive and mental impairments, adults with significant physical disabilities)?

D. Financing and Reimbursement

Financial incentives which would encourage health plans and providers to include people with significant disabilities in managed care are largely lack in today's system. In the absence of such incentives, managed care plans can improve their financial results by selecting ''good risks'' while avoiding bad ones.

Providers who encourage the enrollment of disabled individuals in plans that are fully capitated face significant challenges. First, there is little empirical basis for predicting the added costs (if any) of serving a population with disabilities. To the extent that a managed care plan or provider does try to cover more high risk populations in private plans, premium rates must be adjusted or the plan could end up losing money. However, if premium rates are adjusted too high, more health participants will opt out of the plan. Within this issue area, the following types of questions are pertinent:

- How are capitation rates sets for health plans enrolling significant numbers of people with disabilities? How and to what extent are disability characteristics taken into account in setting such rates? How well do the rates work for all interested parties?
- How do different risk sharing mechanisms affect the willingness/capacity of the managed care plan to enroll disabled populations and insure access to a broader range of services for disabled populations (e.g., risk pools, reinsurance, sharing costs with other payers, etc.)?
- What are the advantages and disadvantages of various risk sharing arrangements? How do various arrangements affect service use patterns and outcomes of care?
- What are some of the more promising strategies, or insurance market reforms, to offset the incentives of managed care plans to select out potentially high risk persons?

E. Organization of the Delivery System

Greater attention is necessary to determine how managed care plans should be organized to address the needs of people with disabilities. Whether plans which specialize in disability will work better than plans which include the disabled in a larger, healthier population of enrollees is not clear. Another key design issue in organizing managed care systems for people with disabilities is the extent to which and how long term care services should be integrated/coordinated with acute care services, given that people with significant disabilities may need access to both. The incentives created by leaving one system open-ended while the other is capped are obvious. In addition, there are a variety of models of managed care, and it remains unclear whether some are better than others in providing beneficiaries with good quality services without exposing the plan to unacceptable financial risk. While this issue area, the following types of questions are pertinent:

- What are the advantages and disadvantages of specialized managed care plans which only serve the disabled compared with general plans which incorporate the disabled in a larger population of healthier persons in terms of benefits and costs?
- Which managed care models (e.g., staff and group HMOs, PPOs, open panel HMOs) are more (or less) effective in serving people with special needs and to the extent they are more effective. how do they do it?
- What differences are there in outcomes and consumer satisfaction when services are integrated vertically versus through networking strategies?
- To what extent do managed care plans serving people with disabilities coordinate their benefits with the long term care system?
- What non-financial incentives are important to encouraging health plans to offer more comprehensive services to people with disabilities?
- How do managed care plans manage care for those people consuming the most services?

F. Requirement of All Potential Grantees

Part of the resultant grant, we requiring that grantees commit participate in a one-day meeting in Washington with a Technical Advisory Group. All applicants will be required to attend a Technical Advisory Group (TAG) meeting upon completion of the two year grant award cycle, regardless of the fact that some awards may be completed prior to two years. The TAG, comprised of experts on disability and managed care, will integrate the various components of the ASPE research strategy described in Section II. The Government will to pay for travel to and from Washington for this TAG regardless of whether the grant period has ended or remains in effect.

Part III. Application Preparation and Evaluation Criteria

This part contains information on the preparation of an application for submission under this announcement, the forms necessary for submission and the evaluation criteria under which the applications will be reviewed. Potential applicants should read this part carefully in conjunction with the information and questions provided in Part II.

Applications should be assembled as follows:

1. *Abstract:* Provide a one-page summary of the proposed project.

2. *Goals, Objectives, and Usefulness of Project:* Include an overview which describes the need for the proposed project; indicates the background and policy significance of the issue area(s) to be researched including a critique of related disability specific studies; outlines the specific quantitative and qualitative questions to be investigated; and describes how the proposed project will advance scientific knowledge and policy development on the impact of managed care on people with disabilities.

3. *Methodology and Design:* Provide a description and justification of how the proposed research project will be implemented, including methodologies, approach to be taken, data sources to be used, and proposed research and analytic plans. Identify any theoretical or empirical basis for the methodology and approach proposed. In addition, provide evidence of access to data set(s) proposed to be studied.

Proposals, where data sets permit, should address the areas highlighted in Section II as well as the following quantitative and qualitative issues:

- Utilization of services—both volume and mix of services;
- Tracer measures of specific conditions (e.g., readmission for mental diagnosis, prophylactic treatment for AIDS cases, use of rehabilitative services);
- Selection bias;
- Enrollment trends of disabled individuals in managed car organizations, including reasons for disenrollment;
- Outcome analyses such as mortality rates, use of emergency services, changes in functional status, satisfaction information, and hospital readmissions;

- Overall health care expenditures by disabled groups;
- Cost savings practice patterns (e.g., referrals to cost-effective providers, specialized case management practices, provider discounted fees, concurrent utilization review practices);
- Access to specialty care;
- Benefit package (e.g., long-term rehabilitation services, durable medical equipment);
- Availability of specialty providers;
- Coordination with auxiliary services;
- Risk sharing mechanisms;
- Risk adjustment and capitation rate development;
- Coordination and integration of services.

4. *Experience of Personnel/ Organizational Capacity:* Briefly describe the applicant's organizational capabilities and experience in conducting pertinent research projects. Identify the key staff who are expected to carry out the research project and provide a curriculum vitae for each person. Provide a discussion of how key staff will contribute to the success of the project.

5. *Budget:* Submit a request for Federal funds using Standard Form 424A and provide a proposed budget using the categories listed on this form.

Review Process and Funding Information

A panel of at least three independent experts will review and score all applications that are submitted by the deadline date and which meet the screening criteria (all information and documents as required by this Announcement.) The panel will review the applications using the evaluation criteria listed below to score each application. These evaluation criteria will be the primary elements used by the ASPE in making funding decisions.

HHS reserves the option to discuss applications with other Federal agencies, Central or Regional Office staff, specialists, experts, States and the general public. Comments from these sources, along with those of the independent experts, may be considered in making an award decision.

State Single Point of Contact (E.O. No. 12372)

The Department of Health and Human Services has determined that this program is not subject to Executive Order No. 12372, Intergovernmental Review of Federal Programs, because it is a program that is national in scope and the only impact on State and local governments would be through subgrants. Applicants are not required to seek intergovernmental review of their applications with the constraints of E.O. No. 12372.

Deadline for Submission of Application

The closing date for submission of applications under this announcement is July 14, 1995. Applications must be postmarked or hand-delivered to the application receipt point no later than 4:30 p.m. on July 14, 1995.

Hand-delivered applications will be accepted Monday through Friday prior to and on July 14, 1995. During the hours of 9:00 a.m. to 4:30 p.m. in the lobby of the Hubert H. Humphrey building located at 200 Independence Avenue, SW., in Washington, DC. When hand-delivering an application, call 690–8794 from the lobby for pick-up. A staff person will be available to receive applications.

An application will be considered as meeting the deadline if it is either: (1) Received at, or hand-delivered to, the mailing address on or before July 14, 1995, or (2) on the closing date of receipt from applications and received in time to be considered during the competitive review process (within two weeks of the deadline date).

When mailing application packages, applicants are strongly advised to obtain a legibly dated receipt from a commercial carrier (such as UPS, Federal Express, etc.), or from the U.S. Postal Service as proof of mailing by the deadline date. If there is a question as to when an application was mailed, applicants will be asked to provide proof of mailing by the deadline date. When proof is not provided, an application will not be considered for funding. Private metered postmarks are not acceptable as proof of timely mailing.

Applications which do not meet the July 14, 1995 deadline are considered late applications and will not be considered or reviewed in the current competition. HHS will send a letter to this effect to each late applicant.

HHS reserves the right to extend the deadline for all applications due to acts of God, such as floods, hurricanes or earthquakes; due to acts of war; if there is widespread disruption of the mail; or if HHS determines a deadline extension to be in the best interest of the Government. However, HHS will not waive or extend the deadline for any applicant unless the deadline is waived or extended for all applicants.

Applications Forms

See section entitled ''Components of a Complete Application.'' All of these documents must accompany the application package.

Length of Application

Applications should be as brief and concise as possible, but assure successful communication of the applicant's proposal to the reviewers. In no case shall an application (excluding the resume appendix and other appropriate attachments) be longer than 30 single spaced pages; it should neither be unduly elaborate nor contain voluminous supporting documentation.

Selection Process and Evaluation Criteria

Selection of the successful applicant(s) will be based on the technical criteria laid out in this announcement. Reviewers will determine the strengths and weaknesses of each application in terms of the evaluation criteria listed below, provide comments and assign numerical scores. The review panel will prepare a summary of all applicant scores and strengths/weaknesses and recommendations and submit it to the ASPE for final decisions on award(s).

The point value following each criterion heading indicates the maximum numerical weight that each section will be given in the review process. An unacceptable rating on any individual criterion may render the application unacceptable. Consequently, applicants should take care to ensure that all criteria are fully addressed in the applications. Applications will be reviewed as follows:

Applications will be initially screened for compliance with the timeliness and completeness. If judged in compliance, the application then will be reviewed by government personnel, augmented by outside experts where appropriate. Three (3) copies of each application are required. Applicants are encouraged to send an additional three (3) copies of their application to ease processing, but applicants will not be penalized if these extra copies are not included. The length of the application is limited to 30 single spaced pages; extraneous materials such as videotapes and brochures should not be included and will not be reviewed.

Evaluation criteria

1. *Goals, Objectives, and Potential Usefulness of the Quantitative and Qualitative Analyses* (30 points). The potential usefulness of the objectives and how the anticipated results of the proposed project will advance scientific knowledge and policy development on the impact of managed care on disabled populations.

2. *Methodology and Design* (35 points). The appropriateness,

soundness, and cost-effectiveness of the methodology, including research design, statistical techniques, analytical strategies, degree of inclusion of utilization, cost and functional data and information, innovative and creative selection of existing data sets, and other procedures. The applicant is encouraged to specifically address how they intend, when applicable, to examine the quantitative and qualitative areas previously outlined.

3. *Experience and Qualifications of Personnel* (35 points). The qualifications and experience of the project personnel for conducting the proposed research and indications of innovative approaches and creative potential

Reports

The grantee must submit annual progress reports and a final report. The specific format and content for these reports will be provided by the project officer.

Disposition of Applications

1. *Approval, disapproval, or deferral.* On the basis of the review of an application, the ASPE will either (a) approve the application in whole, as revised, or in part for such amount of funds and subject to such conditions as are deemed necessary or desirable for the research project; (b) disapprove the application; or (c) defer action on the application for such reasons as lack of funds or a need for further review.

2. *Notification of disposition.* The ASPE will notify the applicants of the disposition of their application. A signed notification of award will be issued to notify the applicant of the approved application.

Components of a Complete Application

A complete application consists of the following items in this order:

1. Application for Federal Assistance (Standard Form 424, Revised 4–88);
2. Budget Information—Non-construction Programs (Standard Form 424A, Revised 4–88);
3. Assurances—Non-construction Programs (Standard Form 424B, Revised 4–88);
4. Table Contents;
5. Budget Justification for Section B—Budget Categories;
6. Proof of non-profit status, if appropriate;
7. Copy of the applicant's approved indirect cost rate agreement if necessary;
8. Project Narrative Statement, organized in five sections addressing the following topics;
   (a) Understanding of the Effort,
   (b) Project Approach,
   (c) Staffing Utilization, Staff Background, and Experience,
   (d) Organizational Experience, and
   (e) Budget Narrative;
9. Any appendices/attachments;
10. Certification Regarding Drug-Free Workplace;
11. Certification Regarding Debarment, Suspension and Other Responsibility Matters; and
12. Certification and, if necessary, Disclosure Regarding Lobbying;
13. Application for Federal Assistance Checklist.

Dated: May 3, 1995.

David T. Ellwood,

Assistant Secretary for Planning and Evaluation.

[FR Doc. 95–11832 Filed 5–12–95; 8:45 am]

BILLING CODE 4151–04–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AZ–020–7122–02–5491]

Notice of Correction of Availability of the Cyprus Tohono Corporation Proposed Mine Expansion Final Environmental Impact Statement, Phoenix District, Arizona

AGENCY: Bureau of Land Management, Interior.

ACTION: Correction.

SUMMARY: In compliance with the Federal Land Policy and Management Act of 1976, section 102(2)(c) of the National Environmental Policy Act of 1969, and The United States Department of the Interior Secretarial Order No. 3087, Section 5, Amendment No. 1, The Bureau of Land Management (BLM) has prepared an Environmental Impact Statement (EIS) for the Cyprus Tohono Corporation's (Cyprus) proposed mine expansion on the Tohono O'odham Nation (Nation), Papago Indian Reservation. For additional detail see **Federal Register**, Vol. 60, No. 81, page 20737, dated Thursday, April 27, 1995. The April 27, 1995 Notice incorrectly stated the appeal procedures. The correct appeal procedure can be found at 43 CFR 4.400.

DATES: Appeals must be filed within 30 days of the Notice of Filing by the United States Environmental Protection Agency in the **Federal Register** on May 5, 1995. These procedures can be found in the Code of Federal Regulations (43 CFR 4.400).

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, Attn: Moon Hom, 2015 West Deer Valley Road, Phoenix, Arizona 85027; (602) 780–8090.

Dated: May 8, 1995.

David J. Miller,

Associate District Manager.

[FR Doc. 95–11928 Filed 5–12–95; 8:45 am]

BILLING CODE 4310–32–M

Bureau of Land Management

[NV–930–05–1430–01; N–59758]

Notice of Realty Action, Direct Sale of Public Land to Pershing County, Nevada

SUMMARY: The following described land has been found suitable for direct sale under Sections 203 and 209 of the Federal Land Policy and Management Act of October 21, 1976 (43 U.S.C. 1713 and 1719), at not less than fair market value:

Mount Diablo Meridian, Nevada

T. 30 N., R. 34 E.,
Sec. 24: SE¼SW¼NW¼SE¼.
Containing approximately 2.50 acres.

The lands are not required for federal purposes. Disposal is consistent with the Bureau's planning for this area and would be in the public's interest. This land is being offered by direct sale to Pershing County. It has been determined that the subject parcel contains no known mineral values, except oil and gas and geothermal steam and related geothermal resources. Acceptance of a direct sale offer will constitute an application for conveyance of those mineral interests having no knwon value. The applicant will be required to pay a $50.00 non-refundable filing fee for conveyance of the said mineral interests.

The land will not be offered for sale until at least 60 days after publication of this notice in the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Ken Detweiler, Realty Specialist, Bureau of Land Management, 705 E. 4th St., Winnemucca, NV 89445 (702) 623–1500.

SUPPLEMENTARY INFORMATION: The public lands are being offered to Pershing County for operation of a trash transfer station for Unionville, Nevada. The site will be used for placement of a large trash container. The container will be removed from the site on a regular basis. This site is necessary since closure of the Unionville dump is anticipated. No trash will remain on site permanently.

The above described land is hereby segregated from appropriation under the public land laws, including the mining laws, but not from sale under the above cited statutes, for 270 days from the date of publication of this notice, or until