Form	Number of respondents	Responses per respondent	Hours per response	Total hour burden
Hospital Facility Data Abstract	150	1	1	150

Send comments to Susan G. Queen, Ph.D., HRSA Reports Clearance Officer, Room 14–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: January 28, 2000.

Jane Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 00–2433 Filed 2–3–00; 8:45 am]

BILLING CODE 4160–15–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 $25 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. The $25 million in available funding has been appropriated under the FY 2000 HHS Appropriations Act.

In FY 2000, HRSA will provide funding for approximately 20 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.

During the first year of funding for this program, HRSA will support infrastructure development in communities that have already begun to reorganize and integrate their health care delivery systems. FY 2000 funding is not intended to support those communities that have not yet begun the planning and development of necessary organizational structure.

Up to 100 communities may ultimately be funded as part of this national program targeted by the Administration to spend $1 billion over five years. FY 2000 funded communities may be eligible for available FY 2001 funding (assuming continued appropriations) to support further infrastructure development and filling service gaps. In addition, using the experiences of the FY 2000 funded communities as potential models for adaptation, FY 2001 funding is anticipated for support of new communities for planning and system development. Thus, communities that have not yet begun the planning and development of necessary organizational structure should have an opportunity to apply in FY 2001.

Over the years that the program is funded, funds are anticipated to be available to fill service gaps within coordinated systems of care.

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. Thus, CAP will take into account the experiences of these foundations as well as other programs that promote the integration of services to the uninsured and underinsured.

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

February 10, 2000: Application kits and additional guidance will be available through the HRSA Grants Application Center (GAC).

March 7–16, 2000: There will be a series of six pre-application workshops conducted across the country: Boston, MA—March 7, 2000; Atlanta, GA—March 8, 2000; Chicago, IL—March 9, 2000; Dallas, TX—March 14, 2000; Los Angeles, CA—March 15, 2000; Seattle, WA March 16, 2000.

June 1, 2000: Applications due.

July 3–17, 2000: Applications reviewed.

August 2000: Site visits to selected applicants.

September 2000: Grant awards announced.

ADDRESSES: To receive a complete application kit (*i.e.,* application instructions, necessary forms, and application review criteria), contact the HRSA GAC at: HRSA GAC, 1815 N. Fort Meyer 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 9A–30, 5600 Fishers Lane, Rockville, MD 20857, Phone: (301) 443–0536, Fax: (301) 443–0248.

SUPPLEMENTARY INFORMATION: In 1998, 44.5 million people in the United States did not have health insurance. Of these, 24.6 million were employed—18.7 million worked full time and 5.9 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, 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, that 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 health 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, two-way learning between providers and community, and participation in priority setting and governance by the community are essential components of this vision. This will reduce out migration for services in rural areas and assure sustainability of the system.

Program Description

In implementing a system of coordinated care for the uninsured and underinsured in a community, 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 system. The successful applicant will design a program 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, in any event, will sustain the delivery of services and funding after these federal grants no longer exist. 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 several models that already exist and that each community may draw from in creating a program to address its own needs.

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

- 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;
- Redistributed caseload to private providers because of the forced closure of public hospitals;
- 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 and are able to create seamless transitions between Medicaid, uninsured, and insured status for low income populations;
- Linked behavioral and acute care service provision; and
- Created networks to allocate uncompensated ambulatory care loads among physicians.

We are looking for applicants with clear goals, an operational plan for meeting those goals, a history of commitment to serving indigent populations, and enough of a track record to indicate a fair chance at being successful. Innovative proposals for sustaining the service delivery component of projects could include state redirection of DSH funds or general assistance funds, creative 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.

Funded Projects Will Contain Several Common Elements

Community Need: Communities funded through this program 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: The proposed system should 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: The proposed system 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: The proposed system will demonstrate coordination with state (e.g., memorandum of agreements) programs to ensure that eligible beneficiaries are enrolled in public insurance programs (e.g., S–CHIP, Medicaid).

Community Involvement: There is strong community support for these efforts that provide a broad foundation of assistance to the provider community undertaking this project. Management and governance structures are 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 will be evident. This should include the leadership within the appropriate legislative and executive bodies, providers identified above, health plans and payers, and community leaders.

Sustainability: A plan for long-term sustainability is designed and has community consensus. There is 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 various types of system integration models, this program seeks a variety of

applicants representing all types of communities. Applicants who 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, private, and 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 who represent a range of services (*e.g.,* mental health and substance abuse treatment, maternal and child health care, oral health, HIV/AIDS).

Examples of eligible applicants who 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 health professions education schools)
- Local government agencies (*e.g.,* local public health departments with service delivery components)
- Tribal governments
- Managed care plans or other payers (*e.g.,* HMOs, insurance companies)

Agencies of State governments, multi-state health systems, or special interest 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.

Competing applications for the same patient population will not be considered for funding; therefore, applicants from the same community are required to collaborate.

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 and budget plan
- 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. While each community should design a program that best addresses the needs of the uninsured and underinsured, and the providers in their community, funding is intended to encourage safety net providers to develop coordinated care systems for the community's uninsured and underinsured.

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.

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 15 percent of grant funds may be used for:

- Alteration or renovation of facilities
- Primary care site development
- 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 coverage 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, 2000.

Claude Earl Fox,

Administrator.

[FR Doc. 00–2567 Filed 2–3–00; 8:45 am]

BILLING CODE 4160–15–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Advisory Council; Notice of Meeting; Correction

In **Federal Register** Document 00–1032 appearing on page 2634 in the issue for Tuesday, January 18, 2000, the February 10–11, 2000, meeting dates of the ''National Advisory Council on Migrant Health'' are incorrect. The meeting will be held on February 11–12, 2000; 9:00 a.m.–5:00 p.m.

All other information is correct as it appears.