

Uniform Application for the Mental Health Block Grant and Substance Abuse Block Grant FY 2014-2015 Application Guidance and Instructions

SUPPORTING STATEMENT

A. Justification

1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA), is requesting approval from the Office of Management and Budget (OMB) for a revision to the 2014-2015 Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) Application Guidance and Instructions. The OMB clearance for the current 2012-2013 Application Guidance (0930-0168), will expire on 07/31/2014.

Title XIX, Part B of the Public Health Service Act (PHS Act), as amended, establishes the MHBG and SABG programs. Under sections 1917(42 USC 300x-6), Application for MHBG plan is received by the Secretary no later than September 1 of the fiscal year prior to the fiscal year for which a state or jurisdiction (here after referred to as states) is seeking funds, and the report from the previous fiscal year as required under section 1941 is received by December 1 of the fiscal year of the grant.

Section 1932 (42 USC 300x-32) requires states and jurisdictions (here after referred to as “states”) to submit their respective SABG applications no later than October 1 of the fiscal year for which they are seeking funds.

In 1981 the Federal Government envisioned a new way of providing assistance to states for an assortment of services including substance abuse and mental health. Termed block grants, these grants were originally designed to give states maximum flexibility in the use of the funds to address the multiple needs of their populations. This flexibility was given in exchange for reductions in the overall amount of funding available to any given state. Over time, a few requirements were added by Congress directing the states’ use of these funds in a variety of ways. Currently, flexibility is given to allow states to address their unique issues. However, while there will continue to be flexibility in the block grants, additional information will be requested to ensure services are cost-effective, evidenced-based, and responsive to the changing health care systems, laws, knowledge and conditions. Today, more direction is needed to assure that the Nation’s behavioral health system is providing the best and most cost effective care possible, based on the best possible evidence, and tracking the quality and outcome of services so impact can be reported and improvements can be made as science and circumstances change.

From their inception, some assumptions about the nature and use of block grants have evolved.

Over time, block grants have gained a reputation as a mechanism to allow states unrestricted flexibility without strong accountability measures. In the meantime, the field of behavioral health has developed newer, innovative, and evidence-based services that have gone unfunded or without widespread adoption. This “science to service” lag and a lack of adequate and consistent person-level data have resulted in questions from stakeholders and policy makers, including Congress and OMB, as to the effectiveness and accountability achieved through SAMHSA’s block grants.

The SABG and the MHBG differ on a number of practices (e.g., data collection at individual or aggregate levels) and statutory authorities (e.g., method of calculating MOE, stakeholder input requirements for planning, set asides for specific populations or programs, etc.). Historically, the Centers within SAMHSA that administer these block grants have had different approaches to application requirements and reporting. To compound this variation, states have different structures for accepting, planning, and accounting for the block grants and the prevention set aside within the SABG. As a result, how these dollars are spent and what is known about the services and clients that receive these funds varies by block grant and by state.

National economic conditions, a growing prevention science, and healthcare reform create a dynamic critical for SAMHSA to address. Furthermore, the Mental Health Parity and Addictions Equity Act (MHPAEA) significantly enhances access to behavioral health services for millions of Americans, including treatment and other services for persons with or at risk of mental and substance use disorders. These factors will increase the nation’s ability to close service gaps that have existed for decades for far too many individuals and their families.

In 2014 more individuals will be eligible for Medicaid and private insurance. This expansion of health insurance coverage will have a significant impact on how State Mental Health Authorities (SMHAs) and State Substance Abuse Authorities (SSAs) use their limited resources. In 2009, more than 39 percent of individuals with serious mental illnesses (SMI) or serious emotional disturbances (SED) were uninsured. Sixty percent of individuals with substance use disorders whose treatment and recovery support services were supported wholly or in part by SAMHSA block grant funds were also uninsured. A substantial proportion of this population, as many as six million people, will gain health insurance coverage in 2014 and will have various outpatient and other services covered either through Medicaid, Medicare, or private insurance. However, these plans will not provide access to the full range of support services necessary to achieve and maintain recovery for most of these individuals and their families.

Given the changes that will occur over the next several years, SAMHSA proposes that block grant funds be directed toward four purposes: 1) to fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage; 2) to fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and/or supporting recovery; 3) to fund universal, selective and targeted prevention activities and

services; and 4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment and recovery support services and to plan the implementation of new services on a nationwide basis.

SAMHSA needs to begin planning now for the significant change in the health insurance market that will begin when critical provisions of the Affordable Care Act go into effect in FY 2014. Therefore, SAMHSA intends to use 2013 to work with states to plan for and transition the block grants to these four purposes. This transition includes fully exercising SAMHSA's existing authority regarding states' use of block grant funds, and a shift in SAMHSA staff functions to support and provide technical assistance for states receiving block grant funds as they move through these changes.

To help states meet the challenges of 2014 and beyond, and to foster a good and modern mental health and addiction service system, SAMHSA must establish standards and expectations that will lead to an improved system of care for individuals with or at risk of mental and substance use disorders. The Department must also spend more time assisting states in building and maintaining more effective behavioral health systems for prevention, treatment, services and recovery supports that are aligned with a good and modern service system. Based on the critical issues outlined above, SAMHSA is requesting approval of this application and guidance for FY 2014-2015.

Application Overview

Consistent with previous applications, the FY 2014-2015 application has sections that are required and other sections where additional information is requested, but not required. Opting not to provide additional information that is requested but not required will not affect state funding in any way (amount or timeliness of payment). The FY 2014-2015 application requires states to submit a face sheet, a table of contents, a behavioral health assessment and plan, reports of expenditures and persons served, executive summary, and funding agreements, assurances, and certifications. In addition, SAMHSA is requesting information on key focus areas that are critical to implementation of provisions as related to improving the quality of life for individuals with behavioral health disorders.

While states are encouraged but not required to submit a single application, they will be encouraged to submit a combined plan for any funds used for the treatment of persons with a co-occurring mental and substance use disorder. States will also be encouraged to submit a combined plan for primary/behavioral health care integration and recovery support services.

States are required to use forms approved by the Office of Management and Budget and to submit the application in a specified time period. The block grant application changes the timeframes in which states will submit applications and report progress on their goals and measures. Although the statutory deadlines remain unchanged, SAMHSA is urging states to submit their application(s) in accordance with the time frames set out in the application

guidance. SAMHSA believes that plans should be developed in line with state fiscal years and that information provided in the reports should reflect state fiscal year data as well. For applications for fiscal year 2014, plans covering the period July 1, 2013 through June 30, 2015 are to be submitted by April 1, 2013. The annual report for federal fiscal year 2014 funding will be due on December 1, 2014 and cover the period July 1, 2013 through June 30, 2014 and the report for federal fiscal year 2015 funding will be due on December 1, 2015 and cover the period July 1, 2014 through June 30, 2015.

| Application(s) for FY | Application Due | Plan Due | Planning Period | Reports Due |
|-----------------------|-----------------|----------|------------------|-------------|
| 2014 | 4/1/13 | Yes | 7/1/13 – 6/30/15 | 12/1/13 |
| 2015 | 4/1/14 | No * | | 12/1/14 |
| 2016 | 4/1/15 | Yes | 7/1/15 – 6/30/17 | 12/1/15 |
| 2017 | 4/01/16 | No * | | 12/1/16 |

The application requires the states under both programs to set goals and quantifiable and measurable objectives to be achieved over the length of the plan. Such goals and objectives are to be based on the assessment that the state has conducted a review of its current capacity and resources. The objectives are to be accompanied by activities that the state will undertake to meet those objectives. In the case of objectives that will take longer than one year to achieve, the state is to set milestones to reach along the way. The milestones give both the state and SAMHSA an opportunity to revisit the objectives and or the activities being carried out to achieve the objectives to ensure that they will be met. It also offers an opportunity for SAMHSA to provide or secure needed technical assistance for the state if desired.

SAMHSA believes that requiring states to submit plans for their behavioral health care systems is in keeping with SAMHSA’s governance of federal funds to require states to explain what their objectives are in the use of the funds and how they intend to spend them. Having the states submit a plan including performance measures allows SAMHSA to hold the states accountable for goals that they have set for themselves. It is SAMHSA’s understanding, after consulting with states, that most states already develop such a plan for substance use services for their State

legislatures.

The application also includes the state annual report. Section 96.122(h) requires the state to submit an annual report for both the MHBG and the SABG to the Secretary as part of the application that, among other things, addresses the state's progress in meeting the objectives in the state plan. The report includes information to ensure that the state carried out its obligations as stipulated in the statute and the regulation. All the information provided will be according to most states' fiscal year (July 1 through June 30th of the following year).

Each state is required to establish and maintain a state advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages states to expand this council to a behavioral health advisory council to advise and consult regarding issues and services for persons with, or at risk of, substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of the behavioral health advisory council will be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance use disorders as well as individuals with mental disorders within the state. States are strongly encouraged to include American Indians and/or Alaskan Natives; however, their inclusion on the Council does not by itself suffice as tribal consultation.

2. Purpose and Use of Information

SAMHSA's SABG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental disorders, substance use disorders and associated problems. The goals of the block grant programs are consistent with SAMHSA's vision for a high-quality, self-directed, and satisfying life in the community for everyone in America. This life in the community includes:

- a) A physically and emotionally healthy lifestyle (**health**);
- b) A stable, safe and supportive place to live (a **home**);
- c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a **purpose**); and,
- d) Relationships and social networks that provide support, friendship, love, and hope (a **community**).

Additional aims of the block grant programs reflect SAMHSA's overall mission and values, specifically:

- To promote participation by people with mental and substance use disorders in shared decision making and self direction of their services and supports.

- To ensure access to effective culturally and linguistically competent services for underserved populations including Tribes, racial and ethnic minorities, and LGBT.
- To promote recovery, resiliency and community integration for adults with serious mental illness and children with serious emotional disturbances and their families.
- To increase accountability for behavioral health services through uniform reporting on access, quality, and outcomes of services.
- To prevent the use, misuse, and abuse of alcohol, tobacco products, illicit drugs, and prescription medications.
- To conduct outreach to encourage individuals injecting or using illicit and/or licit drugs to seek and receive treatment
- To provide HIV prevention as early intervention services at the sites at which individuals receive substance use disorder treatment services.
- To coordinate behavioral health prevention, early identification, treatment and recovery support services with other health and social services.
- To increase accountability for prevention, early identification, treatment and recovery support activities through uniform reporting regarding substance use and abstinence, criminal justice involvement, education, employment, housing, and recovery support services.
- To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, dental services, and health services, as well as behavioral health services and supports.

These goals are significant drivers in the revised block grant application. SAMHSA's and other federal agencies' focus on accountability, person directed care, family-driven care for children and youth, underserved minority populations, Tribal sovereignty, and comprehensive planning across health and specialty care services are reflected in these goals. States should use these aims as drivers in developing their application.

SAMHSA envisions a new generation of block grants that will be used by states for prevention, recovery supports and other services that will supplement services covered by Medicaid and private insurance. SAMHSA has been involved in planning with our stakeholders for FY 2014 when more persons will be covered by Medicaid or private insurance. This expansion of health insurance coverage will require that SAMHSA build upon its prior work and use FY 2013 to continue to work with States to plan for and transition the block grants to assure non-duplication

of necessary service delivery. This transition includes fully exercising SAMHSA's existing authority regarding states' use of block grant funds and a shift in SAMHSA staff functions to support and provide technical assistance for states receiving block grant funds as they move through these changes.

Proposed Revisions

To facilitate an efficient application process for States in FY 2014-2015, SAMHSA convened an internal workgroup to develop the application and planning sections for the uniform block grant. In addition, SAMHSA consulted with representatives from the State Mental Health and State Substance Abuse Authorities to receive input regarding the proposed changes to the block grant. Federal partners invited to submit comments have included the Department of Health and Human Services (HHS), the Office of National Drug Control Policy (ONDCP), the Office of Management and Budget (OMB), and the Assistant Secretary for Financial Resources (ASFR). Other stakeholders consulted have included the National Association of State Alcohol Drug Abuse Directors, (NASADAD) and the National Association of State Mental Health Program Directors, NASMHPD.

In development of the FY 2014-2015 application, SAMHSA has not made major revisions to the FY 2013-2014 application. The proposed revisions are based primarily on previous instructions provided in the FY 2012-2013 application guidance. In building on the 2012-2013 guidance, SAMHSA has proposed revisions to expand the areas of focus (environmental factors) for states to describe their comprehensive plans to provide treatment, services, and supports for individuals with behavioral health needs. These revisions will enable SAMHSA to assess the extent to which states plan for and implement provisions of the Affordable Care Act and determine whether block grants funds are being directed toward the four purposes of the grant.

The proposed revisions reflect changes within the planning section of the application. The most significant of these changes relate to prevention, particularly primary prevention; data and quality; enrollment of individuals and providers; and descriptions of Good and Modern behavioral health services. States are encouraged to address each of the focus areas. SAMHSA has provided a set of guiding questions to stimulate and direct the dialogue that states may engage in to determine the various approaches used to develop their responses to each of the focus areas.

The proposed revisions are described below:

Areas of Focus/Environmental Factors

- Coverage for M/SUD Services –Beginning in 2014, block grant dollars should be used to pay for (1) people who are uninsured, (2) services that are not covered by insurance and Medicaid, (3) prevention, and (4) the collection of performance and outcome data. Presumably, there will be similar concerns at the state level that state dollars are being

used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for Qualified Health Plans (QHPs) and their expanded Medicaid program. States should begin to develop strategies that will monitor the implementation of the Act in their states. States should begin to identify whether people have better access to mental health and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering services for mental and substance abuse disorders and whether services are offered consistent with provisions of MHPAEA.

- Affordable Insurance Exchanges – Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to much needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state’s new eligibility determination and enrollment system. They should also understand how insurers (commercial, Medicaid and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set targets or recommendations for the number of providers who will be participating in insurers’ networks that are currently not billing third party insurance.
- Program Integrity –The Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside the Exchanges, Medicaid benchmark and benchmark equivalent plans, and basic health programs must cover these EHBs. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a “typical employer plan” in a state as required by the Act.

At this point in time, many states will know which mental health and substance abuse services are covered in their benchmark plans offered by QHPs and Medicaid programs. SMHAs and SSAs should be focused on two main areas related to EHBs: monitoring what is covered and aligning block grants and state funds for what is not covered. These include: 1) ensuring that QHPs and Medicaid programs are including EHBs as per the state benchmark plan; 2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; 3) ensuring that people will utilize the benefits despite concerns that employers will learn of mental health and substance abuse diagnosis of their employees; and 4) monitoring utilization of mental health and substance abuse benefits in light of utilization review, medical necessity, etc.

SAMHSA expects states to implement policies and procedures that are designed to ensure that block grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management

and oversight strategies to accommodate the new priorities. They may also need to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

- Use of Evidence in Purchasing Decisions – SAMHSA is interested in whether or how states are using evidence in their purchasing decisions, educating policymakers or supporting providers to offer high quality services. In addition, SAMHSA is interested in additional information that is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services.
- Quality – Up to 25 data elements, including those in the table below will be available through the Behavioral Health Barometer which SAMHSA will prepare at least bi-annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas. States will receive feedback on an annual basis in terms of national, regional and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the block grant funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

| | Prevention | Substance Abuse Treatment | Mental Health Services |
|-----------|---|---|---|
| Health | Youth and Adult Heavy Alcohol Use- Past 30 Day | Reduction/No Change In substance use past 30 days | Level of Functioning |
| Home | Parental Disapproval Of Drug Use | Stability in Housing | Stability in Housing |
| Community | Environmental Risk/Exposure to Prevention Messages And/or Friends Disapproval | Involvement in Self-Help | Improvement/Increase in quality/number of supportive relationships among SMI population |
| Purpose | Pro-Social Connections- Community Connections | Percent in TX employed, in school, etc.- TEDS | Clients w/SMI or SED who are employed, or in school |

- Trauma – In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies such as exposure therapy or trauma-focused cognitive behavioral approaches should be adopted to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma informed care approach consistent with SAMHSA’s trauma informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.
- Justice – The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-arrest, pre-adjudication and pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. However, there are a number of different types of problem-solving courts. In addition to drug courts and mental health courts, some jurisdictions, for example, operate courts for DWI/DUI, veterans, family, teen, reentry, as well as courts such as gambling, domestic violence, truancy, etc. States are also encouraged to work with municipalities to determine whether municipal mental health or drug courts might be viable. Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes can be emphasized. States should place emphasis on screening, assessment, and services provided prior to arrest, adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. Secondarily, states should examine specific barriers such as lack of identification needed for enrollment, loss of eligibility resulting from incarceration, and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives for detention.
- Parity Education – SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.
- Primary and Behavioral Health Care Integration Activities – Numerous provisions in the Affordable Health Care Act and elsewhere improve the coordination of care for patients through the creation of health homes, where teams of health professionals will be

rewarded to coordinate care for patients with chronic conditions. States that had approved Medicaid State Plan Amendments (SPAs) received 90 percent Federal Medicaid Assistance Percentage (FMAP) for health home services for eight quarters. At this critical point in time, some states are ending their two years of enhanced FMAP and rolling back to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects. States should indicate how these changes and opportunities affect their application.

- Health Disparities – In the block grant application, states are asked to define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services; American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community; and African American women may be at greater risk for contracting HIV/AIDS due lack of access to education on risky sexual behaviors in urban low-income communities, etc. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served and not being served within their communities, including in what languages services are provided, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services and outcomes are critical measures of quality and outcomes of care for diverse groups. In order to address the potentially disparate impact for their block grant funded efforts, states will be asked to address access, use and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection and sexual orientation (i.e., lesbian, gay, bisexual).
- Recovery - SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. SAMHSA has launched BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center Strategy). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from mental or substance use disorders.
- Children and Adolescents Behavioral Health Services – Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the System of Care approach in states and communities around the country. This has been an ongoing

program with over 160 grants awarded to states and communities. Every state has received at least one CMHI grant. In 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to build a state infrastructure for substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidenced-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential (e.g., wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance use disorder intensive outpatient services, continuing care, mobile crisis response, etc.), supportive services (e.g., peer youth support, family peer support, respite services, mental health consultation, supported education and employment, etc.) and residential services (e.g. therapeutic foster care, crisis stabilization services, inpatient medical detoxification, etc.).

Summary of Changes as a Result of the 60-Day Federal Register Notice

SAMHSA received 232 comments from 36 individuals or organizations. The comments expressed general support for the option to submit a combined plan for mental and substance use disorders (M/SUD) for both block grants, the movement to the behavioral health barometer, the expressed four priorities for the block grants, the two-year planning cycle, and tribal consultation. Many comments were duplicative and included requests that SAMHSA eliminate any reference to initiatives in the President's budget proposal and include a discussion of only those initiatives that are authorized; ask only for what is required information and not include any areas that are requested; clarify that SABG dollars cannot be used for mental health promotion; provide clear operational definitions for each outcome measure; simplify the data collected; reduce or clarify the expanded area of focus; change the acronym for the substance abuse block grant back to SAPTBG; address a concern from some states that the April 1 deadline will be difficult given other priority activities in the states; emphasize older adults and veterans; require substance abuse representation on the planning council for those states submitting a combined application; and, address a concern that the use of block grant funds are becoming more prescriptive instead of giving states maximum flexibility.

SAMHSA received some comments about the "Behavioral Health Advisory Council Composition by Member Type" table indicating that the reference to members from diverse racial and LGBTQ populations is potentially confusing and creates a dilemma as to which category members should be ascribed, the term 'leading state experts' is also confusing and somewhat arbitrary, and the membership categorization for "Federally Recognized Tribe

Representatives" could be confused with council members who happen to be tribal members. SAMHSA agrees with the recommendations that the request for a number of individuals and providers from diverse racial, ethnic, and LGBTQ backgrounds in the table will skew the calculation of the percentage of consumers/state members. SAMHSA has moved this information request, as well as the request to identify any member who is an individual in recovery from SUD or advocating for SUD services to the bottom of the table and removed it from the calculation. "Leading state expert" is deleted. Federally Recognized Tribal Representatives are individuals who are officially designated by the tribe to sit on the Council.

SAMHSA added clarifying language within the prevention section that clarifies that states will be allowed to use some of their current Mental Health block grant to support mental health promotion and mental illness prevention activities related to adults with serious mental illnesses and children with serious emotional disturbances and their families. In addition, the 20% set aside funds of the Substance Abuse block grant must be used for substance abuse primary prevention activities by the state. Many evidenced-based substance abuse programs have a positive impact on the prevention of substance use and abuse as well as other health and social outcomes such as education, juvenile justice involvement, violence prevention and mental health.

SAMHSA reduced the number of questions in the prevention planning section, in the Primary and Behavioral Health Care Integration Activities section, and in the Technical Assistance needs section.

SAMHSA has renumbered and, in some instances, renamed tables throughout the document to eliminate the redundancy in the table numbers between the planning and reporting sections and improve user navigation. SAMHSA also revised the table entitled 'Behavioral Health Advisory Council Composition by Member Type.' In addition, SAMHSA enhanced the tables of contents in the reporting sections to facilitate user navigation.

3. Use of Information Technology

The uniform application instructions and guidance will be available to all states through the SAMHSA website at www.samhsa.gov/grants/blockgrant. The FY 2014-2015 guidance will request that states submit applications using the web-based application process, called Web Block Grant Application System (BGAS). BGAS utilizes Microsoft Active Server Pages (ASP), JavaScript, Hypertext Markup Language (HTML), Adobe Acrobat, and Oracle Database technologies.

Use of BGAS significantly reduces the paperwork burden for submission, revision, and reporting purposes. BGAS has the ability to transfer standard information from previous year's plans, thus pre-populating performance indicator tables, planning council membership, and maintenance-of-effort figures. In addition to transferring both narrative information and data, states are able to upload specific instructions and information necessary to complete their plans.

If a respondent chooses not to use BGAS and submits an application in hard copy, the state is asked to submit an original and two copies. .

4. Efforts to Identify Duplication

The SAMHSA block grant application is primarily narrative and descriptive. States describe their systems of care, certain planned expenditures, services provided, and progress toward meeting the state's community-based mental and substance use disorder service goals. The Report sections, which includes state mental health reporting on the Uniform Reporting System (URS) Tables, and state substance use disorder reporting through the Treatment Episode Data Set (TEDS) is the only routine or uniform initiative collecting data of the type requested to provide a national picture of the public mental and substance use disorder system.

5. Involvement of Small Entities

There is no small business involvement in this effort. The applications are prepared and submitted by states.

6. Consequences if Information is Collected Less Frequently

The legislation requires that states apply annually for MHBG funds and report annually on their accomplishments. Less frequent reporting would not comply with legislative requirements and would make it impossible for SAMHSA to award MHBG funds or monitor the states' use of their grants. In addition, federal reporting requirements for reports to Congress, as well as intervening requirements for legislative testimony before Congress on specific mental health issues, require the availability of up-to-date information and data analyses.

The authorizing legislation and implementing regulation requires states to apply annually for SABG funds and to report annually on SABG activities and services and the purposes for which the SABG funds were expended. Less frequent reporting would be in violation of the authorizing legislation and would also result in difficulty linking activities with fiscal year funding. Internal control processes and program management requirements are addressed through the collection, database management, and analysis of information collected in this application. Federal reporting requirements for reports to Congress, as well as intervening requirements for legislative testimony before Congress covering specific issues regarding the prevention of substance abuse and the treatment of substance use disorders, require the availability of up-to-date information. Without submission of an annual report and intended use (State) plan in accordance with regulations published by the Secretary, SABG awards cannot be made available to the States.

7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

This information fully complies with 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required in 5 CFR 1320.8(d) was published in the Federal Register on July 13, 2012 (Vol. 77, Page 41432). SAMHSA received 232 comments from 36 individuals or organizations.

The individual copies of public comments are provided at Attachment B and SAMHSA’s response to them can be found in Attachment C.

9. Payment to Respondents

No payments will be provided to respondents to participate.

10. Assurance of Confidentiality

States submit Client-level data through the Treatment Episode Data System (TEDS). The responsibility for assigning facility and client identifiers resides with the individual States. Client identifiers consist of unique numbers within facilities, and, increasingly, unique numbers within State behavioral health data systems. Records received into TEDS are stored in secured computer facilities, where computer data access is limited through the use of key words known only to authorized personnel. In preparing TEDS public use files, a contractor conducts a disclosure analysis of the data. Client and facility identifiers are removed, certain variables are recoded, and cells are collapsed or otherwise masked as needed to ensure that individuals cannot be identified.”

11. Questions of a Sensitive Nature

This application does not solicit information of a sensitive nature. It includes narrative and aggregate information to administer and monitor the block grant program.

12. Estimates of Annualized Hour Burden

The estimated annualized burden for the uniform application is 37,429 hours. Burden estimates are broken out in the following tables showing burden separately for Year 1 and Year 2. Year 1 includes the estimates of burden for the uniform application and annual reporting; Year 2 includes the estimates of burden for the application update and annual reporting. The reporting burden remains constant for both years.

Table 1. Estimates of application and reporting burden for Year 1:

| Application | No. | Responses/ | Burden/ | Total Burden | Hourly | Total Hour |
|-------------|-----|------------|---------|--------------|--------|------------|
|-------------|-----|------------|---------|--------------|--------|------------|

| Element | Respondents | Respondents | Response (Hours) | | Wage Cost | Cost |
|-------------------------------------|------------------------|-------------|------------------|---------------|-----------|--------------------|
| Application Burden: | | | | | | |
| Yr One Plan (separate submissions) | 30 (CMHS) 30 (SAPT) | 1 | 282 | 16,920 | \$35 | \$592,200 |
| Yr One Plan (combined submission) | 30 | 1 | 282 | 8,460 | \$35 | \$296,100 |
| Application Sub-total | 60 | | | 25,380 | | \$888,300 |
| Reporting Burden: | | | | | | |
| MHBG Report | 59 | 1 | 186 | 10,974 | \$35 | \$384,090 |
| URS Tables | 59 | 1 | 35 | 2,065 | \$35 | \$72,275 |
| SABG Report | 60 ¹ | 1 | 186 | 11,160 | \$35 | \$390,600 |
| Table 5 | 15 ² | 1 | 4 | 60 | \$35 | \$2,100 |
| Reporting Subtotal | 60 | | | 24,259 | | \$849,065 |
| Total | 119 | | | 49,639 | | \$1,737,365 |

1Redlake Band of the Chippewa Indians from MN receives a grant.

2Only 15 States have a management capacity to complete Table 5.

Table 2. Estimates of application and reporting burden for Year 2:

| Application Element | No. Respondents | Responses/ Respondents | Burden/ Response (Hours) | Total Burden | Hourly Wage Cost | Total Hour Cost |
|------------------------------|-----------------|------------------------|--------------------------|--------------|------------------|-----------------|
| Application Burden: | | | | | | |
| Yr Two Plan | 24 | 1 | 40 | 960 | \$35 | \$33,600 |
| Application Sub-total | 24 | | | 960 | | \$33,600 |
| Reporting Burden: | | | | | | |
| MHBG Report | 59 | 1 | 186 | 10,974 | \$35 | \$384,090 |

| | | | | | | |
|---------------------------|------------|---|-----|---------------|------|------------------|
| URS Tables | 59 | 1 | 35 | 2,065 | \$35 | \$72,275 |
| SABG Report | 60 | 1 | 186 | 11,160 | \$35 | \$390,600 |
| Table 5 | 15 | 1 | 4 | 60 | \$35 | \$2,100 |
| Reporting Subtotal | 60 | | | 24,259 | | \$849,065 |
| Total | 119 | | | 25,219 | | \$882,665 |

The total annualized burden for the application and reporting is 37,429 hours (49,639 + 25,219 = 74,858/2 years = 37,429).

13. Estimate of Total Annualized Cost Burden to Respondents

There are no capital or start-up costs associated with this activity. States submitting applications are expected to use existing retrieval software systems to perform the necessary data extraction and tabulation. In addition, no operating, maintenance or purchase of services costs will be incurred other than the usual and customary cost of doing business.

14. Estimates of Annualized Cost to the Government

(a) Staff support for regulation interpretation and enforcement:

| | | |
|--------------------|---|------------------|
| OGC | (1) GS -14/6 (\$119,844) x .15 hours = | \$ 17,977 |
| BG Staff | (3) GS – 14/6 (\$119,844) x .50 hours = | <u>\$179,766</u> |
| Total Cost: | | \$197,743 |

(b) Staff support for application review, compliance monitoring, technical assistance and inquiries:

| | | |
|----------|--|--------------------|
| BG Staff | (34) GS – 13/5 (\$100,904) x .50 hours = | \$1,715,368 |
|----------|--|--------------------|

15. Changes in Burden

There are no changes to the burden statement.

16. Time Schedule, Publication, and Analysis Plans

The FFY 2014-2015 SAMHSA BG applications are due 04/01/2013 for a two year planning period.

In order for the Secretary of the U.S. Department of Health and Human Services, acting through

the Administrator of SAMHSA, to make an award under the programs involved, states must submit an application, prepared in accordance with the authorizing legislation, implementing regulation, and guidance, for the federal fiscal year for which a state is seeking funds. The funds awarded will be available for obligation and expenditures¹ to plan, carry out, and evaluate activities and services described in the plan.

A grant may be awarded only if an application submitted by a state includes a state plan^(2,3) in such form and containing such information including, but not limited to, detailed provisions for complying with each funding agreement for a grant under section 1911 of Title XIX, Part B, Subpart I of the Public Health Service (PHS) Act or section 1921 of Title XIX, Part B, Subpart II of the PHS Act that is applicable to a state. This state plan should include a description of the manner in which the state intends to obligate the grant. The state plan must include a report⁽⁴⁾ in such form and containing such information as the Secretary determines to be necessary for securing a record and a description of the purposes for which the grant was expended. The state plan should also describe the activities and services purchased by the states under the program involved and a description of the recipients and amounts provided in the grant. States will have the option of updating their plans during the two year planning cycle.

17. Display of Expiration Date

The expiration date for OMB approval will be displayed.

18. Exception to Certification Statement

This information collection involves no exception to the Certification for Paperwork Reduction Act Submissions. The certifications are included in this submission.

B. Collection of Information Employing Statistical Methods

This information collection does not involve statistical methods.

1 Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52)

2 Section 1912 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.C. § 300x-2)

3 Section 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-32(b))

4 Section 1942(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a))

List of Attachments

- A. 2014-2015 Application Guidance & Instructions
 - 1. Planning Section
 - 2. Reporting Sections
 - 3. CEO Funding Agreements/Certifications
- B. Public Comments
- C. SAMHSA's Response to the Comments