Uniform Application for the Mental Health Block Grant and Substance Abuse Block Grant
FY 2016-2017 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 2016-2017 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 2014-2015 Application Guidance (0930-0168), will expire on 05/31/2016.

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.

Increasingly, under the Affordable Care Act, more individuals are eligible for Medicaid and private insurance. This expansion of health insurance coverage will continue to have a significant impact on how State Mental Health Authorities (SMHAs) and Single State Agencies (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 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.

To help states meet the challenges of 2016 and beyond, and to foster the implementation of an integrated physical health and 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. Therefore, this application package includes fully exercising SAMHSA's existing authority regarding states', territories' and the Red

Lake Band of the Chippewa Tribe's (subsequently referred to as "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 fully integrate behavioral health services into health care.

Consistent with previous applications, the FY 2016-2017 application has sections that are required and other sections where additional information is requested. The FY 2016-2017 application requires states to submit a face sheet, a table of contents, a behavioral health assessment and plan, reports of expenditures and persons served, an executive summary, and funding agreements and certifications. In addition, SAMHSA is requesting information on key areas that are critical to the states success in addressing health care integration. Therefore, as part of this block grant planning process, SAMHSA is asking states to identify their technical assistance needs to implement the strategies they identify in their plans for FY 2016 and 2017.

To facilitate an efficient application process for states in FY 2016-2017, SAMHSA convened an internal workgroup to develop the application for the block grant planning section. In addition, SAMHSA consulted with representatives from SMHAs and SSAs to receive input regarding proposed changes to the block grant. Based on these discussions with states, SAMHSA is proposing several changes to the block grant programs, discussed in greater detail below. Based on the critical issues outlined above, SAMHSA is requesting approval of this application and guidance for FY 2016-2017.

Application Overview

Consistent with previous applications, the FY 2016-2017 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 20164-2017 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. 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.
While the statutory deadlines and block grant award periods remain unchanged, SAMHSA encourages states to turn in their application as early as possible to allow for a full discussion and review by SAMHSA. Applications for the MHBG-only is due no later than September 1, 2015. The application for SABG-only is due no later than October 1, 2015. A single application for MHBG and SABG is due no later than September 1, 2015.

The Plan will cover a two-year period (7/1/15- 6/30/17) to align with most states' FY budget cycle.[1] States will have the option, but will not be required, to amend their Plans when they submit their FY 2017 application.

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

1 Reporting timeframes for Synar will remain on the current schedule. Annual Synar Reports (ASRs) are due on December 31. The data reported in the FFY 2017 ASR, which is due on December 31, 2016, will be from inspections completed in FFY 2016 (October 1, 2015, through September 30, 2016). http://www.samhsa.gov/synar

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:

1. The focus is about everyone, not just those with an illness or disease, but families, communities, and the whole population, with an emphasis on prevention and wellness activities.
2. To ensure access to a comprehensive system of care, including education, employment, housing, case management, rehabilitation, medical and dental services, as well as behavioral health services and supports, to include services to the rural and homeless populations, and provider training activities.
3. The activities are data driven: a public health agency uses surveillance data as well as an analysis of other public health drivers/levers to identify targets of opportunity.
4. There is an emphasis on access to services and availability.
5. There is an emphasis on policy impact and support: an analysis of the laws, rules, and infrastructure that inform and support the work.

These goals are significant drivers in the block grant application. SAMHSA's and other federal

agencies' focus on accountability, person-directed care, family-driven care for children and youth, underserved 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(s).

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 2016 when more persons will be covered by Medicaid or private insurance. 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

The proposed revisions reflect changes within the planning section of the application. The most significant of these changes relate to evidenced based practice for early intervention for the MHBG, participant directed care, medication assisted treatment for the SABG, crisis services, pregnant women and women with dependent children, community living and the implementation of Olmstead, and quality and data readiness collection.

The FY2014-2015 application sections on the Affordable Care Act, health insurance marketplace, enrollment and primary and behavioral health care integration have been consolidated into a Health Care System and Integration section moving the emphasis to implementation of health care systems rather than preparation of the Affordable Care Act. Additionally, the FY2014-2015 Quality, Data and Information Technology sections have been consolidated into one section in the FY2016-2017 application. 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:

- Health Care System and Integration – This section is a consolidation of the FY2014-2015 sections on the Affordable Care Act, health insurance marketplace, enrollment and primary and behavioral health care integration. It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. Health care professionals, consumers of mental, substance use disorders, co-occurring mental, and substance use disorders treatment recognize the need for improved coordination of care

and integration of primary and behavioral health care. Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care. Use of EHRs -- in full compliance with applicable legal requirements -- may allow providers to share information, coordinate care and improve billing practices.

Implementation by SMHAs, SSAs and their partners of the Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. In a recent report, the Congressional Budget Office estimates that by 2018, 25 million persons will have enrolled in the Affordable Care Act Marketplace and 12 million in Medicaid and the State Children's Health Insurance Program (SCHIP). The Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) estimates that 32 million Americans will acquire coverage for mental and substance use disorder treatment as a result of the Affordable Care Act, including both previously uninsured persons and those enrolled in plans that lacked adequate coverage. In 2014, non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

- Evidenced-based Practices for Early Intervention for the MHBG - In its FY 2014 appropriation, SAMHSA was directed to require that states set aside 5 percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age. SAMHSA worked collaboratively with the National Institutes of Health, National Institute on Mental Health (NIMH) to review evidence showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded *Recovery After an Initial Schizophrenia Episode (RAISE)* initiative, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness.

  States can implement models across a continuum, which have demonstrated efficacy, including the range of services and principles identified by NIMH. Utilizing these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

- Participant Directed Care - As states implement policies that support self-determination and improve person-centered service delivery, one option that states can consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain expanded

access to care and to enable individuals to play a more significant role in the development of their prevention, treatment and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with critical recovery support services, such as care coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, housing support, employment/education support, peer resources, family/parenting services or transportation.

States interested in utilizing a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, leading them though the innovations and inherent system change processes results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders.

- Medication Assisted Treatment (MAT) - There is a voluminous literature on the efficacy of Food and Drug Administration (FDA)-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. still offer only abstinence-based treatment for these conditions. The evidence base for medication assisted treatment of these disorders is described in several of SAMHSA's Treatment Improvement Protocol Series (TIPS) publications numbered 40, 43, 45, and 49. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to utilize MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

- Crisis Services - In the on-going development of efforts to build an evidence-based robust system of care for adults diagnosed with an SMI, children with a serious emotional disturbance (SED) and persons with addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to behavioral health crises. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to effectively respond to crisis as experienced by people with behavioral health conditions.

A crisis response system will have the capacity to recognize and respond to crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis response system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources

- Pregnant Women and Women with Dependent Children - Substance-abusing pregnant women have been a leading priority population throughout the history of the SABG (Section 1922(b) of Title XIX, Part B, Subpart II, of the PHS Act (42 USC § 300x-22(b)). The authorizing legislation required states to expend not less than 5 percent of the FY 1993 and FY 1994 SABG to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of these programs is to expand the availability of comprehensive, residential substance use disorder treatment, and recovery support services for pregnant and postpartum women and their minor children, including services for non-residential family members. This population continues to be of utmost concern, since by helping such women along their recovery journey, additional benefits may result: fetal alcohol spectrum disorder may be prevented; a normal birth-weight may be achieved; and intergenerational transmission of addiction may be interrupted. Women with dependent children are also identified as a priority for specialized treatment (as opposed to treatment as usual) in the implementing regulations governing the SABG. In 1995 and subsequent fiscal years states are required to expend no less than an amount equal to that spent by the state in prior fiscal years for treatment services designed for pregnant women and women with dependent children.

- Community Living and the Implementation of Olmstead – The community living and Olmstead section was included in the environmental factors/background section of the FY2014-2015 application and has been added to the planning section of the FY2016-2017 application. The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the tenth anniversary of the Supreme Court's *Olmstead* decision, then HHS Secretary Sebelius directed the creation of the Coordinating Council on Community Living at the HHS. SAMHSA has been a key member of the Coordinating Council on Community Living and has funded a number of

technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with mental/substance use disorders. The Department of Justice (DOJ) and HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and HHS OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. States should ensure Block Grant funds are allocated to support treatment and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

- Quality and Data Readiness Collection – The FY2014-2015 Quality, Data and Information Technology sections have been consolidated into one section in the FY2016-2017 application and is part of the planning section. SAMHSA is moving forward on the task of advancing a system for the collection of client level substance abuse and mental health treatment data. As such, SAMHSA is undertaking a series of efforts designed to develop a set of common core performance, quality, and cost measures to demonstrate the impact of SAMHSA's discretionary and block grant programs and guide SAMHSA's evaluation activities.

  The foundation of this effort is National Quality Behavioral Health Framework, which derives from the National Quality Strategy and seeks to improve the delivery of health care services, individual patient health outcomes, and the overall health of the population. The overarching goals are to ensure that services are evidence-based and effective; that they are person/family-centered; that care is coordinated across systems; that services promote healthy living; and that they are safe, accessible and affordable.

  For the FY 2016-2017 MHBG and SABG reports, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are harmonized across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state partners.

SAMHSA anticipates this movement is consistent with the current state authority's movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands some modifications to data collection systems may be necessary, but will work with the states to minimize the impact of these changes.

Other Changes

The overall format has been streamlined to integrate the environmental factors throughout the behavioral health assessment and plan narrative. This has reduced the length of the application by 10 pages.

While the statutory deadlines and block grant award periods remain unchanged, SAMHSA encourages states to turn in their application as early as possible to allow for a full discussion and review by SAMHSA. Applications for the MHBG-only is due no later than September 1, 2015. The application for SABG-only is due no later than October 1, 2015. A single application for MHBG and SABG is due no later than September 1, 2015.

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

SAMHSA received 146 comments from 52 individuals or organizations. The comments expressed general support of the streamlined planning narrative, focus on the implementation of the Affordable Care Act and addition of a common data platform, participant directed care, medication assisted treatment, crisis services, pregnant women and women with dependent children and the community living and the implementation of Olmstead. Many comments were also received on the impact of the common data platform implementation for states. SAMHSA has taken these comments under advisement and will work with states to lessen the impact of the transition.

Most organizations are in favor of using block grant funds to pay individuals co-pays and premiums. SAMHSA has also added that block grant funds can be used for deductibles. SAMHSA plans to work with stakeholder to develop further guidance on using block grant funds for co-pays, deductibles and premiums. Many comments were duplicative suggesting the addition of Clubhouses to list of evidence based practices for recovery. SAMHSA has added Clubhouses to the list of evidence based practices for recovery.

Clarifying language and questions were added to the Community Living and Implementation of Olmstead section to better align with DOJ's Olmstead guidance. Minor language changes have also been made within the Health Care System and Integration section. SAMHSA has clarified the language regarding the importance of assuring access to medication assisted treatment based upon each individual's needs.

Table 2 of the plan was modified to clarify the tables represent a two year period, align sub-

totals, and remove state hospital expenditures from the mental health block grant reporting line. SAMHSA has also updated reporting Tables 32 and 32 to include "unknown ethnicity" as a category.

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/block-grants. The FY 2016-2017 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 January 8, 2015 (Vol. 80, Page 1032). 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 Element	No. Respondents	Responses/ Respondents	Burden/ Response (Hours)	Total Burden	Hourly Wage Cost	Total Hour 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 = $179,766

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

While the statutory deadlines and block grant award periods remain unchanged, SAMHSA encourages states to turn in their application as early as possible to allow for a full discussion and review by SAMHSA. Applications for the MHBG-only is due no later than September 1, 2015. The application for SABG-only is due no later than October 1, 2015. A single application for MHBG and SABG is due no later than September 1, 2015.

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 expenditures[2] 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 ([3],[4]) 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 [(5)] 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

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

3 Section 1912 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.C. § 300x-2)
4 Section 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-32(b))
5 Section 1942(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a))

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.

List of Attachments

A. 2016-2017 Application Guidance & Instructions
    1. Planning Section
    2. Reporting Sections
    3. CEO Funding Agreements/Certifications

B. Public Comments and SAMHSA's Response to the Comments