Application for the Mental Health Block Grant and Substance Abuse Block Grant
FY 2018-2019 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 2016-2017 Application Guidance (0930-0168) will expire on 06/30/2018.

Title XIX, Part B, Subparts I, II and III of the Public Health Service (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 states or jurisdictions (here after referred to as states) are seeking funds, and the implementation report from the previous fiscal year as required under section 1942(a) is received by December 1 of the fiscal year of the grant.

Section 1932 (42 USC § 300x-32) requires states to submit their respective SABG applications no later than October 1 of the fiscal year for which they are seeking funds and the reports from the previous fiscal year as required under section 1942 is received concurrently. In recognition of the many states whose executive branch authority includes both mental health and substance abuse, SAMHSA provided states with the flexibility to prepare and submit the SABG report not later than December 1 of the fiscal year of the grant.

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, regulations, 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 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 primary 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 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 have gained health insurance coverage in 2016 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 these changes, SAMHSA has conveyed 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.

To help states meet the challenges of 2018 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. The Department must also spend more time assisting states in building and maintaining more effective behavioral health systems for prevention activities, treatment services and recovery supports that are integrated with the health care systems. Based on the critical issues outlined above, SAMHSA is requesting approval of this application and guidance for FY 2018-2019.

Application Overview

Consistent with previous applications, the FY 2018-2019 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 2018-2019 application which includes both the plan and report, 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.

States are required to use forms approved by the Office of Management and Budget and to submit the application in a specified time period. Although the statutory deadlines remain unchanged, SAMHSA is urging states to submit their application(s) as early as possible to allow for meaningful review. 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. Applications for the MHBG-only is due no later than September 1, 2017. The application for SABG-only is due no later than October 1, 2017. A single application for MHBG and SABG is due no later than September 1, 2017.

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, at minimum, to be based on the populations described in the authorizing legislation for the MHBG and SABG and 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 1942(a) of Title XIX, Part B, Subpart III 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 authorizing legislation applicable to the MHBG and SABG and the implementing regulation applicable to the SABG. All the information provided will be according to most states' fiscal year (July 1 through June 30). 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 authorizing legislation for the MHBG, 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 mental disorders as well as individuals with substance use 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 and 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 appropriate 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 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 early intervention services for HIV 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.

- To provide continuing education regarding substance abuse prevention and substance use disorder treatment services to any facility or program receiving amounts from the SABG for such activities or services.

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.

Proposed Revisions

The proposed revisions reflect changes within the planning section of the application. The most significant change involves a movement away from a request for multiple narrative descriptions of the state's activities in a variety of areas to a more quantitative response to specific questions, reflecting statutory or regulatory requirements where applicable, or reflecting specific uses of block grant funding. In addition, to respond to the requests from states, the required and requested sections have been clearly identified.

The FY2016-2017 application sections that gave states policy guidance on the planning and implementation of system issues which were not authorized services under either block grant have been eliminated to avoid confusion. In addition, the statutory criteria, which govern the plan, report, and application, have been included in the document as references.

Health Care System, Parity and Integration – This section is a consolidation of the FY2016-2017 sections on the health insurance marketplace, parity, enrollment and primary and behavioral health care integration. It is vital that SMHAs and SSAs programming and planning reflect the strong connection between behavioral and physical health. 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.

Evidenced-based Practices for Early Intervention for the MHBG - In its FY 2016 appropriation, SAMHSA was directed to require that states set aside 10 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.

21st Century Cures Act Requirements - The CURES Act required several language changes, to include: a change from Administrator of SAMHSA to Assistant Secretary for Mental Health and Substance Use; a change from "Substance Misuse Prevention" to "Substance Use Disorder Prevention" and others. In addition, the Act eliminated section 1929 governing the annual treatment needs assessment and changed the specific requirements for the state determination of need to include estimates on the number of individuals who need treatment, who are pregnant women, women with dependent children, individuals with a co-occurring mental health and substance use disorder, persons who inject drugs, and persons who are experiencing homelessness.

3. Use of Information Technology

The FY 2018-19 Block Grant application instructions and guidance will be available to all states through the SAMHSA website at www.samhsa.gov/grants/blockgrant. The FY 2018-2019 guidance instructs 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.

4. Efforts to Identify Duplication

The behavioral health assessment and plan section of the application is proposed as primariy objective and quantitative responses to a series of specific questions. These questions allow states to 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 in ways that are easily analyzable. The MHBG and SABG report sections, which include mental health reporting on the Uniform Reporting System (URS) Tables, and substance misuse prevention and substance use disorder treatment reporting through SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) National Houshold Survey on Drug Use and Health (NSDUH) and the Behavioral Health Services Information System Treatment Episode Data Set (TEDS), respectively. URS, NSDUH and TEDS are the only routine or uniform data collection initiatives of the type requested to provide a national picture of the states' public mental and substance use disorder systems.

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 authorizing legislation requires that states apply annually for MHBG funds and report annually on their accomplishments and the purposes for which such funds were expended. 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 such funds were expended. Less frequent reporting would be in violation of the authorizing legislation and implementing regulation 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. .

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 November 22,

2016 (81 FR 83859). SAMHSA received 38 separate comments from 5 entities.

9. Payment to Respondents

No payments will be provided to respondents to participate.

10. Assurance of Confidentiality

States submit client-level data through the Center for Behavioral Health Statistics and Quality (CBHSQ) Behavioral Health Services Information System (BHSIS)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 BHSIS/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 BHSIS/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 Block Grant application is 33,374 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:

Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grants							
	Authorizing Legislation SABG	**Authorizing Legislation MHBG**	**Implementing Regulation**	**Number of Respondent**	**Number of Responses Per Year**	**Number of Hours Per Response**	**Total Hours**
Reporting:	**Standard Form and Content**						
	42 U.S.C. § 300x-32(a)						

SABG	**Annual Report**						**11,160**
	42 U.S.C. 300x-52(a)		**45 CFR 96.122(f)**	**60**	**1**		
	42 U.S.C. 300x-30-b			**5**	**1**		
	42 U.S.C. 300x-30(d)(2)		**45 CFR 96.134(d)**	**60**	**1**		
MHBG	**Annual Report**						**10,974**
		42 USC § 300x-6(a)		**59**	**1**		
		42 U.S.C. 300x-52(a)					
		42 U.S.C. 300x-4(b)(3)B		**59**	**1**		
	State Plan (Covers 2 years)						
SABG elements	**42 U.S.C. 300x-22(b)**		**45 CFR 96.124(c)()1)**	**60**	**1**		
	42 U.S.C. 300x-23		**45 CFR 96.126(f)**	**60**	**1**		
	42 U.S.C. 300x-24		**45 CFR 96.127(b)**	**60**	**1**		
	42 U.S.C. 300x-27		**45 CFR 96.131(f)**	**60**	**1**		
	42 U.S.C. 300x-29		**45 CFR 96.133(a)**	**60**	**1**		
	42 U.S.C. 300x-32(b)		**45 CFR 96.122(g)**	**60**	**1**	**120**	**7,200**
MHBG elements		**42 U.S.C. 300x-1(b)**		**59**	**1**	**120**	**7,080**
		42 U.S.C. 300x-1(b)(11)		**59**	**1**		
		42 U.S.C. 300x-2(a)		**59**	**1**		
	Waivers						**3,240**
	42 U.S.C. 300x-24(b)(5)(B)			**20**	**1**		
	42 U.S.C. 300x-28(d)		**45 CFR 96.132(d)**	**5**	**1**		
	42 U.S.C. 300x-30(c)		**45 CFR 96.134(b)**	**10**	**1**		
	42 U.S.C.			**1**	**1**		

	300x-31(c)						
	42 U.S.C. 300x-32(c)			7	1		
	42 U.S.C. 300x-32(e)			10			
		300x-2(a)(2)		10			
		300x-4(b)(3)		10			
		300x-6(b)		7			
Recordkeeping	42 U.S.C. 300x-23	42 U.S.C. 300x-3	45 CFR 96.126(c)	60/59	1	20	1200
	42 U.S.C. 300x-25		45 CFR 96.129(a)(13)	10	1	20	200
	42 U.S.C 300x-65		42 CFR Part 54	60	1	20	1200
Combined Burden							42,254

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

	Number of Respondent	Number of Responses Per Year	Number of Hours Per Response	Total Hours
Reporting:				
SABG	60	1	186	11.160
MHBG	59	1	186	10,974
Recordkeeping	60/59	1	40	2360
Combined Burden				24,494

The total annualized burden for the application and reporting is

33,374 hours (42,254 + 24,494 = 66,748/2 years = 33,374).

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

Currently there are 37,429 total burden hours in the OMB inventory. SAMHA is requesting 33,374 hours. The program change of a decrease of 4,055 burden hours is due solely to the move from narrative descriptions to quantitative responses.

16. Time Schedule, Publication, and Analysis Plans

The FFY 2018-2019 MHBG and SABG applications for those states who are submitting a combined behavioral health assessment and plan, or a stand-alone MHBG application is due on or before September 1, 2017, and for those states submitting a stand-alone SABG application is due on October 1, 2017 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, if applicable, and guidance, for the federal fiscal year for which a state is seeking funds. The funds awarded will be available for obligation and expenditures 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 ([1],[2]) 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,

1 Section 1912 of Title XIX, Part B, Subpart I of the Public Health Service Act (42 U.S.C. § 300x-2)
2 Section 1932(b) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-32(b))

Subpart I of the PHS Act or section 1921 of Title XIX, Part B, Subpart II of the PHS Act that is applicable to a state. The state plan should include a description of the manner in which the state intends to obligate the MHBG and/or SABG. The state plan must include a report [3] 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.

3 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. 2018-2019 Application Guidance & Instructions
    1. Planning Section
    2. Reporting Sections
    3. CEO Funding Agreements/Certifications

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