

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act. To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

Project: Community Mental Health Services Block Grant and Substance Abuse and Prevention Treatment Block Grant FY 2018–2019 Plan and Report Guidance and Instructions (OMB No. 0930-0168)—Revision

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting approval from the Office of Management and Budget (OMB) for a revision of the 2016–17 Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) Plan and Report Guidance and Instructions.

Currently, the SABG and the MHBG differ on a number of their 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.

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 has gained health insurance coverage through Medicaid, Medicare, or private insurance. However, coverage provided by these plans and programs do not necessarily provide access to the full range of support services needed 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 indicated 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 and management 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 as they fully integrate behavioral health services into the broader health care continuum.

Consistent with previous applications, the FY 2018–2019 application has sections that are required and other sections where additional information is requested. The FY 2018–2019 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 both their promising or effective strategies as well as their technical assistance needs to implement the strategies they identify in their plans for FYs 2018 and 2019.

To facilitate an efficient application process for states in FYs 2018–2019, SAMHSA convened an internal workgroup to review and modify the application for the block grant planning section. In addition, SAMHSA utilized the questions and requests for clarification from representatives from SMHAs and SSAs to inform the proposed changes to the block grants. Based on these discussions with states, SAMHSA is proposing several changes to the block grant programs as discussed in greater detail below.

Changes to Assessment and Planning Activities

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 FY 2016–2017 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.

Other specific proposed revisions are described below:

- *Health Care System, Parity and Integration*—This section is a consolidation of the FY 2016–2017 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 Serious Mental Illness 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 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.

- *Statutory changes required by the 21st Century CURES Act*—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.

Other Changes

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, 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.

Estimates of Annualized Hour Burden

The estimated annualized burden for the uniform 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 recordkeeping 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). Annual Report						11,160
SABG	42 U.S.C. 300x-52(a) ... 42 U.S.C. 300x-30-b ... 42 U.S.C. 300x-30(d)(2) Annual Report		45 CFR 96.122(f) 45 CFR 96.134(d)	60 5 60	1 1 1		
MHBG		42 U.S.C. 300x-6(a) 42 U.S.C. 300x-52(a). 42 U.S.C. 300x-4(b)(3)B.		59 59	1 1		10,974
SABG elements	State Plan (Covers 2 years). 42 U.S.C. 300x-22(b) ... 42 U.S.C. 300x-23 42 U.S.C. 300x-24 42 U.S.C. 300x-27 42 U.S.C. 300x-29 42 U.S.C. 300x-32(b) ...		45 CFR 96.124(c)(1) ... 45 CFR 96.126(f) 45 CFR 96.127(b) 45 CFR 96.131(f) 45 CFR 96.133(a) 45 CFR 96.122(g)	60 60 60 60 60 60	1 1 1 1 1 1		
MHBG elements		42 U.S.C. 300x-1(b) 42 U.S.C. 300x-1(b)(11) 42 U.S.C. 300x-2(a)		59 59 59	1 1 1	120 120	7,200 7,080
	Waivers			20	1		3,240
	42 U.S.C. 300x-24(b)(5)B). 42 U.S.C. 300x-28(d) ... 42 U.S.C. 300x-30(c) ... 42 U.S.C. 300x-31(c) ... 42 U.S.C. 300x-32(c) ... 42 U.S.C. 300x-32(e) ...		45 CFR 96.132(d) 45 CFR 96.134(b)	5 10 1 7 10	1 1 1 1 1		
		300x-2(a)(2) 300x-4(b)(3) 300x-6(b)		10 10 7			
Recordkeeping	42 U.S.C. 300x-23	42 U.S.C. 300x-3	45 CFR 96.126(c)	60/59	1	20	1,200

TABLE 1—ESTIMATES OF APPLICATION AND REPORTING BURDEN FOR YEAR 1—Continued

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
Combined Burden	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	1,200
	.....	.....	.....	.....	.....	.....	42,254

Report	300x-29—Statewide Assessment of Need	300x-31(c)—Construction
300x-52(a)—Report	300x-32(b)—State Plan	300x-32(c)—Certain Territories
300x-30(b)—Exclusion of Certain Funds (SABG)	State Plan—MHBG	300x-32(e)—Waiver amendment for 1922, 1923, 1924 and 1927
300x-30(d)(2)—Maintenance of Effort (SABG)	42 U.S.C. 300x-1(b)—Criteria for Plan	Waivers—MHBG
300x-4(b)(3)B—Maintenance of Effort (MHBG)	42 U.S.C. 300x-1(b)(11)—Incidence and prevalence in the state adults with SMI and Children with SED	300x-2(a)(2)—Allocations for Systems Integrated Services for Children
State Plan—SABG	42 U.S.C. 300x-2(a)—Allocations for Systems Integrated Services for Children	300x-4(b)(3)—Waiver of Statewide Maintenance of Effort
300x-22(b)—Allocations for Women	Waivers—SABG	300x-6(b)—Waiver for Certain Territories
300x-23—Intravenous Substance Abuse	300x-24(b)(5)(B)—Rural requirement regarding EIS/HIV	Recordkeeping
300x-24—Requirements Regarding TB and HIV	300x-28(d)—Additional Agreements	300x-23—Waiting list
300x-27—Priority in Admissions to Treatment	300x-30(c)—Maintenance of Effort	300x-25—Revolving loan fund
		300x-65—Charitable Choice

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	2,360
Combined Burden	60	.....	.....	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).

Link for the application: <http://www.samhsa.gov/grants/block-grants>.

Written comments and recommendations concerning the proposed information collection should be sent by April 14, 2017 to the SAMHSA Desk Officer at the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB). To ensure timely receipt of comments, and to avoid potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, commenters are encouraged to submit their comments to OMB via email to: OIRA_Submission@omb.eop.gov. Although commenters are encouraged to send their comments via email, commenters may also fax their comments to: 202-395-7285. Commenters may also mail them to: Office of Management and Budget, Office of Information and Regulatory

Affairs, New Executive Office Building, Room 10102, Washington, DC 20503.

Summer King, Statistician.

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG-2016-1059]

Towing Safety Advisory Committee; April 2017 Meeting

AGENCY: Coast Guard, Department of Homeland Security.

ACTION: Notice of Federal Advisory Committee meeting.

SUMMARY: The Towing Safety Advisory Committee will meet in Memphis, Tennessee, to review and discuss recommendations from its Subcommittees and to receive briefs on items listed in the agenda under

SUPPLEMENTARY INFORMATION. All meetings will be open to the public.

DATES: The Subcommittees will meet on Tuesday, April 11, 2017, from 8 a.m. to 5:30 p.m. The full Towing Safety Advisory Committee will meet on Wednesday, April 12, 2017, from 8 a.m. to 5:30 p.m. These meetings may close early if the Subcommittees or Committee have completed its business.

ADDRESSES: All meetings will be held at the Doubletree Hotel by Hilton, 5069 Sanderlin Avenue, Memphis, Tennessee 38117. The telephone number for the Doubletree Hotel is 800-222-8733. The hotel Web site is: <http://doubletree3.hilton.com/en/hotels/tennessee/doubletree-by-hilton-hotel-memphis-MEMEHD/index.html>

For information on facilities or services for individuals with disabilities, or to request special assistance at the meetings, contact the individual listed in **FOR FURTHER INFORMATION CONTACT** below as soon as possible.

Instructions: You are free to submit comments at any time, including orally