Application for the SAMHSA Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant

FY 2016-2017 Application Guidance and Instructions

Summary of Key Points for National Council Associations

Overview
On January 8, 2015, SAMHSA released its FY 2016-2017 combined Block Grant application for comment. All documents can be accessed here. Comments are due to SAMHSA by March 9, 2015 and can be submitted via email to blockgrants@samhsa.hhs.gov.

This document does not attempt to provide an overview of the entire Block Grant application guidance; rather, it summarizes substantial revisions from the FY 2014-2015 application. Throughout this document, the National Council summarizes provisions of the application by using wording directly from SAMHSA documents.

Specifics
The FY 2016-2017 Block Grant application continues to allow states to submit an application for both mental health and substance use services as well as a biennial plan. Further, the guidance reflects the Affordable Care Act’s emphasis on coordinated and integrated care along with the need to improve services for persons facing behavioral health crises.

Other Highlights
Block grant funds should be directed toward four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery; (3) for SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

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. Application for the MHBG-only is due no later than September 1, 2015. The application for the 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 addition to the targeted/required populations and/or services required in statute, states are encouraged to consider the following populations, and/or services:

- Individuals with mental and/or substance use disorders who are homeless or involved with the criminal justice systems
- Individuals with mental and/or substance use disorders who live in rural areas
- Underserved racial and ethnic minority and LGBT populations
- Persons with disabilities
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and “late” adopters of prevention strategies.

**Program Integrity**

While some states have indicated an interest in using block grant funds for individual co-pays and premium payments, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit entity. If a state chooses to allow the use of block grant funds for these purposes, specific policies and procedures for assuring compliance with the funding requirements must be in place. Under 42 USC 300x-55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management.

SAMHSA indicates that the overall format has been changed to integrate the environmental factors throughout the assessment and plan narrative sections. This has reduced the length of the application by 10 pages and has reduced the redundancy in narrative. In reviewing the draft, the new sections relate to evidenced based practice for early intervention for the MHBG [a requirement added by the Appropriation Committee through report language], participant directed care, medication assisted treatment for the SABG, crisis services, pregnant women and women with dependent children, community living/Olmstead, and quality and data readiness collection.

There is also a Health Care System and Integration section that emphasizes the implementation of health care systems rather than preparation for the Affordable Care Act. Additionally, the FY14/15 Quality, Data and Information Technology sections have been consolidated into one section in the FY16/17 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 and physical health. Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.

- **Evidenced-based Practices for Early Intervention for the MHBG** - In its FY 2014 and FY 2015 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 serious mental illness (SMI) including but not limited to psychosis at any age. States can
implement models across a continuum which have demonstrated efficacy, including the range of services and principles identified by NIMH.

- **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. 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.

- **Medication Assisted Treatment** - There is extensive 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.

- **Crisis Services** - In the on-going development of efforts to build a robust evidence-based system of care for adults diagnosed with a severe mental illness (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 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. 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 Olmstead** – The community living and Olmsted 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 arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings.

States should ensure Block Grant funds are allocated to support treatment and recovery services in community settings whenever feasible.

- **Quality and Data Collection Readiness** – The FY2014-2015 Quality, Data and Information Technology sections have been consolidated into one section in the FY2016-2017 application. SAMHSA’s 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.

The initial draft set of measures developed for the block grant programs can be found at [http://www.samhsa.gov/data/quality-metrics/block-grant-measures](http://www.samhsa.gov/data/quality-metrics/block-grant-measures). These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

**Questions? Please email Chuck Ingoglia, Senior VP for Policy and Practice Improvement, ChuckI@thenationalcouncil.org.**