Comments Due Date: Comments regarding this information collection are best assured of having their full effect if received within 60-days of the date of this publication.

Dated: June 28, 2012.

Laura Lee,

Project Clearance Liaison, Warren Grant Magnuson Clinical Center, National Institutes of Health.

[FR Doc. 2012–17120 Filed 7–12–12; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Project: Uniform Application for the Mental Health Block Grant and Substance Abuse Block Grant FY 2014–2015 Application 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 2014 and 2015 Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) Guidance and Instructions into a uniform block grant application.

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 had 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.

In addition, between 2013 and 2015, 32 million individuals who are uninsured will have the opportunity to enroll in Medicaid or private health insurance. This expansion of health insurance coverage will have a significant impact on how State Mental Health Authorities (SMHAs) and State Substance Abuse Authorities (SSAs) use their limited resources. Many individuals served by these authorities are funded through Federal Block Grant funds. SAMHSA proposes that Block Grant funds be directed toward four purposes: (1) To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage; (2) to fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and/or supporting recovery; (3) to fund universal, selective and targeted prevention activities and services; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment and recovery support services and to plan the implementation of new services on a nationwide basis.

States should begin planning now for FY 2014 when more individuals are insured. To ensure sufficient and comprehensive preparation, SAMHSA will use FY 2013 to continue to work with states to plan for and transition the Block Grants to these four purposes. This transition includes fully exercising SAMHSA's existing authority regarding States' and Jurisdictions' (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 move through these changes.

The proposed MHBG and SABG build on ongoing efforts to reform health care, ensure parity and provide States and Territories with new tools, new flexibility, and state/territory-specific plans for available resources to provide their residents the health care benefits they need. The planning section of the Block Grant application provides a process for states and Territories to identify priorities for individuals who need behavioral health services in their jurisdictions, develop strategies to address these needs, and decide how to expend Block Grant Funds. In addition, the Planning Section of the Block Grant requests additional information from states that could be used to assist them in their reform efforts. The plan submitted by each state and Territory will provide information for SAMHSA and other federal partners to use in working with states and Territories to improve their behavioral health systems over the next two years as health care and economic conditions evolve.

The 2014–2015 Block Grant application provides states and Territories the flexibility to submit one rather than two separate Block Grant applications if they choose. It also allows states and Territories to develop and submit a bi-annual rather than an annual plan, recognizing that the demographics and epidemiology do not often change on an annual basis. These options may decrease the number of applications submitted from four in two years to one.

Over the next several months, SAMHSA will assist states and Territories (individually and in smaller groups) as they develop their Block Grant applications. While there are some specific statutory requirements that SAMHSA will look for in each submitted application, SAMHSA intends to approach this process with the goal of assisting states and Territories in setting a clear direction for system improvements over time, rather than as a simple effort to seek compliance with minimal requirements.

Consistent with previous applications, the FY 2014–2015 application has sections that are required and other sections where additional information is requested, but not required. The FY 2014–2015 application requires states to submit a face sheet, a table of contents, a behavioral health assessment and plan, reports of expenditures and persons served, executive summary, and funding agreements, assurances, and certifications. In addition, SAMHSA is

requesting information on key areas that are critical to their success to address health reform and parity. States will continue to receive their annual grant funding if they only chose to submit the required section of their state plans or choose to submit separate plans for the MHBG or SABG. Therefore, as part of this Block Grant planning process, SAMHSA is asking states and Territories to identify their technical assistance needs to implement the strategies they identify in their plans for FY 2014 and 2015.

To facilitate an efficient application process for states in FY 2014–2015, SAMHSA convened an internal workgroup to develop the application for the Block Grant planning section. In addition, SAMHSA consulted with representatives from the State Mental Health and State Substance Abuse Authorities to receive input regarding proposed changes to the Block Grant. Comments were requested from federal partners including HHS, OMB, ONDCP, and ASFR. Other stakeholder groups consulted with included NASADAD and NASMHPD. Based on these discussions with states, federal partners, and stakeholder groups, SAMHSA is proposing the following revisions to the Block Grant application.

Changes to Assessment and Planning Activities

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

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

Areas of Focus/Environmental Factors

• *Coverage for M/SUD Services*—Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured, and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state level that state dollars are being used for people and/or services not otherwise covered. States (or the federal exchange) are currently making plans to implement the benchmark plan chosen for Qualified Health Plans (QHPs) and their expended Medicaid program. States should begin to develop strategies that will monitor the implementation of the Act in their states. States should begin to identify whether people have better access to mental health and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental and substance abuse services and whether services are offered consistent with provisions of MHPAEA.

• *Affordable Insurance Exchanges*—Affordable Insurance Exchanges (Exchanges) will be responsible for performing a variety of critical functions to ensure access to much needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system. They should also understand how insurers (commercial, Medicaid and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

• *Program Integrity*—The Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside the Exchanges, Medicaid benchmark and benchmark equivalent plans, and basic health programs must cover these EHBs. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a ''typical employer plan'' in a state as required by the Act.

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

SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

• *Use of Evidence in Purchasing Decisions*—SAMHSA is interested in whether or how states are using evidence in their purchasing decisions, educating policymakers or supporting providers to offer high quality services. In addition, SAMHSA is interested in additional information that is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services.

• *Quality*—Up to 25 data elements, including those in the table below will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. Using this information, states will select specific priority areas. States will receive feedback on an annual basis in terms of national, regional and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in

providing technical assistance to improve behavioral health and related outcomes.

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

• *Trauma*—In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies such as exposure therapy or trauma-focused cognitive behavioral approaches should be adopted to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma informed care approach consistent with SAMHSA's trauma informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

• *Justice*—The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication and pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. However, there are a number of different types of problem-solving courts. In addition to drug courts and mental health courts, some jurisdictions, for example, operate courts for DWI/DUI, veterans, family, reentry, as well as courts such as gambling, domestic violence, truancy, etc. Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes can be emphasized. States should place emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. Secondarily, states should examine specific barriers such as lack of identification needed for enrollment, loss of eligibility resulting from incarceration, and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives for detention.

• *Parity Education*—SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

• *Primary and Behavioral Health Care Integration Activities*—Numerous provisions in the Afordable Health Care Act and elsewhere improve the coordination of care for patients through the creation of health homes, where teams of health professionals will be rewarded to coordinate care for patients with chronic conditions. States that had approved Medicaid State Plan Amendments (SPAs) received 90 percent Federal Medicaid Assistance Percentage (FMAP) for health home services for eight quarters. At this critical point in time, some states are ending their two years of enhanced FMAP and rolling back to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

• *Health Disparities*—In the Block Grant application, states are asked to define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services; Native American youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the Native American community; and African American women may be at greater risk for contracting HIV/AIDS due lack of access to education on risky sexual behaviors in urban low-income communities, etc. While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served and not being served within their communities, including in what languages services are provided, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services and outcomes are critical measures of quality and outcomes of care for diverse groups. In order to address the potentially disparate impact for their Block Grant funded efforts, states will be asked to address access, use and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection and sexual orientation (i.e., lesbian, gay, bisexual).

• *Recovery*—SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for

people in recovery from substance use and/or mental health disorders.

• *Children and Adolescents Behavioral Health Services*—Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the System of Care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities. Every state has received at least one CMHI grant. In 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to build a state infrastructure for substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidenced-based treatment for youth with substance use disorders.

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

Although the statutory dates for submitting the Block Grant application, plan and annual report remain unchanged, SAMHSA requests that the MHBG and SABG applications be submitted on the same date. In addition, the dates for submitting the plans have changed to better comport with most states fiscal and planning years (July 1st through June 30th of the following year).

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

Estimates of Annualized Hour Burden

The estimated annualized burden for a 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	Number of respondents	Responses/ respondents	Burden/ response (hours)	Total burden
Application Burden:				
Yr One Plan (separate submissions)	30 (CMHS) 30 (SAPT)	1	282	16,920
Yr One Plan (combined submission	30	1	282	8,460
Application Sub-total	*60*			*25,380*
Reporting Burden:				
MHBG Report	59	1	186	10,974
URS Tables	59	1	35	2,065
SAPTBG Report	60[1]	1	186	11,160
Table 5	15[2]	1	4	60
Reporting Subtotal	*60*			*24,259*
Total	119			49,639

[1] Redlake Band of the Chippewa Indians from MN receives a grant.
[2] Only 15 States have a management information system to complete Table 5.

TABLE 2—ESTIMATES OF APPLICATION AND REPORTING BURDEN FOR YEAR 2

Application element	Number of respondents	Responses/ respondents	Burden/ response (hours)	Total burden
Application Burden:				
Yr Two Plan	24	1	40	960
Application Sub-total	*24*			*960*
Reporting Burden:				
MHBG Report	59	1	186	10,974
URS Tables	59	1	35	2,065
SAPTBG Report	60	1	186	11,160

TABLE 2—ESTIMATES OF APPLICATION AND REPORTING BURDEN FOR YEAR 2—Continued

Application element	Number of respondents	Responses/ respondents	Burden/ response (hours)	Total burden
Table 5	15	1	4	60
Reporting Subtotal	*60*			*24,259*
Total	*119*			25,219

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

Link for the application: *www.samhsa.gov/grants/blockgrant.*

Send written comments to Summer King, SAMHSA Reports Clearance Officer, Room 2–1057, One Choke Cherry Road, Rockville, MD 20857 *OR* email a copy to *blockgrants@samhsa.hhs.gov.* All written comments should be received within 60 days of the published date of this notice.

Cathy Friedman,

Public Health Analyst.

[FR Doc. 2012–17084 Filed 7–12–12; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5600–FA–08]

Announcement of Funding Awards; Fair Housing Initiatives Program Fiscal Year 2012

AGENCY: Office of the Assistant Secretary for Fair Housing and Equal Opportunity, HUD.

ACTION: Announcement of funding awards.

SUMMARY: In accordance with section 102(a)(4)(C) of the Department of Housing and Urban Development Reform Act of 1989, this announcement notifies the public of funding decisions made by the Department for funding under the Notice of Funding Availability (NOFA) for the Fair Housing Initiatives Program (FHIP) for Fiscal Year (FY) 2012. This announcement lists the names and addresses of those award recipients selected for funding based on the rating and ranking of all applications and the amount of the awards.

FOR FURTHER INFORMATION CONTACT: Myron Newry, Director, FHIP Division, Office of Programs, Office of Fair Housing and Equal Opportunity, Department of Housing and Urban Development, 451 Seventh Street SW., Room 5230, Washington, DC 20410. Telephone number 202–402–7095 (this is not a toll-free number). Persons with hearing or speech impairments may access this number through TTY by calling the toll-free Federal Relay Service at 800–877–8339.

SUPPLEMENTARY INFORMATION: Title VIII of the Civil Rights Act of 1968, as amended, 42 U.S.C. 3601–19 (the Fair Housing Act) provides the Secretary of Housing and Urban Development with responsibility to accept and investigate complaints alleging discrimination based on race, color, religion, sex, handicap, familial status or national origin in the sale, rental, or financing of most housing. In addition, the Fair Housing Act directs the Secretary to coordinate with State and local agencies administering fair housing laws and to cooperate with and render technical assistance to public or private entities carrying out programs to prevent and eliminate discriminatory housing practices.

Section 561 of the Housing and Community Development Act of 1987, 42 U.S.C. 3616, established FHIP to strengthen the Department's enforcement of the Fair Housing Act and to further fair housing. This program assists projects and activities designed to enhance compliance with the Fair Housing Act and substantially equivalent State and local fair housing laws. Implementing regulations are found at 24 CFR part 125.

The Department published its Fair Housing Initiatives Program (FHIP) NOFA on February 16, 2012 announcing the availability of approximately $42,500,000 out of the Department's FY 2012 appropriation, to be utilized for FHIP projects and activities. Funding availability for discretionary grants included: the Private Enforcement Initiative (PEI) ($30,050,000), the Education and Outreach Initiative (EOI) ($5,880,000), and the Fair Housing Organizations Initiative (FHOI) ($5,250,000). This Notice announces grant awards of approximately $41,180,000.

For the FY 2012 NOFA, the Department reviewed, evaluated and scored the applications received based on the criteria in the FY 2012 NOFA. As a result, HUD has funded the applications announced in Appendix A, and in accordance with section 102(a)(4)(C) of the Department of Housing and Urban Development Reform Act of 1989 (103 Stat. 1987, 42 U.S.C. 3545), the Department is hereby publishing details concerning the recipients of funding awards in Appendix A of this document.

The Catalog of Federal Domestic Assistance Number for currently funded Initiatives under the Fair Housing Initiatives Program is 14.408.

Dated: July 6, 2012.

Bryan Greene,

General Deputy Assistant Secretary for Fair Housing and Equal Opportunity.

Appendix A—FY 2012 Fair Housing Initiatives Program Awards

Applicant name	Contact	Region	Award amt.
Education and Outreach/Affirmatively Furthering Fair Housing Component			
Connecticut Fair Housing Center, Inc., 221 Main Street, Hartford, CT 06106	Erin Kemple, 860–247–4400	1	$125,000.00
Westchester Residential Opportunities, Inc., 470 Mamaroneck Avenue, Suite 410, White Plains, NY 10605.	Geoffrey Anderson, 914–428–4507.	2	125,000.00
Housing Opportunities Project for Excellence, Inc., 11501 NW 2nd Avenue, Miami, FL 33168.	Keenya Robertson, 305–759–7755.	4	125,000.00