Form name	Number of respondents	Responses/respondent	Hours/response	Total hour burden
Survey	1,080	1	.333	508
Total	1,080			778

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to: Allison Herron Eydt, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: December 11, 2002.

Richard Kopanda,

Executive Officer, SAMHSA.

[FR Doc. 02–32332 Filed 12–23–02; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Community Mental Health Services Performance Partnership

AGENCY: Substance Abuse and Mental Health Services Administration (SAMHSA), HHS.

ACTION: Notice: Request for comments.

SUMMARY: Section 1949 of the Public Health Service Act as amended by Pub. L. 106–310 requires the Secretary of Health and Human Services to submit a plan to Congress detailing how the Secretary intends to change the current Community Mental Health Services (CMHS) Block Grant into a performance partnership. The plan, by statute, must include the following:

—A description of the flexibility that would be given to the States under the plan;
—The common set of performance measures that would be used for accountability;
—The definitions for the data elements to be used under the plan;
—The obstacles to implementation of the plan and the manner in which such obstacles would be resolved;
—The resources needed to implement the performance partnerships under the plan; and
—An implementation strategy complete with recommendations for any necessary legislation.

Section 1949 requires that the Secretary develop the plan in conjunction with the States and other interested parties. SAMHSA has been in discussion with the States for several years over this proposal. This FRN provides State and other interested parties an opportunity to comment on those discussions.

DATES: Comments on the information must be in writing and should be sent to: Joseph D. Faha, Director of Legislation/SAMHSA, 5600 Fishers Lane, Room 12–95, Rockville, Maryland 20857, by February 24, 2003.

FOR FURTHER INFORMATION CONTACT: Joseph D. Faha, Director of Legislation/SAMHSA, 5600 Fishers Lane, Room 12–95, Rockville, Maryland 20857. Mr. Faha may be reached on (301) 443–4640.

SUPPLEMENTARY INFORMATION: SAMHSA seeks comments on its proposal to develop a plan for the changing of the CMHS Block Grant from its current emphasis on requirements, earmarks, and accountability based on expenditures to a system referred to as a ''Performance Partnership'' that offers States more flexibility in the expenditure of funds while basing accountability on how well the system is providing access to quality mental health services for adults with serious mental illness and children with serious emotional disturbance as measured by the appropriateness and the outcomes of services.

The current CMHS Block Grant program had its origins in the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant first legislated in 1981. The ADMS Block Grant gave Federal funds to States based on a formula in statute for the purposes of providing substance abuse and community-based mental health services with minimal programmatic and reporting requirements. Over time, however, a number of requirements, earmarks and set asides were added to the statute. In mental health, though the requirements have traditionally been far less than those imposed for the use of substance abuse funding, the statute, at one time, required that States spend at least 50 percent of their allotment for mental health services on new programs, 10 percent of their mental health funds on children with a serious emotional disturbance, and services had to be provided through community mental health centers.

In 1992, the ADMS Block Grant was replaced by two separate block grant programs, one for substance abuse and one for mental health services. At that time, some requirements were dropped, some changed and others were added. Very few changes were made in the reauthorization of the programs in 2000.

A Performance Partnership for the CMHS program represents a new paradigm in Federal and State relations and cooperation. It is built on three principles:

—That the Federal Government and the State governments are partners in the provision of mental health services and that our shared goal is ''continuous quality improvement.''
—That States understand the needs of their population and should be given more flexibility in the use of the funds.
—That accountability should be built on performance not entirely on expenditures.

The first principle is reached in this proposal when both the Federal and State governments identify the strengths and weaknesses of various systems of service and work in tandem to improve those systems. The new partnerships will be built on incentives to improve services rather than penalties for non-compliance.

The second principle is achieved in this proposal by reducing the number of requirements, simplifying the planning process, giving greater freedom in the use of the funds to States and reducing administrative costs and burden. States have tremendous flexibility in the use of the funds now which this proposal retains.

The shift to mutually agreed upon performance measures provides a focus on the efficiency and effectiveness of services and, therefore, helps both the Federal and State governments to identify how to improve the system of services. For example, the measures will permit both the Federal and State governments to identify steps that need to be taken to further improve the system of care to increase favorable outcomes.

Current Program

In fiscal year (FY) 2002, $433 million was appropriated to assist States in providing community based mental health services for adults with serious mental illness and children with serious emotional disturbance. States are

eligible for their allotment under a statutorily prescribed formula if they submit an application that is approved by the Secretary. The application must include (1) assurances from the State that it will comply with the requirements of the statute; (2) a State mental health plan developed within the framework of five criteria that describe the community based system of care for adults with serious mental illness and children with serious emotional disturbance complete with goals and measures; and (3) an implementation report detailing the extent to which the State mental health plan for the previous year was implemented. The Secretary is required to review the application and determine whether the State ''completely implemented'' its plan. If a State failed to ''completely implement'' its plan for the year, the State may be subject to a 10 percent penalty against its allotment.

The five criteria from section 1912(b) of the Public Health Service Act that provide the frame work of the State mental health plans are:

''(1) *Comprehensive Community-Based Mental Health Systems*—The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act. The plan shall include a separate description of case management services and provide for activities leading to reduction of hospitalization.

''(2) *Mental Health System Data and Epidemiology*—The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

''(3) *Children's Services*—In the case of children with serious emotional disturbance, the plan—

(A) Subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act);

(B) Provides that the grant under section 1911 for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and

(C) Provides for the establishment of a defined geographic area for the provision of the services of such system.

''(4) *Targeted Services to Rural and Homeless Populations*—The plan describes the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

''(5) *Management Systems*—The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved.''

States are permitted to use the block grant funds for the following purposes:

—Carrying out the State mental health plan;
—Evaluating programs and services carried out under the plan; and
—Planning, administration, and educational activities related to providing services under the plan.

The block grant funds may not be used:

—To provide inpatient care;
—To make cash payments to patients;
—To purchase or improve land or to construct or provide major renovations to a facility and to purchase major medical equipment;
—To use the funds to satisfy any requirement for a State match against another Federal program; and
—To make grants to for-profit organizations.

Some of the statutory requirements include:

—The State must spend at least as much on community-based mental health services for children with serious emotional disturbance as it did in 1994; if the State relies on community mental health centers, those centers must meet certain requirements stipulated in Federal statute;
—The State must have and maintain a State Mental Health Planning Council that meets specific membership requirements and reviews the State mental health plan and implementation report providing recommendations for modifications to the plan when necessary; serves as an advocate for persons with mental illness; and monitors, reviews, and evaluates, not less than once each year, the allocation and adequacy of mental health services within the State;
—Unless waived for extraordinary economic conditions, the State is required to maintain State expenditures for community-based mental health services for adults with serious mental illness and children with serious emotional disturbance at a level equal to the average of what the State spent over the previous 2 years;
—The State must conduct an audit of the funds;
—The State is to ensure an opportunity for public comment; and
—The State is required to conduct an independent peer review of no less than 5 percent of entities receiving funding a year.

Proposal

After considerable discussion with the States and the National Association of State Mental Health Program Directors, SAMHSA is seeking your comments on a proposal to implement a performance partnership by creating more flexibility for States and accountability based on performance. This proposal is offered in two parts. The first will deal with the operationalization of the program—how will it work? The second will present the performance measures that are currently under discussion.

Operationalization

Under the performance partnership, the 50 States, the District of Columbia and the Territories would be eligible for direct funding and the current formula for distribution of the funds would still apply. (For the purposes of this discussion, the term ''States'' will include the District of Columbia and the Territories.) States would still be able to use the funds to carry out their mental health plan; to evaluate programs and services carried out under the plan; and to plan, administer, and carry out educational activities related to providing services under the plan.

The current restrictions on the use of funds related to inpatient care, cash

payments, purchase and renovation of properties, matching against other Federal funds, and making grants to for-profit organizations would remain in place.

Currently the funds must be spent on community-based mental health services for adults with serious mental illness and children with serious emotional disturbance. The terms ''adults with serious mental illness'' and ''children with a serious emotional disturbance'' were defined in the May 20, 1993, **Federal Register** on page 29422 and following. The new program would continue to focus on these populations.

Under the new program, States would be required to submit yearly mental health plans but may opt to submit plans every 2 or 3 years. The plans may be modified with the Secretary's approval if the State or the Secretary believes circumstances dictate the need to revise the plan in the interim.

The plans would include three sections, the first of which would describe the system of services using as a framework the five elements in current statute. SAMHSA does request your comments on how these elements might be made more meaningful to the system of care.

SAMHSA is well aware that the single State agency for mental health does not necessarily provide for all of the services that may be detailed in the plan. This section is only intended to help SAMHSA and other policymakers on how mental health services are provided in each of the States.

A second section would discuss the system using any State and/or Federal data that might be available including performance data that the State is collecting and an analysis of the data that describes both the strengths of the system and areas where improvement may be needed. This section would include the presentation and analysis of the basic measures which all States will be required to submit.

A third section, based on an analysis in the second section, would propose for the Secretary's approval the areas the State wishes to focus on, the specific objectives/targets the State wants to achieve during the course of the plan and the measures that would be used to assess the State's progress on those objectives. For the purpose of assessing the progress and to inform both the Federal and State governments of such progress, the State is expected to choose basic measures as its performance indicators. If a State chooses to focus on a particular area not among those covered by the basic measures, then the Secretary would have to approve both the focus and the measures. Where a pattern develops of several States focusing on the same particular area, not measured by the basic measures, *e.g.*, stigma, SAMHSA and the States will work to develop a common measure for that area.

A State would be required to submit annual reports to the Secretary detailing how it has complied with the requirements that would continue in statute and how well it met its objectives. The performance measurement data that is submitted annually to the Secretary would be used by the Department to help the State further improve its system of care. The Secretary has no interest in comparing and contrasting one State against another. A comparison report would create an unhealthy and unnecessary competition based on the comparison of divergent systems and divergent populations. SAMHSA will in using the data abide by four rules:

—When presenting data, States must be given the opportunity to provide explanatory notes regarding the data presented.

—States should have a respective protocol to address notifications and/or approvals needed with certain parties before data is released to the public. (There could be a specific internal process for States to review and comment upon data before release to the public.)

—If a State is not able to report on certain data requirements, reasons should be cited as to why it is not available.

—It is recommended that a standard statement of disclaimer be adopted and cited to explain issues around comparability to serve as a warning or caution when readers attempt to make State comparisons.

The Secretary would use the information from the State annual reports in preparing an annual report to Congress summarizing the programs in each State and their progress in meeting their objectives.

In the spirit of partnership and continuing quality improvement, SAMHSA proposes to eliminate the penalties for non-compliance except in the case of maintenance of effort choosing instead to work with the States to improve services. This will significantly change the agency's relationship with the States and cause SAMHSA to consider how the agency provides assistance to the States. SAMHSA's responsibility for technical assistance and dissemination of best practices will replace much of its current monitoring role. To meet the requirements of its changing role, SAMHSA staff will have to be trained in their new responsibilities and funding for technical assistance and continued performance measurement support will be needed.

With regard to some of the particular requirements listed above, the proposal would retain the *set-aside for children's services* but change it to require States to maintain funding for children with serious emotional disturbance at a level that is equal to the average of what the State spent over the previous 2 years. To create an incentive for States to increase funding, SAMHSA proposes to grant the Secretary authority to remove from the calculation one-time infusions of State funds that are for a non-recurring purpose. The change in the requirement is being made to be consistent with the general maintenance of effort requirement in the statute.

The proposal would require States to use only appropriate qualified community programs to provide the services as described in current law.

The State Planning Councils would be retained in their current form and continue to provide the State with recommendations on how to improve services. The Planning Councils remain a critical element of the planning and reporting process.

SAMHSA proposes to keep the Maintenance of Effort requirement along with the waiver and penalty authority and the new authority to remove certain expenditures from the calculation of the Maintenance of Effort requirement. The proposal also would retain the limit on State use of funds for administrative expenses to 5 percent.

With the implementation of Performance Partnership, SAMHSA is considering requiring States to use a certain percentage of any new funds to increase the use of evidence-based practices in the community-based mental health service system and would appreciate your comments.

SAMHSA proposes to eliminate the requirement that States independently peer review 5 percent of facilities under the program each year to assess the quality, appropriateness and efficacy of treatment services. The rationale for this decision is explained later in this FRN.

Performance Measures

All States will be required to submit data on a set of basic measures as part of their annual report to the Secretary which are intended to give a ''snapshot'' of how well the system of care is performing in the State. In developing this set of basic measures, several principles are taken into consideration. First, it is difficult to reach agreement

on what such a basic set of measures should be, what specific data elements should be collected and what the definitions should be for those data elements. Fortunately, SAMHSA has the benefit of several years of work with the States in the development and testing of such measures both through the Community Mental Health Services Block Grant and the current 16 State Pilot Study on Performance Measures. Second, basic measures that are identified today may need revision or replacement. It may also be found that the measures need to be expanded to improve the snapshot of the system. Third, it is costly and administratively burdensome to collect and report data. Outcome data requiring post-treatment measurement is particularly expensive. The more data required the greater the cost and less money for services is available.

This remains an issue of critical importance. Without improved data infrastructures in States, many will not be able to collect and report on performance measures. States will begin to submit performance data according to their ability to do so. Their ability to do so, in many cases, will be dependent on the resources available to develop the data infrastructure needed to collect and report on such data.

There are now two categories of measures: basic and developmental. The difference is the degree to which the measures have been worked out and to which the States have agreed and are prepared to submit them. With regard to the basic measures, while they remain subject to further clarification and evaluation, most of the work has been completed and States have agreed and are prepared to submit data.

With regard to the developmental measures, there remains a great deal of work to clarify the intent of these measures and the definitions of terms. States will not be required to submit this data until this work has been completed. It is expected that most of this work will be completed in fiscal year 2003 and, if so, then States would submit the data in their fiscal year 2005 applications which would be submitted to SAMHSA in September of 2004.

Basic Measures

With these understandings SAMHSA proposes the following basic measures be used:

—What is the estimated number of adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) in each State for the reporting year and 3 years into the future?

—What is the total number of individuals in the State who received public mental health services in institutional and community settings in the reporting year?

—What are the living arrangements of individuals (homeless or other) served by the State public mental health system (institutional and non-institutional settings) in the reporting year?

—What is the employment status of adult clients served in the reporting year by age and gender?

—How many people received services supported by Medicaid funding sources in the reporting year? What are their gender, and race/ethnicity?

—What is the rate of client turnover in State hospitals and community programs by age in the reporting year?

—What are the expenditures for public mental health services for the State and the source of funding in the reporting year?

—What are the community mental health block grant expenditures for non-direct service activities in the reporting year?

—What is the range of services provided or funded by the State mental health agency in the reporting year?

—What are the agencies receiving community mental health block grant funds directly from the State mental health agency in the reporting year?

—What are the State findings for client perceptions of care in the reporting year on the following:

• Percentage of clients reporting positively about access to care.

• Percentage of clients reporting positively about quality and appropriateness of care.

• Percentage of clients reporting positively about outcomes.

• Percentage of family members of children reporting positively about care received by their children.

—For the following topics, what is the State mental health agency profile?

• Percentage of adults with SMI and children with SED meeting the Federal definitions.

• Percentage of adults with SMI and children with SED with a dual diagnosis of mental illness and substance abuse.

• State responsibilities for mental health services provided through Medicaid/Medicaid managed care.

• State capacity to report unduplicated data.

These basic measures have been scrutinized and are generally accepted by the States and SAMHSA. They have also been subject to review and comment by the public when they were published as part of the revised block grant application for fiscal years 2002 through 2004.

Developmental Measures

There is also a list of additional measures that will be scrutinized for the next year that are not ready for inclusion in the basic list of measures but are expected to be added if the scrutiny bears them out. They include the following:

—What is the estimate of unmet need for services in the State in the reporting year? (Unmet need is defined as adults with serious mental illness and children with serious emotional disturbance who need mental health services now and who will need to rely on the public sector for assistance but who are not yet being served.)

—How many adults with SMI and children with SED are served by the public mental health system in the reporting year? What is their profile by age, gender and race/ethnicity?

—How many children served by the State Mental Health Agency have family-like living arrangements or other 24-hour residential care in the reporting year and what are their ages and gender? How many adults served live independently and/or in other 24-hour residential care in the reporting year and what are their ages, gender and race/ethnicity?

—How many adults received supported housing services in the reporting year and what are their ages and race/ethnicity?

—What is the rate of client turnover in general hospitals and in high priority services such as assertive community treatment, new generation medication, supported housing, supported employment, and therapeutic foster care?

—For the following outcomes, what are the State findings for client perceptions in the reporting year?

• Percent of children with SED who have an increase in the level of school attendance.

• Percent of children with SED who have had contact with the juvenile justice system.

• Percent of adults with SMI who have had contact with the criminal justice system.

Explanation

The performance partnership for the CMHS program is built on three principles:

• That the Federal Government and the State governments are partners in the provision of mental health services and that our shared goal is ''continuous quality improvement.''

• That States understand the needs of their population and should be given more flexibility in the use of the funds.

• That accountability should be built on performance not entirely on expenditures.

The first principle is reached in this proposal when both the Federal and State governments identify the strengths and weaknesses of various systems of service and work in tandem to improve those systems. The new partnerships will be built on incentives to improve services rather than penalties for noncompliance.

The second principle is achieved in this proposal by reducing the number of requirements, simplifying the planning process, giving greater freedom in the use of the funds to States and reducing administrative costs and burden. States have tremendous flexibility in the use of the funds now which this proposal retains.

The shift to performance measures provides a focus on the efficiency and effectiveness of services and therefore helps both the Federal and State governments to identify how to improve the system of services. For example, the measures will permit both the Federal and State governments to identify steps that need to be taken to further improve the system of care to increase favorable outcomes.

The States, Territories and the District of Columbia will continue to be the only eligible entities for PPG funds and there is no attempt in this proposal to change the distribution of the funding. This proposal addresses a new paradigm in the relationship between the Federal Government and eligible entities.

The use of funds will remain as flexible as it is in current law. The restrictions will be retained to ensure that the funds will be used for community based mental health services.

Plans will have a slightly different twist. While States will continue to discuss their respective programs for the provision of community-based mental health services, and provide data on that system, there will be a requirement that States examine the system and establish objectives for improving the system. The objectives will be targeted improvements in certain basic measures or in areas not addressed by the basic measures for which the State will offer measures.

States will continue to be responsible for providing the Secretary with annual reports detailing their progress in meeting their goals and for providing necessary expenditure data to demonstrate compliance with such provisions as maintenance of effort and the set aside for children with serious emotional disturbance.

The Annual Report to Congress is not part of current law. SAMHSA and its predecessor agency, the Alcohol, Drug Abuse and Mental Health Administration were on occasion required to submit a report to Congress. The last such report was in 1994 but it only dealt with the Substance Abuse Prevention and Treatment Block Grant. The report will serve to demonstrate to Congress that the funds are being used efficiently and effectively and to show how the State systems are improving. The reports will not compare and contrast State systems. SAMHSA believes this would be counterproductive to our goal of continuing quality improvement as States would present themselves in the best of light. The reports will be responsive to the needs of Congress and the submission will coincide with the appropriation process.

States are currently required to ensure that individuals have an opportunity to review and comment on the State plan. SAMHSA proposes to continue this requirement but at the same time to elicit ways of improving public participation.

Current statute authorizes the Secretary to penalize States for non-compliance. Penalties, however, serve only to remove funds from the mental health system of the State and grip both the staff of the State and the Federal government in a bureaucratic process that keeps both from carrying out their mission and goals. Instead, SAMHSA requests ideas on an incentive to encourage States to improve their service system.

Maintenance of effort presents an economic burden on States especially in these times where the State budgets are running in the red and they are looking for ways to reduce spending. SAMHSA, however, proposes to retain the requirement to ensure continuation of services for those in need of community-based mental health services.

SAMHSA proposes to eliminate the requirement that States independently peer review 5 percent of facilities under the program each year to assess the quality, appropriateness and efficacy of treatment services. While this specific provision was added with the Anti-Drug Abuse Act of 1988, there had always been a provision in statute requiring States to evaluate the performance of facilities receiving funds under the Block Grant program. The Department has monitored the usefulness of the requirement and believes that it has not achieved the purpose for which it was included in statute largely because the States, while they fulfilled their obligation under the provision, did not use it to improve performance. In addition, the Department believes that this provision not only requires that it be done but that it stipulates the way it should be done when there is nothing to suggest that an independent peer review is the best way to accomplish the goal of the provision.

The Department is extremely interested in improving the quality of services. This is one of the purposes of the whole Performance Partnership program—continuous quality improvement. It is our belief, however, that the State analysis that has to be done as part of the second section of the plan will identify where the State, as a whole, needs to improve if the system is to improve. The only way that States have of improving their system is to work with the individual providers. As an example, the analysis may very well identify that programs are not using evidenced based practices. If this is true, the Department can work with the States to share the findings from the National Institute on Mental Illness services research programs, knowledge gained from other States or communities, findings from the Department's own programs, information from the technical assistance centers that the Department supports and from other sources. It would naturally be in the best interest of the State to ensure that the providers are actually then using those practices. The end result is that the State undertakes activities in support of its own interests and not because of a requirement in statute.

Performance Measures

The performance measures used in this program have been developed after considerable consultation with experts in the field and State commissioners. Their acceptance, however, is largely based on what we know today. In 1 or 2 years after some experience, SAMHSA and the States may find that the measures do not measure what we thought they would or that what they measured was not critical to understanding the service system. Therefore, the performance partnership program must have built into it the ability to change the basic measures.

SAMHSA has also considered the practicality of the measures that it has been and will be developing. The collection and reporting of data on individuals, much of which will have to be gathered from individuals not living in facilities, is a very expensive undertaking and administratively

burdensome. So while SAMHSA is interested in getting a picture of the system, SAMHSA wants to accomplish this without requiring the States to incur a significant financial and administrative burden. SAMHSA believes that it has accomplished that goal. In giving comments, SAMHSA asks that you keep this criterion in mind.

Critical to the collection and reporting on performance measures is the ability to upgrade the data infrastructure of the State. This involves ensuring that each mental health program begins to collect standardized data and has the infrastructure to record and report it. It also assumes that States have the ability to receive and analyze that data. While some States are in a good position as far as data infrastructure is concerned, many are not and will need further financial assistance to bring their data infrastructure in line. SAMHSA and the States accept shared responsibility for this financial burden.

Questions for You To Consider in Making Your Comments

In General

1. Please comment, if you care to, in general about the benefits and challenges of converting to performance partnerships. What areas of greater flexibility are needed in the administration of the CMHS BG and what measures of accountability are needed in the performance of the program and for the overall community based system of care?

2. Please comment, if you care to, on the use of a ''continuous quality improvement'' model instead of a penalty structure?

Operationalization

1. Please comment, if you care to, about the continuation of the flexibility in the use of funds under the program for carrying out the mental health plan, to evaluate programs and to plan and administer the program.

2. SAMHSA is proposing new elements for the mental health plan. Please comment, if you care to, about those elements and make recommendations for their improvement.

3. SAMHSA proposes to maintain the current restrictions on the use of funds as are in current statute. Please comment, if you care to, on both the proposal and the value of the restrictions themselves.

4. SAMHSA is proposing to retain the set aside for children's services but is simplifying it to ensure that States maintain their level of support for children with serious emotional disturbance at a level equal to the average expenditures of the previous 2 years. Please comment, if you care to, on retaining the provisions and the change in the maintenance of effort requirement on children's services.

5. States would be required to submit yearly reports showing their progress in meeting their objectives under the program. SAMHSA would then use this information to create a report for Congress to demonstrate how each State is using the funds efficiently and effectively to provide access to quality care. The report to Congress would not be a comparison of States but a presentation on the programs in each State and what steps the States are taking to further improve their system of services. Please comment, if you care to, on the annual State report and the report to Congress.

6. Please comment, if you care to, on SAMHSA's proposal to continue the current maintenance of effort requirement including the exclusion from the calculation funds for one time expenditures of a singular purpose.

Performance Measures

1. Under the proposal, 12 basic measures and 6 developmental measures are identified. Please comment, if you care to, about the benefits and challenges of using this information to describe performance by individual States and to describe the overall capacity, accountability and effectiveness of the systems of community based services for the Nation.

2. How would you improve the measures if you could? Which measures do you believe should be kept, which ones dropped, and which ones amended and how? Are there other measures that you believe should be added that do not appear?

3. This notice suggests that States will be ready to submit basic measurement data in time for their applications for FY 2005 funds. Do you believe that this time table is realistic?

4. SAMHSA has developed a matrix of program priorities and cross cutting principles that now guides the agency's daily operations and overall program and management decisions. Programs and issues prioritized in this matrix include: co-occurring disorders; substance abuse treatment capacity; seclusion and restraint; prevention and early intervention; children and families; New Freedom Initiative (including the President's Mental Health Commission); terrorism/bio-terrorism; homelessness; aging; HIV/AIDS and Hepatitis C; and criminal justice. As we move forward in measuring the extent to which the agency has been successful in these 11 areas, we are asking the public to comment on how to begin work on ways to measure progress by the States in these and other program areas.

Economic Impact

We have examined the impact of this notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), as amended by Executive Order 13258 (February 2002, Amending Executive Order 12866 on Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980; Public Law 96–354), the Unfunded Mandated Reform Act of 1995 (Public Law 104–4), and Executive Order 13132 (August 1999, Federalism). Executive Order 12866 (the Order), as amended by Executive Order 13258, which direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize the benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in 1 year). We have determined that the proposed rule is consistent with the principles set forth in the Order, and we find that the proposed rule would not have an effect on the economy that exceeds $100 million in any one year. In addition, this rule is not a major rule as defined at 5 U.S.C. 804(2). In accordance with the provisions of the Order, the rule was reviewed by the Office of Management and Budget.

It is hereby certified under the RFA that this proposed regulation, will not have a significant economic impact on a substantial number of small entities. This proposed rule applies only to States.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribunal governments, in the aggregate, or by the private sector, of $100 million. As noted above, we find that the proposed rule would not have an effect of this magnitude on the economy.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or

otherwise has Federalism implications. We have reviewed the proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that this proposal does not impose substantial direct requirement costs on State and local governments, preempt State law, or otherwise has Federalism implications. On the contrary, the proposal provides for more flexibility for the States in the use of Federal funds, and establishes a working relationship between the Federal and State governments that will help the States improve access to quality care for those individuals in need of substance abuse or mental health services.

Paperwork Reduction

This proposal would assume information collection requirements that would be subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980. This **Federal Register** notice, however, is only seeking comment on proposed information collection and is not establishing a collection requirement. Therefore, doing a Paperwork Reduction Act analysis would be premature. The Department will comply with the requirements of the Paperwork Reduction Act when determinations have been made on the information to be collected and in advance of requiring the submission of that information.

Dated: November 18, 2002.

Charles G. Curie,

Administrator, Substance Abuse and Mental Health Services Administration.

Dated: December 18, 2002.

Tommy G. Thompson,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Community Mental Health Services Performance Partnership

AGENCY: Substance Abuse and Mental Health Services Administration (SAMHSA), HHS.

ACTION: Notice: Request for comments.

SUMMARY: Section 1949 of the Public Health Service Act as amended by Public Law 106–310 requires the Secretary of Health and Human Services to submit a plan to Congress detailing how the Secretary intends to change the current Community Mental Health Services (CMHS) Block Grant into a performance partnership. The plan, by statute, must include the following:

A description of the flexibility that would be given to the States under the plan;

The common set of performance measures that would be used for accountability;

The definitions for the data elements to be used under the plan;

The obstacles to implementation of the plan and the manner in which such obstacles would be resolved;

The resources needed to implement the performance partnerships under the plan; and

An implementation strategy complete with recommendations for any necessary legislation.

Section 1949 requires that the Secretary develop this plan in conjunction with the States and other interested parties. SAMHSA has been in discussion with the States for several years over this proposal. This FRN provides States and other interested parties an opportunity to comment on those discussions.

DATES: Comments on the information must be in writing and should be sent to: Joseph D. Faha, Director of Legislation/SAMHSA, 5600 Fishers Lane, Room 12–95, Rockville, Maryland 20857, by February 24, 2003.

FOR FURTHER INFORMATION CONTACT: Joseph D. Faha, Director of Legislation/SAMHSA, 5600 Fishers Lane, Room 12–95, Rockville, Maryland 20857. Mr. Faha may be reached on (301) 443–4640.

SAMHSA seeks comments on its proposal to develop a plan for the changing of the current SAPT Block Grant from its current emphasis on process requirements, financial earmarks, and accountability based on narrative documentation of compliance and expenditure reports to a system referred to as a performance partnership that offers States more flexibility in the expenditure of funds while basing accountability on performance and develops a partnership between the Federal Government and State governments in the provision of substance abuse prevention and treatment services.

The current SAPT Block Grant program has its origins in the Alcohol, Drug Abuse and Mental Health Services Block Grant, first legislated in 1981. In its conception, the Federal Government gave funds to States based on a formula in statute for the purposes of providing substance abuse and community based mental health services with minimal programmatic and reporting requirements. Over time, the statute authorizing the program was changed to require the States to spend certain stipulated amounts on or to emphasize public health issues such as HIV, tuberculosis, pregnant addicts and others.

Performance Partnership Grants (PPG) represent a new paradigm in Federal and State relations and cooperation. Under this grant program, the Federal Government would acknowledge the ability of States to both recognize their own needs and to address them as they relate to the provision of substance abuse prevention and treatment services by increasing flexibility for the States in their use of block grant funds. It would also shift State accountability away from Federal monitoring of State processes and related expenditures to identifying the strengths of a State's service system and areas where it could be improved to the benefit of those in need of such services. The goal is ''continuous quality improvement.''

The next section of this notice presents the proposal. The first part of this section discusses how the new program will work and the second part of this section will share the measures that have been agreed to so far in our discussions with the States. This is followed by a section that lends some explanation for the changes. Finally, there is a section suggesting both general and specific questions to which you may wish to respond. Public comments will be taken into consideration in developing the plan the Secretary will submit to Congress.

Proposal

Operationalization

Eligibility and Distribution of Funds: SAMHSA proposes that those entities which are currently eligible to receive direct funding under the SAPT Block Grant would continue to be eligible and that the formula, recently revised, would be retained. Eligible entities include the 50 States, the District of Columbia, the Territories and the Red Lake Indian Tribe of Minnesota.

Use of Funds: SAPT Block Grant funds would be available as they are now for substance abuse prevention and treatment activities and for carrying out programs required under section 1924 of the Public Health Service Act which deals with early intervention services for HIV and with tuberculosis services. Language would be added to clarify in statute that funds may be used to train counselors and to collect and report performance measurement data.

In addition, under performance partnerships, SAMHSA proposes