

SUPPORTING STATEMENT

Application for the Mental Health Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) FY 2026-2027 Application Guidance

Check off which applies:

- ☐ New
- ☒ Revision
- ☐ Reinstatement with Change
- ☐ Reinstatement without Change
- ☐ Extension
- ☐ Emergency
- ☐ Existing

A. Justification

A1. Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA) is requesting approval from the Office of Management and Budget (OMB) for the revision of the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) (formally known as the Substance Use Prevention and Treatment Block Grant (SUBG)) Application Guidance and Instructions data collection. The OMB clearance for the current 2024-2025 Application Guidance (0930-0168) will expire on 03/31/2026.

Title XIX, Part B, Subparts I, II and III of the Public Health Service (PHS) Act, as amended, establishes the MHBG and SUPTRS BG programs. Under section 1917(42 USC § 300x-6), application for the MHBG plan is received by the Secretary no later than September 1 of the fiscal year prior to the fiscal year for which states¹ or jurisdictions (here after referred to as states) are seeking funds. Section 1942(a) (42 USC § 300x-52) requires states to submit a report to the Secretary describing the purpose and activities associated with the grant received from the previous fiscal year. This report is due December 1 of the fiscal year of the MHBG.

Section 1932 (42 USC § 300x-32) requires states to submit their respective SUPTRS BG

¹ The SUPTRS BG provides funding for a total of 60 grantees representing 50 states, the District of Columbia (D.C.), five U.S. Territories, three freely associated states, and one Indian Tribe while the MHBG provides funding for a total of 59 grantees representing 50 states, D.C., five U.S. Territories and three freely associated states. Throughout this document, the word "state" is used to describe all of these grantees.

applications no later than October 1 of the fiscal year for which they are seeking funds. However, like the MHBG, reports required under section 1942(a) are received on December 1. In recognition of the many states whose executive branch authority includes both mental health and substance use, SAMHSA provided states with the flexibility to prepare and submit a combined SUPTRS BG plan application no later than September 1 of the fiscal year of the grant.

In 1981, the federal government envisioned a new way of assisting states to provide an assortment of services including substance use and mental health services. Termed block grants, these grants were originally designed to give states maximum flexibility in the use of federal funds to address the multiple needs of their populations. This flexibility was given in exchange for reductions in the overall amount of funding available to any given state. Over time, a few requirements were added by Congress directing the states' use of these funds in a variety of ways. Currently, flexibility is given to allow states to address their unique issues, provide the most effective care possible, and track the quality and outcome of services such that the effect of these efforts can be reported, and improvements can be made as science and circumstances change.

Assumptions about the nature and use of block grants have evolved over time. Block grants have gained a reputation as a mechanism to allow states unrestricted flexibility without strong accountability measures. Meanwhile, the field of behavioral health has developed new, innovative, and evidence-based services that have gone unfunded or without widespread adoption. This "science to service" lag and a lack of adequate and consistent person-level data have resulted in questions from stakeholders and policy makers, including Congress and OMB, as to the effectiveness and accountability achieved through SAMHSA's block grants.

The SUPTRS BG and MHBG differ on a number of practices (e.g., data collection at individual or aggregate levels) and statutory authorities (e.g., intended population, method of calculating maintenance of effort (MOE), stakeholder input requirements for planning, set asides for specific populations or programs, etc.). Historically, the centers within SAMHSA that administer these block grants have had different approaches to application requirements and reporting. To compound this variation, states have different structures for accepting, planning, and accounting for the block grants and the primary prevention set aside within the SUPTRS BG. 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.

The Affordable Care Act (ACA) significantly enhances access to behavioral health services for millions of Americans, requiring Marketplace plans to cover psychotherapy and counseling, mental and behavioral health inpatient services, and substance use disorder treatment, while providing parity protections between mental health and substance use benefits and medical and surgical benefits. The ACA also permitted States to expand Medicaid eligibility to cover more low-income Americans. Coupled with the Mental Health Parity and Addictions Equity Act (MHPAEA), this has increased the nation's ability to close service gaps that have existed for decades for far too many individuals and their families.

The creation of 988 is a once-in-a-lifetime opportunity to strengthen and expand the Lifeline and

transform America's behavioral health crisis care system to one that saves lives by serving anyone, at any time, from anywhere across the nation. Preparing the Lifeline for full 988 operational readiness will require a bold vision for a system that provides direct, life-saving services to all in need and links them to community-based providers uniquely positioned to deliver a full range of crisis care services. SAMHSA sees 988 as the linchpin and catalyst for a transformed behavioral health crisis system in much the same way that, over time, 911 spurred the growth of emergency medical services in the United States.

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 and that demonstrate success in improving outcomes and/or supporting recovery; (3) to fund universal, selective, and indicated substance use 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. Additionally, SAMHSA strongly supports that states provide additional recovery support services with SUPTRS BG funds beyond the scope of treatment programs currently available in most communities across the nation.

States need help to meet future challenges with fostering the implementation of an integrated physical health, mental health, and substance use disorder service system. SAMHSA is working with states to establish standards and expectations that lead to an improved system of care for individuals with or at risk of mental and substance use disorders. HHS has devoted significant resources in assisting states in building and maintaining more effective behavioral health systems for prevention activities, treatment services and recovery supports that are integrated with health care systems. To continue this work, SAMHSA is requesting approval of this application and guidance for FY 2026-2027 MHBG and SUPTRS BG.

Application Overview

The FY2026-2027 application contains previously approved sections that are required and other sections where additional information is requested. The FY2026-2027 application, which includes both the plan and report, requires states to submit a face sheet, a table of contents, a behavioral health assessment and plan, reports of expenditures and persons served, executive summary, and funding agreements, assurances, and certifications. Consistent with prior applications, SAMHSA is requesting information on key focus areas that are critical to implementation of provisions related to improving the quality of life for individuals with behavioral health disorders.

States are required to use forms approved by OMB and to submit the application in a specified period. Although the statutory deadlines remain unchanged, SAMHSA is urging states to submit

their application(s) as early as possible to allow time for a meaningful review. SAMHSA believes that plans should be developed in line with state fiscal years and that information provided in the reports should also reflect state fiscal year data. Applications for the MHBG-only are due no later than September 1, 2025. The application for SUPTRS BG-only is due no later than October 1, 2025. A single application for MHBG and SUPTRS BG is due no later than September 1, 2025.

The application requires the states under both programs to set goals and quantifiable and measurable objectives to be achieved over the length of the plan. Such goals and objectives are, at minimum, to be based on the populations described in the authorizing legislation for the MHBG and SUPTRS BG and the state's assessment of its current capacity and resources. The objectives are to be accompanied by activities that the state will undertake to meet those objectives. In the case of objectives that will take longer than one year to achieve, the state is to set milestones to reach along the way. The milestones give both the state and SAMHSA an opportunity to revisit the objectives and/or the activities being carried out to achieve the objectives to ensure that they will be met. It also offers an opportunity for SAMHSA to provide or secure needed technical assistance for the state if desired.

Requiring states to submit plans for their behavioral health care systems is in keeping with SAMHSA's governance of federal funds to require states to explain why and how they intend to spend them. Having the states submit a plan including performance measures allows SAMHSA to hold the states accountable for goals that they have set for themselves. It is SAMHSA's understanding, after consulting with states, that most already develop such a plan for substance use services for their state legislatures.

The application also includes the state annual report. Section 1942(a) of Title XIX, Part B, Subpart III requires the state to submit an annual report for both the MHBG and the SUPTRS BG to the Secretary as part of the application that among other things, addresses the state's progress in meeting the objectives outlined in the state plan. The report includes information to ensure that the state carried out its obligations as stipulated in the authorizing legislation applicable to the MHBG and SUPTRS BG and the implementing regulations applicable to the SUPTRS BG. All information provided will be according to most states' fiscal year (July 1 through June 30) or the relevant federal fiscal year. Each state is required to establish and maintain a state advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages states to expand this council to a behavioral health advisory council to advise and consult regarding issues and services for persons with, or at risk for, substance use disorders. In addition to the duties specified under the authorizing legislation for the MHBG, a primary duty of the behavioral health advisory council will be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with mental disorders as well as individuals with substance use disorders within the state. States are strongly encouraged to include American Indians and/or Alaskan Natives; however, their inclusion on the Council does not by itself suffice as tribal consultation.

A.2. Purpose and Use of Information

SAMHSA's SUPTRS BG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental and substance use disorders and associated problems. The goals of the block grant programs are consistent with SAMHSA's vision that people with, affected by, or at risk for mental health and substance use conditions receive care, achieve well-being, and thrive. Furthermore, block grant program goals are consistent with SAMHSA's four major dimensions that support a life in recovery:

- (a) A physically and emotionally healthy lifestyle (**health**);
- (b) A stable, safe and supportive place to live (a **home**);
- (c) Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society (a **purpose**); and
- (d) Relationships and social networks that provide support, friendship, love, and hope (a **community**).

Additional aims of the block grant programs reflect SAMHSA's overall goals and values, specifically:

- To reduce and prevent substance use, SAMHSA will support efforts to strengthen prevention programs, policies, and practices.
- To prevent overdose deaths in America, SAMHSA will support efforts to transform systems and services that increase access to and utilization of harm reduction approaches and effective treatments.
- To advance recovery, SAMHSA will support strengths-based approaches to reduce barriers and create more opportunities to thrive.
- To improve health and well-being of all Americans, SAMHSA will support mental health promotion and early intervention programs and services for individuals at risk for or living with mental health conditions.
- To save lives and improve well-being, SAMHSA will lead public health efforts to reduce suicidal ideation and behavior.
- To deliver crisis care across all communities, SAMHSA will improve the quality and accessibility of the crisis care system and access to suicide prevention and mental health Services.

- To improve the quality and accessibility of care, SAMHSA will strengthen treatment and recovery services for individuals at risk for or living with mental health and substance use conditions.
- To ensure that all children, youth, and families have opportunities to thrive, SAMHSA will increase access to a comprehensive array of equity-driven behavioral health programs by increasing program integration and expanding pediatric behavioral health capacity.
- To meet the specific needs of children, youth, and their families, SAMHSA will support the dissemination and implementation of evidence-based and culturally appropriate prevention and behavioral health services.
- To promote whole-person care and improve health outcomes, SAMHSA will advance bi-directional integration of healthcare services across systems for people with behavioral health conditions.
- To promote whole-person care and improved health outcomes, SAMHSA will advance policies and programs to address social determinants of health.
- To meet the behavioral health needs of the nation, SAMHSA will support the active recruitment, training, and retention of diverse, qualified individuals into the behavioral health workforce.
- To improve the quality of behavioral health care, SAMHSA will promote and support professional development initiatives to improve the competencies of service providers.
- To increase the accessibility of behavioral health providers in all communities, SAMHSA will reduce barriers to the continuum of high-quality services.

SAMHSA emphasizes four overarching guiding principles across all policies and programs to support SAMHSA in achieving its mission and vision. These include equity, trauma-informed approaches, a commitment to data and evidence, and recovery. States should use these principles as drivers in developing their application.

Proposed Revisions

SAMHSA's five priorities (Preventing Substance Use and Overdose; Enhancing Access to Suicide Prevention and Mental Health Services; Promoting Resilience and Emotional Health for Children, Youth and Families; Integrating Behavioral and Physical Health Care; and Strengthening the Behavioral Health Workforce) are highlighted and states are encouraged to incorporate them into their systems improvement efforts.

For the planning tables, Table 4a was added to reflect grantee planned expenditures using MHBG. Under the Environmental Factors, a section was added for data collection activities. In addition, to address comment received under the 60-day FRN, clarifying language for the use of MHBG funds under the Population Served section has been added.

On the MHBG report there are changes with the addition of one new table to the state agency expenditures reports section (Table 4b on the MHBG). With the addition of this new table, the original MHBG table 4 has been relabeled 4a. In addition, an appendix with a list of data definitions have been added to aid states in reporting data. The additional table should not require excessive effort as all data will already be collected by the states on how MHBG funds are spent on direct and non-direct services.

Proposed revisions for substance use disorder treatment services in the FY 26-27 SUPTRS BG Plan and Report include revisions related to removal of stigmatizing language, with the deletion of the term '*abuse*', and replacement with the term '*use*', per the Consolidated Appropriations Act, 2023. The Plan and Report also include the universal adoption of '*Recovery Support Services*' as a stand-alone category for SUPTRS BG Plan and Report tables. These changes affect Plan Tables 1, 2b, 4b, and 6b, and Report Tables 1, 2, 4, 6, 7.

Editorial changes and minor stylistic changes have been made to tables and language. Footnotes have been revised that define the COVID-19 and ARP Supplemental Funding expenditure periods, including the addition of explicit instructions on the second No Cost Extension (NCE) for the COVID-19 funding, and the expiration date for the ARP funding. Finally, the SUPTRS BG Report Table 11c has been revised to reflect the Number of Persons Admitted to Treatment by Sexual Orientation and Race/Ethnicity, in a reporting format that is compatible with the format and content of the comparable CMHS table for the MHBG.

Proposed revisions for prevention services in the FY 26-27 SUPTRS BG Plan include those revisions that are related to a more intentional use of language, with strengthened statements with the addition of statistics, and added language to reinforce the interrelatedness between mental health and substance use. There is also reinforcement of SUPTRS BG primary prevention set-aside funds to support universal, selective, and/or indicated substance use prevention strategies.

Updated tables ensure consistency in Tables 5a –5c for both Plans and Reports, and updated language for substances in Table 5c. The term ‘*abstinence*’ has been removed from the Prevention National Outcome Measures (NOMs) to better reflect current terminology. Report Tables 31 and 32 have been combined into a new Report Table 31, which reduces burden for grantees and removes redundant, obsolete reporting requirements. Gender categories in Table 31 have been updated to align with CSAT gender categories. Other than the above changes and minor edits, the application and report are consistent with the FF2024-2025 application, plan, and report and responsive to questions received in the last application cycle, with clarifications of instructions where necessary.

A.3. Use of Information Technology

The FY 2026-2027 Block Grant application instructions and guidance will be available to all states through the SAMHSA website at www.samhsa.gov/grants/blockgrant. The FY 2026-2027 guidance instructs that states submit applications using the web-based application process, called Web Block Grant Application System (BGAS). BGAS utilizes Microsoft Active Server Pages (ASP), JavaScript, Hypertext Markup Language (HTML), Adobe Acrobat, and Oracle Database technologies.

Use of BGAS significantly reduces the paperwork burden for submission, revision, and reporting purposes. BGAS can transfer standard information from previous year’s plans, thus pre-populating performance indicator tables, planning council membership, and maintenance of effort (MOE) figures. In addition to transferring both narrative information and data, states can upload specific information necessary to complete their plans.

A.4. Efforts to Identify Duplication

The behavioral health assessment and plan section of the application is proposed as primary objective and quantitative responses to a series of specific questions. These questions allow states to describe their systems of care, planned expenditures, services provided, and progress toward meeting the state’s community-based mental and substance use disorder service goals in ways that are easily analyzable. The MHBG and SUPTRS BG report sections include mental health reporting on the Uniform Reporting System (URS) Tables, and substance use prevention and substance use disorder treatment reporting through SAMHSA’s Center for Behavioral Health Statistics and Quality (CBHSQ) National Household Survey on Drug Use and Health (NSDUH) and the Behavioral Health Services Information System (BHSIS) Treatment Episode Data Set/Mental Health Client Level Data Systems (TEDS, MH-TEDS, and MH-CLD), respectively. URS, NSDUH and TEDS are the only routine or uniform data collection initiatives of the type requested to provide a national picture of the states’ public mental and substance use disorder systems.

A. 5. Involvement of Small Entities

There is no small business involvement in this effort. The applications are prepared and

submitted by states.

A. 6. Consequences if Information is Collected Less Frequently

The authorizing statute requires that states apply annually for SUPTRS BG and MHBG funds and report annually on their accomplishments and the purposes for which such funds were expended. Less frequent reporting would not comply with statutory requirements and would make it impossible for SAMHSA to award MHBG funds or monitor the states' use of their grants. In addition, federal reporting requirements for reports to Congress, as well as intervening requirements for legislative testimony before Congress on specific mental health issues, require the availability of up-to-date information and data analyses.

The authorizing statute and implementing regulation require states to apply annually for SUPTRS BG funds and to report annually on activities and the purposes for which such funds were expended. Less frequent reporting would be in violation of the authorizing statute and implementing regulation and would also result in difficulty linking activities with fiscal year funding. Internal control processes and program management requirements are addressed through the collection, database management, and analysis of information collected in this application. Federal reporting requirements for reports to Congress, as well as intervening requirements for legislative testimony before Congress covering specific issues regarding the prevention of substance use and the treatment of substance use disorders, require the availability of up-to-date information.

A.7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

This information fully complies with 5 CFR 1320.5(d)(2). However, SAMHSA is committed to achieving the goals of the revised Statistical Policy Director No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (SPD 15) effective on March 28, 2024, across its discretionary, block grant, and other data collections. At this time, SAMHSA is requesting additional time for the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention and Treatment Block Grant (SUPTRS BG) Reports to implement modifications to the race and ethnicity data classification, required by the revised SPD 15.

In the "Revisions to OMB's Statistical Policy Directive No. 15" Federal Register Notice (FRN) published on March 29, 2024 (89 FR 22182), OMB acknowledges that, "*certain programs that involve interconnected data across multiple agencies or offices, or that rely on data collected and provided by non-Federal entities, may take longer to implement than programs like statistical surveys,*" and "*agencies may use the detailed categories employed by the U.S. Census Bureau's most recently fielded American Community Survey.*"

Both the MHBG and SUPTRS BG rely on all 50 state agencies, U.S. territories, and their subrecipients for the collection of client-level data, inclusive of measures for race and ethnicity.

As a result, adoption of the revised SPD 15 categories of race and ethnicity will require changes at the provider and state and territory systems levels. These changes can take between 18 to 24 months to implement due to the individual nature of state/territory subcontract agreements, the number of state/territory systems involved in gathering all of these data (e.g. South Carolina alone manages 6 different state systems to capture all the required data for block grant reporting), and the time needed to develop, test, and uniformly adopt the systems across all levels of funded care.

An additional challenge to the adoption of the revised SPD 15 race and ethnicity categories is the retrospective nature of state annual reporting for the MHBG and SUPTRS BG Reports (typically lagging by approximately 12 months). The current application will include MHBG and SUPTRS BG Reports reflective of State Fiscal Year (SFY) 2025, which will have started at the time the FY2026/2027 MHBG and SUPTRS BG Application and Report packages are released. Therefore, states will not have collected race and ethnicity data as required for the first year of reporting covered in this FY2026/2027 package. Furthermore, in light of the time and burden required to adopt these changes as outlined above, we do not anticipate states will be fully able to report uniformly and accurately before state FY (SFY) 2027. For most states this is July 1, 2026 to June 30, 2027, so reporting will occur starting December 1, 2027, during the FY2028/2029 MHBG and SUPTRS BG Reports period.

Lastly, there is a need to align the race and ethnicity data classification with the Census Bureau's implementation schedule because Census Bureau data are used in the MHBG and SUPTRS BG key measurement and national outcome reporting. For example, MHBG reports client characteristics of mental health clients that received treatment by race and by ethnicity. Rates per 1,000 population are calculated using the U.S. Census Bureau Annual State Resident Population Estimates for 5 Race Groups (5 Race Alone or in Combination Groups) by Age, Sex, and Hispanic Origin.

In considering the need to collaborate with non-Federal entities and to align with the Census Bureau for the MHBG and SUPTRS BG Reports, SAMHSA requests additional time to adopt revisions to the race and ethnicity data collection for these programs. SAMHSA would like to request adoption of these changes to the MHBG and SUPTRS BG Reports by the FY2028/2029 application cycle, which will be submitted to OMB in FFY2026 and implemented for reporting December 1, 2027 – still well within the five-year adoption time frame set out by the Office of Management and Budget. In the interim, SAMHSA is working closely with states and their partners to provide the necessary guidance, technical assistance, and other resources to ensure successful adoption of SPD 15 as efficiently and effectively as possible.

A.8. Consultation Outside the Agency

The notice required in 5 CFR 1320.8(d) was published in the *Federal Register* on August 15, 2024 (89FR66424). Public comments were received and responded to. See attached comment matrix.

A.9. Payment to Respondents

No payments will be provided to respondents to participate.

A.10. Assurance of Confidentiality

Data will be kept private to the extent allowed by law. States submit client-level data through the CBHSQ BHSIS TEDS/MH-TEDS/MH-CLD. The responsibility for assigning facility and client identifiers resides with the individual states. Client identifiers consist of unique numbers within facilities and increasingly, unique numbers within state behavioral health data systems. Records received into BHSIS systems are stored in secured computer facilities, where computer data access is limited through two-factor authentication procedures known only to authorized personnel. In preparing public use files of these data, a contractor conducts a disclosure analysis. Client and facility identifiers are removed, certain variables are recoded, and cells are collapsed or otherwise masked as needed to ensure that individuals cannot be identified.

A.11. Questions of a Sensitive Nature

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. These instruments will be used to report on performance at the aggregate level. There are no questions of a sensitive nature that are asked of individuals as the data collection is focused at the grantee level and not the individual participant level.

A.12. Estimates of Annualized Hour Burden

Table 1 and Table 2 provides an overview of the data collection method, frequency of data collection, and number of data collections for each data collection instruments.

Table 1. Estimates of application and reporting burden for Year 1:

Substance Use Prevention, Treatment, and Recovery Services (SUPTRS BG) and Community Mental Health Services (MHBG) Block Grants							
	Authorizing Statute SUPTRS BG	Authorizing Statute MHBG	Implementing Regulation	Number of Respondents	Number of Responses Per Year	Number of Hours Per Response	Total Hours
Reporting:	Standard Form						

	and Content						
	42 U.S.C. § 300x-32(a)						
SUPTRS BG	Annual Report						11,190
	42 U.S.C. 300x-52(a)		45 CFR 96.122(f)	60	1		
	42 U.S.C. 300x-30-b			5	1		
	42 U.S.C. 300x-30(d)(2)		45 CFR 96.134(d)	60	1		
MHBG	Annual Report						11,003
		42 USC § 300x-6(a)		59	1		
		42 U.S.C. 300x-52(a)					
		42 U.S.C. 300x-4(b) (3)B		59	1		
	State Plan (Covers 2 years)						
SUPTRS BG elements	42 U.S.C. 300x-22(b)		45 CFR 96.124(c)(1)	60	1		
	42 U.S.C. 300x-23		45 CFR 96.126(f)	60	1		
	42 U.S.C. 300x-27		45 CFR 96.131(f)	60	1		
	42 U.S.C. 300x-32(b)		45 CFR 96.122(g)	60	1	120	7,230
MHBG elements		42 U.S.C. 300x-1(b)		59	1	120	7,109
		42 U.S.C. 300x-1(b) (2)		59	1		
		42 U.S.C. 300x-2(a)		59	1		
	Waivers						3,240
	42 U.S.C. 300x-24(b)(5) (B)			20	1		
	42 U.S.C. 300x-28(d)		45 CFR 96.132(d)	5	1		
	42 U.S.C. 300x-30(c)		45 CFR 96.134(b)	10	1		
	42 U.S.C. 300x-31(c)			1	1		
	42 U.S.C. 300x-32(c)			7	1		
	42 U.S.C. 300x-32(e)			10			
		42 U.S.C. 300x-2(a)		10			

		(2)					
		42 U.S.C 300x-4(b) (3)		10			
		42 U.S.C 300x-6(b)		7			
Recordkeeping	42 U.S.C. 300x-23	42 U.S.C. 300x-3	45 CFR 96.126(c)	60	1	20	1200
	42 U.S.C. 300x-25		45 CFR 96.129(a)(13)	10	1	20	200
	42 U.S.C 300x-65		42 CFR Part 54	60	1	20	1200
Combined Burden							42,373

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:				
SUPTRS BG	60	1	187	11,220
MHBG	59	1	187	11,033
Recordkeeping	60	1	40	2360
Combined Burden				24,613

The total annualized burden for the application and reporting is

33,493 hours ($42,373 + 24,613 = 66,986/2 \text{ years} = 33,493$).

A.13. Estimate of Total Annualized Cost Burden to Respondents

There are no capital or start-up costs associated with this activity. States submitting applications are expected to use existing retrieval software systems to perform the necessary data extraction and tabulation. In addition, no operating, maintenance, or purchase of services costs will be incurred other than the usual and customary cost of doing business.

A.14. Estimates of Annualized Cost to the Government

(a) Staff support for regulation interpretation and enforcement:

OGC	(1) GS -14/6 (\$142,950) x .15 hours =	\$ 21,443
BG Staff	(3) GS – 14/6 (\$142,950) x 0.5 hours =	<u>\$214,425</u>

Total Cost: **\$235,868**

(b) Staff support for application review, compliance monitoring, technical assistance, and inquiries:

BG Staff	(34) GS – 13/5 (\$117,516) x .50 hours =	\$1,997,772
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A.15. Changes in Burden

There is an approximate change in burden of approximately one hour per participant to allow for changes. This accounts for approximately 0.5 hours per section of application (both for MHBG and SUPTRS BG) and the same for the changes to the respective reports.

A.16. Time Schedule, Publication, and Analysis Plans

The FFY2026-2027 MHBG and SUPTRS BG applications for those states who are submitting a combined behavioral health assessment and plan, or a stand-alone MHBG application is due on or before September 1, 2025, and for those states submitting a stand-alone SUPTRS BG application is due on October 1, 2025, for the two-year planning period.

For the Secretary of the U.S. Department of Health and Human Services, acting through the Assistant Secretary for Mental Health and Substance Use, to make an award under the programs involved, states must submit an application, prepared in accordance with the authorizing legislation, implementing regulation, if applicable, and guidance for the federal fiscal year for which a state is seeking funds. The funds awarded will be available for obligation and expenditures to plan, carry out, and evaluate activities and services described in the plan.

A grant may be awarded only if an application submitted by a state includes a state plan ^(2,3) in such form and containing such information including, but not limited to, detailed provisions for complying with each funding agreement for a grant under section 1911 of Title XIX, Part B, Subpart I of the PHS Act or section 1921 of Title XIX, Part B, Subpart II of the PHS Act that is applicable to a state. The state plan should include a description of how the state intends to obligate the MHBG and/or SUPTRS BG. The state plan must include a report ⁽⁴⁾ in such form and containing such information as the Secretary determines to be necessary for securing a record and a description of the purposes for which the grant was expended. The state plan should also describe the activities and services purchased by the states under the program involved and a description of the recipients and amounts provided in the grant. States will have

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

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

4 Section 1942(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a))

the option of updating their plans during the two-year planning cycle.

A.17. Display of Expiration Date

The expiration date for OMB approval will be displayed.

A.18. Exception to Certification Statement

This information collection involves no exception to the Certification for Paperwork Reduction Act Submissions. The certifications are included in this submission.

A.19. Collection of Information Employing Statistical Methods

This information collection does not involve statistical methods.

List of Attachments

- A. 2026-2027 Application Guidance & Instructions
 - 1. Planning Section
 - 2. Reporting Sections
 - 3. CEO Funding Agreements/Certifications
- B. Public Comments and SAMHSA's Response to the Comments