

Generic Supporting Statement
Medicaid Certified Community Behavioral Health Clinic (CCBHC) Services
State Plan Amendment Coverage Template
(CMS-10398 #99, OMB 0938-1148)

Notes: This 2026 iteration is being submitted to OMB for review and approval as a new generic collection of information request.

The contents of this Supporting Statement and the associated attachments have been reviewed to ensure that they are consistent with the Trump administration's policies, goals, and objectives.

A. Background

The Centers for Medicare & Medicaid Services (CMS) works in partnership with States to implement Medicaid and CHIP. Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to comply with new statutory provisions. CMS also continues to work with States through other methods, including program waivers and demonstrations, and other technical assistance initiatives.

The Center for Medicaid and CHIP Services (CMCS) adjudicates over 2,000 actions annually, including state plan amendments (SPAs), waiver applications, Advanced Planning Documents, and more. CMCS also engages in extensive work in the oversight of current programs, the development of new policy (regulations, State Medicaid letters, on-going technical assistance to states, etc.) to keep pace with state and industry innovations.

States will submit their amendments through [the One Medicaid and Chip \(OneMAC\) System](#) online submission portal where States can upload completed (PDF or Word) state plan pages. This portal was created to replace the previous email submission process with a standard point of submission. Please note, OneMAC accepts submissions independently and is not affiliated with the MACPro or MMDL system or process. Technical Assistance in submitting these plan pages will be available from CMS.

CMS review time can vary, based on any revisions needed by the state. Generally, once they are submitted, CMS has 90 days to review and approve or disapprove a submission or respond with a formal Request for Additional Information (RAI). The state's timeline for a response is indeterminate, generally less than 90 days. Once a response is received, CMS has 90 days to review and approve or disapprove the submission. The timeline is not expected to exceed 270 calendar days, but can be as little as 2 days for simple approvals involving no revisions or requests for additional information.

Approved SPAs are publicly posted to [Medicaid.gov](#). In accordance with 42 CFR 430.20, the effective date of a SPA may be no earlier than the first day of the quarter in which it was

submitted (with the exception of 1915(i) SPAs which must be approved with a prospective effective date).

B. Description of Information Collection

On March 9, 2024, section 209 in Title I of Division G of the Consolidated Appropriations Act, 2024 (CAA, 2024) (Pub. L. 118-42) amended section 1905 of the Social Security Act (the Act) to establish a new, optional Certified Community Behavioral Health Clinic (CCBHC) State plan benefit at section 1905(a)(31), and as defined in section 1905(jj) of the Act.¹ CCBHCs are defined at section 1905(jj)(2) as organizations that: 1) have been certified by the State Medicaid agency as meeting the most recent version of the CCBHC Certification Criteria (“the Certification Criteria”); 2) provide the nine service categories, such as crisis mental health services, defined at section 1905(jj)(1) and do so in a manner that reflects person-centered care; and 3) submit ongoing data on the provision of services, such as data on service encounters and clinical outcomes, to the State or Secretary. The Certification Criteria that States use to certify CCBHCs establish a basic level of service at which CCBHCs should operate.

While the CAA, 2024 enacted the new CCBHC State plan benefit, States have long had the option to apply to participate in a CCBHC Demonstration program established in 2014 under section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113-93) and to use Medicaid authorities to implement the CCBHC model to coordinate comprehensive mental health and substance use disorder treatment and support services.²

The amendments to the Act as a result of the passage of the CAA, 2024 provide the authority for SPAs to add this optional Medicaid coverage of section 1905(a)(31) CCBHC services. The attached template has been developed to simplify the SPA submission to add the 1905(a)(31) CCBHC services benefit to their State plan.

States submitting State plan pages adding optional coverage for the section 1905(a)(31) will be required to utilize and submit the template no later than the end of the quarter in which their effective date falls.

There are no plans to publish the reported information for statistical use.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

Wage Estimates

¹ Section 209, Title I, Division G, Consolidated Appropriations Act, 2024, Pub. L. 118-42, (enacted March 9, 2024). See: <https://www.congress.gov/118/bills/hr4366/BILLS-118hr4366enr.pdf>. Section 209 adds “certified community behavioral health clinic services” to the list of optional benefits in Section 1905 of the Social Security Act (the Act) with the addition of a new section 1905(a)(31).

² For more information on the CCBHC model of care, see: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

To derive average costs, we are using data from the U.S. Bureau of Labor Statistics' (BLS') May 2025 National Occupational Employment and Wage Statistics for all salary estimates (<https://www.bls.gov/oes/tables.htm>). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

BLS's wage estimates are updated annually. Current and historic wage figures can be found at the above BLS address and can be used to calculate current cost estimates. May 2025 is current as of the date of this collection of information request.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Business Operations Specialist	13-1000	44.63	44.63	89.26
General and Operations Manager	11-1021	64.87	64.87	129.74

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate the total cost is a reasonably accurate estimation method.

Requirements and Associated Burden Estimates

We estimate a potential of 56 Medicaid respondents consisting of 50 States, the District of Columbia, American Samoa, Commonwealth of the Mariana Islands, Guam, Puerto Rico, and the US Virgin Islands.

We estimate it will take a Business Operations Specialist 2 hours at \$89.26/hr to prepare an initial SPA and potentially make occasional and periodic amendments to their SPA pages. We also estimate that it will take a General and Operations Manager 3 hours at \$129.74/hr to review and approve the SPA for submission to CMS.

In aggregate we estimate a one-time state burden of 280 hours (56 states x 5 hr/response) at a cost of \$31,793 [(2 hr x \$89.26/hr x 56 states) + (3 hr x \$129.74/hr x 56 states)] or a maximum state share of \$15,897 (\$31,793 * 0.5) when considering the 50 percent Federal Financial Participation (FFP) federal match rate for general administration.

Since we have no reliable basis for estimating the number of template amendments we may receive each year, the 280-hour estimate is an annual figure that addresses the initial one-time burden at the beginning of this effort as well as the occasional burden for preparing and submitting amendments. We acknowledge that this is likely an overestimate, but we will refine our on-going estimates if/when applicable.

Burden Summary

Requirements	Number of Respondents	Total Number of Responses	Time per Response (hours)	Total Time (hours)	Labor Rate (\$/hr)	Total Cost (\$)	Fed Match (\$)	State Share (\$)
CCBHC SPA Template	56 States	56	5	280	varies	31,793	15,897	15,897

Information Collection Instruments and Instruction Documents

- Medicaid CCBHC Services SPA Coverage Template (New)

E. Timeline

The 14-day notice published in the Federal Register on April 16, 2026 (91 FR 20458). Comments were received and are attached to this collection of information request along with our response to such comments.

CMS hopes to deploy this collection within 30 - 45 days from our submission to OMB. These Medicaid state plan documents are essential for States implementing the new benefit and should be available as soon as possible. States will need adequate time to complete and vet these documents.