

Generic Supporting Statement
Certified Community Behavioral Health Clinic (CCBHC) Cost Report
CMS-10398 #43, OMB 0938-1148

This 2025 iteration revises our active 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. This includes compliance with Executive Order 14168 and OMB’s SPD 15 standards.

A. Background

Certified Community Behavioral Health Clinics (CCBHCs) are designated clinics that provide mental health and substance use disorder care to individuals regardless of their ability to pay for services, or place of residence. As critical components of the public mental health system, these clinics were initially authorized under Section 223 of the 2014 Protecting Access to Medicare Act (PAMA) under “Demonstration Programs to Improve Community Mental Health Services.” The initial two-year federal demonstration project enabled CCBHCs to be paid through prospective payment systems (PPS) by state Medicaid programs. To support participation, the PAMA appropriated Federal funding which allowed the Centers for Medicare & Medicaid Services (CMS) in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA) to award one-year planning grants to states to develop their CCBHC programs and to apply to join the demonstration. The table below summarizes how the demonstration has expanded since its initial authorization.

2014 PAMA	<ul style="list-style-type: none">Following a one-year planning grant awarded to 24 states in 2015, eight states were selected in 2016 to implement the CCBHC demonstration beginning in 2017.
2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act	<ul style="list-style-type: none">CARES Act directed HHS to select two additional demonstration states.Michigan and Kentucky were selected and launched their demonstration programs in 2021 and 2022, respectively.
2022 Bipartisan Safer Communities Act (BSCA)	<ul style="list-style-type: none">Section 1101 of the BSCA extended the demonstration through September 2025 for the original eight states and allowed for an additional 10 states to be added to the demonstration in 2024 and 2026.Following a one-year planning grant awarded to 15 states in 2023, ten states were selected to implement the CCBHC demonstration as early as July 2024.In January 2025, 15 additional states were awarded a one-year planning grant and will be eligible to apply to be selected for the next cohort of 10 demonstration states to be added in 2026.

When the demonstration for the original eight states ends in September 2025, there will be 22 states remaining in the demonstration (2 states added as part of the 2020 CARES Act and 20 states added by the BSCA). Thus, we calculated burden estimates assuming 22 demonstration states.

CCBHCs are required to meet 6 program requirements related to staffing, available and accessible services, care coordination, scope of services, quality and other reporting, and their organizational authority, governance and accreditation. The requirements to provide available and accessible services include a requirement that CCBHCs offer crisis management services 24

hours a day. A state health official letter released on December 28, 2021 (SHO # 21-008) describes the optional benefit for states to claim up to 85 percent federal medical assistance percentage (FMAP) matching rate allowable under section 9813 of the American Rescue Plan Act of 2021¹ for expenditures associated with qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within a five-year period during which a state meets the conditions outlined in statute to qualify for the increased match². To enable CCBHCs to take advantage of this opportunity, on May 12, 2023, CMS released proposed updates to the 2015 CMS CCBHC PPS Technical Guide for public comment on Medicaid.gov for two weeks, followed by a listening session with states. The updates included two additional PPS rate options (Certified Clinic (CC) PPS-3 and PPS-4) that were proposed to address the high costs associated with mobile crisis intervention services and other crisis services provided onsite at a crisis stabilization facility. CC PPS-3 which is a daily payment rate, and CC PPS-4, the monthly rate option supports expansion of crisis intervention services and gives states and clinics flexibility to address the special needs and characteristics of these types of services that may affect provider reimbursement³. Based on positive feedback from states on the two additional rate methodologies, as well as feedback on restructuring the quality bonus payment (QBP) requirements and standardized rebasing timeframes, CMS released updates to the formal [CCBHC PPS Technical Guidance](#) in February 2024 along with the related Quality Measures for Behavioral Health Clinics Technical Specifications (CMS-10398 #48, OMB #0938-1148) and Resource Manual and Guidance to Planning Grant States to Apply to Participate in the Section 223 CCBHC Demonstration Program (CMS-10398 #45, OMB #0938-1148).

The pertinent changes to the cost report materials in September 2025 are:

- In April 2024, the Office of Management and Budget (OMB) revised requirements under 2 CFR 200.414 to increase the minimum federal indirect rate from 10% to up to 15% for eligible contractors, effective October 1, 2024. Additionally, the certification language in 2 CFR 200.415 was revised. The cost report template, instructions, and cost report elements for states required revisions to comply with those changes.
- The instructions for the trial balance tab have been updated to clarify how states should report fringe benefits.
- In the cost report template and reflected in the cost report elements for states, fields were added for states to indicate whether the cost report is being used to rebase or whether an MEI-adjusted rate is being paid during the rate period.
- In the cost report template, a field was added to indicate whether the location is a satellite facility.
- Guidance for states' review of the cost report were added to the instructions.

B. Description of Information Collection

The CCBHC cost report allows clinics in the demonstration to calculate PPS rates using clinic-specific cost and visit data associated with delivery of the 9 statutory services as outlined under the authorizing PAMA at section 223(D) Scope of Services. CCBHCs used the cost report to

¹ <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>

² <https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf>

³ <https://www.medicaid.gov/sites/default/files/2023-07/ccbh-pps-prop-updates.pdf>

calculate rates based on the existing CC PPS-1 daily, or CC PPS-2 monthly rate that did not include separate crisis rate options. Calculation of the new daily and monthly special crisis services PPS rates required CMS to revise the existing CCBHC cost report to include the addition of worksheets to address the new crisis rate offerings that were finalized in the February 2024 CCBHC Technical Guidance. Special crisis services (SCS) rates were made effective January 1, 2024, for any existing states that are interested in implementing either CC PPS-3 or CC PPS-4. New states entering the program beginning in July 2024 have the option to choose from among the four PPS rate options made available under the 2024 [Technical Guidance](#) and CCBHC cost report.

CCBHCs in states that choose the CC PPS-2 rate methodology will require additional time to gather data for special populations and account for outlier thresholds. States and clinics selecting either the CC PPS-3 or CC PPS-4 crisis rate methodology will require additional time to separate costs and visit data for up to three special crisis services rates.

Because use of the cost report involves participation in the CCBHC demonstration program, the information is expected to be collected annually, assuming rates are trended forward for the second year of the program using the Medicare Economic Index (MEI), rebased in the third year of the demonstration and trended forward for the fourth year of the demonstration using the MEI. However, if the state requires CCBHCs to rebase rates for other years of the demonstration using CCBHC cost report data, the provider would be required to complete the cost report each time the state rebases the rate. CMS does also require CCBHC demonstration states to submit cost reports in trended years although rates may only reflect changes based on MEI adjustment for inflationary changes. The state should indicate if the current cost report is used to rebase for the rate period or the rate that will be paid during the rate period if the rate changes solely by an MEI adjustment.

C. Deviations from Generic Request

This collection of information request does not include any deviations.

D. Burden Hour Deduction

Wage Data

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2024 National Occupational Employment and Wage Estimates for all salary estimates (https://www.bls.gov/oes/2024/may/oes_nat.htm). In this regard, the following table presents BLS' median hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Accountants and Auditors	13-2011	44.96	44.96	89.92
Chief Executive	11-1011	126.41	126.41	252.82

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Financial Manager	11-3031	86.76	86.76	173.52

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 total cost is a reasonably accurate estimation method.

Collection of Information Requirements and Associated Burden Estimates

The same cost report is used for rebasing and trending by MEI, and there is no difference in burden for completing the cost report for either of those purposes. Cost reports are only completed annually per section 2.5 of the [PPS guidance](#). PPS rates are effective for the entire demonstration year and may not be changed during the demonstration year.

CCBHC Burden

The burden for CCBHCs to complete the cost report is estimated to average 56.33 hours per response for CC PPS-1, 112.66 hours per response for CC PPS-2, 72.33 hours per response for CC PPS-3, and 132.66 hours per response for CC PPS-4. This includes time for reviewing instructions, searching existing data sources, analyzing that data, and completing and reviewing the collection of information.

Since CC PPS-2 rate methodology requires additional time to gather data for certain populations, we anticipate that it would take twice as long ($112.66 \text{ hr} = 56.33 \text{ for CC PPS-1 hr} \times 2$) to complete and review each cost report. Since CC PPS-3 and CC PPS-4 rate methodologies require additional time to parse out costs and visit data for each special crisis service rate, we anticipate the extra time needed would be 16 hours for CC PPS-3 ($72.33 \text{ hr} = 56.33 \text{ hr for CC PPS-1} + 16 \text{ hr}$) and 20 hours for CC PPS-4 ($132.66 \text{ hr} = 112.66 \text{ hr for CC PPS-2} + 20 \text{ hr}$) as most of this data is already available for CC PPS-1 and CC PPS-2, respectively.

We anticipate that the complexity of the cost report and the certification requirements will require varying levels of employees to gather, input, and review the data.

Regardless of the methodology used, we expect that an Accountant and Auditor (13-2011) at a rate of \$89.92/hr would complete the report and that a Chief Executive (11-1011) at a rate of \$252.82/hr would review and certify the report.

Projecting a total of 220 CCBHC respondents (at 10 clinics per state), we anticipate 150 respondents for CC PPS-1 (15 states x 10 clinics per state), 40 respondents for CC PPS-2 (4 states x 10 clinics per state), 20 respondents for CC PPS-3 (2 states x 10 clinics per state) and 10 respondents for CC PPS-4 (1 state x 10 clinics per state), based on polling data during the technical assistance sessions and experience from the states currently participating in the demonstration.

For 150 **CC PPS-1** cost reports, we estimate an annual burden of 8,450 hours (150 responses x 56.33 hr/response) at a cost of \$808,649 [(150 responses x 54.33 hr x \$89.92/hr) + (150 responses x 2 hr x \$252.82/hr)].

For 40 **CC PPS-2** cost reports we estimate an annual burden of 4,506 hours (40 responses x 112.66 hr/response) at a cost of \$431,279 [(40 responses x 108.66 hr x \$89.92/hr) + (40 responses x 4 hr x \$252.82/hr)].

For 20 **CC PPS-3** cost reports, we estimate an annual burden of 1,447 hours (20 responses x 72.33 hr/response) at a cost of \$136,594 [(20 responses x 70.33 hr x \$89.92/hr) + (20 responses x 2 hr x \$252.82/hr)].

For 10 **CC PPS-4** cost reports, we estimate an annual burden of 1,327 hours (10 responses x 132.66 hr/response) at a cost of \$125,804 [(10 responses x 128.66 hr x \$89.92/hr) + (10 responses x 4 hr x \$252.82/hr)].

CCBHC Burden Summary

Cost Report	No. Respondents	Total No. Responses	Time per response (hr)	Total Time (hr)	Adjusted Hourly Wage (\$/hr)	Total Cost (\$)
CC PPS-1	150	150	54.33	8,150	89.92	732,803
			2	300	252.82	75,846
<i>Subtotal: CC PPS-1</i>	<i>150</i>	<i>150</i>	<i>varies</i>	<i>8,450</i>	<i>varies</i>	<i>808,649</i>
CC PPS-2	40	40	108.66	4,346	89.92	390,828
			4	160	252.82	40,451
<i>Subtotal: CC PPS-2</i>	<i>40</i>	<i>40</i>	<i>varies</i>	<i>4,506</i>	<i>varies</i>	<i>431,279</i>
CC PPS-3	20	20	70.33	1,407	89.92	126,481
			2	40	252.82	10,113
<i>Subtotal: CC PPS-3</i>	<i>20</i>	<i>20</i>	<i>varies</i>	<i>1,447</i>	<i>varies</i>	<i>136,594</i>
CC PPS-4	10	10	128.66	1,287	89.92	115,691
			4	40	252.82	10,113
<i>Subtotal: CC PPS-4</i>	<i>10</i>	<i>10</i>	<i>varies</i>	<i>1,327</i>	<i>varies</i>	<i>125,804</i>
TOTAL	220	220	varies	15,729	varies	1,502,327

State Burden

States will be required to review the cost reports through a desk-review or an audit. We estimate the average time for a Financial Manager (11-3031) at a rate of \$173.52/hr to complete a desk review is: 22 hours for CC PPS-1, 44 hours for CC PPS-2, 30 hours for CC PPS-3, and 52 hours for CC PPS-4.

Projecting a total of 220 CCBHC respondents (at 10 clinics per state), we anticipate 150 respondents for CC PPS-1 (15 states x 10 clinics per state), 40 respondents for CC PPS-2 (4 states x 10 clinics per state), 20 respondents for CC PPS-3 (2 states x 10 clinics per state) and 10 respondents for CC PPS-4 (1 state x 10 clinics per state), based on polling data during the technical assistance sessions and experience from the states currently participating in the demonstration.

For 150 **CC PPS-1** cost reports, we estimate an annual burden of 3,300 hours (22 hr x 150 reports) at a cost of \$572,616 (3,300 hr x \$173.52/hr).

For 40 **CC PPS-2** cost reports, we estimate an annual burden of 1,760 hours (44 hr x 40 reports) at a cost of \$305,395 (1,760 hr x \$173.52/hr).

For 20 **CC PPS-3** cost reports, we estimate an annual burden of 600 hours (30 hr x 20 reports) at a cost of \$104,112 (600 hr x \$173.52/hr).

For 10 **CC PPS-4** cost reports, we estimate an annual burden of 520 hours (52 hr x 10 reports) at a cost of \$90,230 (520 hr x \$173.52/hr).

In aggregate for all PPS methodologies, we estimate an annual burden of 6,180 hours at a cost of \$1,072,354.

The CCBHC Cost Report Elements for States is provided to states as a guide for use when in lieu of using the Federal OMB approved CCBHC cost report, the state may choose to modify an existing state-level cost report to align with elements as outlined in the CCBHC cost report crosswalk. For those using the crosswalk, there may be additional time requirements needed to make revisions to an existing state cost report, which will depend on the areas they are changing, and how broad and deep the changes are. We estimate any modifications to the state specific cost report along with edits to supplemental instructions, could take an additional 1 to 4 hours of time depending on these factors. The state must submit the revised state-level cost report to CMS for review to ensure alignment with the Federal CCBHC cost report and crosswalk elements prior to use.

State Burden Summary

Cost Report	No. Respondents	Total No. Responses	Time per response (hr)	Total Time (hr)	Adjusted Hourly Wage (\$/hr)	Total Cost (\$)
CC PPS-1	15	150	22	3,300	173.52	572,616
CC PPS-2	4	40	44	1,760	173.52	305,395
CC PPS-3	2	20	30	600	173.52	104,112

CC PPS-4	1	10	52	520	173.52	90,230
TOTAL	22	220	varies	6,180	173.52	1,072,354

Total Burden

Total CCBHC and State Burden

Cost Report	No. Respondents	Total No. Responses	Time per response (hr)	Total Time (hr)	Adjusted Hourly Wage (\$/hr)	Total Cost (\$)
CCBHC Burden	220	220	varies	15,729	varies	1,502,327
State Burden	22	220	varies	6,180	173.52	1,072,354
TOTAL	242	440	varies	21,909	varies	2,574,680

Collection of Information Instruments and Instructions

- CCBHC Cost Report (Revised, see the attached Crosswalk and Redline for details)
- CCBHC Cost Report Elements for States (Revised, see the attached Crosswalk and Redline for details)
- CCBHC Cost Report Instructions (Revised, see the attached Crosswalk and Redline for details)

E. Timeline

The 14-day notice published in the Federal Register on November 26, 2025 (90 FR 54328). Comments must be received on/by December 10, 2025.

We request OMB's approval as soon as possible, but no later than 30 days from the date the package is submitted to OMB. Ideally, we would like to make the updated CCBHC Cost Report and instructions available for state use on October 30, 2025.