State Plan under Title XIX of the Social Security Act
State/Territory: [Select State or Territory]

Section 1905(a)(31) and 1905(jj)
Certified Community Behavioral Health Clinic (CCBHC) Services

The state provides coverage for this optional benefit as defined at sections §§1905(a)(31) and 1905(jj) of the Social Security Act (the Act) as follows:

CCBHC Mandatory Assurances (Required)
[Select all checkboxes below.]

☐ The state assures coverage of all nine (9) mandatory categories of service listed below and described in 1905(jj)(1) of the Act.

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization;
2. Screening, assessment, and diagnosis, including risk assessment;
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
4. Outpatient mental health and substance use services;
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk;
6. Intensive case management services;
7. Psychiatric rehabilitation services;
8. Peer support and counselor services and family supports; and
9. Intensive, community-based mental health care for members of the armed forces and veterans who are eligible for medical assistance, particularly such members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

☐ The state assures coverage of all mandatory services as specified in the Substance Abuse and Mental Health Services Administration CCBHC Certification Criteria (CCBHC Certification Criteria).

☐ The state assures that all CCBHC services are furnished in a manner reflecting person-centered care which, if not available directly through a certified CCBHC, may be provided or referred through formal relationships with other providers in accordance with 1905(jj)(1) and 1905(jj)(2) of the Act.

PRA Disclosure Statement - This use of this form is mandatory, and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing sections §§1905(a)(31) and 1905(jj) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #99). Public burden for all of the collection of information requirements under this control number is estimated to take about 5 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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☐ CCBHC organizations have been certified by the state as meeting the definition at 1905(jj)(2), including the CCBHC Certification Criteria.

☐ The state has a reasonable process to ensure that CCBHC organizations will meet the most recent version of the CCBHC Certification Criteria and make any updates necessary when changes are made to the criteria to comply with those revisions, including updates to coverage of mandatory services.

Optional CCBHC Services (Mandatory if covering optional services)
[Select the checkbox below for coverage of additional CCBHC services at the state's option.]

☐ The state will cover additional optional CCBHC services in alignment with the CCBHC Certification Criteria.

The state may describe in the text box below (Optional):

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Coverage Limitations (Mandatory if the state has any coverage limitations)
[Select the checkbox below to indicate coverage limitations on amount, duration or scope and describe. Please indicate if limits can be exceeded based on medical necessity.]

☐ This benefit has a coverage limitation.

Additional Benefit Description (Optional)
At its option, the state may provide additional information below. **[Describe below.]**:

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