Appendix A.5: NJ CCBHC Modifications to SAMSHA Criteria

New Jersey CCBHC Criteria[1]	New Jersey Modifications from SAMHSA Criteria
Section 1: Staffing **Program Requirement 1b (Licensure and credentialling of providers)**	
1.b.2 The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and	• Minor addition of “in accordance with NJ law and regulations” in reference to technologies used by CCBHCs.

[1] Text in red font indicates added language to the criteria. Text that has been struck out indicates language deleted from the criteria.

subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers. Note: Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies in accordance with New Jersey laws and regulations, to the extent possible, to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision.	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 2: Availability and Accessibility of Services **Program Requirement 2b (Requirements for timely access to services and assessment)**	
2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in-person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up. If the triage identifies an	• Amended language to require CCBHCs to request and review recent information with the person receiving services and to incorporate this information into the CCBHC health records.

urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made. If the triage identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. ~~At the~~ CCBHC's must ~~discretion~~, review recent information ~~may be reviewed~~ with the person receiving services and incorporate~~d~~ it into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period.	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 3: Care Coordination **Program Requirement 3b (Health information systems)**	
3.b.1 The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. Or utilizes any state developed database or sanctioned system required by DHS.	• Minor edits to add clarification to the last sentence in the requirement.
3.b.2 The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement	• Removed last sentence due to a lack of clarity in the requirement.

and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. ~~While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.~~	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 3: Care Coordination **Program Requirement 3c (Agreements to support care coordination)**	
3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: • Schools • Child welfare agencies • Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty crisis) • State licensed and nationally accredited child placing agencies for therapeutic foster care service • Other social and human services. • CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following:	• Added veterans service organizations to the list of possible partnerships. • Added a requirement for CCBHCs to develop a care coordination partnership with all 988 Suicide & Crisis Lifeline call centers and to use the DHS-developed template for this agreement.

○ Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders. ○ Suicide and crisis hotlines and warmlines ○ Veterans service organizations ○ Indian Health Service or other tribal programs ○ Homeless shelters ○ Housing agencies ○ Employment services systems ○ Peer-operated programs ○ Services for older adults, such as Area Agencies on Aging Aging and Disability Resource Centers ○ State and local health departments and behavioral health and developmental disabilities agencies ○ Substance use prevention and harm reduction programs ○ Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers ○ Legal aid ○ Immigrant and refugee services ○ SUD Recovery/Transitional housing ○ Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs ○ Coordinated Specialty Care programs for first episode psychosis ○ Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food, and transportation programs) In addition, the CCBHC has a care coordination partnership with ~~the~~ all 988 Suicide & Crisis Lifeline call centers. ~~serving the area in which the CCBHC is located.~~ The agreement clarifies referral and care coordination activities between the CCBHC and the 988 Lifeline Center by outlining roles and responsibilities of each party. CCBHCs must use the approved template developed by DHS for this care coordination agreement (See Appendix A.7).	

Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4a (General service provisions)**	
4.a.1 Whether delivered directly or through a DCO agreement or care coordination agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person centered and family-centered treatment planning; outpatient ~~behavioral~~ mental health and substance use services; outpatient primary care screening and monitoring; comprehensive ~~targeted case~~ care management; psychiatric rehabilitation; and peer support and counselor services and family supports. ~~and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.~~ ~~The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.~~	• Removed "intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans" as a covered service. • Removed the requirement that at least 51% of encounters are provided directly by the CCBHC; CCBHCs are directed to provide specific services rather than a majority percentage. • Minor, non-substantive changes to verbiage throughout; including naming convention for targeted case management to comprehensive care management.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4b (Requirement of person-centered and family-centered care)**	
4.b.1 The CCBHC ensures all CCBHC services, including those supplied by its DCOs or through a care coordination agreement, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family centered, recovery-oriented care; being	• Minor change indicating services may be provided via DCO or through a care coordination agreement for peer and family support services provided through a peer-run or family support agency.

respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach. ***Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.***	
4.b.2 Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation, and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. ~~For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.~~	• Removed reference to services being provided by a tribal organization on account of no federally recognized tribes in New Jersey. • Minor, non-substantive changes to verbiage.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4c (Crisis behavioral health services)**	
4.c.1 The CCBHC shall provide immediate crisis receiving/intervention services directly and State-sanctioned crisis services directly or through a DCO agreement or care coordination agreement ~~with existing state-sanctioned, certified, or licensed system or network~~ for the provision of crisis behavioral health services. ~~HHS recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so.~~ ~~PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO~~	• Clarifies that State-sanctioned crisis services must be provided by a DCO or care coordination agreement (where applicable).

CCBHCs must have the internal capability to deliver immediate crisis intervention services in walk-in scenarios, in addition to offering crisis services to current service recipients as necessary within the treatment framework. • Crisis receiving/intervention: The CCBHC provides crisis receiving/intervention services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. State-sanctioned crisis services must be provided by a DCO agreement or care coordination agreement (as appropriate), including: • Emergency crisis intervention services: The ~~CCBHC~~ DCO provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC)21 systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile	

crisis team response, crisis stabilization, and post crisis follow-up care. • 24-hour mobile crisis teams: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (two hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed three hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the two-hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan. Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises. ***Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning,***	

including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4d (Screening, assessment, and diagnosis)**	
4.d.1 The CCBHC directly ~~or through a DCO,~~ provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. ***Note: See program requirement 3 regarding coordination of services and treatment planning.***	Screening, assessment, and diagnosis, including risk assessment must be provided directly by the CCBHC rather than through a DCO.
4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum: 1. Preliminary diagnoses. 2. The source of referral. 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved. 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services. 5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications. 6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful.	• Minor edit to item 7 – Added “abuse” in reference to alcohol and/or other drugs

7. The use/abuse of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications. 8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors. 9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence. 10. Assessment of need for medical care (with referral and follow-up as required). 11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services. For children and youth, whether they have system involvement (such as child welfare and juvenile justice).	
4.d.4 A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable State, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include: 1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. 2. An overview of relevant social supports; social determinants of health; and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. 3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP. 4. Pregnancy and/or parenting status. 5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.	• Minor edit to item 9 – Added “drug and alcohol” in reference to substance use disorder

6. Relevant medical history and major health conditions that impact current psychological status. 7. A medication list including prescriptions, over -the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. 8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement based care) and 9. Drug and alcohol history substance use disorders (including tobacco, alcohol, and other drugs). 10. Basic cognitive screening for cognitive impairment. 11. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. 12. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. 13. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, ~~targeted case~~ comprehensive care management, psychiatric rehabilitation services). 14. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. 15. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. 16. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.	
4.d.5	• Clarifies that CCBHCs are accountable to State identified measures, rather than those identified in SAMHSA criteria.

Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and applicable clinic-collected quality measures identified by the State ~~and Appendix B of these criteria. The CCBHC should not take non-inclusion of a specific metric as a reason not to provide clinically indicated behavioral health screening or assessment. The state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.4 or Appendix B.~~	• Removed the last sentence to improve clarity of the requirement.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4e (Person~~-centered~~ and family-centered treatment planning**	
4.e.1 The CCBHC directly ~~, or through a DCO,~~ provides person~~-centered~~ and family-centered treatment planning, including but not limited to, risk assessment and crisis planning ~~(CCBHCs may work collaboratively with DCOs to complete these activities~~. Person~~-centered~~ and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person receiving services involvement and self-direction. ***Note: See program requirement 3 related to coordination of care and treatment planning.***	• Person and family-centered treatment planning must be provided directly by the CCBHC rather than through a DCO. • Minor, non-substantive changes to verbiage.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4f (Outpatient mental health and substance use services)**	
4.f.1 The CCBHC directly~~, or through a DCO,~~ provides outpatient behavioral health care, including psychopharmacological treatment (ASAM WM-1 must be provided directly by the CCBHC; higher ASAM levels of care may be provided through a DCO or care coordination agreement). The CCBHC ~~or the DCO~~ must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall	• Outpatient mental health and substance use services must be provided directly by the CCBHC rather than through a DCO (with the exception of ASAM levels above WM-1, which may be provided through a DCO or care coordination agreement). • Removed struck out language to improve clarity of the requirement.

be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through ~~referral or other formal arrangement~~ a care coordination agreement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with State and federal laws and regulations. ~~The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC area.~~ Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. ***Note: See also program requirement 3 regarding coordination of services and treatment planning.***	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4g (Outpatient clinical primary care screening and monitoring)**	
4.g.1 The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. ~~Whether directly provided by the CCBHC or through a DCO,~~ The CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations of DOH, DHS and other established medical organizations ~~with scores of A and B, of the United States Preventive Services Task Force Recommendations~~ (these recommendations specify for which populations screening is appropriate) for the following conditions:	• Outpatient clinical primary care screening and monitoring must be provided directly by the CCBHC rather than through a DCO. • Removes the reference to the US Preventive Services Task Force • Removes reference to Appendix B.

• HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and other Reporting and **applicable** clinic-collected quality measures identified by the State ~~Appendix B~~ • Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director, and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population	
4.g.2 The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions (e.g., tobacco use, weight/BMI, and diabetes risk) and any conditions or diseases that are relevant or prevalent in the population being served or that are treatment-related). ~~experienced by CCBHC populations across the lifespan.~~ Protocols will include: • Identifying people receiving services with chronic diseases. • Ensuring that people receiving services are asked about physical health symptoms; and • Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider or with an affiliated primary care staff person on or off site to ensure that screenings occur for the identified conditions. The CCBHC should establish an agreement with the nearest FQHC if there are multiple clients who access services at the FQHC or could reasonably access services from the FQHC outside of the service area if there is not a FQHC in the service area. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.	• Identifies new primary care screening and monitoring expectations. • Increases coordination of care expectations with primary care providers on and off site of the CCBHC, including with FQHCs who may serve CCBHC members for primary care services.

4.g.3 The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following: • Ensuring individuals have access to primary care services. • Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions. • Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and • Promoting a healthy behavior lifestyle. • Assessing and resolving issues of polypharmacy, medication side-effects, and contraindications. Medical and nursing staff within CCBHCs are responsible for obtaining and monitoring vital signs (e.g., weight, height, temperature, pulse rate, and blood pressure) and these staff shall monitor routine blood work (e.g., hemoglobin A1C control for clients with diabetes, metabolic indices such as a lipid panel, etc.). Note: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the ~~Section 223 CCBHC demonstration~~ PPS. ***Note: See also program requirement 3 regarding coordination of services and treatment planning.***	• Expands responsibilities of CCBHC medical staff to obtain and monitor vital signs and routine blood work. • Removed reference to the Section 223 demonstration. • Added #5 - Requiring CCBHCs to assess and resolve issues of issues of polypharmacy, medication side-effects, and contraindications.
4.h.1 The CCBHC is responsible for providing directly ~~, or through a DCO, targeted~~ comprehensive ~~case~~ care management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, behavioral health, ~~social, legal, educational, housing, vocational,~~ and other services and supports to restore the beneficiary to their best possible functional level. CCBHC ~~targeted~~ comprehensive ~~case~~ care management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC	• Changed terminology of Targeted Case Management to Comprehensive ~~case~~ care Management. • Comprehensive care management must be provided directly by the CCBHC rather than through a DCO.

comprehensive care ~~targeted case~~ management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC ~~targeted~~ comprehensive ~~case~~ care management should also be used accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC ~~targeted~~ comprehensive ~~case~~ care management should be used for individuals with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. ~~Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services.~~	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4i (Psychiatric rehabilitation services)**	
4.i.1 The CCBHC is responsible for providing directly, or through a DCO or care coordination agreement, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery support that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers. Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with ongoing support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to:	• Added the option of delivering via a care coordination agreement.

• Participate in supported education and other educational services; • Achieve social inclusion and community connectedness; • Participate in medication education, self-management, and/or individual and family/caregiver psychoeducation; and • Find and maintain safe and stable housing. Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers. ***Note: See program requirement 3 regarding coordination of services and treatment planning***	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4j (Peer supports, Peer Counseling, and Family/Caregiver Supports)**	
4.j.1 The CCBHC is responsible for directly providing ~~or through a DCO,~~ peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites26; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support. **CCBHCs may have a DCO with** peer-run organizations or family support services organizations for the delivery of their services.	• Onsite peer and family support services must be provided directly by the CCBHC rather than through a DCO. • CCBHCs may have a DCO with peer-run organizations or family support services organizations. Previously, CCBHCs were allowed to partner with these organizations through a referral agreement.

Note: See program requirement 3 regarding coordination of services and treatment planning.	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4k (Intensive, community-based mental health care for members of the armed forces and veterans)**	
Section 4k criteria is removed. ***Although not an explicit Medicaid-covered benefit, it is strongly encouraged for CCBHCs to adhere to the federal criteria regarding intensive, community-based mental health care for members of the armed forces and veterans. This includes criteria 4.k.1 – 4.k.7***	
~~**4.k.1**~~ ~~The CCBHC is responsible for providing directly, or through a DCO, intensive, community- based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook~~ ~~Note: See program requirement 3 regarding coordination of services and treatment planning.~~	
~~**4.k.2**~~ ~~All individuals inquiring about services are asked whether they have ever served in the U.S. military. Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner: 1. Active-Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF. 2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME~~	

~~Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations. 3. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE authorized provider, network or nonnetwork. Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). Note: See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.~~	
~~**4.k.3**~~ ~~The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.~~	
~~**4.k.4**~~ ~~Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:~~ ~~1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required.~~ ~~2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.~~	

3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision-maker's consent when the veteran does not have adequate decision-making capacity). 4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. 5. The treatment plan is revised, when necessary. 6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision-making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2). 7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.	
4.k.5 Behavioral health services are recovery - oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and	

~~strive to reach their full potential." The following are the 10 guiding principles of recovery:~~ ~~• Hope~~ ~~• Person-driven~~ ~~• Many pathways~~ ~~• Holistic~~ ~~• Peer support~~ ~~• Relational~~ ~~• Culture~~ ~~• Addresses trauma~~ ~~• Strengths/responsibility~~ ~~• Respect~~ ~~As implemented in VHA recovery, the recovery principles also include the following:~~ ~~• Privacy~~ ~~• Security~~ ~~• Honor~~ ~~Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.~~	
~~**4.k.6**~~ ~~All behavioral health care is provided with cultural competence.~~ ~~1. Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.~~ ~~2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.~~	
~~**4.k.7**~~ ~~There is a behavioral health treatment plan for all veterans receiving behavioral health services.~~ ~~1. The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.~~	

~~2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.~~ ~~3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.~~ ~~4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.~~ ~~5. The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.~~	

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 5: Quality and Other Reporting **Program Requirement 5a (Data collection, reporting, and tracking**	
5.a.1 The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below.~~ and in Appendix B. Where feasible, information about people receiving services and care delivery should be captured electronically,using widely available standards.~~ Capacity to collect, report and track data is dependent on Health Information Systems as delineated in Section 3.b of these criteria and Section 9 of the Policy Manual.	• Modified to remove a reference of Appendix B in the SAMHSA CCBHC Criteria. • Refers CCBHCs to Section 3.b of these criteria and Section 9 Policy Manual for requirements pertaining to Health Information Systems.
5.a.2 ~~Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants beginning in 2022~~CCBHCs must collect and report the ~~Clinic-Collected~~ quality measures identified as required in ~~Appendix B~~ Section 9 of the Policy Manual (and Section 8.2.3. of the Policy Manual and related guidance for Quality Incentive Payment measures). ~~Reporting is annual and, for Clinic-Collected quality measures, reporting is~~	• Modified to remove references to the federal demonstration and referred to the policy manual for quality measure reporting requirements.

~~required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA.~~ ~~« States participating in the Section 223 Demonstration must report State-Collected quality measures identified as required in Appendix B. The State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications. Certifying states also may require certified CCBHCs to collect and report any of the optional Clinic-Collected measures identified in Appendix B. Section 223 Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State Collected or Clinic-Collected). Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12 months after the end of the measurement year, as that term is defined in the technical specifications. States participating in the Section 223 Demonstration program are expected to share the results from the State-Collected measures with their Section 223 Demonstration program CCBHCs in a timely fashion. For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report. Note: CCBHCs may be required to report on quality measures through DCOs as a result of participating in a state CCBHC program separate from the Section 223 Demonstration, such as a program to support the CCBHC model through the state Medicaid plan.~~	
~~**5.a.3**~~ ~~In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC identifiable Medicaid claims or encounter data to the~~	• Removed this requirement.

~~evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.~~	
5.a.4 CCBHCs must submit annual cost reports to the State as required by the CCBHC SPA and Section 8 of the Policy Manual. ~~participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS.~~ ~~Note: In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC.~~	• Modified to remove references to the federal demonstration and included cost report submission requirements as cited in the SPA and the Policy Manual.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 5: Quality and Other Reporting **Program Requirement 5b (Continuous quality improvement planning)**	
5.b.1 In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided on an annual basis at minimum. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.	• Added a requirement for CCBHCs to implement a CQI plan on an annual basis at a minimum.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 5: Quality and Other Reporting **Program Requirement 5b (Continuous quality improvement planning)**	
5.b.3 The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting ~~from the CCBHC collected and, as applicable for the Section 223 Demonstration, State-Collected~~ from the required quality measures ~~that may be required as part of the Demonstration~~ reporting as cited in criterion 5.a.2 (including focus on poor performance on one or more of the required quality measures). The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.	• Modified to remove reference to the federal demonstration and referred to the quality measure reporting requirements cited in criterion 5.a.2. • Added a requirement for the CQI plan to include a focus on poor performance on one or more of the required quality measures.

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 6: Organizational Authority, Governance, and Accreditation **Program Requirement 6c (Accreditation)**	
6.c.2 CCBHCs must be certified by their state as a CCBHC. ~~or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services. CCBHC expansion grant recipients are encouraged to seek state certification if they are in a state that certifies CCBHCs.~~ State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. ~~Certifying~~ The state~~s~~ may use an independent accrediting body as a part of their certification process as long as it meets state standards for the certification process and assures adherence to the CCBHC Certification Criteria.	• Removed references to the federal demonstration
6.c.3 The State~~s are~~ encourage~~sd to require~~ accreditation of the CCBHCs by an appropriate independent accrediting body (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean “deemed” status.	• Minor modification to read that the State encourages CCBHCs to pursue accreditation