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Appendix B.1: NJ CCBHC Change in Scope Process

Purpose:
This appendix establishes the policy and process by which Certified Community Behavioral Health Clinics (CCBHCs) in New Jersey may request adjustments to their payment rates due to changes in the scope of services they provide. The policy aligns with New Jersey's regulatory framework to ensure consistency, transparency, and fiscal responsibility.

1. Definition of Change in Scope

A Change in Scope refers to any modification in the services provided by a CCBHC that is expected to significantly impact payment rates. This includes but is not limited to:

- Addition or removal of services covered under the CCBHC model.
- Changes in the type, intensity, or duration of services.
- Changes resulting from regulatory amendments, technology, or medical practice updates.
- Relocation, remodeling, opening, or closing of clinic sites.

2. Threshold for Rate Adjustment Requests

Providers may request a rate adjustment when an anticipated change in scope is expected to alter their individual payment rate per encounter by 4.0 percent or more over one year. The threshold ensures that only significant changes in service delivery that materially affect costs and utilization trigger a formal rate adjustment process.

The State may also require a provider to file for a change in scope submission at any time. The threshold for a State-requested change in scope is met when a provider's individual payment rate per encounter is altered by 4.0 percent or more over one year.

3. Types of Change in Scope Requests

A change in scope may be retrospective or prospective.

- A retrospective change in scope is a change in scope that has already occurred in the past.
- A prospective change in scope is a change in scope that is planned to occur in the future.

4. Submission Requirements

Providers must submit a Change in Scope request to the New Jersey Division of Medical Assistance and Health Services (DMAHS) including:

- A detailed description of the change(s) in scope, including type, intensity, and duration of services.
- Supporting documentation demonstrating the reasonableness of cost changes, consistent with criteria used in baseline rate development.
- For a prospective change in scope (in addition to the first two bullet points):

- Notification must be provided at least 120 days prior to the effective date of the change.
- A pro forma CCBHC Cost Report based on the most recently submitted cost report, and including:
  - The expected cost impact of the new or modified services, including cost centers affected.
  - Projected changes in the number of visits or service encounters.

- For a retrospective change in scope (in addition to the first two bullet points):
  - A CCBHC Cost Report based on the most recently submitted cost report that reflects one full year of the impact of the change in scope.

5. Review and Approval Process

Upon receipt of a Change in Scope request, DMAHS will conduct a thorough review to ensure the submission is complete and accurate. The agency may engage independent auditors or external consultants to review the provider's projections and cost data, as necessary. The approval or denial of the request will be based on the adequacy of the documentation and the provider's compliance with program requirements.

DMAHS will conduct a review and determination for Change in Scope requests within 120 days from the date of submission. This timeframe allows for thorough analysis, potential requests for additional information or clarification, and coordination with federal oversight requirements such as State Plan Amendment (SPA) submissions to the Centers for Medicare & Medicaid Services (CMS). For example, CMS typically allows up to 90 days to review SPAs, with the clock pausing if additional information is requested.

To ensure adequate time for review, potential requests for additional information, and final determination, the State recommends the following for prospective and retrospective submissions, respectively:

- <u>Prospective:</u>
  Providers should be advised to submit their Change in Scope requests at least 120 days (or four months) prior to the intended effective date. This timeline aligns with the expected review period and provides a buffer to address any follow-up questions or clarifications that may arise during the review.

- <u>Retrospective</u>:
  Providers should be advised to submit their Change in Scope requests by no later than 120 days (or four months) after the first full cost reporting period containing 12 months of data reflecting the change in scope event.

6. Frequency and Effective Date of Adjustments

Rate adjustments for changes in scope are generally permitted once per fiscal year and take effect with the annual rate updates. Prospective Change in Scope rate adjustments will be applied at the beginning of the next state fiscal year, and retrospective Change in Scope rate adjustments will be applied retroactively to the beginning on the current state fiscal year. For example, if a provider submits a prospective Change in Scope request and it is approved during the state's annual rate-setting cycle, the adjusted rate would become effective at the start of the next state fiscal year, typically July 1. Mid-year adjustments may be considered in exceptional circumstances, if the change exceeds the established threshold, and the provider meets all documentation requirements. In such cases, the effective date of the adjustment will correspond with the implementation date of the change.

- Prospective Example:
  A CCBHC plans for a qualified change in scope event and a rate adjustment to take effect with the annual rate update on July 1, 2026. To accommodate the 120-day review period, the provider submits a Change in Scope request by February 1, 2026. DMAHS completes its review and approves the request by June 1, 2026, allowing the rate adjustment to take effect as part of the July 1, 2026, annual update.

- Retrospective Example:
  A CCBHC experiences a qualified change in scope event on June 1, 2025. Upon submission of the FY26 cost report (July 1, 2025–June 30, 2026), the provider realizes that that this change had a greater than 4% impact on the cost per visit. On September 1, 2026, the provider submits the Change in Scope request to the State to request that the change in scope retroactively take effect with the annual rate update on July 1, 2026. To accommodate the 120-day review period, DMAHS completes its review and approves the request by November 30, 2026, allowing the rate adjustment to retroactively take effect as part of the July 1, 2026, annual update.

7. Rate Rebasing for Prospective Changes in Scope

Following approval and implementation of a rate adjustment, the adjusted rates will be rebased once the CCBHC submits its first cost report containing a full year of actual cost and visit data that reflects the change in scope. Rebasing ensures that payment rates accurately reflect actual costs and service utilization, thereby maintaining the integrity of the payment system. The rebased rates will take effect in the subsequent state fiscal year. Retrospective rate adjustments will not require a rebase after a year, since the actual cost is captured in the established retrospective rate.

Example:
A CCBHC implements a Change in Scope effective July 1, 2024. The provider submits its first cost report reflecting this change for the fiscal year July 1, 2024, through June 30, 2025, by January 1, 2026. After the State completes its review and approves the report, the rebased

rates based on actual cost and visit data take effect on July 1, 2026, the start of the 2027 State Fiscal Year. This timeline ensures that the rebasing uses one full year of actual data and that the updated rates are implemented in the fiscal year following the data collection period, consistent with the Change in Scope rebasing intent.