New Jersey Certified Community Behavioral Health Clinic Policy Manual

Version 1.0

Effective October 1, 2025

State of New Jersey
Department of Human Services

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Version 1.0
October 2025

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1. Preface

The New Jersey Certified Community Behavioral Health Clinic (CCBHC) Policy Manual provides comprehensive guidance to current and prospective CCBHC providers for implementation of services under New Jersey's Medicaid State Plan Amendment (SPA). This Manual serves as the primary reference document for providers seeking to establish, maintain, and operate a CCBHC in compliance with federal and State requirements. The information contained herein is effective as of October 1, 2025, the anticipated implementation date of New Jersey's CCBHC SPA under the rehabilitative services section.

2. Introduction to the CCBHC Model

2.1. The CCBHC Model

The CCBHC model represents a comprehensive approach to community behavioral health service delivery, designed to integrate mental health, substance use disorder treatment, and primary care screening and monitoring. CCBHCs are required to serve all individuals regardless of their ability to pay, place of residence, or insurance status, making them a critical component of the behavioral health safety net.

CCBHCs were initially established under Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 as a demonstration program. PAMA requires CCBHCs to provide a comprehensive set of nine core services that attend to the full spectrum of behavioral health and social needs. [1] These services constitute a comprehensive approach to behavioral health care that addresses the full spectrum of needs for individuals with mental health and substance use disorders. The CCBHC model emphasizes accessibility, quality, and coordination of care, with specific requirements for crisis services, evidence-based practices, and integration with physical health care.

2.1.1. Types of CCBHCs

It is important to understand the distinction between state CCBHC programs and Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC grants, as these represent different funding streams and operational requirements.

- State CCBHC Programs:
  - Operate under state authority through the PAMA Medicaid Section 223 Demonstration, SPA, or 1115 Demonstration Waivers;
  - Utilize Prospective Payment System (PPS) methodology for reimbursement;
  - Are subject to state certification and oversight; and

[1] Congress.gov (2014). H.R. 4302 – Protecting Access to Medicare Act of 2014. Retrieved from: https://www.congress.gov/113/statute/STATUTE-128/STATUTE-128-Pg1040.pdf.

- Must meet federal and/or state CCBHC requirements.

- SAMHSA CCBHC Grants:
  - Direct federal grants to provider organizations;
  - Are time-limited funding not tied to Medicaid payment systems;
  - Require that providers self-attest to meet CCBHC requirements; and
  - May serve as a pathway to, but not supplant, state CCBHC certification.

New Jersey has both State-certified CCBHCs and organizations with SAMHSA CCBHC grants. Additionally, there are some State-certified providers that also have SAMHSA grants. This Policy Manual specifically describes how CCBHCs certified by the State under the SPA will operate. While SAMHSA grant funding may help facilitate attainment of New Jersey's CCBHC certification, it is not a substitute for State certification.

2.2. CCBHCs in New Jersey

New Jersey is one of the eight original states selected to participate in the CCBHC Section 223 Demonstration program that began in 2017. Through this participation, New Jersey established seven CCBHCs with 17 sites that have demonstrated significant improvements in access to care and clinical outcomes. Data from New Jersey's Section 223 Demonstration has shown reductions in emergency department use, decreased psychiatric hospitalizations, and improved access to medication-assisted treatment for substance use disorders.[2]

The transition from the Section 223 Demonstration program to a permanent Medicaid SPA reflects New Jersey's commitment to sustaining and expanding this successful model of care. The SPA will allow for continued operation of existing CCBHCs while potentially providing opportunities for additional behavioral health providers to become certified and participate in the program. The specific services authorized under the CCBHC Rehabilitative Services in the Medicaid State Plan benefit comprise the following:

1. Crisis Services
2. Screening, Assessment, and Diagnosis, including Risk Assessment
3. Person- and Family-Centered Treatment Planning
4. Outpatient Mental Health and Substance Use Services
5. Outpatient Primary Care Screening and Monitoring

[2] NJAMHA (2020). New Jersey's Certified Community Behavioral Health Clinics: https://njamha.org/links/publicpolicy/CCBHC-Flyer.pdf

6. Psychiatric Rehabilitation Services
7. Peer Supports, Peer Counseling, and Family/Caregiver Supports
8. Comprehensive Case Management

While CCBHCs must serve any person with a behavioral health need or experiencing a mental health or substance use-related crisis, the following populations are of particular focus for the New Jersey CCBHC program: individuals with serious mental illness (SMI), individuals with substance use disorders (SUD), children and adolescents with serious emotional disturbance (SED), and individuals with post-traumatic stress disorder (PTSD).

2.2.1. CCBHC Eligibility Requirements

2.2.1.1. Diagnostic Eligibility

Individuals seeking CCBHC services must have a diagnosis reflecting an ICD-10 diagnosis code associated with one of the four special populations (i.e., SMI, SUD, SED, PTSD) or the standard population as cited in Appendix C.1. The standard population comprises all mental health and substance use disorder diagnoses not encompassed in the special population diagnoses. The State has organized the diagnosis code list to properly capture severity of the diagnoses commensurate with the needs of the special and standard populations.

2.2.1.2. Service Exclusions:

CCBHCs will not receive monthly PPS payment if a beneficiary is currently receiving any of the following services, program status codes (PSCs), or special program codes (SPCs):

- PACT
- ICMS
- Children's CMS
- Behavioral Health Home

2.2.1.3. Program Exclusions

Beneficiaries enrolled in any of the following programs, program status codes (PSCs), or special program codes (SPCs) are not eligible for CCBHC services[3]:

- DDD/DSNP
  - PSC 140, 2XX & 5XX or;
  - PSC 600, 650 (ages <18) or 620 (ages 18-26) or;

[3] This list is subject to change.

- PSC 480, 481, 482, 483, 461 (<19 Yrs. Of Age)

- MLTSS/DSNP
  - SPCs 60-67

Note: while beneficiaries enrolled in the preceding categories may not be eligible for CCBHC services, the State requires that CCBHCs coordinate care and referrals, as appropriate.

2.3. Authority

2.3.1. Federal

At the federal level, the CCBHC is overseen by the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The following reflect the federal statutory and regulatory authorities for CCBHC services:

- Section 223 of PAMA (as amended by the Bipartisan Safer Communities Act of 2022)
- 42 CFR Part 440.130(d): Rehabilitative Services covered under a Medicaid SPA
- CMS CCBHC PPS Guidance (2024)
- SAMHSA CCBHC Certification Criteria (2023)

2.3.2. State

In New Jersey, the Department of Human Services (DHS), specifically the Division of Mental Health and Addiction Services (DMHAS) and the Division of Medical Assistance and Health Services (DMAHS) serve as the joint State authority for the programmatic, financial, and certification components of the CCBHC program. DMAHS administers the Medicaid program and oversees the financial aspects of the CCBHC program. Together, these agencies establish and enforce State-specific CCBHC requirements in alignment with federal standards. The Department of Children and Families (DCF), Children Systems of Care (DCF) works in a consultative role with DHS. The following reflect the State statutory and regulatory authorities for CCBHC services:

- Medicaid State Plan Amendment NJ-25-XXXX (proposed effective date of October 1, 2025)

- New Jersey Statutes Annotated (NJSA):
  - Mental Health and Addiction statutes (NJSA 30:4-27 et seq.)
  - Alcohol and Drug Abuse statutes (NJSA 26:2B-1 et seq.)

- New Jersey Administrative Code (NJAC):
  - Standards for Licensure of Mental Health Programs (NJAC 10:190)
  - Standards for Licensure of Outpatient Substance Use Disorder Treatment (NJAC 10:161B)
  - Standards for CCBHCs (NJAC XX:XXX – to be determined)

- New Jersey Policy Manuals and Guidance Documents

3. CCBHC Requirements

The State's requirements for CCBHCs are listed below, including pre-requisites that prospective CCBHCs must meet before the State considers them for certification.

3.1. Pre-Requisites to CCBHC Certification Consideration

3.1.1. Organizational Status

Prospective CCBHCs must be organized as one of the following:

- A nonprofit organization and/or?
- Part of a local government behavioral health authority

3.1.2. Licensure

Prospective CCBHCs must be licensed as both a provider of Mental Health Programs (NJAC 10:190) and Outpatient Substance Use Disorder Treatment (NJAC 10:161B) and any future licensing standards required or modified by the State.[4] All staff must practice within the scope of their respective State licenses, certifications, or registrations and in accordance with all applicable laws and regulations.

3.1.3. DMHAS Contract

Prospective CCBHCs must hold a contract (or affiliation agreement) in good standing with DMHAS.

3.1.4. National Provider Identifier

Prospective CCBHCs must obtain and maintain a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES) website as required by CMS. The NPI is a unique number that CCBHCs will use for all Medicaid billing and reporting activities. As such, CCBHCs must:

[4] Integrated Care Rule N.J.A.C. 8:43K (docx)

- Apply for and obtain a NPI via the NPPES website that designates a provider as a CCBHC (this is in addition to any other NPIs a provider may currently maintain.

- Use the following "Taxonomy" for the CCBHC NPI:
  - Code: 251S00000X
  - Type: Community/Behavioral Health
  - Classification: Clinic/Center
  - Specialization: Public Health, State or Local
  - Level: Level III - Area of Specialization

3.1.5. Medicaid Enrollment

Prospective CCBHCs must be an enrolled provider in good standing with the New Jersey Medicaid program (e.g., New Jersey FamilyCare). This includes, but is not limited to the following:

- Have a valid New Jersey Medicaid Provider Number
- Comply with Medicaid documentation standards
- Adhere to Medicaid claims submission requirements
- Participate in program integrity activities and audits
- Maintain all necessary licenses, certifications, accreditations
- Meet financial solvency standards and maintain adequate liability insurance coverage
- Serve all Medicaid beneficiaries enrolled in either fee-for-service or managed care delivery systems

3.1.6. Service Delivery Requirements

Prospective CCBHCs must have the capacity to serve individuals across the lifespan. Additionally, prospective CCBHCs must provide tailored, culturally, and developmentally appropriate services to all individuals, including but not limited to veterans, military service members, and their families.

3.1.7. Health Information Technology Requirements

Prospective CCBHCs must have an electronic health record (EHR) capable of meeting all State or federally required billing, data reporting, and care coordination requirements. In addition, prospective CCBHCs must participate in a Health Information Exchange (HIE) or any statewide CCBHC database required by DHS.

3.1.8. Other Minimum Requirements

Prospective CCBHCs must also:

- Adhere to all federal and State requirements pertinent to the CCBHC benefit, including the Medicaid State Plan, laws, regulations, and policies
- Adhere to all applicable privacy, consent, and data security laws, regulations, and policies
- Practice in accordance with accepted standards, guidelines, and policies as promulgated by DHS
- Participate in ongoing conferences, events, or technical assistance provided by the State and/or its affiliates (e.g., audits, site visits, trainings, webinars, etc.)

3.2. CCBHC Certification

CCBHCs must be certified by DHS as a CCBHC (see Section 4 for more information).

4. CCBHC Certification

4.1. Overview

In addition to the requirements outlined in Section 3, CCBHCs must be certified by DHS to be eligible to provide the CCBHC Medicaid State Plan benefit and receive the monthly PPS reimbursement. New Jersey's CCBHC Certification Criteria is included as Appendix A.2 and will be used by the State to assess the qualifications of current and prospective CCBHCs. In evaluating certification applications, DHS will consider documented behavioral health needs and related State and local data — including the New Jersey Statewide Behavioral Health Needs Assessment and other credible State data sources such as Medicaid/claims, utilization, workforce, crisis, and mortality data — and will assess the extent to which an applicant's proposed services, capacity, geographic coverage, and target populations align with those documented needs. New Jersey's CCBHC Certification Criteria generally follows the 2023 SAMHSA CCBHC Certification Criteria[5] and is comprised of the following areas:

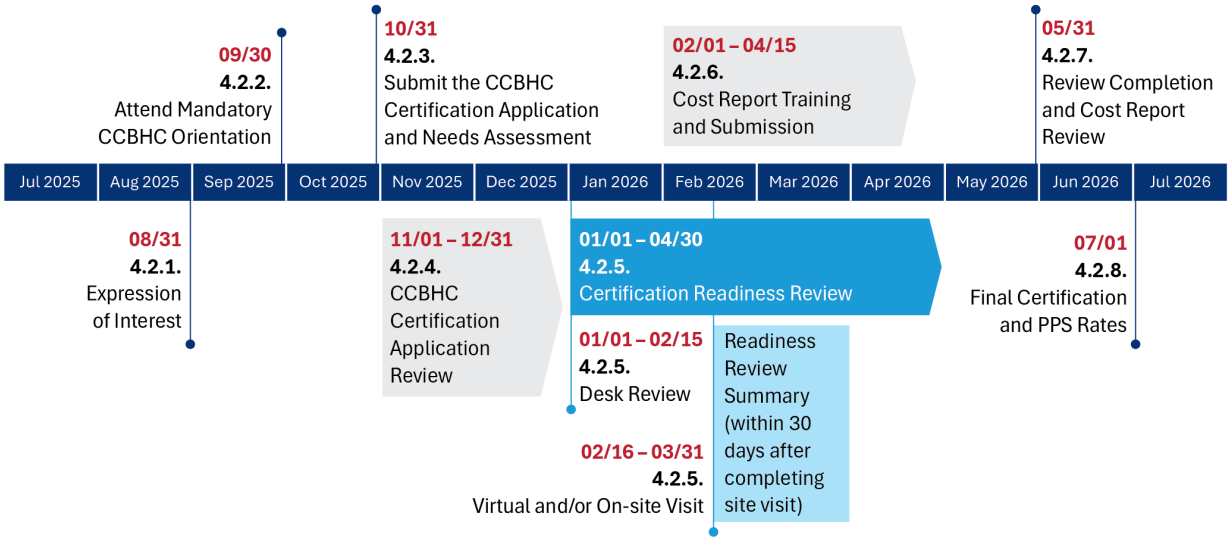
1. Staffing
2. Availability and accessibility of services
3. Care coordination
4. Scope of services
5. Quality and other reporting
6. Organizational authority, governance, and accreditation

4.2. Certification Process

CCBHC certification is an annual multi-step process that follows the State's fiscal year (July 1–June 30), which is illustrated in the timeline graphic below. The process consists

[5] SAMHSA (2023). 2023 CCBHC Certification Criteria: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

of an expression of interest, mandatory CCBHC orientation, the New Jersey CCBHC Application, readiness and site reviews, cost report training and submission, finalization of monthly PPS rates, certification issuance, and ongoing certification review. Details of this process and the preceding components, including submission and review timelines, are delineated in the sub-sections below.



4.2.1. Expression of Interest (by August 31)

Prospective CCBHCs must express interest to DHS and DCF by August 31 via email to MAHS.CCBHC@dhs.nj.gov.

4.2.2. Attend Mandatory CCBHC Orientation (by September 30)

Prospective CCBHCs having expressed interest per 4.2.1. above shall attend the mandatory CCBHC orientation sponsored by the State.

4.2.3. Submit the CCBHC Certification Application and Needs Assessment (by October 31)

Prospective CCBHCs must attest to compliance with all prerequisites outlined in Section 3.1 and submit a completed certification application and required documents/exhibits by October 31. The application includes agency information (e.g., name, address, licensures, certifications, accreditations, populations served, service areas, current revenue sources, basic governance attributes, etc.), key points of contact, CCBHC services information (e.g., core CCBHC services provided, implementation plan, planned CCBHC site location(s), evidence-based practices [EBPs], partnerships, etc.), a completed community needs assessment, a self-assessment using the New Jersey CCBHC Criteria Readiness Assessment and scoring rubric cited in Section 4.3, an organizational chart/CCBHC staffing

plan, copies of any executed designated collaborating organizations (DCO) agreements, attestations, and a signature from an authorized representative of the prospective CCBHC. The New Jersey CCBHC Application, including detailed instructions, can be found in Appendix A.1. Additionally, the New Jersey CCBHC Criteria Readiness Assessment (which is part of the application) can be found in Appendix A.2.

4.2.3.1. Consideration of State Behavioral Health Needs and Data

In evaluating CCBHC certification applications, the State will consider documented behavioral health needs and related data to inform certification decisions. Primary data sources will include associated state-, county-, and local-level indicators, along with other credible State-level data sources such as Medicaid/claims and utilization data, crisis services and emergency department behavioral health data, and public health surveillance information. Together with the application and submitted needs assessment, the State may use this data to assess the appropriateness of applicant location and proposed service capacity, and to inform decisions about certification status, prioritization, or conditions attached to provisional certification.

4.2.4. CCBHC Certification Application Review (November 1–December 31)

The State will review submitted applications and materials for completeness and follow-up with prospective CCBHCs if additional information is needed within two to four weeks of the application submission due date. If all prerequisites are met and the applicant has submitted all of the required documents, prospective CCBHCs will proceed to the Certification Readiness Review stage consisting of a desk review and virtual and/or on-site visit (see 4.2.5. below). Prospective providers will also be required to participate in the cost report training and submission process (see 4.2.6. below). The State will inform prospective CCBHCs of the results of the CCBHC application review by December 31.

4.2.5. Certification Readiness Review (January 1–April 30)

New Jersey's CCBHC Readiness Review is comprised of the following three-pronged process:

1. Desk review (January 1–February 15)
   The desk review is an extensive evaluation of policies and procedures aimed at determining the readiness of applicants. Applicants will be asked to submit policies, procedures, and relevant information to the State to demonstrate compliance with the CCBHC criteria.

2. Virtual and/or on-site visit (February 16–March 31)
   After the desk review, the State will interview the applicant's key personnel and assess the capacity to adhere to the CCBHC model. This includes, but is not limited to, the provision of required CCBHC services, individual chart and billing record review, use and documentation of any care coordination agreement(s) or DCO agreement(s), the implementation of and fidelity to evidence-based practices, suitable staffing levels, the culture of the CCBHC, and compliance with the New Jersey CCBHC certification standards. The State will aim to complete site visits by March 31.

3. Readiness Review Summary (within 30 days after a completed site visit)
   Within 30 days of a completed site visit, the State will provide a written site review summary to the applicant and will categorize prospective CCBHC applications into one of four categories:

   1. Category 1: Full compliance
   2. Category 2: Substantial compliance
   3. Category 3: Partial compliance
   4. Category 4: Non-compliance with or lacking a reasonable plan to achieve compliance with the certification criteria and/or a history of revocation, suspension, non-renewal or denial of certification, sanction(s) or penalties, or other similar disciplinary actions taken by regulatory authorities in any state and/or country, regardless of whether those actions resulted in a settlement in lieu of a sanction.

The written summary will detail any areas for improvement to attain compliance with certification criteria. If applicable, this summary will include a request for a Plan of Correction (POC) to achieve compliance by the July 1 start date.

Applicants in categories 1-3 will be informed by the State of their application category rank and receive an invitation to attend a cost report training.

4.2.6. Cost Report Training and Submission (February 1–April 15)

CCBHC applicants must participate in a CCBHC Cost Report Orientation session conducted by the designated cost reporting vendor appointed by the State. This training will take place during the Readiness Review Process period. Applicants are required to:

- Review the CCBHC Cost Report and PPS Guidance Materials before attending the Cost Report Orientation, including but not limited to:

  - CMS CCBHC Cost Report Instructions
  - CMS CCBHC Cost Report Template
  - CMS Updated CCBHC PPS Technical Guidance
  - Pertinent Federal Regulations Governing Costs, such as:
    - 45 CFR Part 75
    - 42 CFR Part 413
    - 2 CFR Part 200
- Attend a technical assistance session to complete the initial cost report.
- Submit an initial cost report to the State and its designated cost reporting vendor no later than April 15.

4.2.7. Certification Review Completion and Cost Report Review (by May 31)

The State will complete application and readiness reviews and resolve outstanding documentation requests by May 31 of the certification cycle. Following completion of reviews, the State will notify applicants of the outcome and any required next steps. Such notifications do not constitute final certification or authorization to bill the monthly PPS.

Between April 16 and May 31, the State and its designated cost-reporting vendor will review applicants' initial cost reports. Applicants must respond to vendor inquiries and submit any requested updates or supplemental materials within five (5) business days of a request, unless the State specifies an alternate timeline in writing. Failure to provide requested cost reporting materials in a timely manner may affect an applicant's ability to be assigned an initial PPS rate or to progress to final certification.

The State will determine initial PPS rates using validated cost reports where available or a proxy rate where necessary, consistent with the methodology described in Section 8.4.3. Final PPS rates and any billing authorization will be issued only in connection with Final Certification as described in Section 4.2.8.

4.2.8. Final Certification and PPS Rates (target: on or near July 1)

Final certification, the approved monthly PPS rate(s), and any authorization to bill at the approved PPS rate(s) will be issued in writing and will be effective on the date specified in the Final Certification Letter. Final certification and any billing authorization are expressly contingent on the availability of State appropriation for program expansion; the State will not issue billing authorization prior to enactment of the appropriation. The Final Certification Letter will state the certification level, the effective date of certification, the term of certification, and the approved PPS rate(s). Where an applicant receives provisional certification under Section 4.4.2, the conditions and timelines for achieving full certification

will be set out in writing. Fully certified CCBHCs will receive certification for three years per Section 4.4.1 (see Section 4.5 for recertification requirements). PPS rates are established in accordance with the methodology in Section 8.4; any subsequent rebasing or adjustments will follow the procedures in Section 8.4.4.

4.3. Certification Scoring

The State will use a standardized scoring rubric (see Appendix A.2) to rate each CCBHC criterion and sub-criterion. Each sub-criterion will follow the proceeding point system:

- A response of "yes": 1 points
- A response of "in progress: 0.5 points
- A response of "no": 0 points

Under each program requirement, there are "sub criteria" that CCBHCs must meet. The sub criteria responses under each program requirement have equal weight in determining the percentage of compliance within that program requirement (calculated based on the sum of points earned in the program requirement sections out of the number of points available). However, the State will normalize the overall score to 100 points and multiply the percent compliance of each section by the following weights (points):

- Program Requirement 1: Staffing (20%)
- Program Requirement 2: Availability and accessibility of services (20%)
- Program Requirement 3: Care coordination (15%)
- Program Requirement 4: Scope of services (30%)
- Program Requirement 5: Quality and other reporting (10%)
- Program Requirement 6: Organizational authority, governance, and accreditation (5%)

Applicants will be expected to obtain a minimum compliance percentage in each criteria section in addition to an overall minimum score to meet certification. Certification levels will reflect overall compliance percentage as cited in Section 4.4 below.

4.4. Certification Levels

4.4.1. Full Certification

An applicant will receive full certification if it attains an overall score of 75 points and at least 75% compliance within each certification criteria section. Only fully certified applicant agencies can bill the monthly PPS rate. Fully certification awards are valid for a term of three years.

4.4.2. Provisional Certification

An applicant will receive provisional certification if it receives an overall score of 65 points and at least 65% compliance on each certification criteria section. Provisionally certified CCBHCs may not bill the monthly PPS until full certification is met. Applicants receiving provisional certification will be required to submit and complete a Plan of Correction (POC) to the State via the following process:

1. Per feedback from the State, the provisionally certified CCBHC will specify findings that will be improved in each program area needed to meet full certification status. The CCBHC will submit this to the State within 30 calendar days following receipt of its certification letter indicating provisional certification.

2. Within 10 business days, the State will accept or reject the POC. If the POC is rejected, the CCBHC will lose its provisional certification and be considered "Not Certified" as specified in Section 4.4.3.

3. Upon approval of the POC, the CCBHC will complete the work described in its POC and provide updated evidence of compliance within 90 calendar days of receiving its certification letter indicating provisional certification.

Upon review of evidence of compliance provided by the CCBHC, the State will either deem the CCBHC as fully certified or the provisional certification will expire. The provider may apply for New Jersey CCBHC Certification in a future certification period.

4.4.3. Not Certified

An applicant receiving a score less than 65 points and/or less than 65% compliance on each certification criteria section will not be certified. A status of not certified means that a provider cannot hold itself out as a New Jersey State-certified CCBHC or receive the monthly PPS. These applicants may apply for New Jersey CCBHC Certification in a future certification period.

4.5. Recertification

Recertification will be commensurate with the length of certification issued in the applicant's certification award letter. At minimum, recertification will be completed every three years. Recertification will require an overall score of 80 points with at least 80% compliance on each certification criteria section. Any CCBHC not receiving recertification will have their CCBHC certification expire (see 4.6 below).

4.6. Certification Expiration

CCBHC Certification will expire commensurate with the end date cited in the CCBHC's certification letter if recertification is not granted. In addition, if a provisionally certified CCBHC does not fulfil the requirements cited in 4.4.2. above, then they will also be subject to certification expiration. CCBHCs with expired certifications will not be able to hold themselves out as a New Jersey State-certified CCBHC or receive the monthly PPS payment for CCBHC services. CCBHCs with expired certifications may reapply for certification when the next application period opens.

4.7. Decertification

Failure to abide by all terms of the New Jersey CCBHC Policy Manual, the Medicaid SPA, certification criteria, or associated statutes or regulations may result in disciplinary action, including moving a CCBHC to decertification and terminating any associated privileges. Reasons for decertification may include, but are not limited to:

- Failure to provide the State with requested documentation demonstrating CCBHC requirements are met
- Failure to correct identified deficiencies in meeting CCBHC certification requirements
- Failure to serve all individuals eligible for CCBHC services
- Verified complaints from persons served regarding non-compliance with CCBHC policies or CCBHC certification criteria in areas of individual health and safety
- Inability to uphold required licensures and certifications
- Failure to adhere to rate setting requirements, including rebasing
- Misrepresentation or falsification of data
- Inability to report data or missing data

The State will provide 90 days written notice of the intent to decertify. CCBHCs may either accept the decertification or respond with a detailed POC to address the identified reasons for decertification within 15 calendar days from the date of State's decertification notice. The POC must include an implementation plan not to exceed 90 days in duration. Following the 90 days, if the CCBHC site has not met compliance standards as required, the decertification process will continue with a formal final notification being sent to the CCBHC.

In situations where access or issues of client health and safety for individuals served is critically compromised, the CCBHC may be given a reduced timeframe to implement corrective measures. This stipulation may be documented in writing as part of the State's findings. Should the State detect a concern that poses an immediate risk to the health or welfare of an individual served, it retains the authority to mandate an urgent review and response from the CCBHC, which must be finalized within a minimum period to be determined by the state.

4.8. Certification Changes

To maintain the accuracy of CCBHC certification documentation and ensure continuous compliance with requirements, CCBHCs are required to inform the State within 15 calendar days of any significant alterations in policy or practice that could affect a clinic's capacity to meet certification standards. Such changes may include the ability to deliver any of the mandated CCBHC services, updates to DCO agreements, or substantial changes in the capacity to serve the designated populations in adherence to access and accessibility requirements. This may also include any changes to the CCBHC delivery site due to factors such as loss of lease, building damage, etc. The State retains the right to deny any changes notified by the CCBHC to the State. Neglecting to inform the State of changes that impact CCBHC fidelity and comprehensive service delivery may result in an immediate 90-day POC or decertification as cited in 4.7. Specific instances requiring notification may include, but are not limited to:

- Information regarding prospective or current CCBHC recipients eligible for CCBHC services being turned away for any reason
- Closing, opening, or changing a service delivery site
- Initiating or terminating a DCO arrangement
- Changes in agreements or staffing that restrict the capacity to deliver required services
- Change in the ability to provide the required evidence-based practices
- Any changes that may impact ability to complete and/or report on required data elements
- Any changes that result in not being able to bill as described in Section 8 of this manual

4.9. Accreditation and Certification

The State encourages each site to pursue and achieve CCBHC (or similar) accreditation to enhance service delivery quality and streamline the certification process. At the discretion of the State, CCBHCs that obtain accreditation may be permitted to utilize their accreditation to fulfill specific CCBHC certification requirements. The State will monitor the timeframes for accreditation awards.

CCBHCs that use accreditation to assist in fulfilling CCBHC certification criteria will be obligated to submit accreditation survey results to the State. CCBHCs must specify which CCBHC certification criteria to which the accreditation is applicable. Follow-up items noted in the survey results will be reviewed during the State's readiness assessment process. Furthermore, the State will keep track of accreditation expiration dates. If a CCBHC chooses not to maintain an accreditation award, it must inform the State 30 days before the expiration date of the award. Should the accreditation lapse without renewal,

the CCBHC will be required to provide documentation to satisfy each criterion that was previously waived during the certification process.

4.10. Dually Certified CCBHC and Federally Qualified Health Center (FQHC) Requirements

[Placeholder]

5. Managed Care Organization Requirements

[Placeholder]

6. CCBHC Service Requirements

6.1. CCBHC Services

CCBHCs must provide the services and activities outlined in Section 2.2. and as required by the New Jersey CCBHC Certification Criteria.

CCBHC services are comprised of "Core" and "Required" services—these services may trigger a qualifying PPS visit. "Core" services must be provided directly by the CCBHC (i.e., services *may not* be provided by a designated collaborating organization (DCO) or through a care coordination agreement). "Required" services are services that may be provided either directly by the CCBHC (except for crisis which must be provided by DCO entity) or through a DCO or care coordination agreement. CCBHCs are expected to support other services and activities, such as care coordination. See Section 7 for DCO descriptions and requirements.

A list of CCBHC service codes can be found in Appendix D.1. The following subsections further delineate the "Core" and "Required" services:

6.1.1. Core CCBHC Services and Activities (must be provided by the CCBHC):

- Screening, Assessment, and Diagnosis, including Risk Assessment
- Person- and Family-Centered Treatment Planning
- Outpatient Mental Health and Substance Use Services
    - American Society of Addiction Medicine (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
- Outpatient Primary Care Screening and Monitoring
    - CCBHCs are responsible for screening for and monitoring key health indicators (e.g., tobacco use, weight/BMI, and diabetes risk) and any conditions or diseases that are or treatment-related. Protocols for these shall be developed by the Medical Director. 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.). 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 a DCO or care coordination agreement with an organization separate from the CCBHC. The CCBHC must also coordinate with clients' primary care provider or with an affiliated primary care staff person on or off site in order to ensure that screenings occur for the identified conditions. The CCBHC should establish an agreement with the nearest FQHC within their service area. If there is no FQHC in the service area, the CCBHC should be established with the nearest accessible FQHC.

- Peer Support and Counselor Services and Family Supports
    - Peer Support and Counselor Services must be provided directly by the CCBHC, by peer specialists on staff. Peer staff must be adequate in number to ensure that they can provide adequate mentoring of individuals who have support their recovery needs, in addition to the other non-clinical roles that peers provide. However, the CCBHC shall also have DCOs or care coordination agreements with peer run organizations or family support services, including with community wellness centers, community peer recovery support centers, and peer respite programs in their service areas.
- Comprehensive Case Management
    - Services that are intended to support the wellness and recovery goals of individuals with complex and/or chronic behavioral health issues and needs through targeted interventions designed to provide timely, high-quality, and efficient care. Comprehensive Case Management services are organized around goals aimed at providing access to services that encourage individuals to sustain recovery and gain access to needed medical, social, legal, educational, housing, vocational, and other services and supports. Comprehensive Case Management services include, but are not limited to, assessment, service planning, services linkage, ongoing monitoring, ongoing clinical support, and advocacy. Comprehensive Case Management provides an intensive level of support that is different than care coordination, which is a basic expectation for all people served by the CCBHC.
- Clinic-Based Crisis Services

- CCBHCs must have the internal capability (e.g., appropriate staff volume and training, hours of operation, ability to complete warm transfers to other crisis and stabilization services) 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.

6.1.2. Required CCBHC Services (May be provided either directly by the CCBHC or through a DCO or care coordination agreement):

- ASAM Levels above ASAM WM-1Psychiatric Rehabilitation Services
- Peer-Run Organization Services or Family Support Services
- State-Sanctioned Crisis Services (as described in Section 7.6)

6.2. Cost-Only CCBHC Services

A "cost-only" service is a service that may be provided by a CCBHC, but does not count as a "PPS-triggering" event, but must be accounted for on the CCBHC Cost Report and reported for monitoring/quality purposes. Billing guidance for these services can be found in Section 8.3.2.4.1. New Jersey considers the following "cost-only" services for the CCBHC Program:

- Environmental Intervention
- Telephone Assessment
- Telephone Evaluation and Management
- Smoking and Tobacco Cessation
- Supported Employment and Education

"Cost-only" service codes are referenced in Appendix D.1.

6.3. Care Coordination

CCBHCs are required to provide care coordination across the health and human services spectrum, including physical health care (both acute and chronic), behavioral health services, to promote individual wellness and recovery.

Care coordination activities must comply with federal privacy laws such as HIPAA and other confidentiality regulations, as well as the preferences and needs of the individual being served. DCOs or care coordination agreements must be established with the facilities and community service providers as specified in Program Requirement #3 of the NJ CCBHC Certification Criteria. CCBHCs are encouraged to use bachelor's level support staff in providing care coordination.

Additionally, CCBHCs are mandated to coordinate crisis and other referral services, through a DCO, with State sanctioned service providers described in Section 7.6.

The implementation of Health Information Technology (HIT) to enhance effective care coordination and management is crucial to New Jersey's CCBHC Program. As such, CCBHCs are required to possess HIT systems that can be utilized for population health management and quality improvement.

6.4. Outreach

CCBHC care coordination agreements must include formal partnerships with schools, child welfare agencies, juvenile and criminal justice systems, veterans services, homeless shelters, the Department of Veterans Affairs, veterans service organizations, and other community partners. Based on the needs assessment conducted by the CCBHC, they are required to carry out marketing efforts with these entities to increase access to CCBHC services. When appropriate, CCBHCs should establish regular direct contact with these organizations to ensure individuals in vulnerable or underserved communities are connected to CCBHC services. Where available within their service areas, CCBHCs are encouraged to form care coordination partnerships with Opioid Treatment Programs (OTPs), Federally Qualified Health Centers (FQHCs), and other community health providers. Additionally, CCBHCs must use their needs assessments to confirm that outreach efforts effectively reach vulnerable populations—such as those with serious mental illness (SMI), substance use disorders (SUD), serious emotional disturbance (SED), post-traumatic stress disorder (PTSD), and co-occurring disorders—ensuring their needs are addressed.

6.5. Evidence-Based Practices (EBPs)

CCBHCs must offer a minimum set of EBPs as defined by the State. EBPs must be delivered either directly by the CCBHC or via a DCO or care coordination agreement as indicated in the table below. CCBHCs are responsible for ensuring that EBPs are provided by individuals or organizations (i.e., DCO agreements or care coordination agreements) with appropriate training and credentials and have an established process for monitoring model fidelity, either locally or with State site reviews. All required, recommended, and CCBHC-selected EBPs must be documented in the CCBHC's training plan. The following sub-sections delineate the State required and recommended EBPs, respectively.

6.5.1. State Required EBPs:

- Motivational Interviewing (MI)/Motivational Enhancement Therapy (MET)
- Trauma Informed Care (TIC) (in various forms of provider choosing)
- Cognitive Behavioral Therapy (CBT) (in various forms of provider choosing)

- Medication Assisted Treatment, including but not limited to Medications for Opioid Use Disorder (MOUD), Alcohol Use Disorder (AUD), and Tobacco Use Disorder (TUD)
- Evidenced-based practice for family-based therapy that is subject to adherence to fidelity monitoring (in various forms of provider choosing)
- Whole Action Health Management (WHAM) or Learning About Healthy Living
- Zero Suicide Framework
- Gambling Screen (provider choice of validated tool)
- Evidenced-based personal wellness plan that is subject to adherence to fidelity monitoring (in various forms of provider choosing)

EBP	Delivery Method Allowed (directly by CCBHC[6] and/or through a DCO or via Care Coordination Agreement[7])	Notes
1. MI/MET	Directly	
2. TIC	Directly	CCBHCs may choose the type/s of TIC that align with the needs of the populations served by the CCBHC. Needs should be identified via the CCBHCs' submitted community needs assessments.
3. CBT (in various forms of provider choosing)	Directly	CCBHCs may choose the type(s) of CBT that align with the needs of the populations served by the CCBHC. Needs should be identified via the CCBHCs' submitted community needs assessments. Examples to consider for certain populations: • Trauma-Focused CBT (TF-CBT) – Children age 4-17 • For Veterans: ○ Depression (CBT-D) ○ Insomnia (CBT-I)

[6] The State has determined that some required EBPs must be provided directly by CCBHCs. CCBHCs may not utilize a DCO or a care coordination agreement to deliver these EBPs.
[7] The State has determined that some required EBPs may be provided via DCO and/or via a care coordination agreement.

EBP	Delivery Method Allowed (directly by CCBHC[6] and/or through a DCO or via Care Coordination Agreement[7])	Notes
		○ Substance Use Disorders (CBT-SUD) ○ Cognitive Behavioral Conjoint Therapy (CBCT)
4. MAT – MOUD, AUD, TUD	• Directly • Via DCO or Care Coordination Agreement for methadone only	
5. Evidenced-based practice for family-based therapy that is subject to adherence to fidelity monitoring (in various forms of provider choosing)	Directly	Examples of EBPs to consider: • Functional Family Therapy (FFT) • Structural Family Therapy • Systemic Family Therapy • Family Systems Therapy (FST) • Multi-Family Systemic Therapy (MFST) • Family Psychoeducation
6. WHAM or Learning About Healthy Living[8]	Directly	
7. Zero Suicide Framework	Directly	
8. Gambling Screen (provider choice of validated tool)	Directly	Examples to consider: • Nower Screening • Lie/Bet • Brief Gambling Screening
9. Evidenced-based personal wellness plan that is subject to adherence to fidelity	Directly or via DCO with Peer Run Organization	May be delivered by peers if appropriate based on the tool. Examples to Consider: • Wellness Recovery Action Plan (WRAP)

[8] Learning About Healthy Living: 2012_lahl.pdf

EBP	Delivery Method Allowed (directly by CCBHC[6] and/or through a DCO or via Care Coordination Agreement[7])	Notes
monitoring (in various forms of provider choosing)		• Psychiatric Advance Directive (PAD) • Illness and Management Recovery (IMR) • Living in Balance • Gorski-CENAPS Model

6.5.2. Recommended EBPs and Consensus-Based Approaches:

CCBHCs are strongly encouraged to implement any or all of these recommended EBPs, so long as model fidelity is maintained. All recommended EBPs must be provided directly by the CCBHC:

- Dialectical Behavioral Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- EMDR-PTSD
  - Recommended for individuals with PTSD
- Behavioral Activation (BA)
  - Recommended for veterans
- Community Reinforcement and Family Training (CRAFT)
- Care, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
  - Screening tool for children/adolescents
- Multisystemic Therapy (MST)
- Integrated Illness and Management Recovery (I-IMR)
  - Recommended for older adults

6.6. Clinical Initiatives and Guidance

In addition to the recommended EBPs, CCBHCs are encouraged to implement the following clinical initiatives and guidance. Needs should be identified via the CCBHCs' submitted community needs assessments.

- Psychiatric De-Prescribing (poly-pharmacy avoidance)
- Metabolic Screening and Monitoring
- Evidenced-Based Tools for Tobacco Use – Examples to consider:

- Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool: Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool | The Center for Technology and Behavioral Health
- Penn State Nicotine Dependence Index: Nicotine Dependence Index | Penn State
- Fagerstrom Test for Nicotine Dependence: Fagerstrom Test for Nicotine Dependence (FTND) – Addiction Research Center – UW–Madison

- Validated tools for screening for trauma – Examples to consider:
  - ACE - Adverse Childhood Experience [ACE]
  - Life Events Checklist [LEF])
- Emerging practice/s in wellness programming:
  - Zero Overdose
  - Phone-Based Health Coaching for Medication Adherence

6.7. Children and Adolescent Services

CCBHCs must provide services to all individuals, including children and adolescents ages 5 and older. Children and adolescents are eligible for all developmentally and clinically appropriate core and required CCBHC services. In New Jersey, the organization and delivery of most behavioral health and intellectual and developmental disability (IDD) services falls under the Department of Children and Families (DCF) Children's System of Care (CSOC) for youth ages 5 to 21 years.[9] As the CSOC does not directly manage or deliver outpatient mental health services (e.g., individual, family, group and other counseling, and medication prescription administration and review provided in non-residential settings), CCBHCs may deliver these services for children and adolescents who are eligible for and receiving other services through the CSOC. For these children and adolescents, CCBHCs must collaborate with and coordinate care with any mutually serving CSOC provider. For children and adolescents not yet enrolled in the CSOC, CCBHCs must assess for eligibility of CSOC services and refer the member, parent, or legal guardian to the CSOC for eligibility determination as appropriate.

7. Designated Collaborating Organization Requirements

7.1. Overview

A Designated Collaborating Organization (DCO) is an entity that collaborates with a CCBHC to provide specific services that enhance the offerings of the clinic. DCOs may encompass, but are not limited to, community-based organizations, healthcare

[9] The CSOC provides behavioral health services such as mobile response and stabilization services (MRSS), biopsychosocial (BPS) assessments, care management through Care Management Organizations that provide full-service planning for youth and their families with complex needs, and intensive in and out of home services for youth displaying/experiencing significant emotional and behavioral health concerns that place them at risk of removal from their home of psychiatric hospitalization. Services available for youth with developmental disabilities include but are not limited to IDD specialized out of home treatment, intensive in-home services, and family support services.

providers, and social service agencies that deliver mental health, substance use, and other supportive services. A DCO operates independently of the CCBHC's direct supervision but maintains a formal partnership with the CCBHC, delivering services in accordance with the same standards as the CCBHC. DCOs may be either non-profit or private, for-profit entities.

Individuals receiving services from a DCO entity contracted with the CCBHC are recognized as CCBHC recipients. DCO entities and providers are required to comply with CCBHC standards regarding the scope of services and must possess the necessary credentials. Services provided by DCOs must align with the stipulations of Section 2402(a) of the Affordable Care Act, titled “Removal of Barriers to Providing Home and Community-Based Services.” This section mandates that services embody person- and family-centered, recovery-oriented care; respect the needs, preferences, and values of the recipients; and promote involvement and self-direction in service delivery. Services aimed at children and youth must be family-centered, youth-guided, and developmentally suitable.

In New Jersey, CCBHCs may engage DCOs to enhance their capacity to deliver required services and address varying service demands. The community needs assessment conducted by the CCBHC must clearly define the necessity for a DCO partnership, and the CCBHC must modify its staffing plan to demonstrate how DCOs will be utilized to fulfill service demands.

7.2. DCO Service Provision

CCBHCs may enter into a formal agreement with a DCO to deliver the “Required” services specified in Section 6.1.2. and to meet requirements with implementing EBPs as cited in Section 6.3. CCBHCs must enter into a formal “non-financial” agreement with a DCO to provide State-sanctioned Crisis Services.

The following table documents which services must be provided by a CCBHC and which services may be or are required to be provided by a DCO.

CCBHC Service Category	Service must be provided directly by the CCBHC	Services may be provided by other entities
Screening, Assessment, and Diagnosis, including Risk Assessment	✓	
Person- and Family-Centered Treatment Planning	✓	
Outpatient Mental Health and Substance Use Services	ASAM WM-1 must be provided directly by the CCBHC	ASAM levels above ASAM WM-1 may be provided by a DCO
Outpatient Primary Care Screening and Monitoring	✓	
Peer Support and Counselor Services and Family Supports	Peer Support and Counselor Services must be provided directly by the CCBHC	- Family Support Services may be provided by a DCO - CCBHC may have a DCO with a Peer Run Organization
Comprehensive Case Management	✓	
Psychiatric Rehabilitation Services		✓
Crisis Services	CCBHCs must be able to support immediate crisis stabilization services in walk-in scenarios and offer crisis services to current service recipients as necessary within the treatment framework	CCBHCs are required to contract with DCOs to provide State-sanctioned crisis services (e.g., Mobile Crisis and Outreach Team (MCORT) services, Crisis Stabilization Services, Psychiatric Emergency Screening Center services at Designated Screening Centers, Crisis Receiving and Stabilization Center services, Children's mobile response and stabilization services through the CSOC)) **988 Suicide and Crisis Lifeline Center services are provided through a care coordination agreement*

7.3. DCO Eligibility

To be designated as a DCO, organizations must meet the following criteria:

- Be a licensed or certified provider of behavioral health or substance use services in New Jersey unless licensure/certification is not required, such as peer-run organizations or rehabilitation services.
- Have established protocols for collaboration and communication with CCBHCs.
- Comply with all applicable federal, State, and local regulations.
- Have a signed formal agreement with a CCBHC outlining roles, responsibilities, and service expectations.
- Be an active Medicaid provider.

7.4. DCO Agreements

A formal relationship between a CCBHC and a DCO is established through a written and fully executed agreement or other formal written arrangements (e.g., contract, MOU, MOA) that document: 1) the mutual expectations of the CCBHC and DCO; 2) accountability for the services to be provided; and 3) reimbursement arrangements, including payment for services rendered by the DCO. The CCBHC retains financial and clinical responsibility and oversight for the services delivered by the DCO.

During the initial certification or recertification process, an applicant CCBHC must submit all DCO agreements to the State for review prior to receiving full certification status. See Sections 7.7 and 7.8 for adding new DCO agreements and terminating DCO agreements, respectively.

During the periods between certification and recertification, CCBHCs are obligated to submit all new and or updated DCO agreements to the State before the DCO commences service delivery.

The State retains the right to request additional information on DCO agreements. Services provided by a DCO entity on behalf of a CCBHC prior to submission to the State are ineligible for reimbursement. Payments made to a CCBHC for services provided by a DCO that operate in violation of this policy manual may be subject to recoupment.

7.4.1. Minimum Requirements for DCO Agreements:

- References to State DCO requirements (Section 7 of this Policy Manual)
- Identified liaison or lead staff
- The rate for the purchased service(s) under the agreement and the associated CCBHC service codes detailed in Appendix D.1
- Expectations for data sharing and the methodology for gathering necessary information for quality, operational, and financial monitoring and reporting
- Expectations for care coordination (referenced in Section 6.3)

- Evidence that DCO personnel have undergone basic CCBHC training and comprehend the model goals, the responsibilities of a DCO, and the requirements for service delivery and billing
- Evidence that basic CCBHC training is conducted for DCO service providers at least once every three (3) years
- Provisions regarding the delivery and monitoring of EBPs, if the DCO is offering CCBHC-required EBPs, including proof that the DCO adheres to EBP model fidelity at the time the agreement is finalized
- Payment terms for purchased services and the defined allocation of quality incentive payments, if applicable
- Any other information requested by the State deemed as necessary to properly evaluate the DCO Agreement

7.5. CCBHC Oversight of DCOs

CCBHCs must maintain clinical and financial oversight for the provision of services delivered by DCOs. CCBHCs must also ensure DCOs comply with all CCBHC requirements, including but not limited to:

- The DCO is required to possess and uphold the necessary certifications, licenses, and/or enrollments to deliver the services
- The personnel delivering CCBHC services within the DCO must possess and maintain the appropriate licensure for the services rendered
- The DCO complies with CCBHC cultural competency and training standards
- The DCO is obligated to adhere to all federal and State laws and regulations regarding confidentiality and data privacy
- The DCO must comply with the member grievance procedures established by the CCBHC
- The DCO is required to implement the sliding fee scale established by the CCBHC
- The DCO must adhere to CCBHC standards for person and family-centered, recovery-oriented care, which respects the individual's needs, preferences, and values, while ensuring the involvement of the person receiving services and promoting self-direction in the services provided. Services for children and youth should be family-centered, youth-guided, and developmentally appropriate.
- The DCO is expected to engage in initiatives to improve health information exchange (HIE) to enhance coordination between the DCO and the CCBHC
- Implement safeguards to prevent the DCO from receiving duplicate payments for services included in the CCBHC's PPS rate

7.5.1. CCBHC Clinical Oversight of DCOs

CCBHCs are required to oversee the clinical service delivery at the DCO to guarantee that the services provided meet the same standards as those of the CCBHC. To support clinical oversight, CCBHCs must:

- Ensure that the DCO adheres to quality standards and evidence-based practice guidelines with fidelity
- Coordinate care for individuals served by a DCO
- Ensure that the licensure and credentialing of the DCO are accurate and monitored for Fraud, Waste, and Abuse (FWA)
- Promptly inform the State if there is any non-compliance, disruption, or termination in DCO service delivery

7.5.2. CCBHC Financial Oversight of DCOs

Financial arrangements are mandatory for all DCO partnerships, except for DCO agreements between a CCBHC and a State-sanctioned crisis provider. The requirements for agreements with State-sanctioned crisis providers are specified in Section 7.6.

Payment for DCO services is included in the calculation of the CCBHC's monthly PPS rate. CCBHC services provided through a DCO will be classified as CCBHC claims for the purposes of the monthly PPS. Costs related to DCO services that are included in the CCBHC Cost Report must accurately reflect the services specified in the DCO Agreement.

Payments will be made directly to the DCO from the CCBHC based on mutually agreed upon contractual service rates. These rates should represent fair market value and consider the expenses associated with fulfilling the additional obligations of being a DCO. Given that DCOs are mandated to collect data for quality monitoring and reporting, CCBHCs may allocate a portion of any awarded quality incentive payments (QIPs) to DCOs.

CCBHCs are responsible for billing all services provided under contract by a DCO, including submitting Medicaid claims and third-party collections. The financial and payment procedures must adhere to the Payment Section of this manual (see Section X.X). CCBHCs are required to submit DCO-provided CCBHC claims to the State and ensure that individuals served at a DCO are incorporated into required quality data reporting.

7.6. State-Sanctioned Crisis Provider DCO Requirements

CCBHC must have internal capacity (e.g., appropriate staff volume and training, hours of operation, ability to complete warm transfers to other crisis and stabilization

services) to deliver immediate crisis stabilization services in walk-in situations and/or during crisis episodes.

CCBHCs must also utilize existing State-sanctioned crisis providers to ensure appropriate coverage across a CCBHC's service area and to avoid duplication of crisis services. These crisis stabilization services include, but are not limited to:

- Mobile Crisis Outreach Response Team (MCORT) services
- Early Intervention Support Services (EISS)
- Psychiatric Emergency Screening Center services at Designated Screening Centers
- Crisis Receiving and Stabilization Center services
- Children's mobile response and stabilization services through the CSOC*
- 988 Suicide and Crisis Lifeline Center services*

Except for those services indicated with an asterisk (*), CCBHCs must create a non-financial DCO agreement with State-sanctioned crisis service providers within their service area to deliver crisis services. This agreement should explicitly outline the expectations for care coordination, which includes the procedures for data sharing and metric reporting and must confirm that the State-sanctioned crisis provider will offer crisis services to all individuals referred by the CCBHC, regardless of their insurance status or ability to pay.

Services marked with an asterisk (*) may be provided through a non-financial DCO agreement or through a care coordination agreement.

7.6.1. DCOs with Another CCBHC

CCBHCs are permitted to establish DCO agreements with other State certified CCBHCs for the provision of crisis services if the collaborating CCBHC is recognized as a State-sanctioned crisis provider within the designated service area.

7.7. Adding New DCO Agreements

For CCBHCs seeking to add a DCO after full certification status is awarded, the CCBHC must notify the State at MAHS.CCBHC@dhs.nj.gov . The State retains the right to request additional information on DCO agreements.

7.8. Terminating DCO Agreements

CCBHCs are required to give written notice to the State at MAHS.CCBHC@dhs.nj.govno less than 30 calendar days before terminating a DCO relationship. The notice to the State must also document a plan (i.e., DCO with another entity) to continue services after the DCO is terminated. Furthermore, CCBHCs must provide the State with a transition plan that ensures service continuity for all individuals served by the DCO, as

well as how the capacity of services offered by the DCO will be maintained at the CCBHC.

8. CCBHC Payment

8.1. General Provisions for CCBHC Payment

To be eligible for monthly PPS reimbursement, CCBHCs must at minimum meet the requirements specified in Section 3 of this Policy Manual and be certified by the State as a CCBHC. CCBHC monthly PPS rates are developed in accordance with the methodology outlined in the SPA, using information provided by CCBHCs in a State-defined cost report template (e.g., the CMS CCBHC Cost Report Template) or via a proxy rate for a CCBHC's initial year. CCBHCs are required to follow the State's cost reporting process.

CCBHCs are reimbursed at their clinic-specific monthly PPS rate for the provision of qualifying "PPS-triggering" CCBHC services. Each clinic-specific CCBHC monthly PPS rate will be established in the New Jersey Medicaid Management Information System (MMIS) and referenced on the State's rate information website at https://www.njmmis.com/RateInformation.aspx.

8.1.1. Prior Authorization

Prior authorization is not required for any CCBHC service.

8.1.2. CCBHC "PPS-Triggering" Services

A CCBHC "PPS-triggering" service is a service that triggers payment at a clinic's monthly PPS rate. The list of "PPS-triggering" service codes are detailed in Appendix D.1.

8.1.3. CCBHC "Cost-Only" Services

A CCBHC "Cost-only" service does not count as a "PPS-triggering" event, but must be accounted for on the CCBHC Cost Report, entered into Medicaid billing system, and submitted on claims for monitoring/reporting purposes. The list of "Cost-only" service codes are detailed in Appendix D.1.

8.1.4. CCBHC Payment Exclusions

The following list describes exclusions to the CCBHC monthly PPS payment:

1. Outpatient Service Requirement: No CCBHC monthly PPS payment will be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services.

2. Service Exclusions: CCBHCs will not receive monthly PPS payment if a beneficiary is currently receiving any of the following services, program status codes (PSCs), or special program codes (SPCs):
    - PACT
    - ICMS
    - Children's CMS
    - Behavioral Health Home

3. Program Exclusions: CCBHCs will not receive monthly PPS payment if a beneficiary is enrolled in any of the following programs, program status codes (PSCs), or special program codes (SPCs):

    - DDD/DSNP
        - PSC 140, 2XX & 5XX or;
        - PSC 600, 650 (ages <18) or 620 (ages 18-26) or;
        - PSC 480, 481, 482, 483, 461 (<19 Yrs. Of Age)

    - MLTSS/DSNP
        - SPCs 60-67

8.2. CCBHC Payment Methodology

New Jersey utilizes a monthly PPS methodology in which State-certified CCBHCs receive a monthly clinic-specific rate for providing qualifying CCBHC services to Medicaid enrolled beneficiaries with a mental health and/or SUD diagnosis. The monthly PPS is paid once per month, per beneficiary regardless of the number of qualifying services rendered in that same month.

Clinic-specific monthly PPS rates are delineated by State-defined standard and special populations based on characteristics such as acuity, condition, aid category, or other criteria. In some instances, the State also makes outlier payments for clinics with costs exceeding State-defined thresholds. Additionally, the State uses QIPs to reimburse CCBHCs for improvements on State-selected quality measures in addition to monthly PPS payments. PPS rates, outlier payments, and QIP payments are described in greater detail below. CCBHCs may bill for eligible, Medicaid-covered non-CCBHC services using their provider enrollment with DMAHS as an independent clinic for mental health or substance use disorders[10]. These services may be provided and billed outside of the CCBHC PPS arrangement to the extent that the services are covered by covered by

[10] The DMAHS provider enrollment application for substance use disorders is referred to as an "Independent Clinic – Narcotic and Drug Abuse Treatment Center".

Medicaid, and provided to a Medicaid enrolled individual. Such services include, but are not limited to:

- Mental Health Screening & Referral, new clients
- Substance Use Disorder Screening & Referral, new clients
- Gambling Screening & Referral, new clients

8.2.1. Standard and Special Population Monthly PPS Rates

The State identifies five populations for separate monthly PPS rates:

1. Standard population
2. Serious Mental Illness
3. Serious Emotional Disturbance
4. Substance Use Disorder
5. Post-Traumatic Stress Disorder

These populations are represented within the cost report and are categorized by primary diagnosis code based on the definitions for each population as cited in Appendix C.1.

8.2.2. Monthly PPS Outlier Payments

The State has cost outlier thresholds for each of the five populations cited in 8.2.1. to determine when CCBHCs exceed service costs and become eligible for outlier payments. Cost outlier thresholds are population-specific, fixed dollar amounts that apply to all CCBHCs. Applying these thresholds ensures that cost outlier payments will not be made for any cost outlier less than the threshold amount. The State's outlier payment methodology and outlier thresholds can be found in Appendix D.3.

8.2.3. Quality Incentive Payments

The State will pay QIPs to eligible CCBHCs achieving performance improvement thresholds for State-mandated quality measures. All CCBHC providers adhering to the outlined reporting requirements will be eligible to receive the QIP, and CCBHCs will be individually evaluated on QIP benchmark performance. The QIP performance period will align with the calendar year (CY). The first performance period will be CY 2026. The amount available for QIP will not exceed 5% of total annual CCBHC monthly PPS costs (e.g., [state fiscal year monthly PPS visits] * [state fiscal year monthly PPS rate]) dependent upon available State funding. The amount available for a given performance period will be determined within 90 days after the start of the State's fiscal year. The State will fully distribute annual allotted QIP funding, as applicable to eligible CCBHCs, within 28 months of the end of a performance year.

QIP benchmarks will be uniform across all CCBHCs, and the quality metrics will only evaluate performance based on Medicaid beneficiary data. If the CCBHC does not report on all QIP measures, the sites will be ineligible for the QIP for any individual measure, unless reviewed and prior approved by the State. CCBHCs will be required to submit QIP data in State-specified timelines and meet minimum numerator and denominator requirements for each QIP measure for potential incentive determination. If a given CCBHC does not meet QIP benchmarks, that amount will be added to a redistribution pool and distributed to other CCBHCs meeting QIP benchmarks in accordance with the distribution methodology. For example, if a CCBHC did not meet benchmark for measure 5, the money allocated for measure 5 would be returned to the QIP pool.

The QIP methodology (including selected measures, stewards, and benchmarks), distribution methodology, and technical specifications can be found online at [placeholder link for methodology document]in Appendix D.4. The QIP measures will follow the Section 223 CMS CCBHC Demonstration quality bonus payment measures for the first performance year. The methodology will be evaluated annually to ensure alignment with State and program priorities.

8.3. CCBHC Payment Operations

8.3.1. General Requirements

CCBHCs must adhere to the billing requirements set forth in 8.3.2. Generally, CCBHCs are eligible to receive the monthly PPS payment if the site submits a claim with a T1041 CCBHC-encounter code and at least one qualifying and approved CCBHC service in a month as noted in their claim details (“shadow-billed” claims) to an eligible Medicaid beneficiary in one of the five population categories cited in 8.2.1. CCBHCs must submit claim details for all CCBHC services provided to a beneficiary in each month, even though payment is dependent on one qualifying service.

8.3.2. Billing Requirements

8.3.2.1. Claim Form

Providers must submit CCBHC claims to the New Jersey MMIS using the CMS-1500 or 837-P.

8.3.2.2. CCBHC NPI

Providers must submit CCBHC claims using the CCBHC NPI as cited in Section 3.5. For DCO-provided services, please refer to the directions cited in Section 8.3.4.

8.3.2.3. Monthly PPS Codes and Modifiers

The State established T1041 as the monthly PPS code for all CCBHC monthly PPS billing. Providers must submit CCBHC claims with T1041 in addition to applicable modifiers reflecting one of the five population categories as specified below:

CCBHC Population	CCBHC Monthly PPS Code	Modifier 1	Modifier 2
Standard	T1041	HH	
Serious Emotional Disturbance	T1041	HH	HA
Serious Mental Illness	T1041	HH	HE
Substance Use Disorder	T1041	HH	HF
Post-Traumatic Stress Disorder	T1041	HH	HK

The T1041 (with applicable modifiers) should be listed as the first detail on the claim (i.e., at the header level). It should cover the entire month's date span. If a provider's billing system cannot accommodate a date range, then the first date of service through the last day of the month should be used. All "shadow-billed" services included in the claim details must reflect the actual date of service. See 8.3.2.5. for an example.

Additionally, the header level should also include a ICD-10 diagnosis code reflective of the population category being reported on one of the first three diagnosis lines of the claim. For example, a monthly PPS claim for a beneficiary in the SUD population should include T1041HHHF and include a SUD ICD-10 code on one of the first three diagnosis lines of the claim (see Appendix C.1 for CCBHC Population definitions/code groupings). There could be instances where a beneficiary may have multiple diagnoses that cross different population categories. In this event, the CCBHC must use clinical judgement to best determine which population should be reported on the claim.

8.3.2.4. Qualifying Services ("Shadow-Billed" Services)

Providers must provide at least one qualifying and approved "PPS-triggering" service (defined as a "core" or "required" service as noted in 8.1.2. to an eligible Medicaid beneficiary in a month to qualify for monthly PPS reimbursement. "PPS-triggering" services must be reported in the claim detail ("shadow-billed") level of the claim under the T1041 (with applicable modifiers) header. The core and required ("PPS-triggering") codes can be found in Appendix D.1.

8.3.2.4.1. "Cost-Only" Services

As cited in 8.1.3., "cost-only" services do not trigger a monthly PPS reimbursement but must be included on a claim if a service is provided. Generally, these codes will be billed on a claim with a T1041 alongside a "PPS-triggering" code. However, there could be instances where these codes are billed outside of a "PPS-triggering" service. In any instance, "cost-only" CCBHC services will be reimbursed at $0. The "cost-only" codes can be found in Appendix D.1.

8.3.2.5. Example CCBHC Claim

The following table provides an example of a CCBHC claim for a beneficiary in the SUD population receiving a mix of core or required ("PPS-triggering") and "cost-only" services in July 2025 (please note that this is a purely hypothetical scenario for illustrative purposes):

Beneficiary Name	Claim Level	Procedure Code	Modifiers	Units	Diagnosis Code(s)	Date of Service
J Bird	Header	T1041	HH, HF	1	F10.9, F17.21	7/1/25-7/31/25
J Bird	Detail	H0049	HH	1	F10.9	7/1/25
J Bird	Detail	H0050	HH	1		7/1/25
J Bird	Detail	H0014	HH	1	F10.9	7/3/25
J Bird	Detail	H2035	HH	2	F10.9	7/10/25
J Bird	Detail	99406*	HH	1	F10.9, F17.21	7/17/25
J Bird	Detail	H2035	HH	2	F10.9	7/24/25

*99406 is a "cost-only" service but still included in the claim detail for reporting purposes.

8.3.3. MCO Requirements

[Placeholder]

8.3.4. CCBHC and DCO Payment

CCBHCs are paid a monthly PPS rate that covers all services provided by the CCBHC and its DCOs. As a result, DCOs are not permitted to bill separately on a fee-for-service basis for CCBHC services delivered to CCBHC beneficiaries. CCBHCs are responsible for submitting claims and collecting all necessary documentation from DCOs for data collection and billing purposes. Additionally, CCBHCs must have procedures in place to monitor and prevent any duplicative

billing practices between CCBHCs and DCOs. From a claims submission perspective, CCBHCs must denote a service provided by a DCO by reporting the DCO's NPI number in the Service Facility Location loop.

Note: If the DCO is not enrolled as a New Jersey Medicaid provider, they must enroll via the appropriate provider type or as a Referring, Operating, Prescribing, Attending Provider (ROPA). ROPA applicants must complete the "*21st Century Cures Act Application for Individual NJ FamilyCare Health Plan Providers."* The application is located on the NJMMIS "Announcements" page and is linked here, 21stCenturyCuresActApplication.pdf.

8.3.5. Coordination of Benefits/Third-Party Liability Requirements

In cases where Medicaid enrolled members have third party coverage (e.g., Medicare, commercial insurance, workers' compensation, or liability insurance), the State will pay CCBHCs the difference between the CCBHC-specific monthly PPS rate and the amount reimbursed by the third-party payers for "PPS-triggering" services. Since third-party payers will pay at the "detail level" of a claim (i.e., the "shadow-billed" codes), the payment responsibility shall consist specifically of a CCBHC's monthly PPS rate less the sum of third-party payer reimbursement for all "shadow-billed" codes on a given claim.

8.3.6. Payment to Dual CCBHC-FQHC Entities (placeholder information for future eligibility)

Providers or DCOs who are simultaneously certified or enrolled as both an FQHC and a CCBHC must ensure their billing practices comply with the requirements of both PPS systems. FQHCs should adhere to the current claims submission procedures for services exclusive to FQHCs and include all relevant billing codes on the CMS-1500 or 837-P form. When delivering CCBHC services through an FQHC, these should be billed using the CMS-1500 or 837-P forms, following the specified claims submission guidelines outlined in this section. According to federal guidance, the decision on whether to pay the PPS for CCBHC or FQHC, or both, depends on the nature, quantity, and scope of services provided to an eligible beneficiary on a specific day.

For dual CCBHC/FQHCs or DCOs, this falls under four primary scenarios, described below:

- Scenario 1: A beneficiary receives one or more FQHC services but does not receive any CCBHC qualifying services, as outlined in the CCBHC scope of services. Outcome: Providers are only permitted to bill the FQHC PPS using the CMS-1500 or 837-P form.

- Scenario 2: A beneficiary receives one or more CCBHC qualifying services, as outlined in the CCBHC scope of services. Outcome: Providers are required to bill the CCBHC PPS using the CMS-1500 or 837-P forms, even if the services are also Medicaid FQHC services.

- Scenario 3: A beneficiary accesses two or more non-overlapping FQHC and CCBHC services (e.g., FQHC only service(s) and one or more CCBHC qualifying service(s)). Outcome: Providers may bill both the FQHC and CCBHC PPS via the CMS-1500 or 837-P form.

- Scenario 4: If all of the services provided to a beneficiary during the same day are overlapping CCBHC qualifying services and FQHC services. Outcome: The MCO must utilize 'higher of' logic and reimburse the dual CCBHC/FQHC at whichever PPS is higher via either the CMS-1500 or 837-P form.

8.3.7. Timely and Complete Filing Requirements

CCBHCs must adhere to claim submission timelines as prescribed by federal and State regulations. In New Jersey, CCBHCs shall submit claims within 365 calendar days from the date of service.

8.3.8. Reporting ICD-10-CM "Z-Codes"

ICD-10-CM Z diagnosis codes ("Z-Codes") relevant to social determinants of health should be included with CCBHC claims when applicable. These Z-Codes should be listed after any mental health and/or SUD diagnosis on the claim (i.e., the mental health and/or SUD diagnosis codes must be prioritized on the claim). The relevant Z-Codes are provided in the following list:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

8.4. Cost Reporting Requirements

8.4.1. Rate Methodology and Cost Report Elements

8.4.1.1. Overview

New Jersey monthly PPS payment rates for CCBHC services are based on the reporting period total annual allowable CCBHC costs divided by the total annual number of CCBHC visits as reported to the State using the State-designated CCBHC Cost Report. CCBHC monthly PPS rates are established for and follow the state fiscal year (SFY) (therefore, a given rate year follows the SFY).

For the purpose of calculating rates, allowable CCBHC costs and visits encompass both Medicaid and non-Medicaid data. Allowable costs include the salaries and benefits of CCBHC providers, the cost of services provided under agreement, and other direct costs such as insurance or supplies needed to provide CCBHC services. Indirect costs include site and administrative costs associated with providing CCBHC services. Moreover, allowable costs are identified using requirements in 45 CFR §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Department of Health and Human Services Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. CCBHC monthly visits include both services provided by the CCBHC, and DCO services provided under agreement.

8.4.1.2. State-defined Standardized Cost Reporting Template and Instructions

The State will utilize the CMS CCBHC Cost Report Template and the CMS Cost Report Instructions, unless CCBHC providers are notified otherwise. CCBHCs must reference the PPS-2 (monthly PPS) sections and follow the instructions to complete the cost reporting requirements reflecting the PPS-2 rate. CCBHCs must submit a completed Cost Report Template to the State within identified timelines, including during the certification process as cited in 4.2.6. and annually as per 8.4.2.

8.4.1.3. State-required Cost Report Supplemental Documentation

CCBHCs are required to submit the following supplemental documentation each year, along with the completed CCBHC cost report:

- Complete and signed CCBHC Cost Report certification schedule
- The most recently completed audited financial statements
- Working trial balance aligning with the cost reporting period
- Indirect cognizant rate agreement (if applicable)

- Allocation descriptions and calculations (if not included in the working trial balance or cost report)
- Claim level encounter data for CCBHC services including the following fields:
    - De-identified client ID
    - Date of service
    - Service code
    - Population identifier (ICD-10 Code)
    - Service charge

The above list is not exhaustive, and CCBHC providers must submit any additional documentation requested by DHS.

8.4.2. Cost Reporting Cadence

CCBHCs must submit the elements cited in 8.4.1. to the State annually. Cost reports and supplemental documentation based on audited financials are due to the State within 180 days of the next SFY (roughly January 1). Upon receipt from the CCBHC, the cost reports are reviewed independently by the State or a qualified external vendor. Once approved by the State, the monthly PPS rates are set for the following rate year (which is the following SFY).

8.4.3. Initial CCBHC Monthly PPS Rates

8.4.3.1. Existing Demonstration CCBHCs

Effective October 1, 2025, the State will use the current SFY26 Demonstration PPS-2 rates for current CCBHCs to set first year monthly PPS rates.

8.4.3.2. New CCBHCs:

For CCBHCs certified on or after October 1, 2025, the State will set initial rates using, at its sole discretion, either a proxy rate or using audited historical cost report data, as outlined below, respectively:

- Option 1 (proxy rate)
  The State will use the average monthly PPS rate of all current State-certified CCBCs to set first year monthly PPS rates. This includes both standard and any special population monthly PPS rates.

- Option 2 (cost report-based rate)
  The State will establish provider-specific bundled monthly payment rates using audited historical cost report data from the most recently ended complete fiscal year. The bundled monthly rate is calculated by

dividing the total annual allowable costs of CCBHC services by the total annual number of CCBHC Medicaid and non-Medicaid visits and adjusted from the reporting period to the rate period using the Medicare Economic Index (MEI).

8.4.4. Rate Update Methodology

Upon acceptance of the CCBHC cost reports, the State will set the rates for the following rate year. The rate period begins October 1, 2025, for the initial year and follows the SFY thereafter. Each cost report will include one full year of cost and visit data, with a reporting period of the SFY. Rates will be adjusted annually using an appropriate inflationary index, such as the 2017-based MEI, or rates will be rebased using actual, annual cost and visit data adjusted for the effective rate period using the MEI. CCBHC monthly PPS rates are rebased after a full initial rate period, following an optional rate adjustment for a change in scope, and at least every three years.

8.4.4.1. Initial Rate Rebasing for New CCBHCs

For CCBHCs certified on or after October 1, 2025, initial payment rates are rebased once the CCBHC submits the first cost report, including a full year of actual cost and visit data for CCBHC services under the State plan. Upon review and approval from the State, rebased rates take effect the following SFY.

8.4.4.2. Rate Updates After the Initial Rebase

For subsequent years, rates will be adjusted following the process described in the “Rate Update Methodology” section.

8.4.5. Change in Scope

CCBHC providers may request a rate adjustment for changes in scope expected to change individual CCBHC provider payment rates by 4.0 percent or more. The provider must submit information to the State regarding changes in the scope of services, including changes in the type, intensity, or duration of services, the expected cost of providing the new or modified services, and any projected change in the number of visits resulting from the change. Projections are subject to review and approval by the State. Provider specific requests for rate adjustments for changes in scope are permitted once per fiscal year and take effect with annual rate updates. Rates adjusted for a change in scope are rebased once the CCBHC submits the first cost report with a full year of actual cost and visit data, including the change in scope. Rebased rates take effect the following SFY. Further detail regarding the Change in Scope process can be found in Appendix B.1.

9. CCBHC Monitoring and Evaluation

9.1. Overview

This portion of the CCBHC Policy Manual offers comprehensive instructions for CCBHC collection and reporting of mandatory quality measures. The collection and reporting of required quality measures enable the evaluation of care delivery and accessibility, support the implementation of quality improvement initiatives, and serve as valuable data for State assessments. Generally, the State will continue to leverage the monitoring and evaluation requirements from the CCBHC Demonstration, including use of the "SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual" as a basis for its CCBHC data monitoring and evaluation.[11]

9.2. Required CCBHC Quality Measures

9.2.1. Clinic-Collected Quality Measures

Clinic-Collected Quality Measures represent data and results for clients receiving services at the CCBHC. CCBHCs must gather data and report outcomes for the Clinic-Collected Quality Measures specified in the table proceeding this paragraph. These outcomes must be submitted to the State using the specified data reporting template within the established deadlines cited in Section 9.4. These measures are in effect for at least CY 2026.

[11] SAMHSA (2024). Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual. Retrieved from: https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf.

Measure Name	Measure Steward	SAMHSA Manual Page #[12]
Time to Services (I-SERV)	SAMHSA	31
Depression Remission at Six Months (DEP- REM-6)	MN CM	40
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)	NCQA	51
Screening for Social Drivers of Health (SDOH)	CMS	61
Screening for Depression and Follow-Up Plan (CDF-AD): Age 18 and Older	CMS	70; 2025 Errata[13]
Screening for Depression and Follow-Up Plan (CDF-CH): Ages 12 to 17	CMS	77; 2025 Errata[14]
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	85
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C)	Mathematica	98
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	NCQA	106

Note: Please refer to the SAMSHA manual pages for more information about the listed measures.

9.2.1.1. Data Validation

To validate calculations of Clinic-Collected Quality Measures, the State may request additional data. Detailed guidance and training will be provided for any additional data validation requests made by the State.

9.2.2. State Collected-Quality Measures

State-Collected Quality Measures represent data and outcomes for CCBHC clients receiving services. The State will compile and oversee the outcomes for all the State-Collected Quality Measures specified in the table below. Some measures will necessitate further coordination with individual CCBHCs to guarantee

[12] Ibid
[13] SAMHSA (2025). Errata Appendix A: Measure CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older. Retrieved from: https://www.samhsa.gov/sites/default/files/2025-core-set-cdf-ad-for-errata-appendix-a.pdf.
[14] SAMHSA (2025). Errata Appendix B: Measure CDF-AD: Screening for Depression and Follow-Up Plan: Ages 12-17. Retrieved from: https://www.samhsa.gov/sites/default/files/2025-core-set-cdf-ch-for-errata-appendix-b.pdf

accurate data collection or data reporting and submission compliance. These measures are in effect for at least CY 2026.

Measure Name	Measure Steward	SAMHSA Manual Page #[15]
Member Experience of Care Survey Identified by the State		
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS	135
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	CMS*	140
Plan All-Cause Readmissions Rate (PCR-AD)	NCQA*	149
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA†	162
Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	NCQA*	2025 Errata[16]
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	NCQA*	179
Follow-Up After Hospitalization for Mental Illness (FUH-AD): Age 18 and Older	NCQA*	193
Follow-Up After Hospitalization for Mental Illness (FUH-CH): Ages 6 to 17	NCQA†	197
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD): Age 18 and Older	NCQA*	203
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH): Ages 6 to 17	NCQA†	208
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD): Age 18 and Older	NCQA*	214
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH): Ages 13 to 17	NCQA†	219

Note: Please refer to the SAMSHA manual pages for more information about the listed measures.

9.2.2.1. Experience of Care Surveys

CCBHCs must use a member experience of care survey identified by the State, which is intended to gather information regarding the care experiences of youth, adult, and family behavioral health patients. The

[15] SAMHSA (2024). Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual. Retrieved from: https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf.

[16] SAMHSA (2025). Errata Appendix C: Measure GSD-AD: Glycemic Status Assessment for Patients with Diabetes. Retrieved from: https://www.samhsa.gov/sites/default/files/2025-core-set-gsd-ad-for-errata-appendix-c.pdf.

survey consist of numerous questions categorized into specific domains to help CCBHCs pinpoint service areas needing enhancement. Further guidance on the forms to be used, methods of distribution, sample size requirements, and outcomes reporting will be issued separately.

9.2.3. DHS Created Measures

CCBHCs are required to report on the DHS Created Measures cited under this paragraph. CCBHCs are expected to report on these measures using the method and timeline that has historically been used. DMHAS will provide guidance on how to report this information.

1. # of Admissions by Month
2. Peer Recovery Supports
3. Case Management
4. Family Supports
5. Supported Employment
6. Medication Assisted Treatment for Alcohol Use Disorder
7. Drug Use Screening and Brief Intervention

9.3. CCBHC Metric Specifications

9.3.1. Data Sources

Consistent with the "SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual," the primary data sources for all quality measures will generally comprise 1) administrative; 2) medical records; 3) hybrid; or 4) survey. See below for a description of these respective sources:

1. Administrative data consists of transaction data (e.g., claims or encounters)
2. Medical records data includes but is not limited to general medical records, electronic health records (EHRs), paper medical records, clinic registries, or scheduling software
3. Hybrid methods utilize both administrative sources and medical records when calculating numerators for measures
4. Surveys are only utilized to collect and calculate the Patient Experience of Care and Youth and Family Experience of Care measures

Although most Clinic-Collected measures necessitate the use of medical records, the State requires CCBHCs to reference the "SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual" for a more detailed list of permissible data sources for each measure. This may include pharmacy data or data provided by DCOs. CCBHCs are expected to employ the methods and data sources outlined in the technical specifications whenever

possible.[17] The CCBHC is responsible for accurately capturing and reporting services and measures.

9.3.2. Measurement Year

Unless otherwise specified, the Measurement Year (MY) for Clinic-Collected measures will follow the CY (January–December). The following table delineates MYs and corresponding date ranges for the first four years of CCBHC SPA.

SPA MY	Date Range for MY
MY1	January 1, 2026-December 31, 2026
MY2	January 1, 2027-December 31, 2027
MY3	January 1, 2028-December 31, 2028
MY4	January 1, 2029-December 31, 2029

9.3.3. Measurement Periods

Measurement periods are specific to each measure, can vary, and may not correspond with the MYs indicated in the table above. Additionally, the measurement periods for the numerator and denominator may differ. For instance, some measures necessitate reviewing screenings conducted in a previous MY to ensure compliance. CCBHCs are required to follow the exact date ranges for each measure as detailed in the "SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual" or its corresponding Errata.[18]

9.4. Data Reporting Process

9.4.1. Data Reporting Template

The State requires CCBHCs to report data via the SAMHSA Data Reporting Template, the "Substance Abuse and Mental Health Services Administration: Data Reporting Templates for Behavioral Health Clinic Quality Measures Template."[19] This template was released in 2024 to capture the updated quality measures listed within the "SAMHSA Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual."[20] The template is separated into six distinct sections:

1. Case Load Characteristics

[17] SAMHSA (2024). Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual. Retrieved from: https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf.
[18] Ibid
[19] SAMHSA (2024). Data Reporting Templates for Behavioral Health Clinic Quality Measures Template. Retrieved from: https://www.samhsa.gov/sites/default/files/ccbhc-data-demonstration-templates.xlsx.
[20] SAMHSA (2024). Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual. Retrieved from: https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf.

2. Clinic-Collected Measures (Required)
3. Clinic-Collected Measures (Optional)
4. State-Collected Measures (Required)
5. State-Collected Measures (Optional)
6. Rollup Report

CCBHCs are only expected to report on required Clinic-Collected Measures as well as three of the optional measures.

9.4.2. Data Submission and Schedule

CCBHCs are responsible for collecting and submitting data designated within the "Data Reporting Template" section of this report (Section 9.4.1). Once the Data Reporting Template is completed, it must be submitted to the State at MAHS.CCBHC@dhs.nj.gov.

9.4.2.1. Annual Submissions

All annual report files will be named utilizing the following naming convention:

- NJ_NPI_YYYY.XLSX
- NJ: Indicates a New Jersey submission
- NPI: This will be replaced by the NPI of the CCBHC
- YYYY: This will be replaced by the MY for the reporting period

CCBHCs are required to gather, verify, and submit the final annual reporting templates to the State within nine months following the end of the MY.

MY	Annual Report Due Date
MY1 (January 1, 2026-December 31, 2026)	October 1, 2027
MY2 (January 1, 2027-December 31, 2027)	October 1, 2028
MY3 (January 1, 2028-December 31, 2028)	October 1, 2029
MY4 (January 1, 2029-December 31, 2029)	October 1, 2030

Appendix A.1: NJ CCBHC Certification Application

[Placeholder for Appendix A.1]

Appendix A.2: NJ CCBHC Certification Criteria Readiness Assessment

[Placeholder for Appendix A.2]

Appendix A.3: NJ CCBHC Needs Assessment Template

[Placeholder for Appendix A.3]

Appendix A.4: NJ CCBHC Certification Criteria

[Placeholder for Appendix A.4]

Appendix A.5: NJ CCBHC Modifications to SAMSHA Criteria

[Placeholder for Appendix A.5]

Version 1.0
October 2025

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.

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Appendix C.1: NJ CCBHC Population Definitions and Diagnosis Codes

The list of population definitions and diagnosis codes is available online at the following URL: https://www.nj.gov/humanservices/dmhas/documents/docs/Appendix_C_1_-NJ_CCBHC_Population_Definitions_and_Diagnosis_Codes_10_1_25.xlsx

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Appendix D.1: NJ CCBHC Procedure Code List

The procedure code list is posted online at the following URL:

https://www.nj.gov/humanservices/dmhas/documents/docs/Appendix_D_1_NJ_CCBHC_Procedure_Code_List_10_1_25.xlsx

Appendix D.2: NJ CCBHC EBP List

EBP	Required or Recommended EBP	Delivery Method Allowed: Directly by CCBHC[21], and/or via DCO or via Referral Agreement[22]	Notes
1. **Motivational Interviewing (MI)/Motivational Enhancement Therapy (MET)**	Required	Directly	
2. **Trauma Informed Care (TIC)** (in various forms of provider choosing)	Required	Directly	CCBHCs may choose the type/s of TIC that align with the needs of the populations served by the CCBHC. Needs should be identified via the CCBHCs' individual needs assessments.
3. **Cognitive Behavioral Therapy (CBT)** (in various forms of provider choosing)	Required	Directly	CCBHCs may choose the type/s of CBT that align with the needs of the populations served by the CCBHC. Needs should be identified via the CCBHCs' individual needs assessments. Examples to consider for certain populations: • Trauma-Focused CBT (TF-CBT) — Children age 4–17 • For Veterans: ○ Depression (CBT-D)

[21] The State has determined that some required EBPs must be provided directly by CCBHCs. CCBHCs may not utilize a DCO or a referral agreement to deliver these EBPs.
[22] The State has determined that some required EBPs may be provided via DCO and/or via a referral agreement.

EBP	Required or Recommended EBP	Delivery Method Allowed: Directly by CCBHC[21], and/or via DCO or via Referral Agreement[22]	Notes
			○ Insomnia (CBT-I) ○ Substance Use Disorders (CBT-SUD) ○ Cognitive Behavioral Conjoint Therapy (CBCT)
4. **Medication Assisted Treatment (MAT) – Medications for Opioid Use Disorder (MOUD), Alcohol Use Disorder (AUD), Tobacco Use Disorder (TUD)**	Required	Directly Via DCO or referral agreement for Methadone only	
5. **Evidenced-based practice for family-based therapy that is subject to adherence to fidelity monitoring** (in various forms of provider choosing)	Required	Directly	Examples of EBPs to consider: • Functional Family Therapy (FFT) • Structural Family Therapy • Systemic Family Therapy • Family Systems Therapy (FST) • Multi-Family Systemic Therapy (MFST) • Family Psychoeducation
6. **Whole Health Action Management (WHAM) or Learning**	Required	Directly	

EBP	Required or Recommended EBP	Delivery Method Allowed: Directly by CCBHC[21], and/or via DCO or via Referral Agreement[22]	Notes
About Healthy Living[23]			
7. **Zero Suicide Framework**	Required	Directly	
8. **Gambling Screen – provider choice of validated tool**	Required	Directly	Examples to consider: • Nower Screening • Lie/Bet • Brief Gambling Screening
9. **Evidenced-based personal wellness plan that is subject to adherence to fidelity monitoring** (in various forms of provider choosing) – Delivered by peers if appropriate based on the tool.	Required	Directly or via DCO with Peer Run Organization	Examples to Consider: • Wellness Recovery Action Plan (WRAP) • Psychiatric Advance Directive (PAD) • Illness and Management Recovery (IMR) • Living in Balance • Gorski-CENAPS Model
10. **Dialectical Behavioral Therapy (DBT)**	Recommended	Directly	
11. **Eye Movement Desensitization Reprocessing (EMDR)**	Recommended	Directly	
12. **EMDR-PTSD – recommended for individuals with PTSD**	Recommended	Directly	
13. **Behavioral Activation (BA)**	Recommended	Directly	Recommended for veterans

[23] Learning About Healthy Living: 2012_lahl.pdf

EBP	Required or Recommended EBP	Delivery Method Allowed: Directly by CCBHC[21], and/or via DCO or via Referral Agreement[22]	Notes
14. **CRAFT Community Reinforcement and Family Training (CRAFT)**	Recommended	Directly	
15. **Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)**	Recommended	Directly	Screening tool for children/adolescents
16. **Multisystemic Therapy (MST)**	Recommended	Directly	
17. **Integrated Illness and Management Recovery (I-IMR)**	Recommended	Directly	Recommended for older adults

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Appendix D.3: NJ CCBHC Outlier Methodology

A. Cost Outlier Identification

The State will identify cost outliers as described below:

1. The State will use the CCBHC's combined monthly claim volume to estimate participant costs.
2. Estimated participant costs will be calculated by multiplying the CCBHC-specific, cost-to-charge ratio (CCR) by the total covered charges of the combined monthly claims for each CCBHC consumer.
3. CCBHC-specific CCRs, used to develop the final rates, were calculated using DY1 cost report submissions. These will be updated at the State's discretion.
4. The State will identify the consumer as a cost outlier if the estimated participant cost exceeds the State-established cost outlier threshold for the population affiliated with the consumer.

B. Cost Outlier Calculation and Payment

The State's process for calculating and making outlier payments is as follows:

1. The State will make a cost outlier payment to the CCBHC when the estimated cost exceeds the State-designated cost outlier threshold amount (as shown in the table in part C below).
2. The amount of the cost outlier payment to the CCBHC will be the estimated cost in excess of the applicable cost outlier threshold multiplied by a "marginal cost percentage" (75%).
3. The marginal cost percentage is a State-designated percentage used to determine the proportion of estimated cost that will be reimbursed as a cost outlier payment. The State-designated percentage is 75% and was selected because it is consistent with the standard outlier payment hospital reimbursement percentage used by the State.
4. The State-designated marginal cost percentage applies to all CCBHC's and all populations.
5. The State will make cost outlier payments to the CCBHC in addition to the standard monthly-PPS payment amount.
6. Outlier payments will be made on an annual basis and will be paid within 13–15 months after the end of each state fiscal year. The 13–15 month lag in payment will allow for timely submission of claims per 42 CFR 447.45.
7. The outlier payments to be paid to the CCBHCs by population for DY1 will be equal to at least the set aside amounts indicated on Exhibit 2 of the application. After the set aside amounts are met, the State will continue to make outlier payments to CCBHCs for 75% of costs exceeding the established outlier threshold.

8. Cost outlier thresholds are updated annually.

C. Outlier Threshold Exhibit

Population	Prior to DY07 Threshold	DY07 and After Threshold
Standard	$700	$820
SMI	$800	$937
SUD	$1,900	$2,225
PTSD	$1,500	$1,757
SED	$1,300	$1,522

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Appendix D.4: NJ CCBHC Quality Incentive Payment Methodology

A. Key QIP Information

- **QIP Start:** January 2026
- **Measurement Year (MY):** January 1, 2026–December 31, 2026
- **QIP Data Due to DHS:** October 1, 2027
- **Estimated QIP Payment Date**: May 1, 2029
- **Projected Yearly Allotment**: 3% of Annual Monthly CCBHC Visits

B. Measure Table and Weights for MY1:

Quality Measure (QM)	Weight	Policy Manual Reference
QM1: Time to Services (I-SERV)	20%	9.2.1.
QM2: Depression Remission at Six Months (DEP-REM-6)	15%	9.2.1.
QM3: Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	15%	9.2.2.
QM4: Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	15%	9.2.2.
QM5: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	10%	9.2.2.
QM6: Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	5%	9.2.2.
QM7: Plan All-Cause Readmissions Rate (PCR-AD)	20%	9.2.2.

C. Methodology:

The NJ CCBHC QIP is comprised of a select set of quality measures as defined by the State. For MY1, the measures, weights, and policy manual reference are illustrated in the table above. CCBHCs must report all required QIP quality measures to be eligible for payment. CCBHCs must also meet the minimum numerator and denominator requirements for the calculation of a QIP measure for it to be included in the determination of payment. The State will utilize the QIP funding pool to distribute payment to CCBHCs meeting quality benchmarks in accordance with the timeline and process cited in this appendix.

1. QIP Funding Pool

   The QIP funding pool will be determined annually based on the availability of state resources. Each quality measure will be allocated a proportion of the QIP funding pool in relation to its weight. For example, if the QIP funding pool is $5,000,000 and quality

measure 1 (I-SERV) is weighted at 20%, then that measure will be allocated $1,000,000 (20% * $5,000,000 = $1,000,000). The QIP funding pool will be fully optimized each performance year. If a CCBHC does not attain performance on one or more quality measures or is otherwise not eligible to receive the QIP, those dollars will be redistributed to eligible CCBHCs meeting performance. If no CCBHCs meet the benchmark for a given quality measure, the funds originally allocated to that measure will be redistributed to other quality measures at the state's discretion.

2. Quality Benchmarks

When available, DHS will utilize national benchmarks for each measure to determine performance. If a national benchmark is unavailable for a given quality measure, DHS will specify how it will determine performance (e.g., comparison to other CCBHCs, comparison to state mean/median, etc.). CCBHCs meeting or exceeding performance benchmarks for a given quality measure will be considered for payment. Each quality measure will be evaluated independently of other quality measures, thereby allowing a CCBHC to receive payment for achieving benchmark on one quality measure, but not meeting benchmark on a different quality measure.

3. Performance and Award Calculation

A CCBHC will receive a performance credit for each quality measure benchmark it meets or exceeds. A CCBHC's award amount is determined by the proportion of annual monthly PPS visits to all QIP-qualifying CCBHC annual monthly visits for a given quality measure multiplied by the amount allocated to that quality measure from the QIP funding pool from the weights in part B above.

D. Example:

(This example is purely hypothetical and should be used for illustrative purposes only.) This example assumes a $5,000,000 QIP funding pool with quality measures weighted as shown in the table in part B above. In this example, six of the seven CCBHCs submit data for all required quality measures. CCBHC 7 did not report data for QM4 and is therefore disqualified and removed from the award calculation process. The table below shows how the CCBHCs performed on each of the seven quality measures in addition to the breakdown of annual monthly PPS visits by CCBHC:

CCBHC	Quality Measures Met	Annual Monthly PPS Visits
CCBHC 1	1, 2, 3, 4, 5, 7	10,000
CCBHC 2	1, 2, 3, 7	20,000
CCBHC 3	1, 6, 7	15,000
CCBHC 4	2, 3, 6	30,000
CCBHC 5	1, 2, 3, 4, 5	25,000

CCBHC 6	3, 4, 5	5,000
CCBHC 7	DISQUALIFIED for Not Reporting QM4	DOES NOT QUALIFY

In light of the table above, each CCBHCs credit by QM denoted with an "X" in the table below (note that CCBHC 7 is omitted as they were disqualified for not reporting QM4):

Measure	QM1	QM2	QM3	QM4	QM5	QM6	QM7
CCBHC 1	X	X	X	X	X	-	X
CCBHC 2	X	X	X	-	-	-	X
CCBHC 3	X	-	-	-	-	X	X
CCBHC 4	-	X	X	-	-	X	-
CCBHC 5	X	X	X	X	X	-	-
CCBHC 6	-	-	X	X	X	-	-

Next, each CCBHCs proportion of annual monthly PPS visits to all QIP-qualifying CCBHC annual monthly PPS visits is calculated for a quality measure. This is then multiplied by the award amount allocated to a given quality measure based on its weight of the QIP funding pool; in turn, this product yields an award amount for that measure. For example, looking at CCBHC 1's performance on QM1 specifically, the steps are as follows:

1. Award Credit Determination: CCBHC 1 met or exceeded the benchmark for QM1 and therefore receives a credit.

2. Monthly PPS Visit Proportion Calculation: CCBHC 1's monthly PPS visit proportion is calculated by taking the proportion of CCBHC 1's annual monthly PPS visits (10,000) to total annual monthly PPS visits for CCBHCs qualifying for QM1 (70,000, which is the sum of annual monthly PPS visits for CCBHCs 1, 2, 3, and 5); therefore CCBHC 1's monthly PPS visit proportion is 14.3% (10,000/70,000 = 0.143).

3. Award Amount Calculation: CCBHC 1's award amount for QM1 is calculated by multiplying their monthly PPS visit proportion (14.3%) by the QIP funding pool amount allocated to QM1, or $1,000,000 (0.20 [QM1 weight] * $5,000,000 = $1,000,000); ergo, CCBHC 1's awarded amount for QM1 is $142,857.14 (0.143 * $1,000,000 = $142,857.14).

Following the steps above, the full $5,000,000 QIP funding pool award breakdown for this example is shown in the table below:

CCBHC	QM1 Award	QM2 Award	QM3 Award	QM4 Award	QM5 Award	QM6 Award	QM7 Award
CCBHC 1	$142,857	$88,235	$83,333	$187,500	$125,000	$0	$222,222
CCBHC 2	$285,714	$176,471	$166,667	$0	$0	$0	$444,444
CCBHC 3	$214,286	$0	$0	$0	$0	$83,333	$333,333
CCBHC 4	$0	$264,706	$250,000	$0	$0	$166,667	$0
CCBHC 5	$357,143	$220,588	$208,333	$468,750	$312,500	$0	$0
CCBHC 6	$0	$0	$41,667	$93,750	$62,500	$0	$0
Total	**$1,000,000**	**$750,000**	**$750,000**	**$750,000**	**$500,000**	**$250,000**	**$1,000,000**

Appendix E.1: NJ List of Program/Eligibility Codes Excluded from CCBHC

Population	Excluded Codes[24]
DDD/DSNP	Program Status Codes (PSC): 140, 2XX & 5XX or PSC 600, 650 (ages <18) or 620 (ages 18-26) or PSC 480, 481, 482, 483, 461 (<19 Yrs. Of Age)
MLTSS/DSNP	Special Program Code 60-67

[24] Reflects the list of excluded program/eligibility codes as of the policy manual's effective date and is subject to revision.