New Jersey Certified Community Behavioral Health Clinic Policy Manual

Version 1.1

Effective October 1, 2025

State of New Jersey
Department of Human Services

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Version 1.1
October 2025

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Revision History

Version	Change Description
Version 1.1	Addition of Appendix A.4: CCBHC Certification Criteria and Appendix A.5: New Jersey Modifications to SAMSHA Criteria

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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:

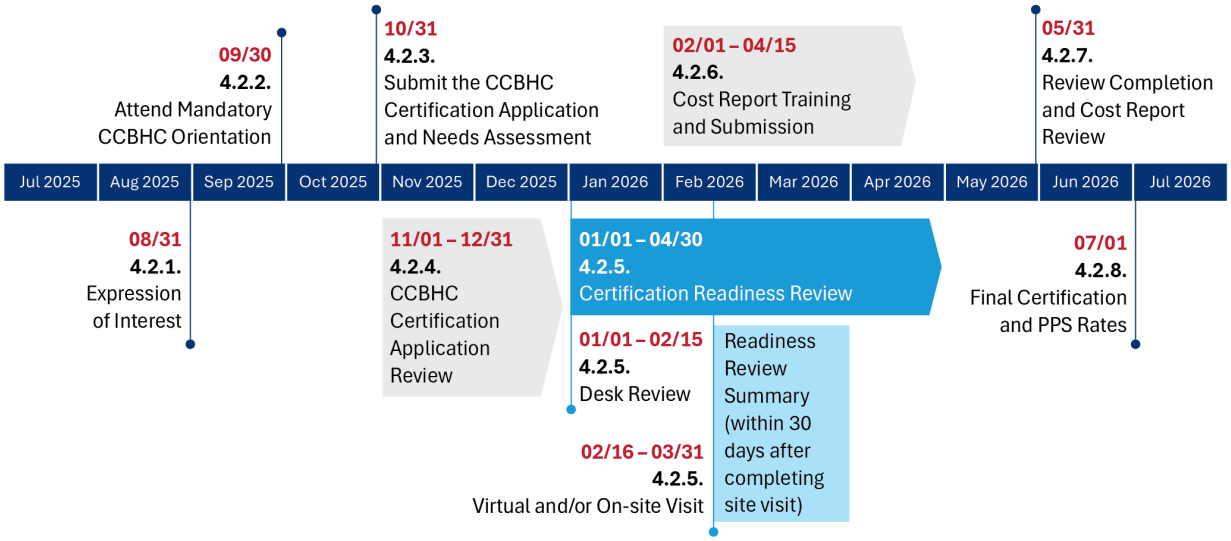
1. Staffing
2. Availability and accessibility of services
3. Care coordination
4. Scope of services
5. Quality and other reporting
6. Organizational authority, governance, and accreditation

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

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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]

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Appendix A.3: NJ CCBHC Needs Assessment Template

[Placeholder for Appendix A.3]

Appendix A.4: NJ CCBHC Certification Criteria

New Jersey CCBHC Criteria
Section 1: Staffing **Program Requirement 1a (General staffing requirements, community needs assessment and staffing plan)**
1.a.1 As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years.
1.a.2 The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer.
1.a.3 The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration and coordination of behavioral health and primary care. *Note: If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.*
1.a.4 The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.
Section 1: Staffing **Program Requirement 1b (Licensure and credentialling of providers)**
1.b.1 All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses,

certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.

1.b.2
The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria.

CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers.

The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with and referrals to other providers. Note: Recognizing professional shortages exist for many behavioral health providers: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies in accordance with New Jersey laws and regulations, to the extent possible, to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision.

Section 1: Staffing

Program Requirement 1c (Training related to cultural competence, trauma-informed care and other areas

1.c.1
The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on:

- Evidence-based practices;
- Cultural competency (described below);
- Person-centered and family-centered,
- recovery-oriented planning and services;
- Trauma-informed care;
- The clinic's policy and procedures for continuity of operations/disasters;
- The clinic's policy and procedures for integration and coordination with primary care;
- Care for co-occurring mental health and substance use disorders.

At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff. Trainings may be provided on-line.

Training shall be aligned with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the Health and Human Services (HHS) website, the Substance Abuse and Mental Health Services Administration (SAMHSA) website, the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration.

Note: See criteria 4.k relating to cultural competency requirements in services for veterans.

1.c.2
The CCBHC regularly assesses the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.

1.c.3
The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. CCBHCs are encouraged to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.

1.c.4
Individuals providing staff training are qualified as evidenced by their education, training, and experience.

Section 1: Staffing

Program Requirement 1d (Linguistic competence)

1.d.1
The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.

1.d.2

Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.
1.d.3 Auxiliary aids and services are readily available, Americans with Disabilities Act (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).
1.d.4 Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.
1.d.5 The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.
Section 2: Availability and Accessibility of Services **Program Requirement 2a (General requirements of access and availability)**
2.a.1 The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.
2.a.2 Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.
2.a.3 Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.
2.a.4 The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.
2.a.5 The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services.
2.a.6

Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.
2.a.7 Services are subject to all state standards for the provision of both voluntary and court-ordered services.
2.a.8 The CCBHC has a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.
Section 2: Availability and Accessibility of Services **Program Requirement 2b (Requirements for timely access to services and assessment)**
2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in-person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up. If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made. If the triage identifies routine needs, services will be provided and the initial evaluation completed within 10 business days. For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. The preliminary triage and risk assessment will be followed by: (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. CCBHC's must review recent information with the person receiving services and incorporate this information into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period. *Note: Requirements for these screenings and evaluations are specified in criteria 4.d.*
2.b.2 The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every six months, unless the state, federal, or applicable accreditation standards are more stringent.
2.b.3

People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response.
Section 2: Availability and Accessibility of Services **Program Requirement 2c (Access to Crisis Management Services)**
2.c.1 The CCBHC directly provides or coordinates with treatment providers to ensure access to crisis management services 24 hours a day, 7 days a week. Crisis management services are provided directly or through a DCO. The CCBHC must provide crisis services either directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services that meet the CCBHC crisis service requirements. Note: See program requirement 4 for a description of required crisis behavioral health services.
2.c.2 A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.
2.c.3 Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).
2.c.4 In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those EDs.
2.c.5 Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations. *Note: See criterion 3.c.5 regarding specific care coordination requirements related to discharge from hospital or ED following a psychiatric crisis.*
2.c.6 Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises. *Note: See criterion 3.a.4 where precautionary crisis planning is addressed*
Section 2: Availability and Accessibility of Services

Program Requirement 2d (No refusal of services due to inability to pay)
2.d.1 The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).
2.d.2 The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities
2.d.3 The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation
2.d.4 The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.
Section 2: Availability and Accessibility of Services **Program Requirement 2e (Provision of services regardless of residence)**
2.e.1 The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of a permanent address.
2.e.2 The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking noncrisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services including telehealth to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience out-of-home placements and adults who are displaced by incarceration or housing instability.
Section 3: Care Coordination **Program Requirement 3a (General requirements of care coordination)**

3.a.1 Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare. *Note: See criteria 4.k relating to care coordination requirements for veterans.*
3.a.2 The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically. *Note: CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.*
3.a.3 Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.
3.a.4 The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving services. Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.
3.a.5 Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.
3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its DCOs, or with any other provider.

3.a.7 The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.
Section 3: Care Coordination **Program Requirement 3b (Health information systems)**
3.b.1 The CCBHC establishes or maintains a health information technology (HIT) system that includes, but is not limited to, electronic health records. Or utilizes any state developed database or sanctioned system required by DHS.
3.b.2 The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange. For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information.
3.b.3 The CCBHC uses technology that has been certified to current criteria under the ONC Health IT Certification Program for the following required core set of certified health IT capabilities (see footnotes for citations to the required health IT certification criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs: • Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible). • At a minimum, support care coordination by sending and receiving summary of care records. • Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice. • Provide evidence-based clinical decision support. • Conduct electronic prescribing. *Note: Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.*
3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.
3.b.5 The CCBHC develops and implements a plan within two years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health

information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.
Section 3: Care Coordination **Program Requirement 3c (Agreements to support care coordination)**
3.c.1 The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. *Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*
3.c.2 The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities, and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services. *Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*
3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to

provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area:

- Schools
- Child welfare agencies
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty crisis)
- State licensed and nationally accredited child placing agencies for therapeutic foster care service
- Other social and human services.
- CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following:
    - Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders.
    - Suicide and crisis hotlines and warmlines
    - Veterans service organizations
    - Indian Health Service or other tribal programs
    - Homeless shelters
    - Housing agencies
    - Employment services systems
    - Peer-operated programs
    - Services for older adults, such as Area Agencies on Aging
    - Aging and Disability Resource Centers
    - State and local health departments and behavioral health and developmental disabilities agencies
    - Substance use prevention and harm reduction programs
    - Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers
    - Legal aid
    - Immigrant and refugee services
    - SUD Recovery/Transitional housing
    - Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs
    - Coordinated Specialty Care programs for first episode psychosis
    - Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food, and transportation programs)

In addition, the CCBHC has a care coordination partnership with all 988 Suicide & Crisis Lifeline call centers. The agreement clarifies referral and care coordination activities between the CCBHC and the 988 Lifeline Center by outlining roles and responsibilities of each party. CCBHCs must use the approved template developed by DHS for this care coordination agreement (See Appendix A.7).

Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care

undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.
3.c.4 The CCBHC has partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type. *Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*
3.c.5 The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission, Discharge, and Transfer (ADT) system. The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and continues until the individual is linked to services or assessed to be no longer at risk. *Note: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*
Section 3: Care Coordination **Program Requirement 3d (Treatment team, planning, and care coordination activities)**
3.d.1 The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning

and care coordination activities are person- and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.
3.d.2 The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. *Note: See criteria 4.k relating to required treatment planning services for veterans*
3.d.3 The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan. *Note: See program requirement 4 related to scope of service and person-centered and family-centered treatment planning.*
Section 4: Scope of Services **Program Requirement 4a (General service provisions)**
4.a.1 Whether delivered directly or through a DCO agreement or care coordination agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person and family-centered treatment planning; outpatient mental health and substance use services; outpatient primary care screening and monitoring; comprehensive care management; psychiatric rehabilitation; and peer support and counselor services and family supports.
4.a.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of a care coordination agreement outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.
4.a.3 With regard to either CCBHC or DCO services, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.
4.a.4 DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.
Section 4: Scope of Services

Program Requirement 4b (Requirement of person-centered and family-centered care)

4.b.1
The CCBHC ensures all CCBHC services, including those supplied by its DCOs or through a care coordination agreement, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach.

Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.

4.b.2
Person and family-centered care is responsive to the race, ethnicity, sexual orientation, and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services.

Section 4: Scope of Services

Program Requirement 4c (Crisis behavioral health services)

4.c.1
The CCBHC shall provide immediate crisis receiving/intervention services directly and State-sanctioned crisis services through a DCO agreement or care coordination agreement for the provision of crisis behavioral health services.

CCBHCs must have the internal capability to deliver immediate crisis intervention services in walk-in scenarios, in addition to offering crisis services to current service recipients as necessary within the treatment framework.

- Crisis receiving/intervention: The CCBHC provides crisis receiving/intervention services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care.

State-sanctioned crisis services must be provided by a DCO agreement or care coordination agreement (as appropriate), including:

- Emergency crisis intervention services: The DCO provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate

in any state, regional, or local air traffic control (ATC)21 systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

- 24-hour mobile crisis teams: The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (two hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed three hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the two hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services if they are in a state that includes this option in their Medicaid state plan.

Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises.

Note: See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.

Section 4: Scope of Services

Program Requirement 4a (Screening, assessment, and diagnosis)

4.d.1
The CCBHC directly provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services.

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

4.d.2
Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.

4.d.3

The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum:

1. Preliminary diagnoses.
2. The source of referral.
3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved.
4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services.
5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications.
6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful.
7. The use/abuse of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications.
8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors.
9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence.
10. Assessment of need for medical care (with referral and follow-up as required).
11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services.
12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice).

4.d.4

A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable State, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include:

1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services.
2. An overview of relevant social supports; social determinants of health; and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status.
3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP.
4. Pregnancy and/or parenting status.
5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.
6. Relevant medical history and major health conditions that impact current psychological status.
7. A medication list including prescriptions, over -the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies.
8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement-based care).
9. Drug and alcohol history substance use disorders (including tobacco, alcohol, and other drugs).

10. Basic cognitive screening for cognitive impairment. **11.** Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. **12.** The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. **13.** Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, comprehensive care management, psychiatric rehabilitation services). **14.** Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. **15.** An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. **16.** The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.
4.d.5 Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and applicable clinic-collected quality measures identified by the State.
4.d.6 The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.
4.d.7 The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.
4.d.8 If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1.
Section 4: Scope of Services **Program Requirement 4e (Person and family-centered treatment planning)**
4.e.1 The CCBHC directly provides person and family-centered treatment planning, including but not limited to, risk assessment and crisis planning. Person-centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.7 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person receiving services involvement and self-direction. *Note: See program requirement 3 related to coordination of care and treatment planning.*

4.e.2 The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.
4.e.3 The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.
4.e.4 Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.
4.e.5 The treatment plan is comprehensive, addressing all services required, including recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.
4.e.6 Where appropriate, consultation is sought during treatment planning as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking).
4.e.7 The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services.
Section 4: Scope of Services **Program Requirement 4f (Outpatient mental health and substance use services)**
4.f.1 The CCBHC directly provides outpatient behavioral health care, including psychopharmacological treatment (ASAM WM-1 must be provided directly by the CCBHC; higher ASAM levels of care may be provided through a DCO or care coordination agreement). The CCBHC must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through a care coordination agreement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with State and federal laws and regulations. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use,

the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. *Note: See also program requirement 3 regarding coordination of services and treatment planning.*
4.f.2 Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs must provide evidenced-based services that are developmentally appropriate, youth-guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) to improve service outcomes.
4.f.3 Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.
Section 4: Scope of Services **Program Requirement 4g (Outpatient clinical primary care screening and monitoring)**
4.g.1 The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. The CCBHC is responsible for ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations of DOH, DHS and other established medical organizations (these recommendations specify for which populations screening is appropriate) for the following conditions: • HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and other Reporting and applicable clinic-collected quality measures identified by the State • Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director, and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population
4.g.2 The Medical Director will develop organizational protocols to ensure screening is available for people receiving services who are at risk for common physical health conditions (e.g., tobacco use, weight/BMI, and diabetes risk) and any conditions or diseases that are relevant or prevalent in the population being served or that are treatment-related). Protocols will include: • Identifying people receiving services with chronic diseases. • Ensuring that people receiving services are asked about physical health symptoms; and • Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g

In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider or with an affiliated primary care staff person on or off site to ensure that screenings occur for the identified conditions. The CCBHC should establish an agreement with the nearest FQHC if there are multiple clients who access services at the FQHC or could reasonably access services from the FQHC outside of the service area if there is not a FQHC in the service area. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.

4.g.3
The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following:

1. Ensuring individuals have access to primary care services.
2. Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions.
3. Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and
4. Promoting a healthy behavior lifestyle.
5. Assessing and resolving issues of polypharmacy, medication side-effects, and contraindications.

Medical and nursing staff within CCBHCs are responsible for obtaining and monitoring vital signs (e.g., weight, height, temperature, pulse rate, and blood pressure) and these staff shall monitor routine blood work (e.g., hemoglobin A1C control for clients with diabetes, metabolic indices such as a lipid panel, etc.).

Note: The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the PPS.

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

Section 4: Scope of Services

Program Requirement 4g (Comprehensive Care Management Services)

4.h.1
The CCBHC is responsible for providing directly comprehensive care management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, behavioral health, and other services and supports to restore the beneficiary to their best possible functional level. CCBHC comprehensive care management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC comprehensive care management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC comprehensive care management should also be accessible during other critical periods, such as episodes of homelessness or transitions to the community

from jails or prisons. CCBHC comprehensive care management should be used for individuals with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition.

Section 4: Scope of Services

Program Requirement 4i (Psychiatric rehabilitation services)

4.i.1

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

- Participate in supported education and other educational services;
- Achieve social inclusion and community connectedness;
- Participate in medication education, self-management, and/or individual and family/caregiver psychoeducation; and
- Find and maintain safe and stable housing.

Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers.

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

Section 4: Scope of Services

Program Requirement 4j (Peer supports, Peer Counseling, and Family/Caregiver Supports)

4.j.1

The CCBHC is responsible for directly providing peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites26; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support. CCBHCs may have a DCO with peer-run organizations or family support services organizations for the delivery of their services.

Note: See program requirement 3 regarding coordination of services and treatment planning.
Section 4: Scope of Services **Program Requirement 4k (Intensive, community-based mental health care for members of the armed forces and veterans)**
Although not an explicit Medicaid-covered benefit, it is strongly encouraged for CCBHCs to adhere to the federal criteria regarding intensive, community-based mental health care for members of the armed forces and veterans. This includes the following:
4.k.1 The CCBHC is encouraged to provide directly, or through a DCO, intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook. *Note: See program requirement 3 regarding coordination of services and treatment planning.*
4.k.2 All individuals inquiring about services are asked whether they have ever served in the U.S. military. Current Military Personnel: Persons affirming current military service will be offered assistance in the following manner: 1. Active-Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF. 2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations. 3. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE authorized provider, network or nonnetwork. Veterans: Persons affirming former military service (veterans) are offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). *Note: See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.*
4.k.3 The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.

4.k.4 Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled:
• Regular contact is maintained with the veteran as clinically indicated if ongoing care is required. • A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis. • Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity). • Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. • The treatment plan is revised, when necessary. • The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2). • The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment plan.

4.k.5
Behavioral health services are recovery - oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery:

- Hope
- Person-driven
- Many pathways
- Holistic
- Peer support
- Relational
- Culture
- Addresses trauma
- Strengths/responsibility
- Respect

As implemented in VHA recovery, the recovery principles also include the following:

- Privacy
- Security
- Honor

Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans adheres to guidelines promulgated by the VHA.

4.k.6
All behavioral health care is provided with cultural competence.

- Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country.
- All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.

4.k.7
There is a behavioral health treatment plan for all veterans receiving behavioral health services.

- The treatment plan includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis.
- The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself.
- As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness.

- The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments.
- The treatment plan is developed with input from the veteran and, when the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.

Section 5: Quality and Other Reporting

Program Requirement 5a (Data collection, reporting, and tracking)

5.a.1
The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: (1) characteristics of people receiving services; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) outcomes of people receiving services. Data collection and reporting requirements are elaborated below. Capacity to collect, report and track data is dependent on Health Information Systems as delineated in Section 3.b of these criteria and Section 9 of the Policy Manual).

Note: See criteria 3.b for requirements regarding health information systems.

5.a.2
CCBHCs must collect and report the quality measures identified as required in Section 9 of the Policy Manual (and Section 8.2.3. of the Policy Manual and related guidance for Quality Incentive Payment measures).

5.a.3
CCBHCs must submit annual cost reports to the State as required by the CCBHC SPA and Section 8 of the Policy Manual.

Section 5: Quality and Other Reporting

Program Requirement 5b (Continuous quality improvement planning)

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

5.b.2
The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan

5.b.3

The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the required quality measures reporting as cited in criterion 5.a.2 (including a focus on poor performance on one or more of the required quality measures). The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.
Section 6: Organizational Authority, Governance, and Accreditation **Program Requirement 6a (Organizational Authority and Financing)**
6.a.1 The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria: • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code • Is part of a local government behavioral health authority • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self Determination Act (25 U.S.C. 450 et seq.)
• Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). *Note: A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.*
6.a.2 To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs shall reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.
6.a.3 An independent financial audit is performed annually for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan (CAP) is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.
Section 6: Organizational Authority, Governance, and Accreditation **Program Requirement 6b (Governance)**

6.b.1
CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making. CCBHCs reflect substantial participation by one of two options:

- Option 1: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families.
- Option 2: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board.

Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into:

- Identifying community needs and goals and objectives of the CCBHC
- Service development, quality improvement, and the activities of the CCBHC
- Fiscal and budgetary decisions
- Governance (human resource planning, leadership recruitment and selection, etc.)

Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website.

6.b.2
If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so. If option 2 is chosen, the State will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.

6.b.3

To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6. b.1.
6.b.4 Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs, local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry
Section 6: Organizational Authority, Governance, and Accreditation **Program Requirement 6c (Accreditation)**
6.c.1 The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative,
statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.
6.c.2 CCBHCs must be certified by the state as a CCBHC. State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. The state may use an independent accrediting body as a part of their certification process as long as it meets state standards for the certification process and assures adherence to the CCBHC Certification Criteria.
6.c.3 The State encourages accreditation of the CCBHCs by an appropriate independent accrediting body (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean “deemed” status.

Appendix A.5: NJ CCBHC Modifications to SAMSHA Criteria

New Jersey CCBHC Criteria[21]	New Jersey Modifications from SAMHSA Criteria
Section 1: Staffing **Program Requirement 1b (Licensure and credentialling of providers)**	
1.b.2 The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA-approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of	• Minor addition of “in accordance with NJ law and regulations” in reference to technologies used by CCBHCs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New Jersey CCBHC Criteria	New Jersey Modifications from SAMHSA Criteria
Section 4: Scope of Services **Program Requirement 4d (Screening, assessment, and diagnosis)**	
4.d.1 The CCBHC directly ~~or through a DCO,~~ provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. ***Note: See program requirement 3 regarding coordination of services and treatment planning.***	Screening, assessment, and diagnosis, including risk assessment must be provided directly by the CCBHC rather than through a DCO.
4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum: 13. Preliminary diagnoses. 14. The source of referral. 15. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved. 16. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services. 17. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications. 18. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful.	• Minor edit to item 7 – Added “abuse” in reference to alcohol and/or other drugs

19. The use/abuse of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications. 20. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors. 21. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence. 22. Assessment of need for medical care (with referral and follow-up as required). 23. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services. For children and youth, whether they have system involvement (such as child welfare and juvenile justice).	
4.d.4 A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable State, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include: 17. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. 18. An overview of relevant social supports; social determinants of health; and health-related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. 19. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP. 20. Pregnancy and/or parenting status. 21. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.	• Minor edit to item 9 – Added “drug and alcohol” in reference to substance use disorder

22. Relevant medical history and major health conditions that impact current psychological status. 23. A medication list including prescriptions, over -the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. 24. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement based care) and 25. Drug and alcohol history substance use disorders (including tobacco, alcohol, and other drugs). 26. Basic cognitive screening for cognitive impairment. 27. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. 28. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. 29. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, ~~targeted case~~ comprehensive care management, psychiatric rehabilitation services). 30. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. 31. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services. 32. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.	
4.d.5	• Clarifies that CCBHCs are accountable to State identified measures, rather than those identified in SAMHSA criteria.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Appendix B.1: NJ CCBHC Change in Scope Process

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

1. **Definition of Change in Scope**
   A Change in Scope refers to any modification in the services provided by a CCBHC that is expected to significantly impact payment rates. This includes but is not limited to:
   - Addition or removal of services covered under the CCBHC model.
   - Changes in the type, intensity, or duration of services.
   - Changes resulting from regulatory amendments, technology, or medical practice updates.
   - Relocation, remodeling, opening, or closing of clinic sites.

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

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

3. **Types of Change in Scope Requests**
   A change in scope may be retrospective or prospective.
   - A retrospective change in scope is a change in scope that has already occurred in the past.
   - A prospective change in scope is a change in scope that is planned to occur in the future.

4. **Submission Requirements**
   Providers must submit a Change in Scope request to the New Jersey Division of Medical Assistance and Health Services (DMAHS) including:
   - A detailed description of the change(s) in scope, including type, intensity, and duration of services.
   - Supporting documentation demonstrating the reasonableness of cost changes, consistent with criteria used in baseline rate development.

- For a prospective change in scope (in addition to the first two bullet points):
    - Notification must be provided at least 120 days prior to the effective date of the change.
    - A pro forma CCBHC Cost Report based on the most recently submitted cost report, and including:
        - The expected cost impact of the new or modified services, including cost centers affected.
        - Projected changes in the number of visits or service encounters.
- For a retrospective change in scope (in addition to the first two bullet points):
    - A CCBHC Cost Report based on the most recently submitted cost report that reflects one full year of the impact of the change in scope.

5. Review and Approval Process

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

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

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

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

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

6. Frequency and Effective Date of Adjustments

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

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

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

7. Rate Rebasing for Prospective Changes in Scope

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

Example:
A CCBHC implements a Change in Scope effective July 1, 2024. The provider submits its first cost report reflecting this change for the fiscal year July 1, 2024, through June 30, 2025, by

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

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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[22], and/or via DCO or via Referral Agreement[23]	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)

[22] 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.
[23] 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[22], and/or via DCO or via Referral Agreement[23]	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[22], and/or via DCO or via Referral Agreement[23]	Notes
About Healthy Living[24]			
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

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

EBP	Required or Recommended EBP	Delivery Method Allowed: Directly by CCBHC[22], and/or via DCO or via Referral Agreement[23]	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[25]
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

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