



*from* NATIONAL  
COUNCIL FOR  
MENTAL  
WELLBEING

# From Demonstration to Enduring Impact: New Jersey's CCBHC State Plan

## NatCon26

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# Session Objectives



**Identify SPA-ready policy frameworks**—including financing, rate-setting, and provider protections—to preserve and grow CCBHC.



**Explore key operational deliverables:** policy manual, certification criteria, financing guidance, provider readiness, and quality measurement templates.



**Discuss integral partnerships within and across state agencies** (Medicaid ↔ Behavioral Health), and clinic engagement strategies.

# The Problem With Demonstrations: They End

The core tension:

Demonstrations build what works.

But they can't sustain what they build.

NJ's answer: A Medicaid State Plan Amendment (SPA) that converts demonstration learning into permanent Medicaid authority.

What made the transition possible:

DMHAS + DMAHS joint  
governance from day one

Real cost and utilization data  
from the demonstration

Clinic engagement throughout  
(not an afterthought)

Toolkits built for operations—  
not just CMS review

# SPA Transition: Four Things That Had to Align

Moving from demonstration authority to an enduring Medicaid benefit requires alignment across four domains—at the same time:

**Policy** → SPA language + provider manual

**Payment** → monthly bundled rate + outlier protection + QIP

**Operations** → claims/IT, DCO governance, billing mechanics

**Measurement** → quality reporting + QIP infrastructure

# The CCBHC Benefit: Eight Service Groupings, One Accountable Provider

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Crisis services

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Screening, assessment, diagnosis & risk assessment

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Person- and/or family-centered treatment planning

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Outpatient mental health and substance use services

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Outpatient primary care screening and monitoring

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Psychiatric rehabilitation services

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Peer, family support & counselor services

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Comprehensive care management / case management

**One entity. One accountable provider. Whole-person care.**

# Core vs. Required Services: Where the CCBHC Stops and the DCO Begins

## Core Services (delivered directly by CCBHC)

- Assessment, diagnosis & risk evaluation
- Treatment planning
- Outpatient MH/SUD (incl. ASAM WM-1)
- Primary care screening & monitoring
- Peer services (peer staff employed by CCBHC)
- Comprehensive care management
- Walk-in crisis capability

## Required services (may be met via DCO agreements)

- Higher ASAM levels (e.g., Inpatient Withdrawal Management)
- Certain crisis components via state-sanctioned providers
- Specialized supports where DCO structure applies (e.g., Family Support Services, Peer-Led Organizations)

**The line between core and required shapes staffing, certification, billing, and rate-setting. Draw it deliberately.**

# Evidence-Based Practices: Required Expectations, Deliberate Choices



EBPs are a formal NJ CCBHC service requirement, not an optional enhancement.



Required EBP selection should reflect the clinic's needs assessment and populations served.



Several core EBPs are expected to be delivered directly by the CCBHC, reinforcing internal clinical capacity.



Readiness review examines both implementation of and fidelity to EBPs.



The goal is not checking a box; it is building a clinically credible, population-responsive model.

## Examples:

- Motivational Interviewing / Motivational Enhancement Therapy
- Trauma-Informed Care
- Cognitive Behavioral Therapy
- Medication Assisted Treatment
- Family-based therapy
- Zero Suicide Framework
- Gambling screening
- Evidence-based personal wellness planning (multiple options available)
- Whole Health Action Management (WHAM), or Learning About Healthy Living

# The Payment Model: Three Problems, Three Solutions



1. Predictable revenue → **Monthly bundled payment**
2. High-need cases can break the math → **Cost outlier payments**
3. Incentives for outcomes → **Quality Incentive Payment (QIP)**

**Bundle pays for access. Outliers pay for protection. QIP pays for outcomes.**

# Monthly Bundle: One Payment Per Month, Population-Specific Rates

## How it works

- One clinic-specific bundled payment per beneficiary per month
- Triggered by  $\geq 1$  qualifying CCBHC service in the month
- No payment if no PPS triggering service occurs
- Providers are required submit “Shadow Billing Claims” that are not a PPS triggering service but are used in rate setting, performance measures, and outlier payments

## Rate development

- Cost-based using the CMS CCBHC Cost Report Template
- Annual updates: MEI trending + periodic rebasing
- Population-specific rates recognize different acuity drivers: Standard, SMI, SED, SUD, PTSD

# Rate Integrity: Change-in-Scope + Annual Updates

## Annual update cycle

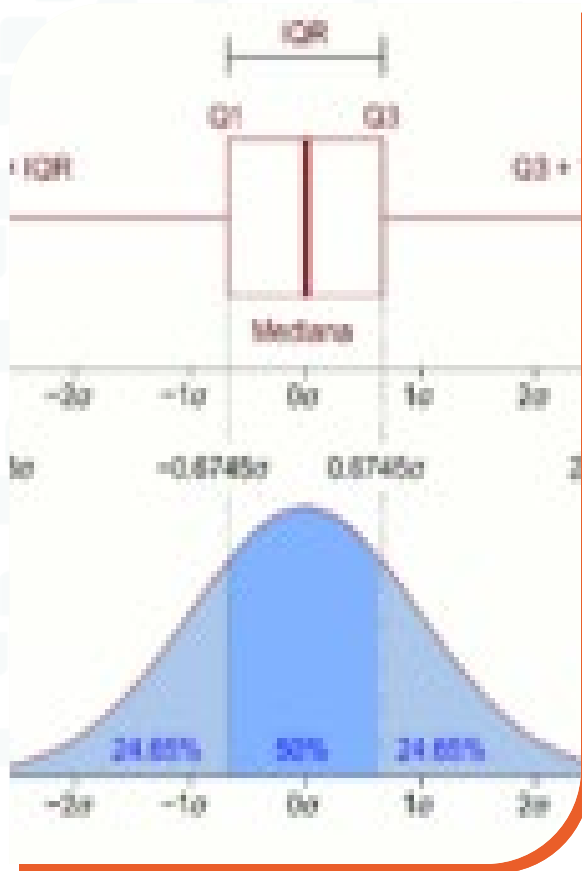
- MEI trending applied each year
- Rebasing every 3 years or when cost data materially changes

## Change-in-scope requests

- Clinics may request review if services, populations, or capacity change materially
- NJ threshold:  $\geq 4.0\%$  expected rate impact
- Incorporated through the cost reporting and rate-setting process

**Bottom line:** Rates stay cost-anchored, predictable, and adjustable when scope changes.

# Cost Outliers: The Safety Net Under the Bundle



- **Purpose:** protect access for beneficiaries with rare, extremely high-cost months
- **How outlier payments work**
  - Estimate monthly cost: cost-to-charge ratio × covered charges
  - Compare to population-specific threshold (high percentile)
  - If cost exceeds threshold → pay a percentage of costs above it
  - Paid annually through reconciliation
- **Real-world effect:** clinics can serve the highest-need beneficiaries without absorbing catastrophic cost—risk is shared above the threshold

# QIP: The Bundle Pays for Access. QIP Pays for Outcomes.

## Quality Incentive Payment (QIP) structure

- Paid in addition to the monthly bundle (not embedded in base rates)
- QIP pool: 3% of total CCBHC SPA payment
- Performance-based: clinics earn QIP by meeting/exceeding benchmarks
- QIP Incentives outcomes that the state feel are the most important, including both adult and children's outcomes

## Why separate matters

- Base rates remain predictable and cost-anchored
- QIP rewards improvement—better performance earns more
- Clinics plan cash flow on the bundle; QIP is the upside

# QIP Measures: Seven Questions We're Paying Clinics to Answer

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## Measurement Year 1 (MY1) Weighting

**I-SERV** — Time to Services (Access) — **20%**

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**PCR-AD** — Plan All-Cause Readmissions (System effectiveness) — **20%**

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**DEP-REM-6** — Depression Remission at Six Months (Clinical outcomes) — **15%**

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**FUH-CH** — Follow-Up After Hospitalization, ages 6–17 (Transitions) — **15%**

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**FUH-AD** — Follow-Up After Hospitalization, ages 18+ (Transitions) — **15%**

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**IET-AD** — Initiation & Engagement of AOD Treatment (SUD entry) — **10%**

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**GSD-AD** — Glycemic Status Assessment for Diabetes (Whole-person) — **5%**

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# Certification: A Scorecard, Not a Black Box

Six domains (weighted scoring to 100 possible points)

Scope of Services (30%)	Staffing (20%)	Availability & Accessibility (20%)	Care Coordination (15%)	Quality & Reporting (10%)	Governance & Accreditation (5%)
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## Thresholds

Full certification: $\geq 75$ overall <b>and</b> $\geq 75\%$ in each domain	Provisional: $\geq 65$ overall <b>and</b> $\geq 65\%$ in each domain (plan of correction)	Not certified: below provisional thresholds
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**NOTE:** Recertification will require an overall score of 80 points with at least 80% compliance on each certification criteria section—an intentionally higher threshold.

# Certification Cycle: Five Steps, Clear Outputs



01

Expression of  
Interest +  
Orientation

02

Application +  
Community  
Needs  
Assessment

03

Readiness  
Review (desk  
review +  
virtual/on-  
site)

04

Cost Report  
Training +  
Submission

05

Certification  
Determination  
+ Rate  
Issuance

**Every step has a defined output—clinics always know what they’re building toward**

Note: Fully certified CCBHCs must submit recertification applications every three years

# From Certified to Operational: Claims/IT Alignment

Certification is necessary—but not sufficient.

Clinics must operationalize **four areas:**

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**Bundle billing mechanics** (monthly billing construct; encounter/shadow-billing workarounds)

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**Quality data capture** (systems, validation, submission readiness)

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**DCO encounter tracking** (referrals, crediting, governance documentation)

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**FFS + MCO alignment** (mechanics that work in both environments)

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**Rule of thumb:** Plan 3–6 months for claims builds and EMR configuration

# From Certified to Operational: Data Collection and Reporting Guidance

- SPA closely follows the Demonstration Performance Metrics
- Rates, Outlier payments, and QIP distribution **needs** good data
- **Two types of data needed for the Performance Measures**
  - Claims data from the shadow billing
  - Provider EHR data
- **Certification requires clinics to**
  - Have EHRs and connections to local HIEs
  - Understand billing and rate settings

# Five Things That Made This Work — And Five Things You Can Replicate



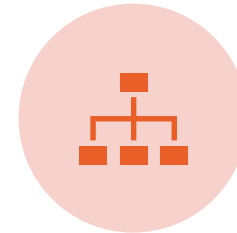
**JOINT  
GOVERNANCE,  
CO-OWNED**  
(BH + MEDICAID  
CO-AUTHOR,  
NOT  
“COORDINATE”,  
PROVIDER  
PARTNERSHIP)



**A  
CERTIFICATION  
SCORECARD**  
(WEIGHTED  
DOMAINS,  
THRESHOLDS,  
PROVISIONAL  
TIER)



**A THREE-PART  
PAYMENT  
MODEL**  
(BUNDLE,  
OUTLIERS, QIP—  
EACH SOLVES A  
DIFFERENT  
PROBLEM)



**A PROVIDER-  
FACING POLICY  
MANUAL**  
(SPA FOR CMS;  
MANUAL FOR  
CLINICS)



**OPERATIONAL  
GUIDANCE**  
(CLAIMS/IT  
SPECS, DATA  
COLLECTION,  
DCO TRACKING,  
QUALITY  
WORKFLOWS)

# State Self-Assessment: Where Does Your State Stand?



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**Governance:** Are BH and Medicaid co-authoring?

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**Policy:** Do you have SPA language + a provider-facing manual?

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**Financing:** Can you defend rates to CMS and to clinics?

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**Certification:** Do clinics have a scorecard—not a black box?

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**Operations:** Have you mapped claims/IT and DCO tracking?

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**Measurement:** Did clinics help select QIP measures?

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**Engagement:** Are clinics at the design table—or the approval table?

# Implementation Checklist



## Policy

- Define service array and DCO approach
- Codify in SPA language + provider-facing policy manual

## Financing

- Cost-based bundled rate methodology + cost reporting cadence
- Annual update mechanism (MEI trending + rebasing)
- Outlier methodology with population-specific thresholds
- QIP measures, weights, benchmarks, and redistribution logic

## Operations

- Claims/IT build guide + encounter capture specifications
- DCO tracking and governance documentation
- Quality reporting workflows and submission calendar

## Partnerships

- Joint governance structure — roles, decision rights, escalation paths
- Clinic engagement plan (design stage, not approval stage)

# Thank You – Questions Welcome!

Nothing to disclose