NEW JERSEY HUMAN SERVICES | DMHAS Division of Mental Health and Addiction Services

New Jersey CCBHC Provider Education and Discussion Session

Operationalizing the New Jersey CCBHC Policy Manual, SPA requirements, and supporting appendices

July 8, 2026

Housekeeping

- Please add questions to the chat as needed. All questions will be addressed at the end of the session.
- This slide deck will be available for future reference on the State's CCBHC website.
- The State may offer additional technical assistance sessions to assist CCBHCs with new and enhanced components of the CCBHC model under the SPA.

Session Objectives

1

Confirm the major New Jersey-specific changes from the prior demonstration-era framing and SAMHSA baseline criteria; understand and navigate the current operational guidance materials.

2

Clarify what must be provided directly, what may be delivered through a DCO or care coordination agreement, and what documentation is needed.

3

Connect service delivery, coding, diagnosis/population assignment, cost reporting, payment, and monitoring.

4

Identify questions that require State follow-up, written clarification, or future technical assistance.

Resource Roadmap

CCBHC Website: Division of Mental Health and Addiction Services | Certified Community Behavioral Health Clinic

Policy Manual: the operating guide for New Jersey CCBHC participation

Appendices A.1 through A.5: application, readiness, needs assessment, certification criteria, and NJ modifications

Appendices C.1 and D.1: population definitions, diagnosis codes, and procedure codes

Appendices D.2 through E.1: EBPs, outlier, QIP, and excluded program or eligibility codes

The Changes Driving Today's Discussion

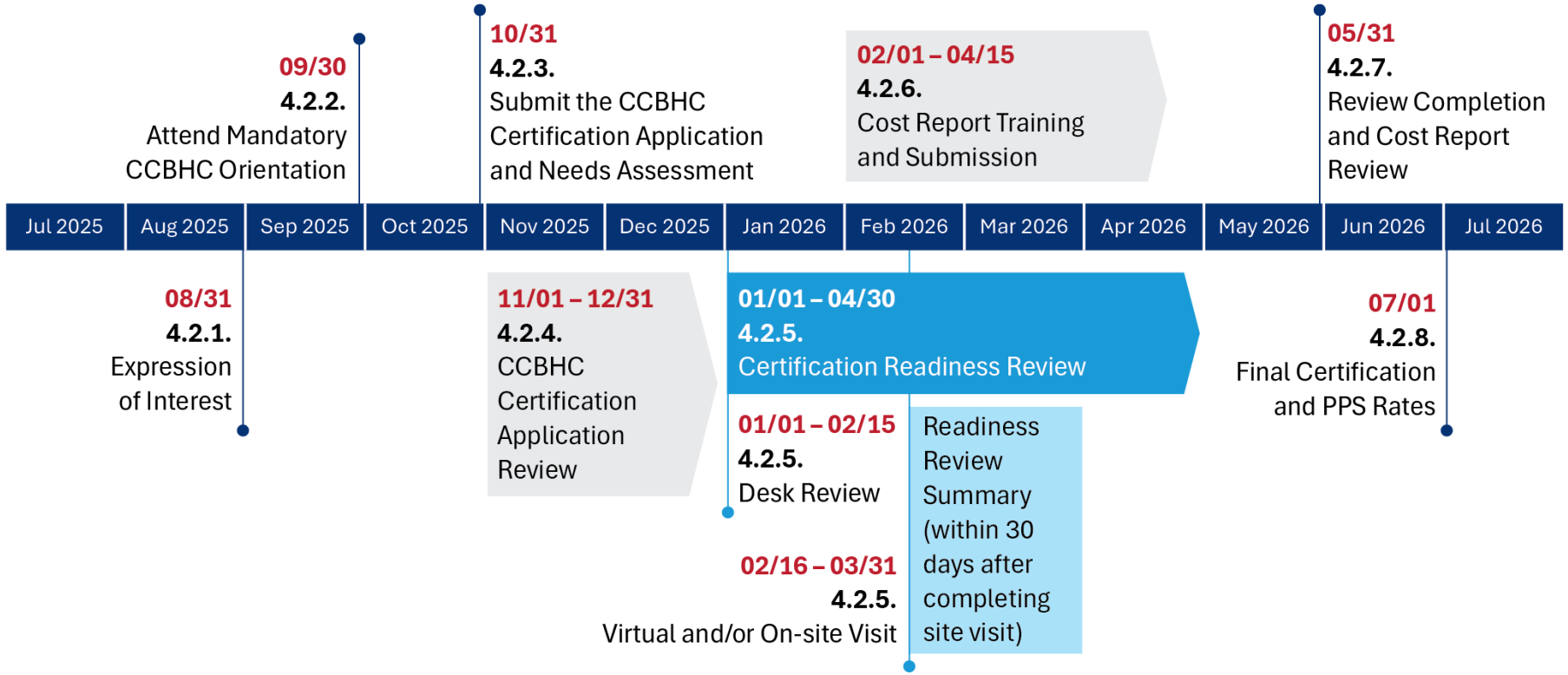
Topic	Provider takeaway
Certification Criteria, Recertification, Timeline, and Process	What changed in the New Jersey criteria and how evidence should be organized for State review. How to prepare for ongoing compliance and surface questions needing State follow-up.
Services: Direct vs. DCO	Which services must be delivered directly, which may be delivered through a DCO, and why the distinction matters.
DCOs and Care Coordination Agreements	When a DCO is needed versus a care coordination agreement or ordinary referral.
EBPs	Required practices, recommended practices, and the operational proof providers should maintain.
Procedure Codes	Core, Required, Cost-only classifications.
Diagnosis and Population Codes	Standard population now explicit, ICD-9 removed, and category overlap/mapping changes.
Billing and Reporting Mechanics	How claim detail should connect member, service, diagnosis, population, CCBHC/DCO identifiers, and PPS.
Cost Reporting and Payment Integrity	Why clean claims and reporting inputs matter for cost reports, outliers, QIP, and monitoring.

Certification Criteria: Significant NJ-Specific Updates

Area	What is significant	What providers need to do
New Jersey criteria vs SAMHSA baseline	Appendix A.4 reflect the New Jersey certification criteria providers will need to work from. Appendix A.5 identifies how New Jersey modified the SAMHSA criteria.	Use A.4/A.5 as the certification crosswalk.
Evidence and scoring	Certification scoring is criteria-based and documentation-driven, with section-level compliance expectations.	Maintain current and ongoing evidence by criteria domain: owner, policy, workflow, gap, and status.
Reporting and quality	The criteria link certification to operational capacity for data, quality, and ongoing monitoring.	Treat reporting workflows and quality measure production as certification evidence, not just administrative work.
Recertification readiness	The criteria become the operating checklist for continued certification, not a one-time application exercise.	Schedule periodic internal reviews before the State review cycle.

Timeline for Certification and Recertification —

To be implemented July 1, 2027



Current CCBHCs will undergo an abbreviated recertification process beginning later in 2026 (exact date TBD) that will extend existing certifications through June 30, 2027.

Required Documents of the Certification/Recertification Process

What changed	What providers need to do
New Jersey will require applicants to submit an application for certification and recertification. The application will also be used for current DHS-certified CCBHCs to add new sites.	The application remains under review. Once published, become familiar with the information required to submit the application.
As part of the application process, **applicants must submit the following:** • Self-assessment using the New Jersey CCBHC Certification Criteria Readiness Assessment • Community Needs Assessment using the required template • CCBHC organizational Chart and/or CCBHC staffing plan • Copies of executed DCO agreements for any core CCBHC service (when permissible)	These documents remain under review. Once published, become familiar with each document and the information required to submit each document.
New Jersey will require applicants to utilize a template for the community needs assessment (due date of October 31, 2026). To complete the community needs assessment, CCBHCs will need to gather input from individuals with lived experience and/or receiving CCBHC services and community partners.	Prepare methods and plan to gather information from a wide variety of individuals and community partners (e.g., stakeholder sessions, surveys, interviews, etc.).

Recertification and Reporting of Changes

Recertification

At minimum, recertification occurs every three years. Recertification requires an overall score of 80 points and at least 80% compliance in each certification criteria section.

Reporting of Changes

Notify the State within 15 calendar days of significant changes that affect services, DCO arrangements, access, EBPs, billing, or sites.

Delivery of CCBHC Services: Direct vs. DCO; Core and Required Services

Core (must be provided directly by CCBHC)

- Screening, assessment, diagnosis, risk assessment
- Person/family-centered treatment planning
- Outpatient MH/SUD services, including ASAM WM-1
- Care coordination
- Clinic-based crisis services
- Outpatient primary care screening and monitoring *(previously allowed via DCO)*
- Peer support/counselor services and family supports provided by peer specialists on staff *(previously allowed via DCO)*
- Comprehensive case management *(previously allowed via DCO; name change from Targeted Case Management)*

Required (may be provided via DCO or referral arrangement)

- ASAM levels of care above ASAM WM-1 (via DCO or referral arrangement)
- Psychiatric rehabilitation services
- State-sanctioned crisis services
- Peer support/counselor and family supports *provided by* a peer-run organization services or family support services *(previously allowed via referral agreement; changed to a* requirement to be provided via DCO or care coordination agreement)
- Under outpatient primary care screening and monitoring:
  - Collect biologic samples (via DCO or through protocols with an independent clinical lab organization)
  - Laboratory analyses (via DCO or care coordination agreement)

DCOs and Care Coordination: Strengthened Requirements

What changed	What providers need to do
New Jersey now makes it clearer when a formal DCO relationship is needed, when a care coordination agreement may be sufficient, and what must be in DCO agreements.	Review all partner arrangements against the service it supports and the minimum agreement elements in the manual.
CCBHC retains clinical and financial responsibility for DCO services and must submit new or updated DCO agreements before service delivery.	Put a control in place so new partnerships, terminations, or service changes are routed to compliance/billing before implementation.
DCO data, claims detail, quality reporting, and cost reporting must be usable by the CCBHC.	Build data-sharing and reporting terms into the agreement, not as an afterthought.

Required Evidenced Based Practices (EBPs)

Under the SPA, CCBHCs must provide the EBPs listed below. All must be provided directly, except for MAT-Methadone which may be provided via DCO or referral agreement.

- Motivational Interviewing /Motivational Enhancement Therapy
- Trauma-Informed Care*
- Cognitive Behavioral Therapy*
- MAT/MOUD-AUD-TUD
- Evidenced-Based Family-Based Therapy*
- Whole Action Health Management (WHAM) or Learning About Healthy Living
- Zero Suicide Framework
- Gambling Screen*
- Evidenced-Based Personal Wellness Plan*

*Indicates the EBP may be provided in various forms of provider choosing

Recommended Evidenced Based Practices (EBPs)

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	Eye Movement Desensitization Reprocessing (EMDR)	EMDR-PTSD	Behavioral Activation
CRAFT (Community Reinforcement and Family Training)	CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)	Multisystemic Therapy	Integrated Illness and Management Recovery

*Indicates the EBP may be provided in various forms of provider choosing

Procedure Codes: Modifications and Requirements

What changed	Why it matters	What providers need to do
Code list structure changed	The updated D.1 workbook classifies codes by service category and policy role: Core, Required, or Cost-only.	Update EHR and billing logic to use D.1 classifications.
Some codes were added/removed	One added code and 11 removed codes, plus description cleanups across shared codes.	Run a legacy-to-updated code crosswalk and remove obsolete configurations.
Cost-only services are explicit	Cost-only services do not trigger PPS but still matter for cost reporting and monitoring.	Keep these services visible in claim detail/reporting and cost report mapping.
Descriptions were standardized	Many shared code descriptions were cleaned up or standardized, which may affect staff understanding even when the code remains.	Update internal billing guides and staff-facing descriptions.

Standard/Special Populations and Diagnosis Codes: Modifications and Requirements

What changed	Why it matters	What providers need to do
Standard population is now explicitly listed. The updated workbook includes Standard, SMI, SUD, PTSD, and SED code categories.	Standard is no longer only defined by exclusion from the special-population list.	Configure EHR and billing logic using the updated appendix, not historical mapping rules.
Diagnosis code universe expanded. The updated workbook is ICD-10 only and includes many codes not in the 2016 ICD-10 list.	More diagnoses may now map to a CCBHC population category, and ICD-9 logic should no longer be used.	Test high-volume and common diagnosis codes against the updated workbook before claims submission.
Some codes changed category or now overlap. Certain diagnoses changed population category; some appear in more than one category.	Old mapping logic may produce the wrong population category, modifier, or encounter code.	Validate population assignment logic where a diagnosis is shared across categories or changed from the prior list.
Population assignment connects to payment. Diagnosis code, population modifier, and monthly T1041 encounter code need to align.	These fields support PPS payment, cost reporting, monitoring, and payment integrity review.	Confirm diagnosis, category, modifier, and T1041 encounter code are consistent before billing.

Practical example	A beneficiary with a PTSD diagnosis should not automatically be treated as standard or folded into another special population. Best practice is to confirm the updated diagnosis in the appendix, select the appropriate population assignment, and make sure the monthly T1041 PTSD encounter code aligns with the claim(s).

Billing and Reporting: Claim-Level Mechanics

Reporting element	What needs to be reflected	Why it matters
Billing provider/CCBHC NPI	Claim is submitted under the certified CCBHC's billing NPI. The CCBHC remains accountable even when a DCO delivers the service.	Ties payment, reporting, and monitoring to the certified CCBHC entity.
DCO identifier, when applicable	For DCO-delivered services, report the DCO NPI in the Service Facility Location loop/field or other State-specified reporting field.	Distinguishes direct CCBHC services from DCO services and helps avoid separate FFS billing or reporting confusion.
Monthly PPS encounter code	Use the applicable T1041 population code for the member/month.	Connects the encounter to the correct Standard, SED, SMI, SUD, or PTSD payment/reporting category.
Detail service lines	Report actual service codes, modifiers, dates, units, and provider/service details.	Shows what was delivered and supports monitoring, shadow reporting, and cost review.
Diagnosis + population category	ICD-10 diagnosis should support the population category and selected encounter code.	Aligns clinical documentation, billing, payment logic, and State reporting.

Cost Reporting, Payment Integrity, Outliers, and QIP

Key Inputs	Where it shows up later	Risk if it is not managed
Qualifying PPS-triggering detail	Monthly PPS payment logic and service utilization monitoring.	Payable encounters may be delayed, denied, or difficult to validate.
Cost-only services	Cost report, monitoring, and complete picture of CCBHC service activity.	The State may see an incomplete service mix even if no immediate claim denial occurs.
DCO service detail and costs	DCO oversight, cost reporting, payment integrity, and future rate review.	DCO services may be underreported or difficult to distinguish from direct CCBHC services.
Diagnosis/population category	Population-level PPS, outlier analysis, QIP denominators, and program monitoring.	Population assignment errors can distort payment and program performance data.
Program/eligibility exclusions	PPS exclusion logic and exception review.	Services may be clinically appropriate but not PPS payable under the CCBHC benefit.
Quality measure data	QIP eligibility, benchmarks, and required monitoring.	Incomplete or inconsistent data can affect QIP readiness even where services were delivered.

Questions?