STRENGTHEN THE FOUNDATION
OF NEW JERSEY'S COMMUNITY-BASED
BEHAVIORAL HEALTH SYSTEM
INVEST IN NEW JERSEYANS' WELL-BEING!
For decades, the community-based behavioral health system has been proven to be highly effective in improving the quality of life, and often saving lives of children and adults throughout New Jersey who have mental illnesses, substance use disorders, intellectual/developmental disabilities and co-occurring disorders.

The community-based behavioral health system infrastructure needs to be strengthened to give all New Jerseyans the opportunity to live as healthfully and successfully as possible. The demand for behavioral health services continues to increase while the capacity of the community-based system continues to decline, primarily due to workforce shortages and inadequate reimbursement rates for several services.

Community-based services are cost-effective. They are significantly less expensive than institutional care and prevent the need for such care. Investing sufficiently in community-based services is the right thing to do for the state’s fiscal viability, as well as the health and well-being of New Jersey residents.
Greater Investment in Community-Based Services will Save Lives, as well as State Funds

The community-based behavioral health system of care is the safety net for New Jersey's most vulnerable residents – those with mental health and/or substance use disorders. More than 500,000 children and adults depend on the services this system delivers every year. These services have been proven effective in helping people manage and recover from their illnesses, achieve personal goals, and reduce other health and social service costs. However, access to these invaluable and cost-effective services continues to be limited, primarily due to inadequate funding that neither covers costs nor allows for competitive wages.

Administrative Recommendations

- **Implement fee-for-service (FFS) oversight**
  The FFS oversight process must move forward immediately with establishment of the Oversight Board and commissioning the comprehensive study of the adequacy of reimbursement rates and the impact of FFS on consumer access, quality and continuity of care.

- **Continuously review and streamline regulatory and licensing requirements**
  An exhaustive review of these requirements must be undertaken and steps taken to resolve issues that are barriers to care, duplicative, inconsistent, unfunded or unnecessarily burdensome, particularly with regard to supporting access to integrated care.

- **Identify alternative funding options for Medicaid programs**
  Alternative funding options are needed to fill gaps that would result from changes in federal policy and the federal budget.

Legislative Recommendations

- **Establish a formula for upward adjustments of rates and contracts:**
  A formula that is tied to an inflationary index must be established to prevent erosion of the adequacy of rates and contracts to cover the actual costs of care.

- **Fully enforce parity:**
  Pass S1339/A2031 into law. This would have New Jersey match the current federal parity law by expanding coverage for behavioral health and autism services, and also would strengthen enforcement and oversight. Establish an ombudsman position in the Department of Banking and insurance that would be dedicated to behavioral health services.
Funding increases need to be accompanied by annual adjustments based on inflationary factors to sustain the adequacy of reimbursements; otherwise insufficiencies are inevitable. The fiscal inadequacies are not new, though they have recently grown dramatically for many mental healthcare providers, specifically outpatient, partial care and Community Support Services. This is due to the recent shift to fee-for-service (FFS) reimbursement from deficit funded contracts for these and other services. Rates must be adequate to support a stable workforce and basic infrastructure. Residential rates are also significantly inadequate. Residential programs struggle with rates that do not cover the costs of care, even if 100% capacity could be maintained.

The salaries that community-based providers are able to offer versus those that state agencies and educational institutions pay began diverging decades ago. The gulf between them now makes recruitment, retention and vacancy issues nearly impossible to address, and continuity of care is threatened. Although certain Medicaid rates were recently increased, some rates still do not cover the full cost of care, and contracts and regulations have always contained costly unfunded mandates. Combined, these fiscal impacts have reached critical levels; system capacity is being reduced at a time of increasing demand.

With adequate funding for all services in the community-based behavioral health system, access will increase, and children and adults will receive the clinical treatment and other support they need to:

- Manage and recover from mental health and substance use disorders.
- Overcome limitations they may encounter as a result of intellectual/developmental disabilities.
- Live in their homes.
- Hold jobs.
- Complete primary education and pursue higher education.
- Keep their families together or reunite with their families.
- Avoid emergency room visits and hospitalizations.
- Avoid activities that could lead to incarceration.

Everyone has mental health needs, whether or not a mental illness is present, and NJAMHAA members are dedicated to meeting all of those needs – and they need sufficient funding to maintain and expand the services that allow them to achieve their vital missions.

Upon discharge from a state psychiatric facility after eight years, “Max” was placed in a group home and enrolled in a partial care program where he received counseling and support as he developed socialization and daily living skills. As he progressed, he assumed leadership roles in various self-help groups. Eventually, Max was hired by the group home as a part-time Residence Counselor. In 2016, he became a full-time Residence Counselor at the group home, where he continues to be employed.

Having exceeded all expectations, Max moved to a semi-supervised apartment where he continued to hone his skills. Max then, with his family’s help, purchased a condo, which he has lived in for more than two years. In addition to his full-time position, Max works part-time as an outreach peer specialist and volunteers at local hospitals, where he also gives motivational speeches.
Inadequate reimbursement levels have negatively impacted providers’ ability to recruit and retain a stable, qualified workforce. A cost of living adjustment (COLA) for contract-based services was last provided in 2008. Community-based providers cannot compete with the salaries, wage increases and benefits that the state offers. These disparities make it extremely difficult for community-based providers to attract and retain qualified staff.

In a FY 2015 report from the New Jersey Department of Children and Families, *NJDCF Workforce: Preliminary Highlights*, the critical need to maintain a skilled workforce is described along with the costs of high turnover. The report also provides the starting salaries for various staffing levels, which are, on average, $10,000 to $15,000 more than the starting salaries that community providers are able to offer. Professionals will continue to leave for similar, yet higher paying positions with the state or educational institutions, or abandon the field for other, more lucrative opportunities.

The inability to recruit and retain quality staff contributes greatly to a lack of continuity of care, often disrupting progress that has been made by an adult or child and their family and resulting in the loss of gains made. As continuity of care is essential, turnover and staff vacancies interfere with progress toward wellness and recovery. The difficulty providers have in retaining experienced staff not only directly impacts the individuals served, but also negatively affects entire organizations, as knowledge, relationships and supervisory capacity are lost. The success of those served is reliant on a stable workforce.

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<tr>
<td><strong>Title</strong></td>
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<tr>
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A Need for Growth & Investment in the Adult Community-based System

Current rates do not cover the costs of care for many mental health programs and while substance use treatment rates are more adequate following recent increases, and have even allowed some organizations to expand, those programs still face critical workforce issues and insufficient capacity to meet needs. The demand for mental health and substance use treatment has always exceeded system capacity, resulting in long wait times for appointments, turning to emergency rooms for some, and a total lack of treatment for others.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently reported that in 2014-2015, of the estimated 366,000 New Jersey adults with any mental illness, 247,000 had a serious mental illness, yet only 143,472 adults received mental health services. The New Jersey Division of Mental Health and Addiction Services (DMHAS), in its 2017 block grant application, estimated that 897,492 New Jerseyans were in need of treatment for drug or alcohol use in 2016. Of the 90,742 adults who sought treatment, only 53,209 received it, leaving 37,533, or 41.4%, of those seeking treatment without any.

Recently, as a result of the shift to fee-for-service (FFS) reimbursement, capacity has been reduced in many programs around the state. Thousands will no longer receive mental health services, which will result in increased hospital admissions and social services costs. In an August 2017 NJAMHAA survey, a combined staff reduction of more than 70 full-time employees, including 5.9 fewer psychiatrists, was reported by just seven organizations. One program alone anticipated a 100-person reduction in the number of individuals served.

In December 2017, NJAMHAA conducted a second survey. Among 17 responding provider organizations, 16 were running FY2018 deficits in 39 outpatient programs, totaling more than $8 million combined. Ten of those organizations had already implemented budget cuts at the beginning of the fiscal year. The total budget cuts (for the eight agencies that provided amounts) totaled more than $4 million across 20 programs.

Of the 13 respondents who had been operating Supportive Housing (SH) programs prior to July 1, 2017, three respondents opted to not continue these programs in the Community Support Services (CSS) FFS reimbursement model (it is known at least a half dozen SH programs did not opt in to CSS); one respondent has informed the state that it will not operate its CSS program past June 30, 2018; and four others are not sure yet if they will operate CSS past June 30, 2018 (one respondent did not provide a status).

CSS Program Outlook

December 2017
NJAMHAA Survey
**Budget Cuts at Beginning of FY2018**

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<td>Partial Care</td>
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<tr>
<td>Residential</td>
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| No. of programs | 8 | 3 | 2 | 1 | 3 | 1 | 2 |

**Deficits in FFS Programs - December 2017**

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<tr>
<td>Partial Care</td>
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| No. of programs | 19 | 2 | 3 | 6 | 9 |

**Budget Recommendations**

Provide for increased reimbursement rates: Outpatient and residential rates must be increased to cover the actual costs of care and meet the increasing demand for services.

Restore and increase the state investment in community-based mental health services, which was reduced by $38.8 million from FY2015 to FY2017.

Provide capital funding: Capital is needed to support both increased capacity and integrated care capability.

Provide funding to sustain the Certified Community Behavioral Health Clinic (CCBHCs) demonstration program.
Need for Statewide Expansion of Critical Services

The Early Intervention Support Services (EISS) program, which works in tandem with emergency screening centers, exists in only 11 of New Jersey’s 21 counties (highlighted in red on the map), leaving individuals in other areas of the state unable to access these critical mental health crisis services.

EISS has been proven to be a very successful and cost-efficient solution to long waits for outpatient services, which average four to six weeks, and high rates of emergency room visits and hospitalizations. EISS programs provide crisis intervention and stabilization while individuals wait for openings in outpatient programs. All EISS programs operate seven days a week and guarantee that clients will be seen within 24 hours. In addition, each client sees a prescriber within 24 hours of the intake session. Clearly, this program needs to be expanded to all counties throughout the state.

Screening services also need to be expanded. Currently, there are 35 screening centers throughout the state. A handful of the screening centers have been able to better serve their designated geographic region by expanding outreach, mobile services and satellite offices with alternate funding sources. Such funding mixes are not reliable from year to year. Funding must be made available to existing screening centers to allow each program to expand according to the specific needs of the geographic area they serve to achieve the greatest benefits from this resource which reduces emergency room visits and hospitalizations.

The Medication Assisted Treatment Initiative (MATI) also needs to be expanded. This evidence-based model for treating substance use disorders should be available to all New Jersey residents. Currently, 40 substance use treatment providers participate in MATI with 54 programs throughout the state. This is far from the number of providers needed, considering the high, and increasing use of opioids and other substances throughout New Jersey. The MATI includes the use of medications approved by the Food and Drug Administration for the treatment of addictions, as well as counseling. The effectiveness of the MATI has been demonstrated by local providers, as well as nationally. In 2017, one New Jersey provider reported a 70% reduction in substance use; 78% compliance with treatment plan goals; and 94% reduction of criminal activity among its MATI clients. Another New Jersey agency reported that 81.5% of clients responding to a survey indicated life had improved since entering the program and 71.5% of urine drug screens showed that no drugs were present.

EISS programs, currently in 11 counties, need to be expanded statewide.

“Leonard” began substance use treatment in 2012, when he had been using 15 to 20 bags of heroin intravenously on a daily basis. He was unemployed and living with a woman who was addicted to opioids. He had various legal charges and had been incarcerated previously. After his admission into the MATI, he still used some heroin sporadically during the first year. However, after a year, he began participating in an intensive outpatient program. He then attended weekly groups and individual counseling. Leonard has now been abstinent from illicit drugs for more than two and a half years. He is also gainfully employed and has purchased a home, where he lives with his new girlfriend, who is also drug free.
Several community-based behavioral health providers also provide primary healthcare services, either within their own facilities or through collaboration with primary care practices. Integrated care improves individuals’ health in all aspects and is achieving positive health outcomes.

For example, one organization with co-located behavioral and primary care services reported that clients are getting colonoscopies and mammograms more frequently than before, so cancers are detected early. Another organization that partners with a primary care facility reported reduced hospitalizations for psychiatric reasons from 14 patients (5%) during the 30 days before program enrollment, to one person (.08%) after six months, to zero upon discharge. Statistics are essentially the same for substance abuse related hospitalizations. Clients also demonstrated reduced emergency room visits for psychiatric reasons, from 5% at baseline to zero after six months; increased abstinence from using illegal substances, from 75% to 82%; and increased obtainment of stable housing, from 44% to 63% of clients. In addition, most clients (87%) experienced no serious psychological distress during the program.

In 2017, New Jersey saw the implementation of a two-year federal pilot program – Certified Community Behavioral Health Clinics (CCBHCs). There are seven CCBHCs in New Jersey. These programs serve adults and children and provide mental health and substance use treatment, crisis services, case management, primary health care and more. A per member/per month rate allows providers the flexibility to deliver truly holistic, integrated care. A study conducted by the National Council for Behavioral Health on the impact of CCBHCs in the first six months reported very positive outcomes.

Those outcomes derive from not only the model itself, but also the reimbursement that is provided, which has enabled New Jersey’s CCBHCs to add new staff positions. The six New Jersey CCBHCs that were surveyed reported “97 new positions have been added, including 11 psychologists and 39 staff with an addiction specialty or focus.”

Burdensome regulatory requirements and a lack of capital funding prevent organizations from providing invaluable and cost-effective integrated care. New Jersey must take greater strides toward comprehensive care by breaking down regulatory barriers and providing capital funds to meet facility requirements that are not waived. New Jersey must also advocate for a federal extension to the CCBHC program and simultaneously plan for sustaining the program.

**Legislative Recommendations**

Pass legislation to expand Early Intervention Support Services (A2391/S1635) to all counties in the state.

Make funding available to existing mental health screening centers (A2389/S1032) so they can more fully serve their designated geographic areas.

Make medication Assisted Treatment available to all New Jerseys.

Pass a resolution supporting a federal extension of the Certified Community Behavioral Health Clinics (CCBHCs) pilot program.
New Jersey CCBHC’s Activities to Expand Services, Technology and Treatment Innovations*

- Improved outreach (hired outreach workers and care coordinators, implemented no show protocols, etc.) - 100%
- Initiated new programs, service lines or locations - 66.7%
- Improved or expanded services to veterans - 66.7%
- Implemented new care delivery or outreach partnerships with hospitals - 66.7%
- Adopted new technologies that support care delivery (Electronic Health Record System Upgrades, mobile apps, telehealth, etc.) - 66.7%
- Expanded capacity to provide crisis care - 66.7%
- Implemented new care delivery or outreach partnerships with criminal justice systems - 50%
- Implemented remote monitoring technologies - 50%
- Implemented new care delivery or outreach partnerships with schools - 33.3%
- Implemented same-day access protocols (Clients to be seen the day of referral) - 33.3%

Source: National Council for Behavioral Health: New Jersey CCBHC Initiative
(*Data reported by six of seven NJ CCBHCs)
New Jersey CCBHC's Activities to Expand Opioid Treatment Capacity*

- Hired or trained new staff with an addiction specialty/focus: 100%
- Launched other opioid treatment or recovery initiatives: 83.3%
- Expanded existing Medication Assisted Treatment (MAT) programs: 66.7%
- Trained staff or community partners in naloxone administration: 66.7%
- Implemented screening protocols for opioid use disorder: 66.7%
- Began offering MAT: 66.7%
- Hired peer recovery specialists to provide recovery support: 50%

Source: National Council for Behavioral Health: New Jersey CCBHC Initiative
(*Data reported by six of seven NJ CCBHCs)
Children’s System of Care Faces Similar Foundational Weaknesses

New Jersey has built a Children’s System of Care (CSOC) for children and adolescents with emotional, behavioral and developmental challenges that is rightly recognized as a national leader for excellence. The tremendous success the system has achieved has brought with it great challenges, as growth and expansion have the system nearly at capacity. The integrity of many of the programs that make up the CSOC is becoming compromised due to rising caseloads, the inability to recruit appropriately trained and certified staff, and reduced rates of reimbursement that do not fully cover the costs of care for many of the programs in the continuum of care. In recent years, both intellectual and developmental disability services and substance use services have been transferred to the CSOC, exacerbating the quality, workforce and funding issues that were already evident. The CSOC is a truly interconnected system with a single point of entry provided by the Contracted Services Administrator (CSA), PerformCare. If one piece of the system falters, it has detrimental effects on the other parts of the system. This is true for programs from outpatient mental health and substance use treatment, to partial care, to residential programs – all of which are critical to the system being able to provide the appropriate level of care when needed.

Children’s System of Care Success Story

Eleven-year-old “Tommy” could not have his hair cut with clippers unless he was held down. Showering was a big struggle because Tommy avoided the water. He could not sit at the table for dinner, because he had to pace. He could not tie his shoes. Fearful of his meltdowns, Tommy’s mother was afraid to push too hard. This is the life of a family struggling to help their son diagnosed with Autism Spectrum Disorder.

The family was desperate for help. They reached out to PerformCare and Tommy was approved for Individual Support Service for 10 hours a week from behavior technicians. Services began in August.

On New Year’s Eve, Tommy sat with his family for the entire dinner for the first time. A month later, his mother texted program staff, “Tommy’s father gave him a haircut yesterday using the clippers and Tommy sat quietly for the entire time. No one had to hold him down, bribe or yell. The interventions are working! But that’s not all – Tommy had on a pair of pants that were a little loose. I watched him pull them up, take the strings and tie them in a bow!”

The Individual Support team is now working with Tommy’s parents on helping him stay safe when in the grocery store. While Tommy’s progress is powerful, it is not unique when the right service and the right techniques, combined with a collaborative team, are available.
Shortages of Qualified Staff for Special Populations

Services for the youth with intellectual/developmental disabilities (I/DD) lag behind those for other populations in the CSOC. There is insufficient capacity to serve this population, which raises concerns about care coordination and the quality of care. The scarcity of Applied Behavior Analysis (ABA) credentialed staff leaves little room to ensure quality standards. This, too, is largely due to rates too low to attract and retain staff. Additionally, finding staff to serve rural areas has been highly challenging as qualified staff are unwilling to drive long distances without reimbursement for either time or mileage. As driving is not reimbursable, services in these areas have been suffering.

The population in need of substance use treatment faces workforce shortage problems similar to those facing the I/DD population. A qualified workforce must be built to properly serve both populations.

As serving youth with I/DD is still relatively new in the human services field, community and four-year colleges do not have comprehensive curricula on serving this population. Quality service provision could be higher if students were graduating with more training in this specialized area of the field and/or if staff had the ability to receive training and be reimbursed for time spent traveling to and participating in such training.

Budget Recommendations

Increase the rates for Board Certified Behavior Analysts to the same level as those of other credentialed professionals.
Allow Intensive In-Home Behavioral and Family Support Services staff to be compensated for time and travel costs for team meetings, as well as other travel and training costs.

Administrative Recommendations

Fully research bed utilization, needs assessments, innovative program models and best practices, particularly for serving youth with co-occurring disorders, and implement new models to enable programs to sustain their bed capacities while best serving children and youth with proper lengths of stays.
Establish additional training avenues that are available more frequently and/or online for staff serving youth with I/DDs and their families in their homes.
Collaborate with New Jersey schools of social work, and counseling and psychology programs to increase clinical and case management training for serving the I/DD population.

Legislative Recommendations

Add children’s rates to the fee-for-service oversight process: Children’s mental health and substance use treatment rates should be included in the evaluation of the adequacy of rates.
Unpredictable Censuses

In addition to the recruitment and retention difficulties that are found in both the adult and children’s systems, the highly unpredictable size of the population to be served by various programs in the CSOC makes managing staff, including keeping to regulatory staffing ratios, difficult for providers. Staff in many programs are being stretched to their limits to accommodate rises in population, in part because inadequate rates make it fiscally impossible to hire new staff when it is as likely that the population will decrease as suddenly as it increased.

Residential Programs: While occupancy rates in residential programs vary, they have consistently reached lows of 65% for substance use treatment beds. Bed utilization, needs assessments, innovative program models and best practices, particularly for serving those with co-occurring disorders, need to be fully researched and new models need to be implemented to permit programs to sustain their bed capacities while best serving children and youth with proper lengths of stays. Many specialty treatment home models exist that need to be explored.

Mobile Response and Stabilization Services (MRSS): MRSS programs must adhere to Department of Children and Families’ expectations that they “will hire 1 Mobile Crisis FTE for every 5 dispatches per month and 1 Mobile Crisis Supervisor for every 6 Mobile Crisis FTE. Should [providers] see an increase and/or decrease in census, [they] can adjust [their] budget and staff based on anticipated revenues and census trends.”

It is incomprehensible that contracts, regulations and oversight bodies would expect programs to adjust staffing every month based on the most recent census, which cannot predict the upcoming census. This is a flawed business model: Programs can neither hire and train nor lay off staff quickly enough to make such a model fiscally viable, and such fluctuation in the hiring and reduction of staff does not address provider and community needs as they occur.

The Critical Need for Adequate Rates

In all of these programs, rates must be sufficient to support a stable workforce amidst fluctuating censuses. Before the recent rate increase for Care Management Organizations (CMOs), caseloads for CMO care managers trended upward directly as a result of the inadequacy of rates. Other programs continue to be similarly stretched. Rates for residential programs are inadequate to cover all costs even if 100% capacity were maintained. When rate increases have occurred, inflationary factors had been absent. If this pattern continues, it will lead to the erosion of sufficiency over time.

As they relate to I/DD Intensive In-Home Supports, the rates of reimbursement do not support staff’s ability to attend the CSOC required trainings, as training is not a reimbursable item. The high demand for Board Certified Behavior Analysts (BCBAs), combined with the highly competitive rates offered by the Department of Education, has made hiring BCBAs extremely difficult for community-based providers. Additionally, the CSOC requirement for staff to be present at Child and Family Team meetings – while certainly a best practice – becomes unreasonable for per-diem staff who will not be reimbursed for their time.
Building for the Future

There are both established, successful programs and newer, innovative models taking root in New Jersey's children's and adults' community-based behavioral health systems of care. Children's CMOs and Mobile Response and Stabilization Services; screening centers, Intensive Intervention Support Services, Drug Courts, and the Medication Assisted Treatment Initiative for adults; and CCBHCs and Behavioral Health Homes for both populations - all serve New Jerseyans well. But, too many of these, and other necessary services along the continuum of care, are operating on fragile foundations.

Sustainable rates are needed to not only cover the current costs of care (and cover deficits), but to also allow for expanded capacity, which will only be sustainable if there is the ability to provide more competitive wages.

Expansion also requires capital investments.

It has been shown again and again that community-based mental health outcomes and use treatment services are cost-effective. The only lack of access to quality community-based care is unaffordable and costly, in both dollars and the quality of care provided. For those in need, and for the taxpayers, the promise of the future is in the community-based system of care's continued expansion and sustainability.