Independent Fee for Service Transition Oversight Board: Status Report 1

October 14, 2019

To: The Honorable Philip D. Murphy, Governor of New Jersey
The Honorable Stephen M. Sweeney, President of the Senate
The Honorable Craig J. Coughlin, Speaker of the Assembly
New Jersey Department of Human Services
New Jersey Division of Mental Health and Addiction Services

Introduction

The New Jersey Division of Mental Health and Addiction Services (DMHAS) operates under the Department of Human Services (DHS) and oversees the provision of community based services for the State of New Jersey.

In 2016, the State of New Jersey began the process to transition from a contract, deficit funded payment methodology for providers of mental health and substance use disorder treatment services. The Medicaid transition began February 2011, with the announcement during the FY 2012 budget address from then Governor Chris Christie of the intended Medicaid reform. From February 2011 to May 2011, the Department of Human Services, Department of Health and Department of Children and Families were called upon to examine options and engage in public input process. In October 2012, The Centers for Medicare and Medicaid Services (CMS) approved the Comprehensive Waiver. The Comprehensive Waiver is a collection of reform initiatives designed for system sustainability for “safety net” providers to the most vulnerable eligible populations.1 As defined by the Institute of Medicine, a core safety net provider is a provider which by mandate or mission offers access to care regardless of ability to pay and whose population includes a substantial share of uninsured, Medicaid or other vulnerable patients.2

The resulting 127.8MM was directed for 90 service types in SFY 2017; enhanced match for third-party liability 107.8MM, net state investment of 20MM for SFY 2017. According to the Division of Mental Health and Addiction Services (DMHAS) communiqué to providers, guiding principles included (1) increased system capacity (2) create greater access for individuals seeking treatment.

1 Transition to Fee for Service PowerPoint Document, Assistant Commissioner Valerie Mielke, MSW, Division of Mental Health and Addiction Services, Thursday June 15, 2017
(3) standardization of reimbursement across providers (4) create greater budgeting and expenditure flexibility for providers.

Factors included in initial cost assumptions were as follows:

- Staffing credentials and composition of program elements.
- Financial data from contract base and expenditure reports, provider data for time-studies and Medicaid claims data.
- Fringe benefit considerations.
- Productivity factor – encompassing multiple components of related cost.

Unifying disparate reimbursement methodologies between Mental Health (MH) and Substance Use Disorder (SUD) service contracts was prioritized and consideration was given to the shift of Medicaid-reimbursed services as a result of the Medicaid expansion and related changes in eligibility and benefits.³

The transition occurred in two phases, starting with substance use disorder levels of care followed by mental health levels of care. In July 2016, most SUD slot-based contracts converted to fee for service (FFS), the Interim Management Entity (IME) began Utilization Management and Care Coordination and the True Up of SUD Alternative Benefits Plan (ABP) began. The True Up allows inclusion of the full continuum of substance use disorder treatment in addition to methadone for NJ Family Care (Medicaid). Mental Health providers were phased in, beginning January 2017. A total of 16 mental health providers transitioned to fee for service under the early optional date of January 1, 2017 and 67 mental health providers transitioned to fee for service on July 1, 2017.

| Number of Consumers Served in Mental Health and Substance Use Disorder |
|-----------------------------|---------------------|---------------------|---------------------|
|                             | FY2016 | FY2017 | FY2018 |
| Mental Health               | 339,047 | 343,340 | 331,854 |
| Substance Use               | 93,954  | 89,480  | 91,838  |

*Above information includes number of consumers served in all services, not limited to FFS.*

Data Source:

Mental Health: Quarterly Contract Monitoring Report (QCMR) - Duplicated

Substance Use: New Jersey Substance Abuse Monitoring System (NJSAMS) – Unduplicated

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³ Transition to Fee for Service PowerPoint Document, Overview for Provider Meetings, February/March 2016, edited June 29, 2016
Background

State of New Jersey Contracted Provider Network

The State of New Jersey works in partnership with healthcare providers for the provision of licensed contracted mental health and substance use disorder treatment through its contract system. The provider types include a broad array of sizes, structures and composition of services. Corporate structures include community based non-profit 501(c)3, large for-profit entities, LLC/LLP practitioners, opioid treatment providers, freestanding community hospitals and large hospital networks with community services. There are also Department of Health, Certificate of Need licensed and, non-contracted Medicaid providers that provide several levels of care.

In addition to the provision of services under the mental health and substance use disorder treatment continuum, many of these same organizations provide psychosocial rehabilitation services such as supported employment. Integrated, multidisciplinary models of care such as the Programs for Assertive Community Treatment (PACT), Behavioral Health Homes (BHH), Certified Community Behavioral Health Clinics (CCBHC) and Federally Qualified Health Centers (FQHC) and certain Delivery System Reform Incentive Payment (DSRIP) structures exist within these organizations and function under episodic or bundled payment methodology. Social services, such as transportation, housing, peer recovery supports and case management are provided directly by contracted providers or shared through bi-directional memorandum of understanding, affiliation or other service agreement among these and other provider networks. Many providers within operating budget sizes of 10MM or greater, provide a mix of aforementioned services and many have a mix of pay sources including Medicare, Medicaid, Managed Care, Commercial Insurance along with a mix of state, county, federal and private contracts. Many providers also fundraise to supplement operating expenses and mitigate inflationary fluctuations.

Scope

Pursuant to the transition to the fee for service reimbursement system, NJ P.L.2017, c.85 provides for two oversight mechanisms for monitoring and evaluation of the transition of mental health and substance use disorder treatment service system through (1) an Independent Fee for Service Transition Oversight Board and (2) a contract for an evaluator with demonstrated competence in evaluating reimbursement systems for state health care programs. The objective of the Board is to evaluate the transition’s effects on access to care, continuity of care and quality of care. The Board’s evaluation will address the impact of sustainability of providers and in particular, the impact of the rates. The Board will consider information provided by the evaluator along with review and consultation with providers on costs, revenue and revenue shortfalls. The Board will
prepare three reports at various intervals throughout a two year process and will disband thirty days following the final report. This report serves as report one, outlining the scope of work and status of the evaluation.

Methodology

The Board convened its first meeting on February 22, 2019. The Board reviewed and discussed the scope of work and requested clarifying information from Department of Human Services staff. The Board elected a Chair at the meeting.

Over the course of the initial six month period, the Board prioritized the program element rates based on those areas that are most problematic to the broadest stakeholder population. Sustainability issues and actuarial concerns with the rates associated with each program element were reviewed. By the second meeting, April 22, 2019, the Board had created a strategy map/priority assessment tool under which they identified priority areas for actuarial analysis, based on level of service. The strategy map was used to delineate between actuarial and sustainability issues and to prioritize rates based on the greatest impact and needs of the provider community. This process serves to qualify the rate issues, to allow for a more focused discussion with stakeholders during the second phase of the Board’s work.

Through this process the Board identified areas of interest that are contributory to sustainability but not directly actuarial in nature. These “parking lot” notations will be further redacted, examined and reviewed for process improvement recommendations. Included in these areas of interest were (1) the web-based New Jersey Mental Health Application for Payment Processing (NJMHAPP) and the Electronic Claims Adjustment System (ECAS) software applications impact to providers (2) Regulatory issues (3) legacy reporting requirements (i.e. USTF, Annex A and QCMR), (4) social service language amendments and contract reconciliation requirements related to revenue and expense caps.

The Board held to the schedule set forth by the Department of Human Services, with formal meetings on February 22 2019, April 18, 2019, June 20, 2019 and August 22, 2019. In between these meetings, the Board held focus group discussion calls, which included the identified subject matter experts on the Board and various stakeholders for each program element. Talking points and observations from the calls with the subject matter experts were then reviewed with the DHS/DMHAS staff to further examine the concern and ensure all aspects of the issues were considered. The observations of Board subject matter experts were then reviewed with the full Board to ensure consensus for inclusion in the report. Additional “parking lot” items will be noted as identified through the course of the Board’s work.
Scope of work by program elements

The scope of work by fee for service program element is as follows:

Substance Use Disorder

- Intensive Outpatient Services (IOP)
- Outpatient (OP)
- Short Term Residential (STR)
- Long Term Residential (LTR)
- Methadone Outpatient Program (OTP)
- Halfway House (HWH)
- Inpatient Withdrawal Management (IWM)
- Ambulatory Withdrawal Management (AWM)

Mental Health

- Outpatient (OP)
- Integrated Case Management (ICMS)
- Partial Care (PC)
- Partial Hospitalization/Acute Partial Hospitalization (PH/APH)
- Programs for Assertive Community Treatment (PACT)
- Supported Employment (SE) and Supported Education (SEd.)

Within each program element is a series of services, delineated by service provider type, length of time and/or unit, with a corresponding rate. A crosswalk of the program elements and services can be found on Appendix A.

Preliminary Observations

Observations: Outpatient MH-SUD - Medication Monitoring/Psychiatric Evaluation/Clinical and Intake Rates

History and Current Factors:

The consensus of the Board is that the current prescriber rates create barriers to sustainability of safety net providers. This issue was discussed in depth with the provider subject matter experts of the Board. The general consensus is that the increase to the Psychiatric Evaluation (PE) rate effective April 2019 is a positive step, however it was noted that the PE code represents approximately 20% of the overall psychiatric medication monitoring services. Additionally, the expense for medication management service varies widely among providers. There are differences in the cost to provide this service between hospital based, private practice, ambulatory
clinics and community based providers. Variable costs include costs for regulatory compliance and revenue cycle management infrastructure. Presently, the enhanced psychiatric evaluation rate only applies to community providers, however corresponding revenue (REV) code enhancements are under review. The positive impact to sustainability as a result of the Psychiatric Evaluation is mitigated somewhat by the increasing cost of the medication management service. The evaluation and management reimbursement code has been increased since the transition; however, providers report that the costs to provide this service continue to rise due to workforce challenges.

Providers and clients noted transportation shortage areas impacting availability of services, resulting in increased potential for increased no-show rates and risk for hospitalization. Mergers and consolidation of provider organizations have resulted in shifts in the number of available prescribers and the location of needed services. Clinical consistency of services is challenged by staffing shortages of safety net providers in conjunction with the influx of new provider organizations. Additional observations are as follows:

- There are disparities for evaluation and management rates among the different provider types, i.e. Medical Doctor or Advanced Practice Nurse.
- There are limitations on multiple services within an episode of care, in particular at intake stage of service. This is also evidenced in the Psychiatric Evaluation process which does not allow for time for an integrated health assessment/review of systems for the patient.
- Current trends for cost for coordination of care with primary care providers should be evaluated.
- Areas of particular provider shortage/high need areas need consideration for an enhanced rate.
- Number of providers in geographic areas need to be assessed and potentially weighted for volume and enhanced transportation access.
- There is a need to provide outreach functions to certain vulnerable sub-populations of the community.
- There is a general trend of lower salaries in safety net provider organizations.

Considerations/Recommendations:
- Labor market rate /Occupational Wage reassessment for prescriber/clinician.
- Review provider types to ensure maximize flexibility of available codes.
- Compare data from other states.
- Evaluate feasibility of voucher programs, bundled payments.
- Evaluate the trends of codes by interactive complexity, i.e. - assess if the 15-minute increment is enough time to do review of systems under medication management for the patient with complex needs.
- Evaluate ability to maximize add-on codes; modifiers.
- Inflation index for clinical and medication management rates.
- Reimbursement for medical case management/case conference activities.
- Use of telehealth should be expanded to include clinical services such as individual outpatient clinical sessions.
- Evaluate actuarial enhancement for no-show rates based on current trends.
- Review the correlation of transportation to no-show rates.
- Turnover factors should be reassessed for inclusion in the rate calculation.
- Monitor wait times by county.
- Proper data entering of medications in electronic health records, medication reconciliation and related medication education is required as part of this medical encounter. Navigation services for pharmacy needs and nursing support for this function should be considered in the productivity factor.
- Cost of clinical supervision and case conference time pursuant to collaborative practice agreements for joint medication protocols for medical staff.
- Fluctuation of Medicaid eligibility creates need for more revenue cycle management resources.

Observations: Short Term/Long Term Residential Bed Rates

History and Current Factors:

Short term and long term residential rates have also been prioritized for focused review. These daily bundles include both facility and service charges, medical and clinical regardless of level of intensity. Of note for this level of service is that the previous rate was used as baseline for new rate. Additional observations are as follows:

- Facility costs are fixed, yet long term room and board bed rate is 50% less reimbursement than short term beds.
- Services carved in and services carved out of FFS need to be aligned with standards of care within residential setting.
- Inflation/market rate adjustment needed to ensure staffing ratios and improve sustainability.
- Influx of fundraising/soft dollars currently being utilized to cover expenses.
- Bundle is too widely applied and encompasses too many services.

Considerations/Recommendations:

- Utilize current BLS data for salary baseline/apply inflation factor.
- No blending of short term and long term beds.
- Utilization review criteria needs to be defined and correlated to rates.
- Redefine service structure of the bundle based on how the services are currently being delivered.
- Ensure bed hold covers all expenses associated with the hold.
Observations: SUD Intensive Outpatient/Outpatient

History and Current Factors:

The Board discussion of these levels of care indicates there are broad interpretations of the regulatory landscape of these services. This is compounded by a variety of interpretations of Substance Use Disorder (SUD) Opioid Treatment Provider (OTP) levels of care and Medication Assisted Treatment (MAT) services. Challenges such as lack of reimbursement for engagement activities, navigation and medical case management exist. These levels of care also have higher provider shortages due to regulatory requirements for appropriately credentialed clinicians and DATA waivered medical staff. Rigid attendance regulations do not facilitate transitions of care easily and there is no payment mechanism for transitions of care from IOP to OP levels of care. Program regulations for IOP are incongruent with billing regulations pertaining to group size. The IOP level of service may run concurrently with MAT or AWM levels 1 and 2 to maximize overall clinical outcomes, however, neither the FFS or regulatory structure supports a flexibly woven integrated or episodic treatment bundle based on level of need, ASAM criteria and/or consumer/patient choice. The current framework does not allow for provision of services identified through diagnosis as necessary, to be provided concurrently. Separate licenses are required for each medical component of the SUD treatment protocol for safety net providers. Services that might otherwise be billable are not billable due to these regulatory restrictions, requiring either/or scenarios for the co-occurring client/patient in need of both mental health and substance use disorder treatment.

Considerations/Recommendations:

- Utilize current BLS data for salary baseline/apply inflation factor.
- Create outcomes incentive reimbursement structure.
- Redefine service structure of the bundle based on how the services are currently being delivered.
- Align regulatory and Medicaid service and code assumptions.
- Review current reimbursement methodology against ASAM criteria to ensure service array includes all aspects of ASAM guidelines for placement, treatment, continued stay, discharge, peer services and linkages to services such as legal, housing and psychosocial rehabilitation services.
- Align FFS billing and regulatory systems with ASAM criteria.

Observations: SUD Opioid Treatment Level of Care (OTP)

History and Current Factors:

The Board reviewed the Opioid Treatment (OTP) level of service. This level of care is unique, as it is ratio based. Reimbursement is contingent upon capacity in accordance with regulatory capacity parameters for each phase of treatment. Providers indicate this system generally works well. Gaps in the system are visible with regard to medical services – specifically for integrated
treatment of medical comorbidities for individuals in these programs. Medical provider shortages impact the OTP providers similar to the other levels of care. Staffing expenses drive the cost of care.

Considerations/Recommendations:

- Allowance of reimbursement for medical case management as an independent, additional rate.
- Allowance for pre-engagement activities.
- Allowance for separate rate for medical case management/navigation with specialty providers.
- Utilize current BLS data for salary baseline/apply inflation factor.

Observations: Halfway House Level of Care

History and Current Factors:

The Halfway House level of service was not included in the 1115 waiver. Currently room and board rate is bundled in the Halfway House level of care. While there are allowances in the billing for client co-pays, the sliding scale precludes providers from receiving full reimbursement for services.

Considerations/Recommendations:

- The recommendation of the board is to open up provider types in the Medicaid system to allow for billing of all services being provided under this level of care to allow for a flexible service delivery system based on individualized needs of the clients.
- It is also recommended that inclusion of halfway house level of care be considered for an increase to room and board rates based on inflation factors.

Observations: Partial Care/Acute Partial Care/Partial Hospitalization Levels of Care

History and Current Factors:

This level of care is medical and clinical, yet gaps exist for medical services, specifically with regard to nursing, navigation to primary care services and integrated on-site services for those with the most complex medical needs. Specific staff to consumer ratios are required for groups; however, regulatory guidance is not aligned with Medicaid reimbursement parameters. Additionally, group size presents challenges with all or nothing billing, based on ratio. Transportation needs for these client populations are significant. Transportation allowance does not cover costs for service for all clients. Prior authorization is required for these levels of service and adds cost to the overall unit of service. Pre-engagement process for partial hospitalization/acute partial hospitalization is lengthy and does not necessarily result in placement
in this level of care. Consultative legal requirements for Krol\textsuperscript{4} case hearings create less prescriber
time in the milieu.

Considerations/Recommendations:

- Allowance of medical support staff reimbursement.
- Increase of transportation rate to cover costs for outlier regions.
- Streamline prior authorization process.
- Allow for a medically enhanced service day for partial care consumers with complex
  medical needs.
- Allow for reimbursement of transport and linkage to specialty providers.
- Utilize current BLS data for salary baseline/apply inflation factor.
- Evaluate options for group size and alternative reimbursement for individual service should
  ratio billing not be available.

Observations: Programs for Assertive Community Treatment (PACT), Integrated Case
Management Services (ICMS), Supported Employment and Supported Education

History and Current Factors:

A preliminary review of Programs for Assertive Community Treatment (PACT), Integrated Case
Management (ICMS) and Supported Employment (SE) and Supported Education (SED.) has been
completed. Supported Employment and Education rates were adjusted and services expanded in
2018. The Board will review this impact with providers. PACT as a bundled service is largely
sustainable, with the exception of the prescriber function which mirrors the outpatient concern of
the cost of the prescribers. Of note is that the prescriber pool is smaller than other service areas.
The Advanced Practice Nurses cannot be utilized in this level of care for prescribing, or as an
alternative to the Medical Doctor credential for any interdisciplinary team functions.

Considerations/Recommendations:

- Utilize current BLS data for salary baseline/apply inflation factor.
- Allow for Advanced Practice Nurse credential as an alternative to Psychiatry credential for
  PACT programs.

Observations: Integrated Case Management (ICMS)

\textsuperscript{4} Krol Status: An individual with mental illness is found not guilty by reason of insanity (NGRI); his/her behavioral
health treatment is monitored by a Superior Court, which issues orders regarding involuntary confinement at a
facility, discharge planning and community reintegration: NJ Department of Human Services, Office of Program
Integrity and Accountability, General Definitions, published September 2013:
9/30/2019
ICMS History and Current Factors:

ICMS providers report reductions in staff as a result of the transition to FFS (between 30% -50%). With regard to hospital referrals, there are limited services which can be billed. There are a large percentage of non-billable services including, but not limited to:

- Case management for court involved cases
- Medical case management
- Supervision and training requirements does not cover full cost including transportation
- Family member/natural support engagement
- Engagement activities including locating clients in the community

There are unique transportation/geographical issues in this level of care which reduce the overall billing time (i.e. transportation to and from hospitals could take up to 1 hour, one way). There is no funding mechanism for vehicle replacements/remote equipment. The ICMS rate was grossed up to 1.5 FTE to account for the occasional double teaming that occurs for safety concerns; however, it is recommended that this be reevaluated based on current trends in the field (i.e. the complex needs of the in-community consumer).

Considerations/Recommendations:

- Clarify definition of purpose and expectation of the ICMS service (i.e. - develop regulatory framework in collaboration with providers).
- Identify and evaluate services that are being provided but not able to be billed.
- Identify reimbursement mechanism for transportation and time allotted to finding and engaging clients.
- Allow for flexibility in unit types to maximize engagement potential.
- Consider bundle or episodic payment methodology.
- Evaluate staff salaries for inflation adjustment.

Observations: Client/Consumer/Patient experience

The Board has developed consensus regarding access and quality concerns. In the course of review through subject matter expert discussions with consumers and consumer advocates, the following questions were examined:

- What is the impact of the lack of an outreach/prevention service on outcomes? In particular, to what degree does this impact justice-involved and substance use disorder patients and clients?
- Has FFS impacted continuity of care for clients and patients?
- Does cost increase as a result of restarting services with new providers?
• Is there a higher percentage of avoidable discharges/terminations from programs and how 
does the lack of transportation services result in late arrivals and no-shows for 
appointments?
• Is the ratio of new providers opening equal to those no longer providing services?
• Are there access and quality consequences of transportation gaps?
• Does prescriber turnover impact client engagement?
• Do our reimbursement systems such as SUD OP/IOP/OTP support clients and patients to 
have individualized and person centered treatment plans?
• Do our systems support the engagement of families and natural supports?

Discussion of Options/Recommendations of the consumer community:

• Explore a carve out of Fee for Service medical services from social determinant functions 
to allow for access to all medical care and multiple medical services within a single episode 
of care or at one treatment facility on the same day.
• Review of scope of practice and licensure to facilitate integration.
• Integration of clinical/medical bundle of services to facilitate client centered, 
interdisciplinary treatment teams.
• Peer reimbursement under FFS suggested.
• Access/Pre-intake/Engagement needs to be expanded as a component of service delivery 
and should be assessed as part of the actuarial work.
• Expansion of the availability of transportation is needed.
• Continuity of prescribers.
• Reduced wait times for prescribers.
• Increase of providers for medically underserved areas and provider shortage areas.

Scope of work for next reporting cycle

With issues and priorities refined, the Board will:

1. Commence Broad Stakeholder Engagement Activities – Board to drill down on the 
sustainability issues for the aforementioned program elements, through stakeholder 
engagement surveys and discussions. As there are many unique factors related to 
sustainability – such as payer mix, operating budget, organization type and service 
continuum, the Board will review stakeholder data in the context of liquidity, efficiency 
and profitability ratios for the identification of trends and patterns among providers.

2. Commence Market Rate Assessment – In an effort to continue the process as we await a 
contract award for an evaluator to provide validated analysis, the Board will identify 
existing resources, databases and surveys that will assist the evaluator with getting up to
speed quickly. Informally, many leaders from safety net provider agencies have identified they are starting to experience cash flow issues, as the residual dollars from the contract closeouts on 2017 have now been expended.

3. Workforce Trends – While economic data and inflation index factors will be assessed by the evaluator, the Board will review overarching issues such as workforce shortages and geographic trends impacting access to services consumers, clients and patients.

4. Parking Lot Items – The Board will continue to identify issues and recommend efficiencies for systems to promote sustainability for safety net providers.

5. Work with Medicaid to identify additional codes that can be utilized by providers, monitor system issues that preclude provider access to certain billing codes, as identified in the REV code issue for the Psychiatric Evaluation for hospitals and maximizing efficiency for programs such as NJMHAPP and ability to maximize service bundles and to further promote opportunities for episodic care that are consistent with the state’s population health objectives.

6. Research and identify new strategies, opportunities for bundled and episodic payment mechanisms to improve efficiencies and maximize health outcomes.

Fee for Service methodology as an evolving system

Over the course of the transition to fee for service reimbursement system, there have improvements, such as the Presumptive Eligibility process hailed by providers as a successful component of the system. Presumptive Eligibility is temporary health coverage for NJ residents who meet preliminary qualifications for NJ Family Care (Medicaid) but have not been final approved for Medicaid benefits. Given that this service requires formal training and certification, an expansion of resources to support the Presumptive Eligibility process is recommended, so that all FFS providers can regularly participate and obtain training for their staff. Additional relief to providers through the recent Psychiatric Evaluation rate increase and the increase to the medication monitoring evaluation and management rate in 2018 have helped to bridge the sustainability gap for safety net providers. The recent addition of the Peer and Navigator codes is a formative step to the advancing client/patient engagement. However, vulnerabilities to sustainability will continue to exist as cost of service continues to outpace rate structure.

The Independent Fee for Service Transition Oversight Board remains committed to this process is grateful for the support and continued partnership with the Department of Human Service and Division of Mental Health and Addictions and Medicaid staff, Office of the Governor and New Jersey Legislature. The Board will diligently continue their work to improve access and quality of Medicaid services for residents of New Jersey. The Board also wishes to thank all of the
individuals from provider organizations and the clients served, who have contributed their time and added valuable perspective to this process.

Respectfully submitted by,

The Independent Fee for Service Transition Oversight Board

- Susan Loughery, Director of Operations, Catholic Charities Diocese of Trenton, Chairperson of the FFS Oversight Board
- Mary Abrams, Senior Health Policy Analyst, NJAMHAA
- Tonia Ahern, Representing individuals/families impacted by Substance Use Disorder
- Robert Budsock, President and CEO Integrity House
- James Cooney, Chief Executive Officer, Ocean Mental Health Services
- Teresa Edelstein, Vice President, Post-Acute Care Polity, New Jersey Hospital Association
- Steve Horvath, President of the County Mental Health Administrators Association
- Barbara Johnston, Director of Policy and Advocacy for the Mental Health Association in NJ
- Phil Lubitz, Associate Director, NAMI New Jersey
- Kendria McWilliams, Chief Executive Officer, Maryville, Inc.
- Kathleen Powers, CFO, Maheny Medical and Educational Center and serves on the Board of Trustees for the NJCPA
- Vera Sansone, President and Chief Executive Officer, CPC Behavioral Healthcare and representing NJPRA
# APPENDIX A

## Mental Health Services Level of Care Continuum

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient (OP)</td>
<td>Mental health services provided in a community setting. Specific services include psychiatric evaluation, medication monitoring, individual therapy, group therapy and family therapy.</td>
</tr>
<tr>
<td>Partial Care (PC)</td>
<td>Individualized, outcome-oriented, structured, non-residential program offered in an ambulatory setting. The program includes active treatment and psychiatric rehabilitation.</td>
</tr>
<tr>
<td>Partial Hospital (PH)</td>
<td>Individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation to assist individuals who have serious mental illness in maximizing independence and community living skills.</td>
</tr>
<tr>
<td>Acute Partial Hospital (APH)</td>
<td>Intensive and time limited acute psychiatric service for individuals who are experiencing, or at risk for, rapid decompensation. This mental health services is intended to minimize the need for hospitalization.</td>
</tr>
<tr>
<td>Integrated Case Management (ICMS)</td>
<td>Individualized, collaborative and flexible outreach service designed to engage, support and integrate individuals with serious mental illness into the community of their choice and facilitate their use of available resources and supports in order to maximize independence. Provided primarily in the consumer’s natural environment. ICMS services include, but are not limited to assessment, service planning, service linkage, ongoing monitoring, ongoing clinical support and advocacy.</td>
</tr>
<tr>
<td>Programs of Assertive Community Treatment (PACT)</td>
<td>Comprehensive, integrated rehabilitation, treatment and support services for individuals with serious and persistent mental illness, who have repeated psychiatric hospitalizations and who are at serious risk of psychiatric hospitalization. Provided in the consumer’s home or other natural setting by a multi-disciplinary treatment team. PACT is the most intensive program element in the continuum of ambulatory community mental health care.</td>
</tr>
<tr>
<td>Supported Employment (SE)</td>
<td>SE is for individuals with severe mental illness, with an interest in working, who require ongoing support services to succeed in competitive employment. Services include supports to access benefits counseling, identify vocational skills and interests, and develop and implement a job search plan to obtain competitive employment in an integrated community setting that is based on the individual’s strengths, preferences, abilities, and needs.</td>
</tr>
<tr>
<td>Supported Education (SEd)</td>
<td>SEd assists individuals with mental illness to participate in an education program so they may receive education and training needed to achieve their learning and recovery goals and become gainfully employed in a career of their choice. SEd provides direct services and support in educational coaching so that consumers may enter and succeed in educational opportunities. The services also include enrollment and registration assistance, teaching study skills, illness management and recovery skills particularly related to school, and assistance and advocacy in obtaining reasonable accommodations from the educational institution.</td>
</tr>
<tr>
<td>Community Residences for Adults with Mental Illness (Supervised Housing)</td>
<td>Rehabilitation and support services provided in a community-based residential setting to adults with mental illness who require assistance to live independently in the community. There are 3 levels of supervised housing, A+ (24 hours day, 7 days a week), A (12 or more hours but less than 24 hours a day, 7 days a week and B (at least 4 hours but less than 12 hours a day, 7 days a week).</td>
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*Data Source: NJ DMHAS MH FFS Annex A*
<table>
<thead>
<tr>
<th>Substance Use Disorder Level of Care Continuum</th>
</tr>
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<tbody>
<tr>
<td><strong>Inpatient Withdrawal Management (IWM)</strong></td>
</tr>
<tr>
<td><strong>ASAM Level 3.7 WM</strong></td>
</tr>
<tr>
<td>Medically Monitored Inpatient Withdrawal Management is an organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. This level provides care to consumers whose withdrawal signs and symptoms are sufficiently severe to require 24-hour medical monitoring care. This level of care includes 2 hours per week of counseling services.</td>
</tr>
</tbody>
</table>

| **Short Term Residential (STR)**               |
| **ASAM Level 3.7**                            |
| Short Term Residential Treatment is provided facility which provides a highly structured recovery environment, combined with a commensurate level of professional clinical services, designed to address specific addiction and living skills problems for persons who are deemed amenable to intervention through short-term residential treatment. STR treatment must include no less than 12 hours per week of counseling services on at least 6 separate occasions and a minimum of 7 hours of structured programming per diem. Medical services must be provided per licensing requirements. |

| **Long Term Residential (LTR)**                |
| **ASAM Level 3.5**                            |
| Long Term Residential Treatment is provided in a licensed long term facility which provides a structured recovery environment, combined with professional clinical services, designed to address addiction and living skills problems for persons with substance use diagnosis who require longer treatment stays to support and promote recovery. Self-help meetings may be included as part of structured activities. LTR includes no less than 8 hours per week of counseling services on at least 5 separate occasions and a minimum of 7 hours per day of structured activities must be provided per diem. Intervention focuses on reintegration into the greater community with emphasis on education and vocational development. Medical services must be provided per licensing requirements. |

| **Halfway House (HWH)**                       |
| **ASAM Level 3.1**                            |
| Halfway House Treatment is provided in a residential facility which provides room, board, and services designed to apply recovery skills, prevent relapse, improve emotional functioning, promote personal responsibility and reintegration the individual into work, education and family life. No less than 3 hours per week of counseling services and a minimum of 7 hours per day of structured activities must be provided per diem. Self-help meetings may be included as part of the structured activities. Medical services must be provided per licensing requirements. |

| **Partial Care (PC)**                         |
| **ASAM Level 2.5**                            |
| Partial Care Treatment provides a broad range of highly clinically intensive interventions. Services are provided in a structured environment for no less than 20 hours per week. A minimum of 4 hours of treatment services must be provided on each billeable day to include one individual counseling session per week. Self-help meetings cannot be counted as billeable services. Programs have ready access to psychiatric, medical and laboratory services. |

| **Intensive Outpatient (IOP)**                |
| **ASAM Level 2.1**                            |
| Intensive Outpatient Treatment provides a broad range of highly intensive clinical interventions. Services are provided in a structured environment for no less than 9 hours per week. A minimum of 3 hours of treatment services must be provided on each billeable day to include one individual counseling session per week. IOP treatment will generally include intensive, moderate and step-down components. Self-help meetings cannot be counted as billeable services. |

| **Ambulatory Withdrawal Management (AWM)**    |
| **ASAM Level 2 AWM**                          |
| Ambulatory Withdrawal Management (AWM) services are delivered by medical and nursing professionals who provide a range of organized services including medical and clinical interventions, laboratory testing, dispensing and/or administration of approved medications provided to treat and monitor consumers undergoing withdrawal from drugs, including alcohol. AWM is indicated when an individual experiences physiological dysfunction during withdrawal, but neither life, nor significant bodily functions are threatened. |
### Substance Use Disorder Level of Care Continuum

**Outpatient (OP)**
ASAM Level 1

Outpatient provides regularly scheduled individual, group and family counseling services for less than 9 hours per week. Services may be provided to consumers discharged from a more intensive level of care, but are not necessarily limited to this population. Self-help meetings cannot be counted as billable services.

**Methadone Outpatient Services (MOP) ASAM Level 1.OMT**

Methadone Outpatient is a weekly bundled service provided by a licensed Opioid Treatment Program (OTP) that includes the following, which may not be claimed separately for payment: case management, medication monitoring, medication and dispensing, and the counseling services (Individual, Group, and Family Therapy) based on intensity of treatment phase (Phases I-VI) assigned to the individual. This service is attached to a Standard Outpatient License Level 1.

*Data Source: NJ DMHAS SUD FFS Annex A*