Critical Needs Require Preserving State Savings from Medicaid Expansion in the Community-Based Behavioral Health System of Care

"The risks for destabilizing the system are enormous, and come at a time when demand continues to increase exponentially. The sufficiency of fee-for-service rates to reimburse the true costs to providers for delivering quality services and supports will determine the continued viability of the community-based system of care."

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Critical Needs Require Preserving State Savings from Medicaid Expansion in the Community-Based Behavioral Health System of Care

Executive Summary

New Jersey’s community based behavioral health system of care is currently in a fragile state due to insufficient funding, increased demand, workforce shortages and system changes being planned without provisions to ensure providers’ viability.

This should not be, since New Jersey, like many other states across the nation, has realized great savings to the State’s General Fund as a result of opting to expand Medicaid under the provisions of the Affordable Care Act (ACA). According to the New Jersey Office of Legislative Services, savings for FY2016 total $609.2 million and increased revenue specifically related to the ACA Medicaid expansion is estimated up to $15 million for FY2016 and up to $26 million for FY2017.

It is the position of the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) that the savings from programs that provide treatment and supportive services to those with a mental illness or substance use disorder should be retained in the community-based behavioral health system along with a portion of increased revenue.

New Jersey’s community-based system of care has historically been, and continues to be, insufficient to meet the needs of all New Jerseyans seeking behavioral health services. The provider network is strained by low reimbursement rates. The inadequacies are not new, but now pose greater risks to the system of care as it undergoes massive changes in New Jersey’s planned transition to a fee-for-service payment system, while demand continues to increase exponentially.

NJAMHAA recommends the following actions to ensure that New Jersey’s community-based behavioral health system remains viable as the State moves to a managed system of care:

- The State Legislature conduct an oversight review of the Department of Human Services’ (DHS’) plans for transforming the current service delivery and payment system.
- The State undertake a Maintenance of Effort of State funds in the Mental Health and Substance Use budgets.
- The State eliminate the Social Service Language Contract Amendments from DHS’ and the Department of Children and Families’ contracts.
- The State include a hold-harmless provision to ensure the viability of all providers during any transition period.

Preserving savings in the Community-based System of Care can go far to not only alleviate capacity and workforce issues, but also contribute to quality of care, improved outcomes and reduced long term costs, all while allowing the State to increase federal drawdowns that fund health services.

The State must not forego the opportunity afforded under the ACA to invest in the critical safety net community-based behavioral health system of care.
Introduction

New Jersey, like many other states across the nation, has realized great savings to the State’s General Fund, as well as increased revenues, as a result of opting to expand Medicaid under the provisions of the Affordable Care Act (ACA). According to the New Jersey Office of Legislative Services (OLS), savings for FY2016 total $609.2 million. OLS estimates additional revenue from insurer and provider assessments that are specifically related to the ACA Medicaid expansion to be as much as $15 million in FY2016 and up to $26 million in FY2017. Savings for the population previously covered at a 50 percent federal match alone (now covered at 100 percent match) are expected to total $3 billion through 2020.¹

It is the position of the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) that the savings from programs that provide mental health, substance use treatment and supportive services to those with a mental illness, substance use disorder (SUD) or co-occurring disorders should be retained in the community-based behavioral health system of care.

Savings and revenues related to behavioral health programs have been realized in a number of ways:

1. Medicaid plans for individuals with mental health and/or substance use disorders aged 21 to 64 who are newly eligible for Medicaid include mental health and substance use treatment benefits that were previously supported solely by state funds.

2. Individuals covered under special eligibility categories (e.g., adult waiver populations, medically needy, pregnant women, disabled) prior to expansion at a state match of 30 to 50 percent are now funded at an enhanced rate.

3. State contributions to Charity Care have been substantially decreased.

4. Federal funding of inpatient services for inmates have significantly increased.

5. Increased revenues from assessments on providers and insurers are anticipated.

New Jersey’s community-based system of care has historically been, and continues to be, insufficient, primarily due to inadequate funding, to meet the needs of all New Jerseyans seeking behavioral health services. The provider network is strained by low reimbursements, lack of reimbursement in some programs for services that are necessary to the provision of care (such as outreach and case management), and lack of cost of living adjustments (COLAs) for its workforce and inflationary factors for other funding. These inadequacies are not new, but now pose greater risks to the system of care as it undergoes massive changes in its transition to a fee-for-service payment system. This transition comes with new infrastructure needs, while providers remain constrained under existing contracts that limit their ability to build reserves and provide for an adequate cash flow.

The risks for destabilizing the system are enormous, and come at a time when demand continues to increase exponentially. The sufficiency of fee-for-service rates to reimburse providers for the true costs of delivering quality services and supports will determine the continued viability of the community-based system of care.

**Insufficient System Capacity**

Due to many factors, the capacity of the community based system of care to serve the mental health and substance use treatment needs of adults and children in New Jersey has never been sufficient to meet demand. If funding remains insufficient, unmet demand will continue to increase as more individuals seek services as a result of Medicaid expansion, Drug Court expansion, the Health Insurance Marketplace and parity requirements. Low Medicaid rates paid by the State are another factor. New Jersey’s Medicaid rates are among the lowest in the nation and do not fully cover the cost of providing services. Both insufficient rates and restrictive contract provisions contribute to workforce shortages, which, in turn, make accessing care more difficult.

Consistently, more than 31,000 New Jersey adults per year who seek substance use treatment services are unable to access them. Children utilizing crisis Mobile Response and Stabilization Services are waiting three to six months to see psychiatrists and are frequently being denied extensions of stabilization services that would keep them out of crisis and out of hospitals while they wait. Both children and adults endure long waits (three to six months or even longer) for outpatient services and during this time, their illnesses often become severe and require more intensive and more costly care. Emergency rooms continue to be over-utilized by individuals in need of substance use or mental health services that they are unable to access anywhere else.

In the face of overwhelming demand and no increase in capacity, it is critical that community based providers be able to maintain their workforce. Inadequate reimbursement rates and a lack of COLAs have led to recruitment and retention problems and safety issues that consequently affect consumers’ access to treatment, as well as continuity and quality of care. Particularly acute is the shortage of psychiatrists, especially child psychiatrists.

Salaries for community workers, who last received a COLA in 2008, rarely grow much beyond what they were at hiring. (See Appendix I) Each year, the gap widens as state workers receive negotiated increases in addition to built-in anniversary increases within each salary range. The disparity of wages between the community based system of care and state and educational organizations has caused nearly insurmountable recruitment and retention problems for community based providers. Vacancies and turnover are not only costly to organizations due to increased training and recruitment costs and lost units of service, but they are also extremely detrimental to the recovery of those they serve whose treatment lacks continuity and requires renewed relationship building, with clients often facing several staff changes.

**The Case for Investing in Behavioral Health**

Reinvesting savings the state has realized in recent years as a result of Medicaid Expansion, the
Insurance Marketplace and other provisions of the ACA can go far to not only alleviate capacity and workforce issues, but also to contribute to quality of care, improved outcomes and reduced long term costs, all while allowing the State to increase federal drawdowns that fund health services. “To the extent states use re-allocated funds for the costs of services provided to expansion adults, they will draw down more federal funding through the enhanced federal (match)...”\(^2\)

The vast majority of individuals with serious mental illness and/or substance abuse disorders, if appropriately diagnosed and treated, will go on to live full and productive lives. And the return on investment is significant. New Jersey’s network of mental health and substance use treatment providers enables thousands of citizens to live independently in their communities instead of in publicly funded institutions, jails and shelters and on the streets.

The National Association of State Mental Health Program Directors provides the following research results:

- Comprehensive community-based mental health services for children and adolescents can result in approximately 40 percent reductions in public hospital admissions and lengths of stay.

- Expanded diagnosis and treatment of depression has a return of investment of $7 for every $1 invested.

- Cost benefit studies of substance abuse treatment have found returns of $4 to $7 per dollar invested.

- School-based substance abuse prevention is generally very cost effective, for example, “Life Skills Training” returned $21 dollars for every dollar spent on the intervention.\(^3\)

New Jersey has historically shown significant support for behavioral health services. In 2010, New Jersey laudably invested $1.7 billion in mental health services, the fourth highest in the nation while ninth highest in population.\(^4\) The state has also been aggressive in fighting stigma and in its prevention and treatment initiatives for addictions. New Jersey must now take a responsible path by seizing the opportunity to invest in services that will benefit its residents while also making a fiscally sound choice for the state.

**Recommendations**

First and foremost, New Jersey must undertake a Maintenance of Effort of state funds in its Mental Health, Substance Use and Supportive Services budgets using FY2014 as a base. This means that the current level of state funding supporting behavioral health services must equal the expenditures


\(^3\) Miller, Joel E. *Executive Summary: Too Significant To Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for Their Families, and for Their Communities*. National Association of State Mental Health Program Directors. 2012.

made for those services in FY2014, with an inflationary factor applied. The savings the state has realized should then be utilized to:

- Increase rates: For a number of years now, NJAMHAA has shared detailed recommendations with legislators and administrators on how rates should be calculated. Those recommendations may be found in Appendix II. The bottom line is that rates must adequately cover the true costs of care and allow for providers the ability to build reserves, develop new programs and expand current programs, as well as make physical facility improvements when needed to ensure safe and health environments for their clients and staff. Anything less would be short-sighted and prevent the system from ever fully meeting the behavioral health needs of New Jerseyans.

- Provide a 5 percent COLA in the current fiscal year; 4 percent in FY 2017 and 4 percent in FY2018.

- Invest in workforce development, particularly in approaches to: encourage entry into Psychiatry, Psychology, Social Work and other mental health professions; provide financial support to students of these disciplines; and encourage service in the non-profit community based system of care.

There are several other steps the state should simultaneously take to strengthen the community based behavioral health network (discussed in more depth in Appendix III):

- Conduct a broad legislative review of the Department of Human Services’ plans for transforming the current service delivery and payment system. Both the State Legislature and the general public must be aware of the significant changes being implemented and planned.

- Eliminate the Department of Human Services’ and Department of Children and Families’ social service language amendments, thereby allowing agencies to build reserves, lift caps on psychiatrists’ salaries, provide more training to staff and purchase vehicles for transporting clients.

- Establish a state-funded line of credit that providers can rely on during the transition to a fee-for-service payment system.

- Establish a billing system Oversight Board.

- Include a hold-harmless provision to cover the fee-for-service transition period for all contracted agencies.

New Jersey’s community based behavioral health system of care is currently in a fragile state due to insufficient funding, increased demand and system changes being planned without provisions made to ensure providers’ viability throughout the transition. The State should not forego the opportunity afforded under the ACA to reinvest in the critical safety net community-based behavioral health system of care.
## COST OF LIVING ADJUSTMENTS (COLAS): NEW JERSEY STATE WORKFORCE (CWA) VERSUS COMMUNITY BASED BEHAVIORAL HEALTH PROVIDERS FISCAL YEARS 2004 THROUGH 2015

<table>
<thead>
<tr>
<th>State Contract Period</th>
<th>Fiscal Year</th>
<th>CWA State Employee Wage Increases</th>
<th>Cost of Living Adjustment for Community Providers</th>
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<td>Non-recurring</td>
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<tr>
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<tr>
<td></td>
<td>2015</td>
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<td>1.00**</td>
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</table>

**TOTAL OVER TWELVE YEARS (RECURRING - ADDED TO BASE)**

|                                 | 27.25 | 7.00 |

* Deferred from July 1, 2009 to January 2011

** A 1% non-recurring adjustment is to be disbursed January 2015
Recommendations on Rate-setting for Adult Service Providers that will Operate under an Administrative Services Organization

Our Goal: Protect Service Quality and Access as well as the Tax-saving Capacity of Mental Health & Substance Use Providers

By preventing high-cost, emergency and inpatient care, non-profit mental health and substance use providers have shrunk the census of state and county psychiatric hospitals by 85% — from more than 15,000 persons in 1970 to less that 2,400 persons in 2013. **Mental health and substance use providers save the taxpayer more than $1 billion per year.** As New Jersey (NJ) transitions to fee-for-service, managed care, the new contracting system should:

1. **protect the tax-saving capacity of mental health and substance use providers** — by funding the true cost of evidence-based care, with periodic adjustments for inflation;

2. **expand the tax-saving capacity of mental health and substance use providers** — by deploying evidence-based behavioral supports to reduce the cost of other chronic diseases, and to help consumers learn illness management, help-seeking and wellness skills;

3. **ensure consumer health and safety** — by eliminating restrictions on access to services; by providing rates sufficient to support effective engagement and evidence-based treatment; by eliminating conflicting regulations that create compliance problems; and by protecting the ability of mental health and substance use providers to save lives and tax dollars.

**Ensure Adequate Funding to Support the Highest Quality, Evidence-Based Care**

Rate-setting should start with stakeholder input into program design, service array, staffing and productivity necessary to provide the evidence-based care truly capable of producing tax-savings and ensuring the health and safety of consumers. Rates should also include:

- **Rate Increase for New Costs**

  Rates determined by current costs should be increased to include new and/or additional costs that will be incurred under managed care:

  - **Utilization Management Staff**
    5% rate increase to fund $100,000 salary/fringe, assuming $2 million in billings 2%-5%

  - **Billing & IT Staff**
    5% rate increase to fund $100,000 salary/fringe, assuming $2 million in billings 2%-5%

  - **Compliance-related Uncompensated Care**
    Uncompensated care allowance for compliance errors @ 5% of total billings 5%

  - **Working Capital**
    Building financial reserves: 10% margin to be earned on billings 10%

  - **Capital Expenses & Other Urgent Needs (Replacing “Accrual Spending”)**
    2.5% rate increase to cover capital expenses and other urgent needs 2.5%

  **Total Rate Increase for New Costs** 21.5%-27.5%
• **Increased Rate to Manage Consumer Safety Problems**

  One hundred per cent (100%) rate increase to provide enhanced services for **consumers posing safety concerns**; enhanced services may include two staff on an outreach visit, additional program security, on-call support, etc.; the need for enhanced services would be justified by special circumstances, documented in the clinical record, according to the Division of Mental Health and Addiction Services (DMHAS) specifications, and subject to audit by the Administrative Service Organization (ASO).

• **Increase Rate for Apartment Repairs**

  Rates for supportive housing, group homes, and other residential services should be increased by 2.5% to compensate providers for apartment damage, bed bug remediation, and other uncompensated costs that would otherwise lead to landlord-tenant problems and evictions, if these costs were not paid.

• **Realistic Productivity Expectations & Reimbursement for Consumer Engagement**

  Rates should be based on realistic expectations for productivity, and recognize that consumers in the highest risk circumstances typically require extensive outreach before they are effectively engaged. Pre-engagement outreach should be reimbursed for up to 10 hours. Because engagement continues after intake, resulting in predictable missed appointments, cancellations, vacancies, etc., these should be reimbursed up to five hours/consumer/year.

• **Full Parity for Substance Use & Mental Health Services**

  Mental health and substance use services save tax dollars, and should be reimbursed by all insurance plans at rates to encourage their use, especially Medicaid. Rates should reflect the full cost of care provided by both substance use and mental health providers, who meet higher licensing standards for quality improvement, compliance, etc. than private practitioners, and should be paid more.

*Increase Tax-savings by Managing Other Chronic Diseases.*

Many substance use and mental health providers offer integrated care to help consumers manage chronic diseases (e.g., metabolic syndrome, diabetes, heart disease, etc.) – despite insufficient resources to do so. Integrated care is required to reduce the health disparities confronting this population. Those with serious mental health problems die 25 years ahead of the general population, and 37 years sooner, if substance use is present.

• **Chronic Disease Management & Prevention**

  Twenty per cent (20%) increase to rates to provide disease management to specific consumers diagnosed with chronic diseases or who are at high risk of chronic diseases; the rate increase will cover nursing care management and care coordination, including unreimbursed phone contacts; 20% rate increase would be based on 1.0 Nurse FTE @ $100,000 for salary/fringe, assuming program budgets of $500,000, to provide integrated care to 65 consumers with serious health problems served by any mental health or substance use provider functioning as the consumer’s primary service provider.
• **Reduce NJ Health Costs**

Expand behavioral supports to help other populations manage chronic diseases – especially high-cost users of emergency and inpatient services. The failure of the primary care system to engage high-cost users has placed NJ among states with the highest health costs. *Mental health and substance use providers can help the state reduce NJ Medicaid and Charity Care costs by providing outreach, engagement and treatment to high-cost users to ensure coordinated and integrated care for all health problems.*

**Cash-Flow Protection**

Mental health and substance use providers are cash-poor because of “deficit-funded” contracts by the State. Cash-flow protections should be implemented to prevent financial instability from escalating, resulting in service disruptions for consumers and increased costs. Options include:

• **Long-term Loan Programs**

Similar to the State’s Capital Improvement program, where a long-term cash infusion – which is collateralized by the provider’s land, buildings, etc., and recoverable by the State. Loans would be issued for 20 years to protect against cash-flow problems related to delayed payments, periods where lines of credit may be unavailable, among other problems.

• **Cash Advances**

Similar to the State’s current practice of providing monthly advances equal to 1/12 of the annual contract ceiling, these advances would continue until the provider’s cash reserves were sufficient to cover three months’ operating expenses.

• **Retention of Contract Funds**

Prior to implementing managed care, mental health and substance use providers should be authorized to build working capital reserves and address urgent capital needs via liberal retention of unspent contract funds.

**Conclusion**

The new managed care contracting system provides an opportunity to take full advantage of the tax-saving potential of mental health and substance use providers. These providers redirect high-cost users away from emergency and inpatient care by helping them learn evidence-based, self-management and illness management skills. While improving consumer health and reducing safety risks, mental health and substance use providers have saved the New Jersey taxpayer more than $1 billion each year for the past 35 years. This tax-saving potential can also be targeted to reduce state spending for other chronic diseases – with even greater tax-savings likely because New Jersey is one of the highest cost states for health care.
There is no doubt that, throughout the years, the current New Jersey contract reimbursement system for behavioral health care has had many positive outcomes and allowed for the development of hundreds of quality mental health and addiction service providers. For all those years, literally hundreds of thousands of our citizens have depended on that system of care during some of the most difficult times in their lives.

Now, as we transition to a Fee-for-Service (FFS) reimbursement system, one negative outcome of the current system philosophies has emerged, and that threatens the ongoing financial health of nearly all provider organizations. Our current contract reimbursement manual, the current capital funding policies, and the more recent Social Service Language Amendments have promoted dependency on contract dollars and advance payments. The “Last dollar In” philosophy, the cancellation of the Operational Incentives policy, and capital grants, which never amortize, have all contributed to organizations that are dependent on the next state contract payment as a solution to “cash flow”.

The transition to the FFS system will place new emphasis on maintaining a healthy cash position, extending each organization’s defensive interval, and planning for billing issues and other events, which disrupt payment methodologies or create unanticipated expenses.

As a result, to ensure the success of the transition to the Fee-for-Service contracting model, NJAMHAA would like to propose the following action steps:

1. **Completion of a Statewide Fiscal Analysis of All Currently Contracted Provider Agencies**
   There is widespread concern among all provider agencies about their financial readiness to undertake this transition. For each agency, cash reserves will be a key factor in its ability to move forward successfully. As a “Readiness Review” is already required by the Medicaid Comprehensive Waiver, an analysis of the following three fiscal indicators should be conducted immediately:
   a. **Current Ratio** (current assets vs. current liabilities)
   b. **Defensive Interval** (time an organization can survive without incoming revenue)
   c. **Cash Positions** (unrestricted cash assets)

   **Note:** These three fiscal indicators are critical to the maintenance of consumer choice; the elimination of provider agencies due to either bankruptcy or mergers may serve to severely restrict/remove consumer choice and significantly impair timely access to care. The “Readiness Review” of all three indicators requires a breakdown by agency budget size, service type and region, and an agency-by-agency analysis of the FFS rate impact should be conducted based on the historical agency performance data and shared with each agency.
2. Implementation of the Transition Plan
   a. Define firm start dates, contract termination dates, and contract closeout dates.
   b. For the current contract year and continuously until the move to FFS, allow agencies to focus their contract accruals on expenses and issues that will assist them in preparing for the changes required of that FFS environment.
   c. Develop a State Funded “Line of Credit”: Based on existing contracts, agencies should have the ability to draw down up to three (3) months of contract dollars to assist cash flow in the event of billing system disruptions or other untoward events that impact the organization’s cash position. Repayment of the “Line of Credit” would be in the form of future billable units of service delivered, or direct payments.
   d. Create a Billing System Training and Oversight Protocol: Interoperability of Electronic Medical Records and billing systems is still highly problematic. An Oversight Board consisting of both State and provider agencies, including members with information technology (IT) credentials/qualifications should be established to provide training to provider agencies as needed (The NJAMHAA IT Project could possibly serve in this role.), ensure timely payments systems, and investigate system-wide payment problems, if any.

3. Establishment and Evaluation of Rates
   a. Re-Evaluation of Rate Effectiveness at Six Months, at One Year, and at Two Years: The Oversight Board should conduct a Rate Effectiveness Review at intervals for at least two years to ensure the rates set are effective for provider agencies, the State and the consumers we serve. In particular, an analysis of agency-by-agency and statewide Medicaid revenue collected vs. contract dollar expenditures for the same period should be conducted to ensure that, absent a significant drop in productivity, provider agencies are not in deficit.
   b. Specialized rates should be re-affirmed for licensed provider agencies (i.e., transitioning from contracted agencies only).
   c. All contracted agencies involved in the transition to FFS should be held financially “harmless” for the first year of the transition. As per the most recent proposal for the agencies contracted with the Division of Developmental Disabilities, a one-year delay in rate implementation should be provided once the rates are finalized, to allow each agency the opportunity to plan their budgets once FFS is fully operational. Allowing the FFS system to run “parallel” would greatly assist provider agencies with preparing for this significant financial system change.

4. Elimination of the Social Service Language Amendments for all Department of Human Services (DHS) and Department and Children and Families (DCF) Contracts
   Assuming programs reimbursed through FFS will no longer be subject to initial budget submissions, budget modifications, detailed reporting and “Last Dollar In” contract reconciliations, the Social Service Language Amendments will be moot for those programs. Maintaining salary caps, limitations on reimbursements for staff training, etc. on those few contracts that continue to exist is not only an onerous overregulation; it is also a financial burden on provider agencies, and expensive and difficult for the State to enforce. Therefore, these amendments should be eliminated.