New Jersey Association of Mental Health and Addiction Agencies, Inc.

Protect & Expand

ACCESS TO BEHAVIORAL HEALTH CARE
When she was a young girl, Rachel, endured the trauma of sexual abuse and, as a result, suffered from depression and Dissociative Identity Disorder. Years later, she got married and was subjected to domestic violence, which led to substance use. Rachel began treatment in an outpatient detox program. Then, she received outpatient counseling and later participated in a partial care program and support groups. She recently moved to Kansas to care for her grandmother. Her future is bright and includes her plans to become a pilot.
New Jersey MUST Protect and Expand Access to Behavioral Health Care

New Jersey’s behavioral health system of care continues to struggle to maintain its capacity and quality of services. One large contributing factor to current difficulties for many organizations is that several fee-for-service (FFS) rates do not cover the actual costs of care, leaving programs with deficits that have led to staff reductions that subsequently reduce capacity.

Additionally, both contracts and FFS rates do not account for the costs of new increased minimum wage, expanded paid family leave and paid sick leave laws.

Inadequate rates more broadly impact the ability of providers to be competitive in recruiting and retaining qualified staff – a problem that always existed and is now exacerbated. Hiring psychiatrists and other prescribers has always been a challenge for community-based providers. Recent market forces, combined with inadequate rates, have severely diminished the availability of psychiatrists and other prescribers in the community-based system of care.

The community-based behavioral health system of care would also benefit from expansion of models of care that have been proven to be effective and efficient. These include various models of integrated care, including Certified Community Behavioral Health Clinics (CCBHCs), Early Intervention Support Services and Screening Center services for those in crisis, and Medication Assisted Treatment (MAT). At the same time, the state must explore new models to fill gaps in the service delivery system, such as children’s screening centers.

Administrative burdens, licensing restrictions, and insufficient support for technology also limit the ability of providers to maximize their resources to best serve New Jersey’s residents. Licensing backlogs, the inability to serve individuals where they are—whether trying to bring primary care to clients or bring professionals to schools, for instance; requiring licensed clinicians to be solely responsible for tasks that others are qualified to do; insufficiently funding capital and imposing other legislative and regulatory limitations – all restrict the capacity of providers to serve their communities.

by building on programs that are working and promising innovative approaches.

with competitive salaries for the full range of professionals and other workforce supports.

with increases to FFS rates.

with streamlined licensing and administration, and increased support of infrastructure.

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The conversion to fee-for service (FFS) has resulted in several program closures and staff reductions across the state, as several rates do not cover the actual costs of care. Even with maximized productivity and business retooling, rates for several behavioral health services – outpatient, partial care, Integrated Case Management Services, long-term residential substance use, and Community Support Services (CSS) – remain inadequate to cover the actual costs of providing these services. These community-based services must be protected and expanded, as they are critical to preventing emergency room visits and hospitalizations and, for many, landing in jail or becoming homeless. Another FFS shortfall is related to the lack of subsidies for those who cannot afford their co-payments or deductibles, which were incorporated into prior contracts but no longer exist, further threatening access to care for many.

Temporary Reprieve for CSS Providers
Fortunately, CSS programs are still operating under contract extensions, as the Department of Human Services (DHS) also recognizes the serious problems with the program model and reimbursement structure, having just announced a further extension of contracts through June 30, 2020. Providers and advocates look forward to working with DHS to fix this program with the understanding that it will not be transitioned to FFS until reimbursement is sufficiently increased and other program model adjustments are in place.

Increased Expectations
The acute co-morbidities of individuals treated for mental illness or substance use disorders by the community-based behavioral health system must be acknowledged. Value-based expectations demand more from programs – more case management and care coordination, integration of primary health care, more highly credentialed staff, direct treatment for co-occurring disorders, engagement and more ongoing care for individuals at higher risk than might have been required in the past. Such expectations require investment in the community-based system of care to support individualized, comprehensive quality care for all.
Unmet Demand for Services
The demand for mental health and substance use treatment has always exceeded system capacity, leading to long wait times for appointments, turning to emergency rooms for some, and resulting in a total lack of treatment for others. The New Jersey Division of Mental Health and Addiction Services (DMHAS), in its 2018 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 substance use treatment, only 53,209 received it, leaving 37,533, or 41.4%, of those seeking treatment without any. DMHAS also stated in the same application that of the 375,825 adults in New Jersey with a Serious Mental Illness (SMI), only 34.2% received services from programs funded by the Single State Agency.

Reduced Capacity
Despite these levels of unmet demand, capacity has been decreased in many programs around the state in recent years following the staff reductions and program closures primarily resulting from the shift to FFS reimbursement. In a February 2019 survey, 16 of the 19 responding organizations that were operating with deficits in their FFS programs reported staff reductions of 118 positions since transitioning to FFS (see chart on opposite page). Access to many services, particularly outpatient clinics, is decreasing – It is time to protect and expand these services!

Unsustainable Deficits
While some staff reductions resulted when organizations revised their budgets downward by millions of dollars in the past two years following the release of the inadequate rates, the cutbacks continue as organizations still collectively face nearly $25 million in deficits in FY2019. NJAMHAA’s most recent survey (February 2019) found that among 28 responding provider organizations, 19 were running FY2019 deficits in their FFS programs, totaling nearly $16 million combined (see chart on the opposite page). This is a representative group of those operating with deficits. We are aware of several other organizations not represented in this survey that are operating deficits – some over $1 million. It is critically important for the Legislature to preserve critical community-based services by passing S2935/A4336 which provides $25 million of FFS safety net funding in FY2019 and to include similar funding in the FY2020 budget to keep providers fiscally viable so they may continue to provide access to needed services.

• Provide $25 million of fee-for-service (FFS) safety net funding.
  Programs that transitioned to FFS and are facing deficits must be kept fiscally viable while the adequacy of rates is studied. Support the $25 million supplemental funding proposed by the Legislature as a safety net for FY2019 (S2935/A4336), and include $25 million in the FY2020 budget.

• Provide for increases to FFS reimbursement rates to cover the actual costs of care.
  Outpatient and residential rates must be increased to cover the actual costs of care and meet the increasing demand for services. These increases must reflect the workforce costs generated by new laws, as well as market forces, as further discussed in the next section.

• 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.

• Contract for fee-for-service (FFS) Independent Study.
  The FFS oversight process must move forward with urgency. The comprehensive study of the adequacy of reimbursement rates and the impact of FFS on consumer access and quality and continuity of care must be contracted immediately as required under P.L. 2017, c. 85 to inform increases to the FFS rates.
A significant part of any investment in the community-based system of care should be dedicated to supporting the workforce - an investment that is long overdue and desperately needed to protect and expand access to behavioral health care. Not only must reimbursement, whether fee-for-service or contract funding, support costs incurred by increases to the minimum wage and new paid sick leave and family leave standards, but they also must take into consideration the current inadequacy of reimbursement in light of labor market forces.

Historic Underfunding and New Costs
Fiscal support for the community-based workforce has historically been severely inadequate, negatively impacting 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.

Market forces have driven up the salaries for all staff, especially licensed clinicians, bilingual staff, and others with similar sought after credentials. This is particularly true for prescribers – psychiatrists and advanced practice nurses. Existing rates are based on average salaries from more than four years ago, while minimum salaries for prescribers have increased by many tens of thousands of dollars. Recruitment and retention in the community have always been extremely difficult, but the current climate has put staff turnover and vacancies at critical levels.

New Jersey must also provide an upward adjustment of rates and contracts to avoid compression of the pay scale between minimum wage workers and professional staff. Professional staff at community-based provider organizations not only have salaries that are significantly below those paid by state agencies, educational institutions and private entities, but many are paid at or just above the proposed minimum wage of $15.00 per hour.

New costs are now being incurred, or will soon be, for newly adopted paid sick leave and family leave policies. While employees will be paying more into the state family leave fund for the expanded benefits, employers will face added costs arising from the need to pay overtime or hire replacement workers to cover for absent employees. In the behavioral health field, which has a preponderance of female workers who are often the caregivers and many of whom are of child-bearing age, these costs will be significant.

- Provide immediate funding to support the increased minimum wage and paid sick leave and family leave policies. Fiscal support to cover the cost of all new policies must be made available as they are implemented. Additional dollars for wages and to avoid compression of the pay scale should accompany increases to the minimum wage as none have been provided in a decade.
- Establish a formula for upward adjustment of rates and contracts. While safety-net funding and funding increases resulting from the independent study, when completed, should factor in all costs, the viability of the rates will erode over time. A formula that is tied to an inflationary index must be established to prevent erosion of the adequacy of rates and contract reimbursement over time.
- 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.
The Children’s System of Care Workforce Issues

In addition to the widely felt impacts of non-competitive wages and new policy costs, the Children’s System of Care has several unique workforce issues. For example, Mobile Response and Stabilization Services (MRSS) programs must adhere to Department of Children and Families’ expectations as set out in regulation that they “will hire 1 Mobile Crisis FTE for every 5 dispatches per month and 1 Mobile Crisis Supervisor for every 6 Mobile Crisis FTEs. 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.

Behavioral health 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 are met. 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 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.

Workforce Innovation Is Needed

New Jersey should also explore innovative approaches to addressing staffing shortages in community-based provider organizations. With the acute shortage of psychiatrists and primary care physicians who are looking to enter behavioral health facilities, the state should explore subsidizing community behavioral healthcare residency programs. These are too expensive for host agencies to support, but would require a relatively small investment by the state for a very large return. Another approach for medical students to experience community behavioral health work is to pair medical students with public health and social work students to work in community organizations during the summers. While limited in scope and impact, current versions of this program are well received by medical students.

The Bottom Line

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 adults, children and their families and resulting in the loss of gains made. 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.

<table>
<thead>
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<th>APNs</th>
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<tr>
<td>Current Mean - BLS (2017 data)</td>
<td>Current Mean - BLS (2017 data)</td>
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</table>

-used to set FFS rates (2016) | -used to set FFS rates (2016) 

*for Psychiatrists, Zip Recruiter Range was used; for APNs, as reported by providers
Early Intervention and Screening for Adults

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

EISS programs must be preserved and expanded. They have 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 its designated geographic service area to achieve the greatest benefits from this resource, which reduces emergency room visits and hospitalizations.
**Children’s Screening**

In addition, screening programs dedicated to serving children and youth must be developed in earnest. Child specialists should be available for children and youth who arrive at screening centers, and they should have a calming space that is separate from the adult population.

**Medication Assisted Treatment (MAT)**

The Medication Assisted Treatment Initiative (MATI) also needs to be expanded. The MATI includes the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders, as well as counseling. The effectiveness of the MATI has been demonstrated by local providers, as well as nationally. This evidence-based model should be available to all New Jersey residents. Currently, seven substance use treatment providers participate in the MATI. This is far from the number of providers needed, considering the high and increasing use of opioids and other substances throughout the state. New Jersey has shown a commitment to expanding access to and awareness of MAT. While NJAMHAA applauds New Jersey’s efforts, including implementation of a new “hub and spoke” model for MAT that will bring MAT to many more primary care physician offices, expansion efforts should include additional investment in the MATI program for substance use treatment providers.

**Certified Community Behavioral Health Clinics**

One boost to MAT programs in New Jersey has been the Certified Community Behavioral Health Clinics (CCBHC) federal demonstration program, launched in 2017 in eight states, including 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. Study after study on the impact of CCBHCs report very positive outcomes.

CCBHCs have dramatically improved access to community-based substance use treatment and mental health care, having had the ability to hire many new substance-use-focused clinicians and expand MAT and other services, while reducing patient wait times. 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. In a February 2019 survey, New Jersey’s CCBHCs reported that 143 of the 195 new hires in their CCBHCs will have to be let go if federal legislation is not passed to extend the program. This includes psychiatrists and other prescribers, addiction specialists, case managers, peers and other staff. Subsequently, almost all new or expanded services will be reduced or cease. Medication assisted treatment alone will see over 500 individuals lose services. With the CCBHC demonstration set to end June 30, 2019, gains in fighting the opioid epidemic could be lost. Advocacy on the federal level is needed to protect these valuable services and the individuals who benefit from them, while planning is done for alternative state funding, should it be needed.

*New Jersey now has nine CCBHCs, though only seven are funded by the initial demonstration funding, with the additional two funded directly by one-time expansion grants appropriated in 2018.*

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**Legislative Recommendations**

- Pass legislation to expand Early Intervention Support Services (A2391/S1635) to all counties in the state.
- Make additional funding available to existing mental health screening centers (A2389/S1032) so they can more fully serve their designated geographic areas.
- Establish children’s screening centers throughout the state. Screening services for children should be provided by staff with licenses, academic training or experience to assess children and delivered in areas separate from adult screening services.
- Expand the Medication Assisted Treatment Initiative (MATI). Increased funding for the Medication Assistance Treatment Initiative should be included in New Jersey’s plans for expanding access to MAT.
- Advocate for H.R. 1767/S.824 to extend the Certified Community Behavioral Health Clinic (CCBHC) program and simultaneously plan for sustaining the program. New Jersey should pass a resolution supporting a federal extension of the CCBHC demonstration program and advocate diligently at the federal level, while planning for alternative state funding sources should a federal extension not be passed.

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**Estimated Staff Reduction if CCBHC Demo Ends = 143 Staff**

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<td>Other Prescribers</td>
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<td>Peers</td>
<td>8</td>
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<tr>
<td>Other Staff</td>
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*New Jersey now has nine CCBHCs, though only seven are funded by the initial demonstration funding, with the additional two funded directly by one-time expansion grants appropriated in 2018.*
Integrated Care

Integrated care is necessary to achieve positive health outcomes for the individuals served by the community-based behavioral health system, who are known to have acute co-morbidities that shorten their life expectancy. They comprise a large portion of the population known as “high utilizers”. While some community-based behavioral health providers currently provide primary healthcare services, either within their own facilities or through collaboration with primary care practices, investment and regulatory changes are needed to expand the ability of all provider organizations to do so. Burdensome regulatory requirements and a lack of capital funding have prevented 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. NJAMHAA acknowledges that work is currently underway to provide a single licensure option for primary, substance use and mental healthcare providers. Since no details are available, NJAMHAA advocates for all existing barriers to be eliminated.

Bringing behavioral health care to primary care sites for those with mild and moderate needs is a good idea. Failing to support the need to bring primary health care to behavioral health organizations ignores the greatest opportunities to best serve New Jersey residents and the state’s bottom line.

**MATT**

After enduring parental abandonment and living in a series of foster homes, where he exhibited dangerous behaviors, Matt was enrolled into a Special Teens Achieving Real Success (STAR) program that provided therapy, medication monitoring and recreational activities. A few years ago, Matt began focusing on developing independent living skills, transitioned to high school and built a small peer group. He was recently discharged since he achieved all treatment goals and he looks forward to graduating high school and entering a vocational training program.

**LEGISLATIVE RECOMMENDATIONS**

- Pass S2559/A3965 to reinstate the 70+ year exemption of vehicle registration fees for nonprofit organizations’ vehicles that was reversed in 2017.
- Pass legislation that would allow Advanced Practice Nurses to sign screening certificates.
- Establish an ombudsman position in the Department of Banking and Insurance that would be dedicated to behavioral health services.
Bringing Services to Children and Youth
Just as the concept of integrated care represents bringing primary medical care to behavioral health facilities and behavioral health care to primary medical care practices, so, too, should services meet children “where they are”. For many years, individualized mental health and substance use treatment services in school settings have been Medicaid billable for eligible children and youth under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program. New Jersey’s children would be best served if the potential for delivery of services in schools – comfortable, mainstream, accessible settings – is maximized.

To expand the availability of substance use treatment for adolescents, the Department of Health licensing division needs to amend the service delivery requirements for such services. Currently, providers licensed to deliver adolescent substance use treatment are restricted to doing so in specific facilities. The license should be amended to allow providers to deliver services in schools, probation offices and other settings that meet youth “where they are”, thereby improving and expanding access to such services and the likelihood of engagement.

We also call on the Department of Children and Families to immediately expand the network of substance use treatment providers that operate within the Children’s System of Care (CSOC). Despite there being many licensed providers with the expertise to treat adolescent substance use, the CSOC network has remained extremely limited and closed to expansion, leaving most communities without access to these services.

Electronic Health Records
Also critical is the need for electronic health records (EHRs) to be interoperable with other data systems, including billing systems. EHRs are not just a business model efficiency tool; they are critical to achieving the best outcomes and they are part of the foundation that is necessary for developing truly integrated care and in battling the opioid crisis. In the current (FY2019) Department of Health (DOH) budget, $10 million was dedicated to building infrastructure for the state’s substance use treatment system. While appreciated, this one-time appropriation falls far short of the level of need to resolve the technology and data entry problems within the state and to make providers’ EHRs interoperable, as well as to help those without EHRs get on board and others to upgrade. DOH has identified interoperable EHR systems for substance use treatment providers as a priority for FY2019; this endeavor must be expanded to all behavioral health providers and additional funding must be provided in FY2020 to properly support the fight against the opioid crisis, as well as an integrated system of care.

Legislation to Address Various Issues
Finally, the New Jersey Legislature and Administration should support and expedite passage of bills that help in other ways to alleviate fiscal and workforce pressures. Among those are:
- S2559/A3965, which would reverse a 2017 Governor’s office decision to discontinue the exemption from vehicle registration fees that a wide range of nonprofit providers had been eligible for since the 1950s.
- Legislation (awaiting re-introduction) to allow Advanced Practice Nurses to sign screening certificates, thereby reducing extended delays caused by the lack of available psychiatrists.
The New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) is a statewide trade association representing 144 organizations that serve New Jersey residents with mental illnesses and/or substance use disorders, and their families. Our members, who employ more than 61,000 individuals, may be found in every county and almost every community statewide. They serve more than 500,000 children and adults each year.

New Jersey's community-based behavioral health system of care remains in a fragile state due to increased demand, workforce shortages and system changes that continue moving forward without fully supporting the costs of the services provided. 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.

NJAMHAA calls on the Legislature and the Administration to protect and expand access to behavioral health care through support and implementation of the administrative, budgetary and legislative recommendations herein.