Stepping up to meet changes on the horizon
The community behavioral health system has been and must continue to be the safety net for New Jersey’s most vulnerable residents. More than 500,000 children and adults in New Jersey depend on community mental health, substance use and developmental disabilities services every year. Tens of thousands are at risk of losing those services as New Jersey transitions to a fee-for-service (FFS) reimbursement system.

In order to meet the needs of individuals currently served and others in the future, providers must stay fiscally viable to remain in business. To do this, they need reimbursement rates that cover the full costs of services.

The time is now to ensure access to fully funded, high-quality, integrated care for every child and adult in need throughout New Jersey!

To achieve these goals, NJAMHAA recommends:

• Continuing contract funding for mental health providers as they transition to FFS.
• Ensuring independent oversight of the FFS system, to monitor the adequacy of rates and maintenance of access to and continuity of high-quality services.
• Supporting the wellness and recovery model with adequate funding to recruit and retain qualified staff.
• Diverting individuals with mental illnesses and substance use disorders from jails, prisons, hospitals and homelessness.
• Increasing rates for children’s services, including Care Management Organizations, Partial Care and Long Term Residential programs, and specialty care professionals to support a stable, quality workforce.
Several Inadequate Rates under Fee-for-Service Put Services at Risk for Thousands of Individuals

Due to the inadequacy of several proposed rates for fee-for-service (FFS) reimbursement, providers of mental health and substance use treatment services continue to have serious concerns about the ability of the system to successfully transition to FFS without a substantial loss of services to thousands of individuals who rely on these critical services to maintain quality, productive lives in the community.

Several other states that have moved to a FFS reimbursement system or to a managed system with inadequate rates have experienced significant decreases in system capacity due to program closures. For example, “Nearly a third of community mental health providers in Massachusetts reported closing clinics from 2013 to 2015. The state Medicaid program, MassHealth, has for years reimbursed providers at rates far below the cost of treatment, meaning they lose money on every person they serve.” (Boston Globe, August 25, 2016).

These experiences serve as stark warnings for New Jersey to prevent similar consequences for provider agencies and, more importantly, for the lives of individuals who depend on these agencies’ services.

The State of New Jersey has increased some rates from what was originally proposed, including the recent doubling of medication monitoring reimbursement rates. These rate adjustments are a great step forward in making the transition to FFS more viable for providers in both mental health and substance use programs.

However, more is still needed to ensure the current level of services can be maintained – or, ideally, increased – as the demand for services continues to increase.

Some of the rates for outpatient mental health and substance use services that have been adjusted still present a challenge to providers. Many were accompanied by simultaneous regulatory changes that negate the perception that rates were increased. For example, the outpatient rate for group therapy sessions is functionally one-third less than the previous rate because the length of sessions was changed from 60 to 90 minutes; therefore $26 for 90 minutes does not represent an increase from the previous rate of $23 for 60 minutes.

Proposed rates for partial care/partial hospital, group therapy and Community Support Services (formerly Supportive Housing) remain inadequate to cover the actual costs of providing these critical services. While community-based providers are mission-driven and not profit-driven, they are still operating businesses and require adequate funding to achieve their mission, which is to save and enhance the lives of individuals with chronic mental illnesses and substance use disorders (SUDs).

Providers throughout New Jersey have shared detailed projections of substantially decreased revenues under FFS with the Department of Human Services (DHS). These estimated deficits range from $500,000 to several million, mostly in outpatient programs. These projected deficits are putting thousands of individuals at risk of losing services that have enabled them to manage symptoms of their illnesses and achieve many other goals, including entering or returning to school or the workforce, and reuniting with their families.
**Continued Contract Funding and Periodic Increases Are Needed**

The deficits being projected from the move to FFS compound the already difficult task of keeping providers of behavioral health services fiscally viable—a challenge that has long existed, due to underfunding. For decades, behavioral health services in New Jersey have been largely funded via contracts, which not only paid for services, but also subsidized those who could not afford their co-payments or deductibles, as well as the uninsured. This will end on day one of each agency’s conversion to FFS, along with the current level of service delivery. A pool of safety net funding, based on the amounts in the former contracts, should be available to ensure providers’ viability throughout the transition to FFS. Without this additional funding, providers will not be able to provide consistent care and individuals will be at risk of severely worsening mental illnesses and SUDs, which could lead to hospitalizations, incarceration and homelessness—all of which are preventable and will cost the State millions of dollars more than the community-based services.

The two months’ worth of cash advances that DHS is making available might be sufficient if all of the proposed FFS rates were adequate.

DHS has asserted that the $127 million in the FY 2017 budget for mental health and substance use treatment Medicaid rates is in addition to current contract funding. A substantial amount of this funding is supporting substance use treatment services, including the True Up program, which expands benefits for substance use treatment under traditional Medicaid benefit plans, making them equal to the full array of services offered under the Alternative Benefits Plan available under the Medicaid Expansion. Yet, a substantial amount of new funding should, by all accounts, also be available to invest in mental health services and should allow the State to easily provide a safety net via contract funding to at least maintain the current level of service delivery.

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**Recommendations to Protect Providers and Service Recipients in the Fee-for-Service System**

- Continue contract funding for mental health providers as they transition to fee-for-service.
- Ensure independent oversight of the fee-for-service system, to monitor the adequacy of rates and maintenance of access to and continuity of high-quality services.
Additional funding needs to be available to help ensure providers’ viability and, therefore, to maximize individuals’ opportunities to recover and live healthy, productive lives.

Further exacerbating the challenge for community-based providers to remain viable is the lack of cost of living adjustments (COLAs). In fact, they have not received a COLA from the State since 2008. In a FY 2015 report from the New Jersey Department of Children and Families, NJDCF Workforce: Preliminary Highlights, the critical need to maintain a skilled workforce is described along with the costs of high turnover. The report also provides the starting salaries for various staffing levels, which are, on average, $10,000 to $15,000 more than the starting salaries that community providers are able to offer. The move to FFS is expected to cause a further dwindling of the community system’s workforce, as many professionals will likely leave for similar, yet higher paying positions with the State or abandon the field for other, more lucrative opportunities.

Legislation to provide for monitoring and evaluation of the transition to FFS beginning in July 2017 has passed both the Senate and Assembly. The provisions of the legislation would ensure that the reimbursement rates are adequate; that individuals’ access to care is maintained; and that both continuity and quality of care are not harmed. It is critical that this bill be signed into law. Unfortunately, without a hold harmless provision during a true transition period, many critical services will disappear before monitoring and evaluation begin.

<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>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2003 - June 30, 2007</td>
<td>2004</td>
<td>0.00</td>
<td>Added to base: 0.00; Non-recurring: 0.00</td>
</tr>
<tr>
<td></td>
<td>2005</td>
<td>2.900</td>
<td>3.50</td>
</tr>
<tr>
<td></td>
<td>2006</td>
<td>2.0 + 2.0</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>2007</td>
<td>2.25 + 2.35</td>
<td>1.00</td>
</tr>
<tr>
<td>July 1, 2007 - June 30, 2011</td>
<td>2008</td>
<td>3.00</td>
<td>3.00*</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>3.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>2010</td>
<td>3.50 **</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>2011</td>
<td>3.50</td>
<td>0.00</td>
</tr>
<tr>
<td>July 1, 2011 - June 30, 2015</td>
<td>2012</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>1.00</td>
<td>0.00</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>1.75</td>
<td>1.00***</td>
</tr>
</tbody>
</table>

**Total Over Twelve Years (Recurring - Added to Base)**

<table>
<thead>
<tr>
<th></th>
<th>2004-2015 Total</th>
<th>2015</th>
<th>2015 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27.25</td>
<td>7.00</td>
<td>1.00***</td>
</tr>
</tbody>
</table>

* Effective Jan. 1, 2008
** Deferred from July 1, 2009 to January 2011
*** A 1% non-recurring adjustment is to be disbursed January 2015
Community-based services have been proven to be effective in enabling individuals to manage and ultimately recover from their illnesses and achieve other personal goals. However, access to these invaluable and cost-effective services continues to be limited.

Salary disparities similar to those already noted between community providers and DCF are also evident between community providers and DHS. In almost every job category, entry-level State salaries are generally about 30%, and the disparity is often even greater. For example, social workers with Master’s degrees currently have starting salaries of $48,416 in state psychiatric institutions, while social workers with the same degrees in community-based organizations have starting salaries ranging from $34,000 to $38,000.

The salary disparity has widened because the State has not allotted the same COLAs that it provides to state employees each year to contracted agencies, and also has not increased contract funds to allow community providers to raise salaries as the State can do.

**Continuity of Care Is Critical to Achieve Wellness and Recovery**

As a result, the community agencies experience high turnover rates and the individuals served experience a lack of continuity in their care. For individuals with serious mental illnesses (SMI) and/or SUDs, it can be a great challenge building relationships with providers and once such relationships are established, they provide a strong foundation for individuals’ progress toward wellness and recovery. When these relationships end because of staff turnover, the individuals served are back at square one with establishing connections with new clinicians.

In addition to having consistency in providers, service recipients need consistent care that follows the wellness and recovery model. Community-based providers work with individuals to identify their unique goals and meet their diverse needs, including housing; development of life, social, job and financial management skills; and supported education and employment in fields of interest, in addition to providing clinical treatment for mental illnesses and SUDs and additional support to address the various stressors in individuals’ lives that can trigger symptoms. This holistic approach is necessary and must be uninterrupted to ensure that individuals can realize their potential and maintain the successes they achieve.

However, access to community-based services is already severely limited. If community-based services become unavailable, there will be an increased use of emergency rooms and increased need for inpatient hospitalizations, which cost the State hundreds of thousands of dollars more than the community-based services. Primary care providers are not equipped to serve individuals with SMI and severe SUDs. Community services have been proven to be highly effective. Barbara’s story (right) is one of many examples.
HEALTH AND USE SERVICES:

Challenging to Provide

The wide disparity between salaries for staff at community based organizations in New Jersey versus those for staff at government, educational and hospital facilities are evident in the figures below from the Bureau of Labor Statistics.

Community Based Providers:

<table>
<thead>
<tr>
<th>New Jersey: Mental Health and Substance Abuse Social Workers</th>
<th>Hourly mean wage</th>
<th>Annual mean wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Food and Housing, and Emergency and Other Relief Services</td>
<td>$17.92</td>
<td>$37,280</td>
</tr>
<tr>
<td>Other Residential Care Facilities</td>
<td>$18.88</td>
<td>$39,260</td>
</tr>
<tr>
<td>Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities</td>
<td>$19.93</td>
<td>$41,450</td>
</tr>
<tr>
<td>Outpatient Care Centers</td>
<td>$20.87</td>
<td>$43,420</td>
</tr>
<tr>
<td>Individual and Family Services</td>
<td>$21.12</td>
<td>$43,930</td>
</tr>
</tbody>
</table>

Among the top paying industries for this occupation:

<table>
<thead>
<tr>
<th>New Jersey: Mental Health and Substance Abuse Social Workers</th>
<th>Hourly mean wage</th>
<th>Annual mean wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Government (OES Designation)</td>
<td>$23.83</td>
<td>$49,560</td>
</tr>
<tr>
<td>Psychiatric and Substance Abuse Hospitals</td>
<td>$25.73</td>
<td>$53,520</td>
</tr>
<tr>
<td>Colleges, Universities, and Professional Schools</td>
<td>$25.91</td>
<td>$53,880</td>
</tr>
<tr>
<td>Specialty (except Psychiatric and Substance Abuse) Hospitals</td>
<td>$26.16</td>
<td>$54,400</td>
</tr>
<tr>
<td>Elementary and Secondary Schools</td>
<td>$27.42</td>
<td>$57,040</td>
</tr>
</tbody>
</table>

BARBARA

Schizophrenia exploded into Barbara’s world with a full-blown psychotic break when she was 19 years old. She dropped out of college and self-medicated with alcohol and marijuana for 14 years and was hospitalized 21 times. The revolving door of hospital stays finally ended in 1995 when Barbara moved into one of NewBridge Services’ group homes in Morris County. The 24-hour supervision enabled Barbara to understand the steps she needed to take to achieve wellness. Barbara became sober, joined a support group for people with addictions and mental illness and began taking her medications for schizophrenia regularly.

Barbara showed steady progress. As she got better, she moved to a NewBridge home that gave her more independence and got to the point where her illness was undetectable most of the time. With newly developed life skills and confidence, Barbara moved into her own apartment a few years ago and has been managing her personal responsibilities, working and volunteering in the community. When she needs help, NewBridge is still there for her.
Recommendations to Ensure Adults’ Opportunities to Recover from Mental Illnesses and Substance Use Disorders

- Support the wellness and recovery model with adequate funding to recruit and retain qualified staff.
- Divert individuals with mental illnesses and substance use disorders from jails, prisons, hospitals and homelessness.

SALLY

When Sally first came to the New Brunswick Respite house, one of several operated by Collaborative Support Services of New Jersey, she was feeling very depressed and having difficulty at home with her son. She stayed for the maximum 30 days and then participated in Rutgers University Behavioral Health Care’s partial hospitalization (PH) program. Recently, Sally returned to the respite house, filled to the brim with positivity, and stated that she needed to take time to focus on self-care and coping skills and learn more about interpersonal relationships. Sally told the staff that her son moved into her sister’s house and she, Sally, was now able to decompress in her own space.

Additionally, Sally stated that, especially at the PH program, many people recognized her positivity and change in spirit, and she became a major support system for friends and others in the program. Over time, she became overwhelmed by having so many people coming to her for advice, which led her to become overly concerned about others’ problems instead of focusing on her own wellness. The New Brunswick Respite team worked with Sally on being assertive and maintaining boundaries with others, as well as developing healthy lifestyle habits. Now, Sally is in follow-up support and calls frequently to check in with staff. Each time Sally calls, she reports that she is doing very well, taking care of herself and protecting her boundaries by closely monitoring her level of support for others.
SERVICES HELP PEOPLE

AVOID INCARCERATION

AND RE-ENTER THE COMMUNITY AFTER INCARCERATION

It is not only unfortunate, but also tragic, that more individuals with mental illnesses and SUDs are in jails and prisons than they are in treatment facilities and in most cases, they are incarcerated for committing crimes that are not violent in nature. While some correctional facilities provide SUD treatment and other support services to foster individuals’ recovery and re-entry into the community, most jails and prisons do not. As a result, individuals are highly likely to commit more crimes and become re-incarcerated. By contrast, treatment has been proven to significantly reduce recidivism.

Due to the overcrowding in jails and prisons throughout New Jersey, the ideal is to divert individuals with mental illnesses and SUDs from being incarcerated at all. This is the crux of the Drug Court program: individuals who have committed nonviolent drug offenses are required to enter substance use treatment programs and are not incarcerated.

Diversionary tactics are also needed for interacting with individuals with mental illnesses. Law enforcement personnel must be trained to recognize the signs of mental illnesses and to intervene appropriately with individuals who are experiencing these symptoms. Such training is under way. The Mental Health Association in Southwestern New Jersey’s Crisis Intervention Training (CIT) program is available in every county.

With proper attention from law enforcement personnel and other first responders, followed by prompt access to appropriate, cost-effective treatment at community-based mental health and substance use treatment agencies, many more individuals would have opportunities to live healthier, productive lives in their communities, while requiring an investment from the State that is a fraction of the cost of incarceration.
Children’s System Needs More Funding to Continue Achieving Successful Outcomes

New Jersey has built a Children’s System of Care (CSOC) for children and adolescents with emotional, behavioral and developmental challenges that is rightly recognized as a national leader for excellence. The tremendous success the system has achieved has brought with it great challenges, as growth and expansion has the system nearly at capacity. As a result, it is getting more and more difficult for the workforce to maintain the integrity of the models of the programs that the CSOC was built upon – Care Management Organizations (CMOs), Family Support Organizations (FSOs) and Mobile Response and Stabilization Services (MRSS). The integrity of the models is becoming compromised due to rising caseloads, the inability to recruit appropriately trained and certified staff, and reduced rates of reimbursement that do not fully cover the costs of care. In recent years, both intellectual and developmental disability (I/DD) services and substance use services have been transferred to the CSOC, exacerbating the already evident quality, workforce and funding issues.

The CSOC is a truly interconnected system with a single point of entry provided by the Contracted Services Administrator (CSA), PerformCare. If one piece of the system fails, it has detrimental effects on the other parts of the system. This is particularly true for the CMOs, which provide the care coordination for the majority of children and youth in the CSOC and serves as the system’s hub.

Strengths of the CSOC
Outcomes for children and youth served by the CSOC have been very positive. The strong models at the core of the system are what have enabled it to successfully take on new populations, despite the continued need for clinical services for these populations to be fully developed. The exceptional work of the CMOs, FSOs and MRSS has led to maintaining more and more children and youth in the community, not only decreasing inpatient stays and residential care, but also contributing greatly to the very significant reduction of the census in juvenile justice institutions. The recently instituted use of MRSS staff for every resource family placement is showing signs that it will meet or exceed expectations for reducing multiple placements. The core programs of the CSOC continue to expand their scope and reach; however, the issues facing the system must be addressed in order to maintain the level of quality and success the system has achieved.

Recommendation to Reinforce the Children’s System of Care

Increase rates for children’s services, including Care Management Organizations, Partial Care and Long Term Residential programs, and specialty care professionals to support a stable, quality workforce.
CMOs Need Rate Increases to Sustain the Model, Optimize Caseloads and Improve Continuity of Care

In 2012, the CMO’s had a per child/per month rate of approximately $1,100, which was reduced to $550 in 2013 when the Youth Case Management program was consolidated into the model statewide and became Unified Care Management (UCM). This rate was never adjusted for inflation, COLA’s, increased caseloads or the addition of new, challenging populations. As a result, it does not allow for recruiting and retaining quality staff, nor does it adequately cover all of the costs of care. The CMO monthly rate needs to increase to $850.

Initially capped at a 1:10 ratio of care manager to youth, the caseload cap was removed under the transition to UCM. UCM is “funded based upon the 1:15 ratio”, as defined by DCF, but a 2014 survey showed an average caseload of 18, and as high as 21. While many served by UCM have more moderate needs than the initial population, all require many of the same services from care managers: assessments, team meetings, etc. In addition, the population to be served is largely unpredictable and inadequate rates make it fiscally impossible to hire new staff and comply with staffing regulations. The result is an inability of care managers to provide all that they would ideally like to for both their high-need and moderate-need children, youth and families.

The inability to recruit and retain quality staff leads to a lack of continuity of care, disrupting the progress that children and their families have made. The difficulty providers have in retaining experienced care managers not only directly impacts the individuals served, but also negatively affects entire agencies, as knowledge, relationships and supervisory capacity are lost. The success of those served is greatly tied to a CMO’s connections to a community, which rely on a stable workforce.

PEDRO

When Pedro was three years old, his parents died and he and his two older siblings went to live with their grandmother. Some time later, Pedro started to display serious behavioral problems and aggressiveness towards his family members. His behavior led to several hospitalizations. Subsequently, Pedro was placed in several foster care homes starting at the age of eight. During this time, he was sexually molested and was then reunited with his grandmother. Some of Pedro’s medications caused hallucinations, which led to him jumping out of the second floor window of his home. After his hospitalization, he was placed at an intensive residential treatment center for three years.

Pedro was then referred to Coordinated Family Care, a Care Management Organization (CMO), for assistance in transitioning back to his home. They worked on issues regarding communication, relationships, impulsivity, anger management and control. The CMO staff helped the family successfully address other issues, including Pedro’s challenges in school and the loss of their home. Since moving into the new home, the family has continued to work on improving their relationships, and Pedro and his grandmother developed a behavioral contract. Pedro was also able to build more trust from his grandmother by participating in a respite weekend program, which resulted in him receiving an award and outstanding marks for positive behavior.

The family’s strengths have carried them to a point of “normalcy”. They have shown perseverance, the ability to be survivors in the face of hardships, the motivation to be a cohesive family, and the ability to be autonomous. The grandmother has been equipped with sustainable community resources and Pedro has become patient, helpful and dedicated to his goal of staying home and returning to the community school district.
Investment Is Needed to Properly Serve Children’s Specialty Populations

Services for youth with developmental disabilities (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.

When youth with DD are referred by MRSS and they are not yet determined DD eligible, they are assigned to Intensive In-Community (IIC) providers. Once they are deemed DD eligible, they are assigned to new providers under the Intensive In-Home (IIH) program. Not only is this disruptive to treatment, but also the scarcity of IIH providers, especially Applied Behavior Analysis credentialed staff, leaves little room to ensure quality standards are met. Contributing to that scarcity are reimbursement rates that are too low to attract and retain quality specialty staff.

The population in need of substance use treatment faces problems similar to those of the DD population. A qualified workforce of professionals with specialized skills and credentials to work with children and youth with SUD’s must be built to properly serve this population.

Financial Investment Must Accompany Best Practices and Optimal Resource Utilization

The enormous growth of the CSOC, including expansion populations (DD and SUD) – without increased resources/rates – is leading to an erosion of the effective treatment model. Significant investments of funds and other resources are needed to restore integrity to the system. First and foremost, rate increases for CMOs and IIH and IIC staff are needed, and rates throughout the system must be evaluated for adequacy. Best practices for children, youth and adolescents with SUD’s and co-occurring disorders must be explored and implemented, and new training programs need to be developed to better serve the DD population. Research on bed utilization, needs assessments and innovative program models is also needed and new models need to be implemented to permit programs to sustain their bed capacities and offer proper lengths of stays to best serve children and youth.

Finally, having IIH providers also certified as IIC providers to serve those children and youth who are to begin receiving IIC services, but whom are expected to eventually be deemed IIH eligible, is needed in order to ensure continuity. Implementing these recommendations would ensure that the CSOC continues to provide the highest quality of care and, in turn, achieve the greatest outcomes for children and families.
Implementing these recommendations would ensure that the CSOC continues to provide the highest quality of care and, in turn, achieve the highest outcomes for children and families.
LOOKING AHEAD

While community providers are either adjusting to the challenges that the FFS system presents or continuing to prepare for when they make the transition to FFS, they also have more changes — and inherent challenges — on the horizon. As indicated in the Division of Medical Assistance and Health Service’s application for the renewal of the Medicaid Comprehensive Waiver, the State’s next change for the community mental health, substance use and developmental disability services system will be value-based purchasing.

Through FFS, the State will gain a full understanding of the true costs of services. However, the volume of services provided will cease to be the metric by which providers are paid. Under value-based purchasing, the State will reimburse providers based on the outcomes achieved by the individuals they serve.

Community-based services have been resulting in many positive outcomes. Individuals have secured independent housing after having been homeless; pursued education and job training that have led to employment and, in some cases, self-employment; strengthened their relationships and, in many cases, reunited with their families. Barbara, Sally and Pedro are three of many compelling examples of how community-based services empower individuals to transform their lives.

Providers need to be adequately reimbursed to ensure they are able to deliver services so such desired outcomes continue to be achieved by many more children and adults throughout the state.

If sufficient funding and a strong, well organized infrastructure are in place for the full continuum of children’s and adults’ community mental health, substance use and developmental disability services, individuals who receive these services will continue to be healthy and successful and will not incur high costs in the healthcare and criminal justice systems.

ON THE HORIZON
Community-based services have been resulting in many positive outcomes. With sufficient funding and a strong, well-organized infrastructure in place, these services will continue to empower New Jersey residents to be healthy and successful.