



1115 Waiver Renewal Concept Paper

The New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) and its members appreciate this opportunity to provide input in advance of the New Jersey Division of Medical Assistance and Health Services (DMAHS) submitting its initial 1115 Waiver renewal concept paper for 2022 to the Centers for Medicare and Medicaid Services (CMS). We provide below a high level framework for initiatives that would endeavor to reduce psychiatric hospital admissions and readmissions, reduce Emergency Department (ED) visits and improve outcomes and the quality of life for those served. Some core components of these initiatives might be more suited to inclusion in a State Plan Amendment (SPA), and, should these or similar initiatives not be included in the 1115 Waiver renewal, we would recommend them for such.

Addressing the Service Gaps/Recidivism Rates for Individuals Discharged from a Hospital

Providers across the state consistently serve individuals who have multiple psychiatric hospital admissions in a year, some reaching levels of a dozen or more in three years. Despite such histories, many are ineligible for Integrated Case Management Services, Programs of Assertive Community Treatment (PACT), Community Support Services (CSS), Behavioral Health Homes, Residential Intensive Support Teams (RIST) and Targeted Case Management or have not engaged with, or have dropped out of, these various levels of care. A demonstration program should be developed that would fill the gap for those excluded from these programs by their eligibility criteria and those who have disengaged from them and who remain in need of significant levels of supports and services.

The general framework for such a demonstration would include an outpatient appointment within seven days of discharge, as well as an appointment for a comprehensive primary care visit within 30 days of discharge. It would also include some form of case management, whether that be by a Community Health Worker, Navigator, Nurse, Case Manager or other designation currently in use. The goal is to provide care based on individualized need and to address social determinants of health, such as transportation and housing. The initiative should encourage hospital/community partnerships with incentives and accountability provided for both. In particular, knowing that serious mental illness is a 30-40 year deteriorating disease, an episode of care payment should offer a premium payment to care for those first diagnosed within the past five years, in the hopes of minimizing lifetime chronicity.

One alternative would be an adequate episode of care rate that might capture a certain number of inpatient days, a comprehensive primary care visit and multiple outpatient visits, while being substantial enough to allow for critical case management, clinical consultation and transportation components, among others. One necessary component for many that has been highlighted during the pandemic is the need for smartphones or laptops and phone/internet service. These not only improve access to services and supports during a pandemic, but help overcome transportation, child care and other barriers at all times.

Housing, while not a component of the 1115 Waiver, is also often a critical factor for individual success, as well as the success of aftercare initiatives. Working with the Department of Community Affairs (DCA) to pursue expansion of Housing First programs, DCA's Moving On Initiative and the Hospital Partnership Subsidy Pilot Program will increase needed access to housing resources. Continuing the effort to restructure the CSS program to include tiers based on acuity that might open access to maintenance levels of support for hospital discharges will be another avenue.

It will also be important to streamline the administrative responsibilities associated with an aftercare program. Pre-authorization requirements, billing, compliance and reporting functions must not be so over-burdensome and costly that they negatively impact the incentives for hospitals and community providers to participate.

Addressing Service Gaps/Recidivism Rates for Individuals in Crisis

Streamlining administrative responsibilities would also be a goal for an initiative that would address the needs of individuals in crisis who arrive in Screening Centers, Early Intervention Support Services (EISS) programs and other mental health urgent care programs in the community. Many of these individuals are also found ineligible for higher levels of care than outpatient services, yet often face subsequent crises that repeatedly bring them back to EDs and elsewhere.

While there are many approaches to addressing this gap in services and the related recidivism, several already exist that could serve as a foundation for initiatives to reduce ED visits and hospital admissions. NJAMHAA has long advocated for both expansion of the EISS program and increased funding for Screening Centers to expand their Mobile Crisis Services. These and other crisis stabilization models should be readily accessible in all 21 of New Jersey's counties. The Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Best Practice Toolkit earlier this year within their National Guidelines for Behavioral Health Crisis Care. The toolkit promotes both Mobile Crisis Services and "Crisis Receiving and Stabilization Services" that are based on a trauma-informed, living room model of care. All of these models of crisis services should be considered for expansion and inclusion in the waiver to provide the additional components suggested above for the post-discharge population: outpatient appointment within seven days, a comprehensive primary care appointment within 30 days, transportation, care coordination that addresses social determinants of health, clinical consultation and other components to address the individualized needs of the target population: those assessed to be in need of a greater level of care than outpatient and ineligible or unengaged from more intensive levels of care.

The other existing approach is to have a Certified Peer with lived experience at each Screening Center to provide follow-up care coordination and support. Several Screening Centers already employ peers for this purpose and have achieved great success in reducing recidivism. The addition of peers to all Screening Centers also lends itself to a Screening Center/Community Provider partnership initiative that would incentivize more comprehensive services and supports in an effort to reduce recidivism and improve outcomes, including wellness measures. A requirement for a certain level of face-to-face meetings in the community is recommended as it

not only leads to greater success in ensuring engagement with services, but allows the program staff to view the home environment and better understand barriers to care. These partnerships could be supported via a value-based payment methodology and encouraged with incentives.

Guiding Principles

NJAMHAA and its members recognize and appreciate that DMAHS, working with the Division of Mental Health and Addiction Services, has completed, and continues to work on, efforts toward more individualized, comprehensive care. Changes that have allowed or will allow peers as part of residential programs, that support care coordination and transportation, and that provide flexibility to providers to best serve each individual, continue to move the system along a path toward improved, cost-efficient outcomes. The various approaches to implementing these changes – through waivers, SPAs, bundles, re-opening or expanding availability of existing codes, and the like – should all be considered to design and implement an aftercare program for those discharged from hospitals, those accessing the Screening Centers that do not get admitted, and others in crisis arriving at EISS and other urgent care type programs in the community.

Regardless of the approach, the design must: be centered around the individual; include the many proven components of ensuring those served not only have access to services that address their individual needs, but the supports and services that maximize the likelihood of their engagement; and ensure that wellness and recovery outcomes are a priority alongside the goal of reduced recidivism.