



New Jersey Association of Mental Health and Addiction Agencies, Inc.
Champions for Transforming Lives and Health Systems

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Office of Legal and Regulatory Affairs

P.O. Box 712

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Trenton, NJ 08625-0712

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Re: Comments on the New Jersey Department of Human Services, Division of Medical Assistance and Health Services Section 1115 Comprehensive Waiver Renewal Application

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The New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) appreciates the opportunity to comment on New Jersey's renewal application for the Section 1115 Comprehensive Waiver (waiver).

NJAMHAA fully supports the goals set out for the waiver renewal, in particular, expanding Medicaid's "ability to better serve the whole person" by testing "new approaches to addressing the social determinants of health" and "greater integration of behavioral and physical health, and continued availability of appropriate behavioral health services for all Medicaid beneficiaries." We also acknowledge the significant accomplishments that have been achieved under the current waiver. We do, however, have several concerns as the state looks to build on those accomplishments to achieve the stated goals.

NJAMHAA looks forward to continuing its partnership with the Division of Medical Assistance and Health Services (DMAHS) and the Division of Mental Health and Addiction Services (DMHAS) as well as with other Departments and Divisions to continue to move New Jersey forward in providing access to high quality mental health and substance use disorder services. The renewal application provides a broad vision of the state's destination and we look forward to working with the various Divisions on the details of the path to get there. This is especially true in regard to the expressed desire to move more behavioral health services to managed care. We are pleased that there is repeated emphasis in the draft proposal to include stakeholders in this process and urge DMAHS to involve stakeholders from day one. Providing avenues



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for those on the front lines of service delivery to share their expertise in meaningful ways can only enhance any initiative.

Numerous initiatives in the waiver proposal have the full support of NJAMHAA without concern. These include, though are not limited to:

- Changes regarding parental income disregards for the Children's Support Services Programs administered by the Children's System of Care (CSOC) within the Department of Children and Families.
- The newly proposed Adjunct Services Pilot which would expand the therapy options for youth served by the Comprehensive Autism Benefit now included in the State Plan.
- Proposed changes to the Community Care Program and Supports Program administered by the Division of Developmental Disabilities. NJAMHAA applauds the proposed changes that aim to: reduce churn between these programs and Managed Long Term Services and Supports (MLTSS); expand eligibility to a younger cohort; provide greater flexibility during transition to these adult programs; improve continuity of care through provision of services during hospital stays; and increase the respite services available to caregivers.
- Continuation of a comprehensive continuum of care for substance use disorders (SUDs). We are extremely pleased to see that the renewal application requests extending this critical component of the SUD continuum of care without modification.
- The proposal to offer support to additional behavioral health provider types under the Substance Use Disorder Promoting Interoperability Program. NJAMHAA applauds this effort to incentivize further adoption of electronic health records, with the goals of connecting siloed systems of care, enhancing care coordination and quality, and reducing duplication of services.
- Pre-release services for incarcerated individuals are a critical component to providing a successful re-entry to the community and reducing overdoses and recidivism. NJAMHAA continues to advocate for passage of federal legislation that would allow Medicaid enrollment 30 days prior to release and greatly appreciates the inclusion of behavioral health services for incarcerated individuals in the waiver proposal.
- NJAMHAA recognizes both the capacity and treatment solutions that sub-acute beds have provided for Medicaid beneficiaries, which serve as a medium-term placement alternative to longer acute-care or psychiatric hospital stays. Maintaining a focus on discharge planning to ensure successful transition back to the community with an average length of stay of 30 days is an appropriate condition for this expenditure authority.



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NJAMHAA does have questions, concerns and/or recommendations regarding several other continuing and new initiatives in the waiver proposal which are detailed below.

Behavioral Health Carve-In

While NJAMHAA's full support for integrated care has already been noted, and is something NJAMHAA and its members work toward on a daily basis, carving programs in to a managed care system to achieve that goal not only generates much concern, it is not necessarily the optimal approach for consumers in all service levels. We acknowledge there are opportunities that carving in programs presents, in particular, accountability on the part of managed care organizations. However, having integration at the payor level does not achieve for the consumer what integrated care at the service level can.

Many behavioral health providers have integrated primary care for their clients either on-site, in collaborative models or through care coordination. So many behavioral health models of care address physical health needs with one of these approaches, from Certified Community Behavioral Health Clinics (CCBHCs) and Behavioral Health Homes, to Programs of Assertive Community Treatment (PACT), Integrated Case Management Services (ICMS), and Community Support Services (CSS) and, of course, residential programs. NJAMHAA and its members have long sought changes to regulatory barriers that have prevented outpatient clinics and other programs from bringing medical services on-site. All of these programs serve individuals with serious mentally illness and/or substance use disorder (SUD) diagnoses. Having a single point of referral in an MCO, even a care manager who supports clients with arranging appointments for both their behavioral health and medical needs, does not make it easier for consumers to actually arrive at both destinations. The engagement and outreach by providers, attending to transportation needs and co-location of services does go further to ensure services are actually received. Our support for integrated care is boundless, but we believe that care must be integrated at the consumer level to achieve the best outcomes.

These barriers are explored in detail in the March 2016 report by the Seton Hall Center for Health and Pharmaceutical Law and Policy, *Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey*. In October 2015, the New Jersey Department of Health issued a memorandum regarding a "Waiver to Permit Sharing of Clinical Space"; however, this waiver applies solely to ambulatory care facilities and needs to be reciprocal to include community mental health providers. As the study indicates, "integration of care for (individuals with severe mental illness) is likely best achieved in a specialty mental health facility or through specialty mental health providers, who collaborate and coordinate with primary medical services." More must be done to break down barriers faced by community mental health providers and to assist them in moving toward integrated care since the population most in need of integrated services, and that stands to gain the greatest benefit, is the population currently being served by the behavioral health community. It is for this population that integrated care can also achieve the greatest state savings. NJAMHAA recommends removing barriers to integrated care for community providers of mental health and substance use treatment, for



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example, providing blanket shared clinical space waivers, as a priority for DMHAS, DMAHS and the Department of Health.

While NJAMHAA applauds the successes of the MLTSS program and its ongoing growth, concerns remain following the *Interim Evaluation Report* completed by Rutgers Center for State Health Policy in 2016 which noted “The one area with negative findings for the managed care population relates to ambulatory care for beneficiaries with behavioral health conditions.” No subsequent report or data has been shared to indicate improvement in this area. This is important to investigate, not only for the behavioral health sub-population within MLTSS, which is relatively small, but in regard to plans to carve-in more of the behavioral health population under the waiver renewal.

Network adequacy is a must if there is to be any progress toward the goal of “continued availability of appropriate behavioral health services for all Medicaid beneficiaries”. Given the historic failure to meet demand, increased demand due to COVID, several inadequate rates and ongoing program deficits under fee-for-service (FFS) and critical workforce challenges, provider hesitancy to carve-ins, with the increased administrative burdens it brings along with anticipated negative impacts on access to care and continuity of care, should be no surprise. Providers’ experiences with the small populations they serve under MLTSS and the other carved-in populations include:

- delayed payments (45 to 60 days versus Medicaid’s 10 day turnaround);
- short-term approvals (only seven days for long-term residential versus 30 days from the Interim Managing entity (IME));
- up to four hours needed to get approvals (versus 15 minutes via the IME);
- non-responsiveness, with phones not answered; and
- denials of pre-authorizations for clearly appropriate services.

If, after careful consideration and evaluation with stakeholders, more behavioral health programs and populations are moved to managed care, NJAMHAA recommends the following:

- Retain the “any willing provider” requirement for MCO networks for a minimum of two years. Initially, when Managed Long Term Supports and Services (MLTSS) were carved in, providers experienced numerous challenges, including confusion regarding appropriate contacts and non-responsiveness from the MCOs that significantly slowed the process.
- Establish universal application and credentialing processes. Among the many challenges providers faced was the individual application/credentialing processes set by each MCO.
- Fair rates that cover the full costs of care should be set by the state **in perpetuity** to ensure fairness and fiscal stability for providers which is necessary to network adequacy. For the previous carve-ins, each provider had to independently negotiate rates with each MCO. Not



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only is this overly burdensome, but providers, particularly smaller organizations, are at significant disadvantage in such negotiations.

- Permanently restrict the use of prior authorizations and other utilization management techniques for these services. The waiver proposal suggests MCOs may be required to establish client-centered interdisciplinary teams, with providers noticeably absent. The fact that a client-centered interdisciplinary approach to care is something that must be requested of MCOs is a statement on their lack of experience with and understanding of the population, its needs and the services provided to meet those needs.

Rates are, of course, a primary concern for all programs being considered for a carve-in. Many currently remain inadequate to cover the cost of care of many behavioral health programs. After eight years of no Cost of Living Adjustments to contracts, programs were transitioned to FFS reimbursement at rates that could not generate the previous inadequate contract amounts, all while more was required in the way of qualifications, billing procedures, and lengths of service under Medicaid regulations. Capacities shrank at many programs while others closed, though the increasing number served by CCBHCs masked this to a great extent. Behavioral health providers had a workforce crisis before COVID and are facing unmatched challenges now as more staff retire, move to private telehealth practices, exit the field for higher paying, less stressful work or are lost to sickness, fear, vaccine mandates or family demands. The community based network's inability to meet demand has been documented regularly in DMHAS' block grant applications prior to COVID. Substantial increases to rates must be provided in order to sustain, then expand system capacity with a qualified workforce or an adequate network will never be achieved under managed care, leading to only longer wait lists than are now the case.

Medicaid, through its recent presentations of the waiver proposal, cited a "North Star" principle of ensuring access and availability of behavioral health services, stating that robust MCO provider networks that support wellness and recovery with appropriate reimbursement to providers will be required. Incorporating the recommendations made above regarding any willing provider, credentialing, rate setting and utilization management are necessary to achieving this.

Certified Community Behavioral Health Clinics

NJAMHAA has long advocated for New Jersey to ensure the sustainability of its CCBHCs and pursue expansion of the model throughout the state and is pleased to see it included in the waiver proposal. When implemented, CCBHCs were hailed as the service delivery model of the future – they have lived up to the expectations.

The State has acknowledged the many successes of the CCBHCs which should include recognition of the contributions to successful outcomes that the model itself makes via a full continuum of both mental health and addiction treatment under one entity, case management that addresses the social determinants of health, primary care (directly or coordinated), crisis care and a



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whole-person, comprehensive, recovery oriented approach. The other significant factor enabling such successful outcomes is the ample reimbursement these programs receive, allowing them to hire and retain the staff needed for such a comprehensive model of care.

NJAMHAA does have concerns about the proposed single state-wide rate for the CCBHCs as their current rates are based on not only regional variations in costs, particularly wages, but on other differences in how they operate. For example, some might have more psychiatrists and others more Advanced Practice Nurses. Some may be serving much larger SUD populations requiring more of scarce addiction specialists on staff. There are variations on what CCBHCs provide themselves and what is provided through one of their Designated Collaborating Organizations (DCOs). We urge DMAHS to explore in great depth the distinctions that result in the current differences in rates to ensure that a single state rate will not negatively impact programs nor diminish their flexibility to serve the unique needs of the communities they serve.

Of note is the key role CCBHCs can play in the State's 988 Crisis Response System (988) that is being planned, as required by federal law for implementation in July 2022. The CCBHC demonstration requires 24 hour mobile crisis teams and crisis stabilization, though, given New Jersey's established Psychiatric Emergency Screening Services (PESS), implementation of these services in New Jersey rolled out differently than in all other states. New Jersey's CCBHCs all entered into MOUs with PESS centers, with not all establishing their own mobile crisis teams. NJAMHAA and other stakeholders recommend building on the existing resources of the CCBHCs, as well as the existing Early Intervention Support Services (EISS) programs and new EISS programs to be established in all counties currently without one, and the planned mental health crisis stabilization centers (to be funded with American Rescue Plan dollars) to create the network of mobile crisis teams needed across the state for 988. The person-centered, wellness and recovery approach of CCBHCs and EISS and their existing collaborations with other community organizations present an ideal foundation for 988 mobile crisis teams, qualities we expect crisis stabilization centers will also embrace.

Housing Supports

Integrated care has already been addressed, but that discussion, like so many others, focused on only the integration of physical and behavioral health. CCBHCs have taken the definition of integrated care much further with the inclusion of case management that addresses the social determinants of health for their clients, as well as peer services to support recovery.

NJAMHAA applauds DMAHS for its inclusion of housing supports in its waiver proposal and believes screening all new members and high-risk populations for the possible need of housing-related services will provide a path to significantly improved health outcomes. We also applaud the comprehensiveness of the service array that will be included under "Housing Transition Services" and "Tenancy Sustaining Services" though wish to note that "Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action" is an area where legal services are often required. We recommend that housing-related legal services



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specifically be identified as an available service given that they are generally required for a successful outcome when faced with eviction and many other types of housing disputes, such as maintenance issues that affect the health of the tenant. These services should be provided by attorneys who specialize in working with vulnerable populations in the community.

In addition, there are questions and concerns about how MCO housing-related services would interact not only with CCBHCs that are doing housing transition and tenancy sustaining services, but many other programs including, but not limited to, Community Support Services (CSS), PACT and ICMS. The staff in these programs not only have established relationships with their clients and more in-depth knowledge of their history and environments, but they also have extensive experience in providing housing-related services, not to mention that these services are required of them by contract. Duplication of services, particularly the potential of services being rendered by community-based programs and then deemed unbillable, must be avoided. NJAMHAA recommends that the waiver proposal address how duplication of services is to be circumvented, beyond stating that MCOs will be required to “coordinate with community-based providers”.

Department of Children and Families

NJAMHAA supports the Department of Children and Families’ newly proposed Supportive Visitation Services program for parents with children in out of home placements but would like to better understand how the delivery of the clinical and support services will intersect with the Children’s System of Care (CSOC), particularly with existing CSOC programs such as Mobile Response and Stabilization Services and Care Management Organizations.

Workforce Revisited

While we laud the admirable goals of the waiver renewal proposal and look forward to working with all Departments and Divisions to achieve them, the current rapidly changing, insufficient workforce is a problem that must first be addressed. There are several programs targeted for expansion in 2022 – EISS and School-Based Youth Services Programs are two – and a new 988 system is slated to roll out with new crisis stabilization centers and mobile crisis teams. The workforce crisis needs immediate attention just to sustain the current network of providers, let alone be able to support these new and expanded initiatives, followed by the many services proposed in the waiver application. Programs require an immediate infusion of substantial fiscal support that will enable providers to offer competitive wages to recruit and retain a qualified workforce, and to fill the deficit gaps left by FFS rates that never fully covered other expenses, let alone new ones that providers continue to incur since the transition to FFS and onset of COVID.

In Closing

NJAMHAA recognizes the ongoing efforts of the Department of Human Services and its various Divisions to continually improve access to, and the quality and outcomes of behavioral health



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services for New Jersey's most vulnerable populations and fully support the goals specified in the waiver application. These can best be achieved through a true partnership with community providers that allows input early on and continuously and that incorporates the expertise of providers, peers, families and other stakeholders into all decision-making in a meaningful way. NJAMHAA and its members look forward to ongoing discussion and planning with DMAHS and others to achieve the admirable goals they have set out in the waiver renewal.

Sincerely,

Debra L. Wentz, Ph.D.
President and CEO