August 19, 2024

Division of Medical Assistance and Health Services via
DMHAS.CMWcomments@dhs.nj.gov

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

The New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA) appreciates the opportunity to comment on New Jersey's FamilyCare 1115 Comprehensive Demonstration (waiver).

NJAMHAA continues to fully support the goals set out for the current waiver, 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".

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 waiver provides a broad vision of the state's destination and we look forward to ongoing work 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 have been significant, consistent and meaningful efforts to include stakeholders in this process. Providing avenues for those on the front lines of service delivery to share their expertise will continue to enhance this and other initiatives.

NJAMHAA

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Numerous initiatives in the waiver have had and continue to have the full support of NJAMHAA. These include, though are not limited to:

- Continuous eligibility that provides adults eligible for Medicaid due to their Modified Adjusted Gross Income (MAGI) 12 months of coverage regardless of income or other changes that might affect eligibility.

- 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 Adjunct Services Pilot which would expand the therapy options for youth served by the Comprehensive Autism Benefit now included in the State Plan.

- Changes to the Community Care Program and Supports Program administered by the Division of Developmental Disabilities.

- Continuation of a comprehensive continuum of care for substance use disorders (SUDs). We are extremely pleased to see that the waiver extended this critical component of the SUD continuum of care without modification.

- The establishment of the Behavioral Health Promoting Interoperability Program (BH PIP), an incentive-based payment program that will provide health information technology (HIT) infrastructure support to targeted Medicaid providers in order to increase HIT use and connectivity to the state's health information exchange (HIE)."

NJAMHAA supports many other continuing and new initiatives in the waiver, though does have questions, concerns and/or recommendations for those as detailed below.

Behavioral Health Carve-In

NJAMHAA and its members greatly appreciate the many stakeholder group forums that have been offered and the responsiveness of the Department to concerns regarding a smooth transition of behavioral health services to Medicaid Managed Care that ensures network sustainability, service quality and consumer access, though many issues remain.

Network adequacy is critical 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, continuing increased demand, several inadequate rates and ongoing program deficits under fee-for-service (FFS), and critical workforce challenges, providers have serious concerns regarding the impact of the carve-in on costs and access to care.

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Increased administrative burdens, which will be ongoing with contract negotiations, credentialing and multiple different processes for both pre-authorizations and claims processing, clearly come with fiscal costs and impacts on access to and continuity of care. As has been noted before, community-based 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 duration approvals (only seven days for long-term residential versus 30 days from the Interim Managing entity (IME)); hours needed to get approvals (versus 15 minutes via the IME); denials of pre-authorizations for clearly appropriate services, and other challenges impacting cost and care. We are grateful to DMAHS for having specifically addressed several of these issues by incorporating changes into the MCO contract effective July1, 2024 and look forward to additional changes and details. The current changes are listed below - those that lacked detail have recommendations attached.

We thank the Division for requiring MCOs to:

- Cover court-ordered behavioral health services

- Contract with all FFS providers actively providing services at the time of the transition and maintain a "robust network of providers who are actively providing Medicaid covered services"

    - NJAMHAA recommends retaining the "any willing provider" requirement for MCO networks for a minimum of two years. This had been shared by DMAHS as a proposed policy back in March, but it is unclear whether the two-year timeframe has been included in the contract.

    - DMAHS should include stakeholders in defining provider to population ratios, geographic and/or other standards that will be used to define an adequate network.

      The policy proposal listed in the March 2024 slides presented at a Behavioral Health Integration Provider subgroup meeting added that the "any willing provider" provision would be in place until the "contracted network meets requirements statewide." It is not clear what those requirements would be nor how a "robust network of providers who are actively providing Medicaid covered services" is defined in the current contract. Knowing that current capacity cannot meet the current demand for services, the present network certainly could not be considered robust, meaning, even with all current providers transitioning, the "robust network" condition could not be initially met. More will be said below about sustaining and expanding the behavioral health network, though it is noted here since building capacity over time must be a consideration for setting network adequacy standards that should grow accordingly.

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- Accept a standardized credentialing tool (CAQH) to reduce requests for duplicative information and process properly completed applications within 60 days
    - MCOs should not be permitted to have their own individualized tools seeking additional information, which would defeat the purpose of a standardized tool.
- Shorten processing timelines for properly submitted behavioral health claims and implement a minimum weekly payment schedule.
    - Claims processing by MCOs should match current FFS Medicaid processing with full transparency to include detailed information on delayed and denied claims.
- Automatically approve all SUD detoxification services
- Issue initial approvals with established minimum durations and meet rapid timelines for processing prior authorizations
    - In the April, 2024 Behavioral Health Integration Advisory Hub slides under "policy updates" it says "Ensure MCO consistency with current prior authorization policies for FFS to reduce provider disruptions." Providers have shared that the IME currently always provides a 30 day initial authorization for SUD long term residential, though it is not clear if that is policy. Similarly, most short-term residential initial approvals are for14 days, though not always. NJAMHAA recommends baseline minimum initial approvals of 30 days for long-term and 14 days for short-term SUD residential.
    - Other "policy updates" in the April slides included "Define standard fields required for "complete" behavioral health prior authorization request" and "Require new MCO report on prior authorization performance to monitor adherence." NJAMHAA recommends that both of these policies be implemented.
    - There was also acknowledgement in April of provider requests for standard definitions of medical necessity, standardization of both the information requested and submission processes for prior authorization across MCOs, and the ability to both request and track prior authorizations electronically. One specific proposed policy is to require annual MCO training on ASAM criteria. These are all practices NJAMHAA recommends as they will reduce administrative burden and cost as well as improve access to care.
- Have a full-time Behavioral Health Medical Director, and
- Identify behavioral health quality and outcome measures to be monitored annually.

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The July 1st changes to the MCO contracts are applauded as they are all beneficial to providers and clients. There are also policies that have been set for the transition period that will do the same, though additional detail is needed there also. These include:

- Automatic approval of prior authorizations during the "initial transition period"
  - NJAMHAA recommends that a definition of the duration of the "initial transition period" is shared so providers may properly prepare for its end.
- FFS rates will serve as the "floor" during the transition period.
  - NJAMHAA recommends that the State set MCO minimum rates that never fall below Medicaid FFS rates, which need to be increased now, and to match inflation over time, to cover the costs of care.

    During the previous carve-ins, each provider had to independently negotiate rates with each MCO. Not only is this overly burdensome, but providers, particularly smaller organizations, are at significant disadvantage in such negotiations. Even with Medicaid rates as a floor, rates will remain a primary concern as many currently remain inadequate to cover the cost of care of many behavioral health programs. When programs were transitioned to FFS reimbursement with inadequate rates and more requirements in the way of qualifications, billing procedures, and lengths of service under Medicaid regulations, capacities shrank at many programs while others closed. While significant increases in FY2023 and FY2024 were appreciated, they did not bring all rates to levels that cover the costs of care. Given the very significant inflation in recent years, particularly for wages, many programs are currently struggling to remain fiscally viable. For example, the Department knows better than we do how many partial care programs have closed in the past two years. Many more are currently taking a close look at their programs to determine if they can continue. Substantial increases to rates must be provided in order to sustain and then expand system capacity with a qualified workforce or an adequate network will never be achieved under managed care.

There are many other policies for the carve-in that have been suggested and discussed but for which no policy status has been determined. Among them are the following that NJAMHAA recommends:

- Establish a policy and process for retroactive prior authorization if a member meets medical necessity criteria.

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- Establish how facility level non-credentialed staff, particularly those in residential programs without credentialed staff, will be able to bill for services.

- Establish a universal application process.

  Among the many challenges providers faced when the special populations were carved-in was the individual application processes set by each MCO.

Medicaid has in the past cited a "North Star" principle for the carve-in 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 all of the above recommendations regarding any willing provider, credentialing, rate setting, prior authorization and other areas are necessary to achieving this.

Housing Supports

NJAMHAA applauds DMAHS for its inclusion of housing supports in its waiver 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 commend the comprehensiveness of the service array that will be included under "Housing Transition Services" and "Tenancy Sustaining Services".

NJAMHAA has participated in the many stakeholder meetings that have focused on the Housing Supports initiative and looks forward to continuing to do so. Questions do remain about how MCO housing-related services would interact with not only 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 have established relationships with their clients and more in-depth knowledge of their history and environments, as well as extensive experience in providing housing-related services. Additionally, 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 clear guidance be developed on how MCOs will "coordinate with community-based providers" and recommends that allowable services be provided by the case managers, care coordinators and other professionals closest to the consumer and the community.

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Denied Authorities

NJAMHAA strongly supports two programs that were not approved by CMS but which can move forward. We are grateful that one, the Certified Community Behavioral Health Clinic, will be developed within the State Plan Amendment and hope that talks will be ongoing regarding the other denied initiative – pre-lease services for incarcerated individuals.

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 that the State is on a path to doing so. A significant factor enabling the remarkable successful outcomes for CCBHC clients is the ample reimbursement these programs receive, allowing them to hire and retain the staff needed for such a comprehensive model of care. Given the success of the demonstration model, NJAMHAA is hopeful the SPA will include language that requires the State model, including its payment system, to always mirror the federal statute and SAMSHA criteria. While the waiver provides a waiver of state-wideness, we also hope that the State will move as quickly as possible to certify new CCBHCs once the SPA is in place.

Pre-release Services for Incarcerated Individuals

Pre-release services for incarcerated individuals are a critical component to providing a successful re-entry to the community and reducing overdoses and recidivism. While CMS denied these services in the current waiver, they left the door open for continued conversations on developing such services in line with federal guidance.

- NJAMHAA recommends pursuing an amendment to the waiver to include pre-release services for incarcerated individuals.

Workforce Revisited

While we laud the admirable goals of the waiver and look forward to continuing to work with all Departments and Divisions to achieve them, the current rapidly changing, insufficient workforce is a problem that must be addressed. The workforce crisis needs immediate attention to sustain the current network of providers and to be able to support new and expanded initiatives. Programs require an immediate and sustainable 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.

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In Closing

NJAMHAA and its members recognize 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 services for New Jersey's most vulnerable populations and look forward to ongoing discussion and planning with DMAHS and others to achieve the admirable goals they have set out in the waiver.

Sincerely,

Debra L. Wentz

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