Gubernatorial Briefing Paper

NJAMHAA represents the full continuum of behavioral healthcare service providers, including hospital-based and freestanding agencies that offer all types of services in various settings for children and adults with mental illnesses, substance use disorders, developmental disabilities, co-occurring health conditions and other challenging life situations, such as lack of housing and unemployment.

Community-based mental health and substance use treatment services save the state billions of dollars by providing timely, cost-effective services that prevent the need for high-cost hospitalizations and other negative consequences of untreated illnesses.

In addition to their contributions to improving the quality of life for New Jersey residents, NJAMHAA's 160 member organizations and their 61,000 employees contribute substantially to the state's economy, both directly and indirectly.
New Jersey’s Community-based Behavioral Health System of Care: A Need for Growth and Investment

The community-based behavioral health system of care is the safety net for New Jersey’s most vulnerable residents – those with mental health and/or substance use disorders. More than 500,000 children and adults depend on the services this system delivers every year. These services have proven effective in helping people manage and recover from their illnesses, achieve personal goals, and reduce other health and social service costs. However, access to these invaluable and cost-effective services continues to be limited.

Background

There are many serious issues plaguing New Jersey’s community-based behavioral healthcare system, including psychiatrist shortages, regulatory barriers to integrated care, and increased demand, yet the pressing issue that is currently endangering existing system capacity and quality of care is inadequate reimbursement for services provided. Current rates do not cover the costs of care for many mental health programs, and, while substance use treatment rates are more adequate following recent increases, and have even allowed some to expand, those programs still face critical workforce issues and insufficient capacity to meet demand.

The fiscal inadequacies are not new, though they have recently grown dramatically for many providers. This is due to the recent shift to fee-for-service (FFS) reimbursement from deficit funded contracts for the majority of services. The salaries that community-based providers are able to offer versus those that state agencies and educational institutions pay began diverging decades ago. The gulf between them now makes recruitment, retention and vacancy issues nearly impossible to address, and continuity of care is threatened. Medicaid rates have historically been near the lowest in the nation and contracts and regulations have always contained costly unfunded mandates. Combined, these fiscal impacts have reached critical levels; system capacity is reduced at a time of increasing demand.

System Capacity Is Inadequate

Demand for mental health and substance use treatment has always exceeded system capacity, resulting in long wait times for appointments, turning to emergency rooms for some, and a total lack of treatment for others.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recently reported that there were an estimated 366,000 New Jersey adults with any mental illness in 2014-2015: 247,000 of them had a serious mental illness, yet only 143,472 of them received mental health services. The New Jersey Division of Mental Health and Addiction Services (DMHAS), in their 2017 block grant application, estimated that in 2016, 897,492 New Jerseyans were in need of treatment for drug or alcohol use. Of the 90,742 adults who sought treatment, only 53,209 received it, leaving 37,533, or 41.4%, of those seeking treatment without any.

The ability of an individual to access behavioral health services is often greatly affected by where they live. Resources are not evenly distributed across the state. For example, the very successful
and cost efficient Early Intervention Support Services Program which works in tandem with Emergency Screening Centers, only exist in 10 of New Jersey’s 21 counties. Recently, as a result of the shift to FFS, capacity has been reduced in many programs around the state, and thousands will miss receiving mental health services that would reduce the need for additional hospital admissions and social services. An informal New Jersey Association of Mental Health and Addiction Agencies’ August 2017 survey of providers regarding the impact of the transition to FFS showed seven agencies had a combined staff reduction of more than 70 full-time employees, including 5.9 fewer psychiatrists. One program alone anticipates a reduction in the number of individuals served of 500 to 600.

**The Workforce Foundation Is Crumbling**

Inadequate reimbursement levels have negatively impacted 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. Medicaid rate increases do not include inflationary factors, which guarantee insufficiencies. Rates must be adequate to support a stable workforce and basic infrastructure. Residential programs struggle with rates that do not cover the costs of care, even if 100% capacity could be maintained.

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. Professionals continue to leave the community-based system for similar, yet higher paying positions with the state or educational institutions, or are abandoning the field altogether.

**Fiscal Instability Further Threatens Capacity**

Mental health and substance use treatment providers are facing precarious fiscal outlooks. To meet reduced revenue projections, staffing has been cut, hours reduced, services discontinued and other changes made to facilitate survival. There is no more room for “tightening the belt”.

And, during this time of sustained fiscal restraint, providers continue to be burdened by costly, often duplicative regulations and licensing standards.

Public Law 2017, c. 85 established two advisory boards, the Independent Mental Health and Addiction Fee-for-Service Transition Oversight Board and the Independent Developmental Disability Fee-for-Service Transition Oversight Board “to monitor and oversee the transition... to a fee-for-service reimbursement system; determine the adequacy of fee-for-service reimbursement rates; and provide recommendations to better facilitate the transition.” The statute required members of these boards to be appointed by June 25th, and required a request for proposals (RFP) to be issued immediately for independent studies to “assess the impact of (the) transition to fee-for-service and the particular rates adopted in the fee-for-service system on the financial sustainability of provider agencies, and on clients’ access to care, continuity of care, and quality of care.” To date, no appointments have been made and no RFP has been issued.

Full implementation and enforcement of federal and state parity laws are also necessary so consumers have access to services and providers are properly reimbursed for services. Also
threatening the system of care’s fiscal stability are potential changes to Medicaid at the federal level; contingency plans are called for.

**Conclusion**

It is critical for the State to fully evaluate and invest in the community-based system of care. Reimbursement, workforce, capacity and parity should be the primary focuses of such evaluation and investment, with the goal of establishing a strong, stable foundation for a system that hundreds of thousands of New Jerseyans rely on for their health and well-being. NJAMHAA’s recommendations for the initial steps in working toward that goal follow.

**Recommendations**

- The FFS oversight process must move forward immediately with establishment of the Oversight Board and commissioning the comprehensive study of the adequacy of reimbursement rates and the impact of FFS on consumer access, quality and continuity of care. Mental health and substance use treatment rates for children should be included in the study.

- A formula for upward adjustments of rates and contracts that is tied to an inflationary index must be established to prevent erosion of their adequacy to cover actual costs of care.

- The state investment in community based mental health services, which was reduced by $38.8 million from FY 2015 to FY 2017 on the Division of Mental Health and Addictions’ “Community Care” budget line, must be restored and increased.

- Policymakers must require a fiscal analysis for any legislation with fiscal impacts on providers, such as expanded Family and Medical Leave Act provisions and an increased minimum wage, and make adequate appropriations/rate increases to enable providers to meet new legislative and regulatory demands.

- Alternative funding options for the Medicaid expansion must be developed to fill gaps that would result from potential federal policy and budgetary changes.

- Federal parity laws must be fully enforced. An ombudsman position dedicated to behavioral health services should be established in the Division of Banking and Insurance; and A4498/S2919, a bill that would have New Jersey law match current federal parity law, should be signed into law once it is reintroduced and passed by the Legislature.

- An exhaustive review of regulatory and licensing requirements must be undertaken and steps taken to resolve issues that are barriers to care, duplicative, unfunded or unnecessarily burdensome.

- Early Intervention Support Services (EISS) should be expanded to all 21 of New Jersey’s counties.