NJ REENTRY CORPORATION

Annual Report

The Scourge of Addiction in New Jersey

January 2024

"For too long we've viewed drug addiction through the lens of criminal justice, the only way ... is to provide treatment – to see it as a public health problem and not a criminal problem." - President Barack Obama

DEDICATION

Wendy Neu

This report is dedicated to Wendy Neu for her unwavering support and tireless commitment to the mission of NJRC and to those individuals returning from prison, jail, addiction treatment, and combat.

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NJ REENTRY CORPORATION

Corporate Office
591 Summit Avenue
Suite 605B
Jersey City, NJ 07306
551.256.9717

January 23, 2024

Dear Fellow New Jerseyans,

Thank you for your support and commitment to assisting those persons who are struggling with addiction and attempting to live healthy lives. Our Annual Report focuses upon the ever-present scourge, which plagues our program participants in the street, in the community, in prison and jail, in combat, as well as at home.

The opioid epidemic continues to take lives every day. Today, there are two million individuals in federal, state, and local correctional facilities, with up to 65 percent battling substance use disorders (SUDs).

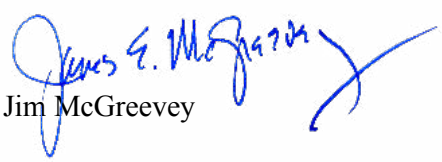
For the individuals we serve at the New Jersey Reentry Corporation, the scourge of addiction is immediately apparent, where approximately 78 percent of program participants have a history of substance use disorder (SUD) and 42 percent have a co-occurring mental health disorder. Indeed, according to our program data, NJRC has referred 11,445 individuals to treatment, with 5,279 receiving Medication-Assisted Treatment (MAT).

While the Murphy Administration and the State have taken significant steps in recent years to improve the provision of behavioral health services in New Jersey, gaps and deficiencies, particularly a Health Information Exchange (HIE), still remain. Responding to those areas of need must be a priority.

The New Jersey Reentry Corporation (NJRC) and the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) have developed a detailed report that presents specific policy objectives that will improve access to addiction treatment and ensure that persons receive comprehensive, integrated care in New Jersey. Lastly, thank you to author Matthew Harper, NJRC, and supportive editing of Dr. Debra Wentz and Mary Abrams, NJAMHAA.

Thank you once again for your commitment to those persons in need of addiction treatment. We must remain committed to addressing this crisis and helping our fellow brothers and sisters follow a path of healing and healthy living.

Sincerely,



Jim McGreevey

NJ REENTRY CORPORATION

January 19, 2024

Corporate Office
591 Summit Avenue
Suite 605B
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551.256.9717

Dear Reader,

In 2022, 2,892 New Jerseyans and 105,452 Americans died of a drug overdose. However, as staggering as these numbers are, they do not fully convey the severity and magnitude of this epidemic. Indeed, in 2021, 1.22 million New Jerseyans, or nearly 16 percent of the state's population, had a substance use disorder.

In recognition of the foregoing statistics, the New Jersey Reentry Corporation (NJRC) and the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) have released a detailed report that presents specific policy recommendations for the State of New Jersey to improve addiction and behavioral health treatment. This report is made subsequently to NJRC's *New Jersey Opioid Addiction Report: A Modern Plague*, which was released in 2018.

I recognize the many steps that New Jersey has taken in recent years, such as being one of the first eight states to have Certified Community Behavioral Health Clinics (CCHBCs) or requiring our students to learn about the risk and harms of drug use during the course of their education. Yet, there is more to be done in stemming the tide of the opioid epidemic in New Jersey.

The recommendations and best practices presented in this report are detailed and cover several critical areas that concern addiction treatment in New Jersey. For example, this report advocates for a robust Health Information Exchange, which would ensure that behavioral health treatment providers and general medical providers are able to electronically transfer medical information, a capability that is highly critical for best outcomes.

I am confident that the specific steps that this report sets forth for the State of New Jersey will save lives and ensure that all persons, regardless of who they are and where they are, have access to behavioral health treatment.

Thank you for taking the time to review this report.

Sincerely,

Robert Carter

Chief Operating Officer, New Jersey Reentry Corporation

New Jersey Association of Mental Health and Addiction Agencies, Inc.
Innovating for Progress|Partnering for Solutions

January 15, 2024

Dear Reader,

New Jersey, along with the rest of the nation, continues to face a serious opioid epidemic, with nearly 107,000 overdose deaths reported nationally in 2021 – of which 3,056 were in New Jersey. At the same time, our mental health crisis continues unabated and there are historically high levels of other substance misuse. As there is an enormous amount of work to be done, I am pleased to share with you the recommendations within this *Addiction Report*, a joint effort of the New Jersey Reentry Corporation (NJRC) and New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA). Of note, Matthew Harper deserves special recognition for the vast amount of research and time he dedicated to this report.

The NJRC has laid out, in consultation with NJAMHAA, the current landscape of substance use treatment, prevention, recovery and other services available to New Jerseyans and shared very specific policy recommendations and best practices that address gaps, barriers and areas for improvement. While the body of the report includes a great deal of data specific to New Jersey, you will also find that the appendices offer a rich library of definitions, history and background for the topics covered. Most importantly, the many avenues by which our mutually shared goals can be achieved are identified in the report.

I wish to profusely thank Governor James McGreevey for his unparalleled leadership and commitment to the re-entry population's successful recovery and transition back to their communities. Moreover, I am grateful to him and all the NJRC staff for their dedication to those they serve and the scope of their vision that they have laid out here. I hope you will join us as we work together to see the many recommendations realized!

With warmest regards,

Debra L. Wentz

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

NJAMHAA

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Introduction

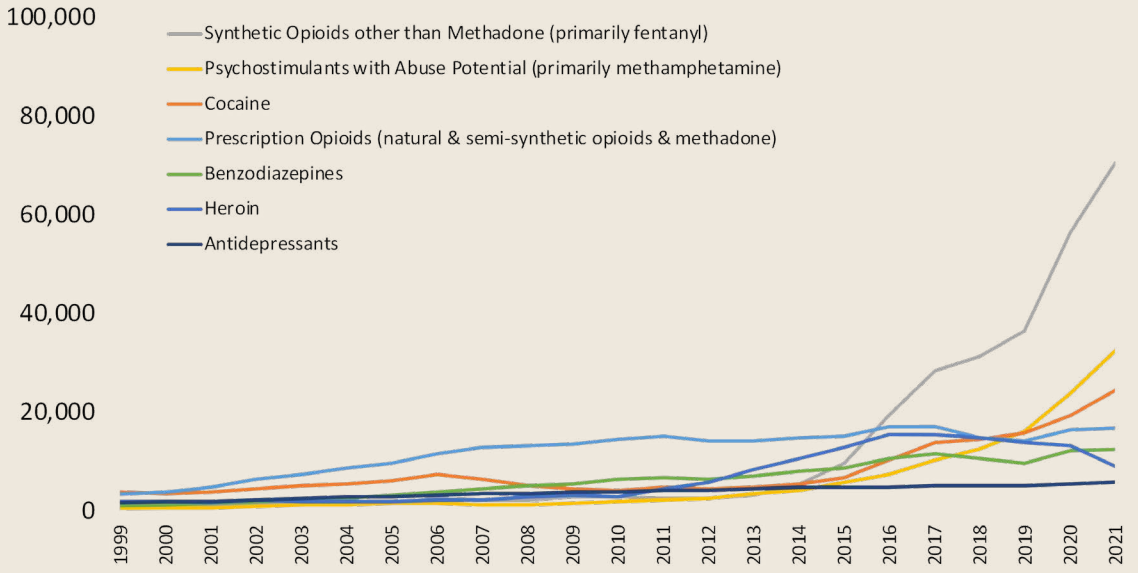
The addiction and overdose epidemic continue to devastate individuals, families, and communities at alarming rates. In 2021, there were 106,699 drug overdose deaths in the United States, a 16.2 percent increase from the 91,799 deaths in 2020 and a 103.6 percent increase from the 52,404 deaths in 2015.[1] These numbers are comparable in New Jersey. In 2021, 3,056 persons died of a drug overdose in New Jersey, a 7.6 percent increase from the 2,840 deaths in 2020 and a 110.2 percent increase from the 1,454 deaths in 2015.[2] Overdose deaths have affected nearly every part of this country and continue to do so.

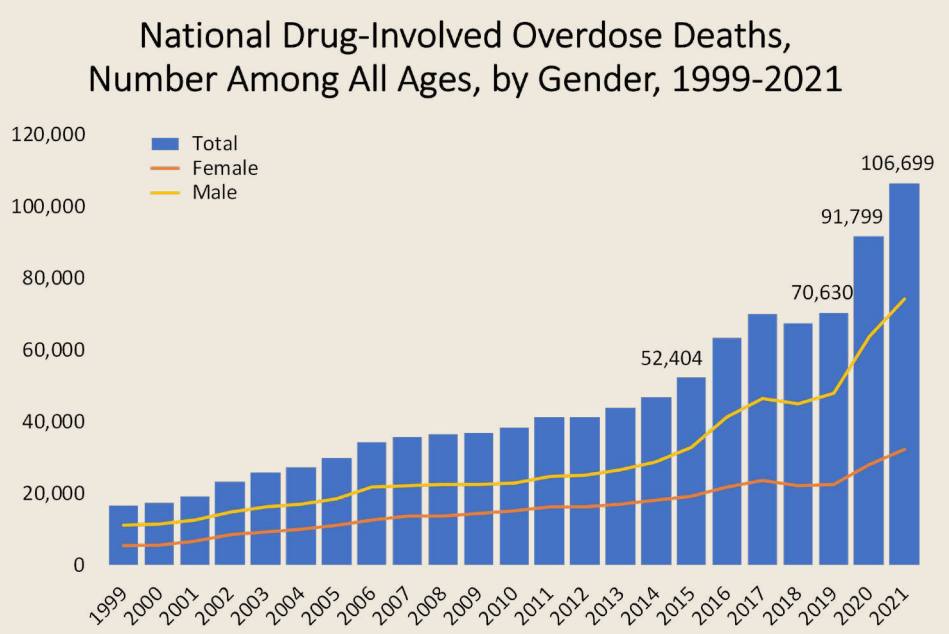
The years 2022 and 2023 have shown a modest decrease in the number of overdose deaths in the country. Provisional data shows that, from 2021 to 2022, the number of drug overdose deaths in the United States decreased by approximately 2 percent to 105,452.[3] In New Jersey, there were 2,892 suspected drug deaths in 2022 and 2,546 deaths in 2023, decreasing from the 3,124 suspected drug deaths in 2021.[4] These decreases are notable and may represent efficacy of current efforts to respond to the addiction epidemic. Yet, future data is necessary to confirm that this decrease is indeed a trend, not an anomaly. Unfortunately, drug overdose deaths nonetheless still remain startlingly high.

These statistics do not fully convey the true extent of addiction in the United States and New Jersey. In 2022, 47.8 million Americans, aged 12 years or older, had a substance use disorder (SUD) in the past year, a 20.8 percent increase from 2020.[5, 6] In New Jersey, 1.22 million New Jerseyans, or 15.51 percent of the population, had a SUD in 2021, and 102,000 New Jerseyans, or 1.30 percent, had opioid use disorder (OUD).,[7,8] Furthermore, persons with SUD are more likely to have mental health problems: in 2021, 19.4 million adults, aged 18 years or older, had a co-occurring SUD and mental illness in the past year, and approximately 33 percent of adults with a mental health illness had a co-occurring SUD.[9] Evidently, the crisis impacts a significant and sizable cross-section of the population in this country and state.

In recent years, this addiction epidemic has been sustained primarily through opioids. The vast majority of overdose deaths are now due to opioids, particularly fentanyl. In 2015, approximately 26.3 percent of all drug overdose deaths were fentanyl-related in New Jersey. This statistic increased sharply to 77.8 percent in 2019.[10] Fentanyl, a synthetic opioid approximately 100 times more potent than morphine, has drastically changed both the nature of the addiction epidemic as well as the manner in which to appropriately address it.[11] Yet, the

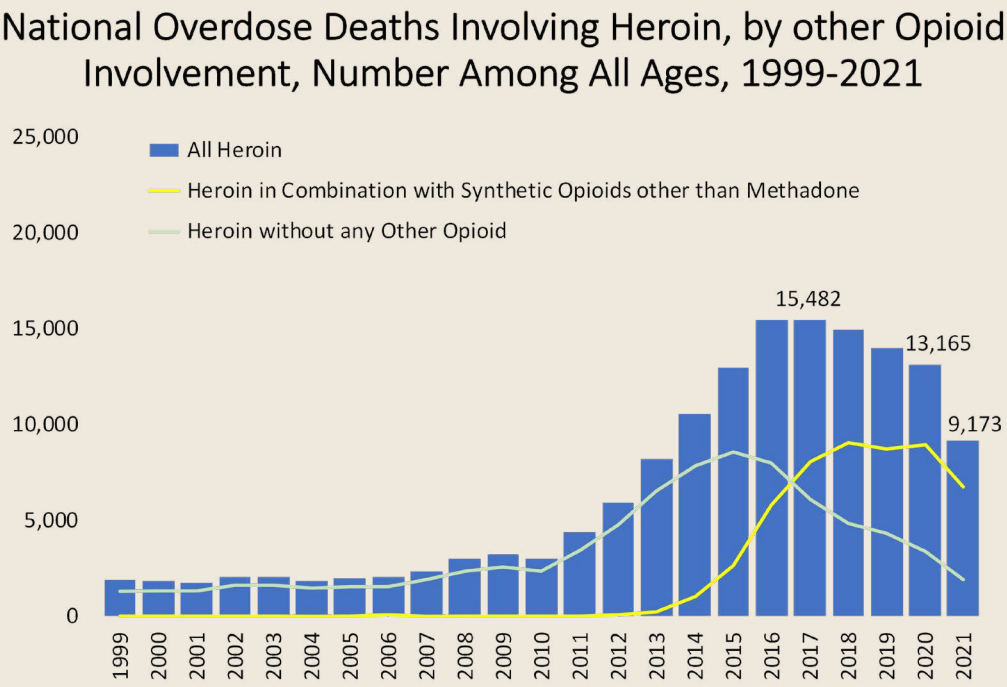
National Drug-Involved Overdose Deaths, Number Among All Ages, 1999-2021



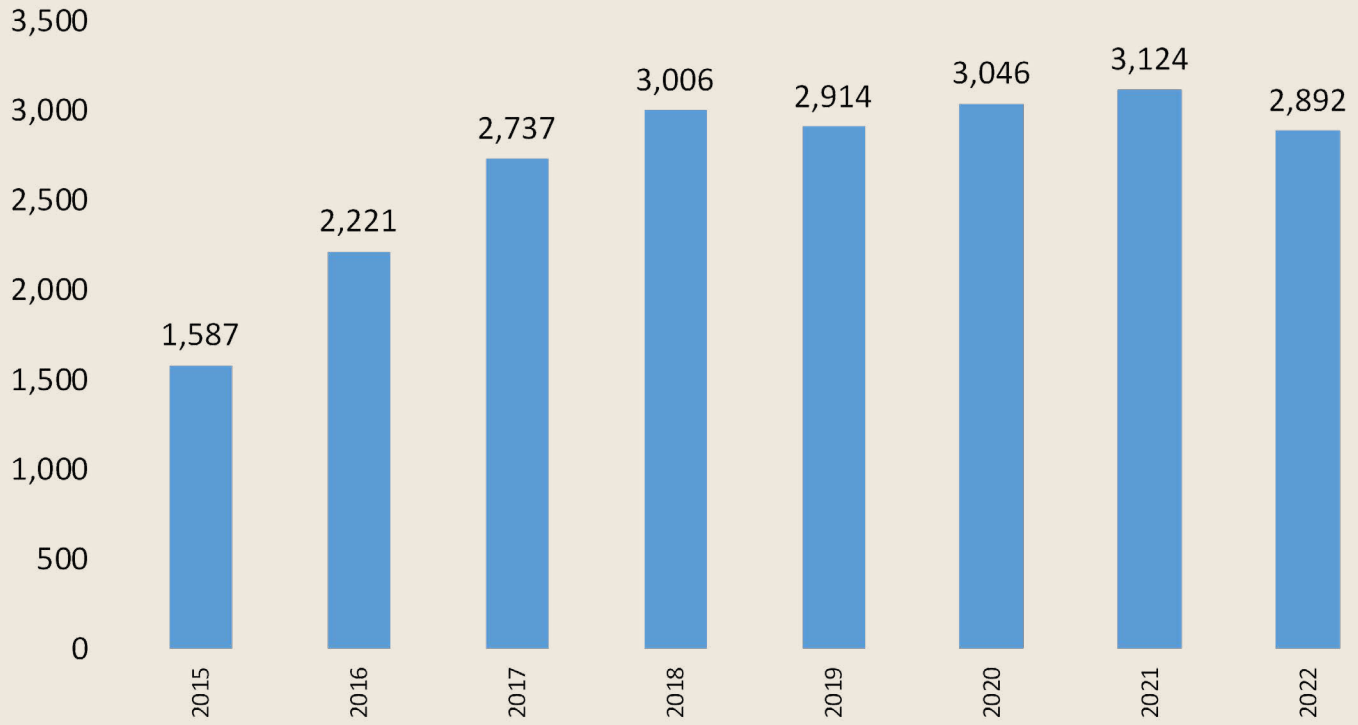


dynamic nature of the illicit drug supply continues to complicate the State's response to this epidemic. Xylazine, a non-opioid veterinary tranquilizer, has been identified in approximately one-third of suspected heroin and fentanyl seizures in 2022, rising to 45 percent in the first quarter of 2023.[12] Although fentanyl and other opioids are overwhelmingly the primary cause of overdoses, current and future efforts to curtail this epidemic must also be tailored to address emerging threats in the illicit supply.

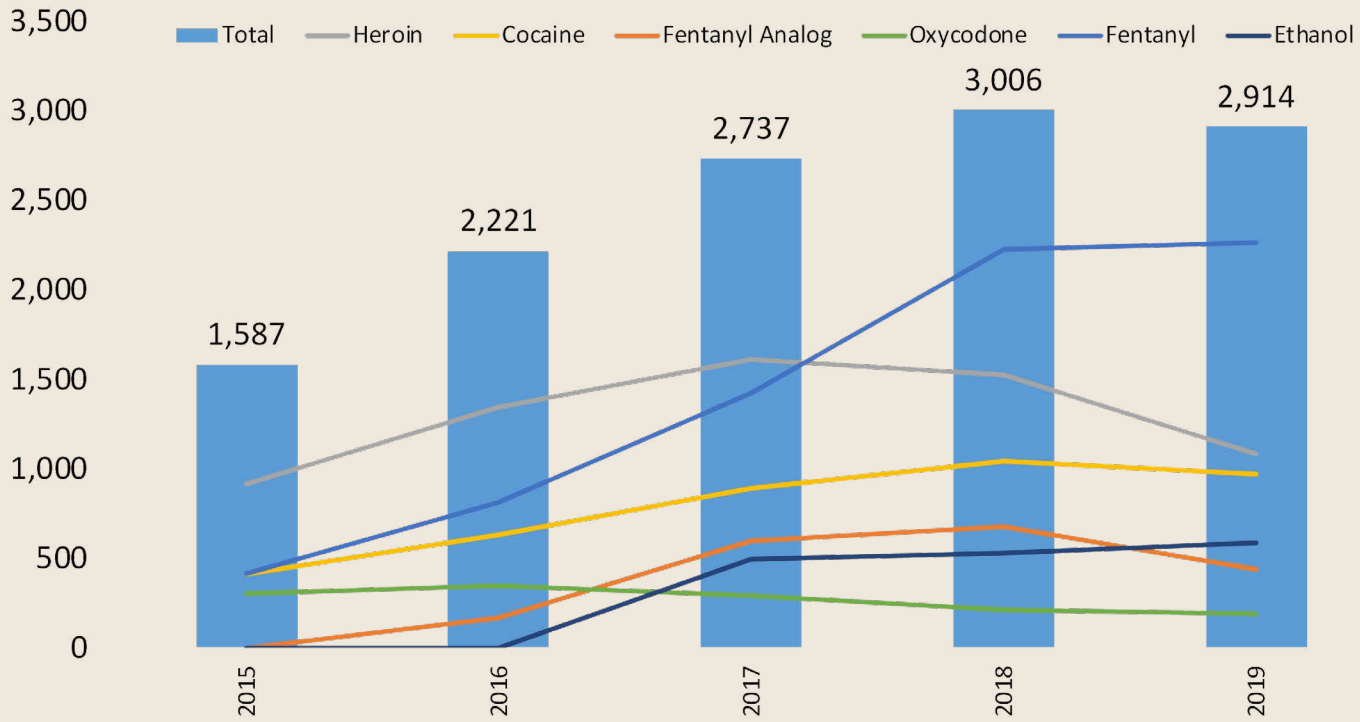
This report presents tailored policy recommendations, best practices, and proposals to address the opioid epidemic in the State of New Jersey. As this crisis continues to claim more lives and negatively impact nearly all New Jersey communities, it is imperative that substantial, evidence-based steps be taken to reduce opioid use and deaths. These recommendations build upon current efforts to address this epidemic, make them more efficient, and respond to observed barriers that limit the access and extent of comprehensive, integrated behavioral health care in New Jersey. The State of New Jersey plays a fundamental and central role in addressing the addiction epidemic within its borders. As such, these recommendations are proposed particularly for the State as best practices to expand access to addiction treatment, improve its effectiveness, and, most importantly, save lives.



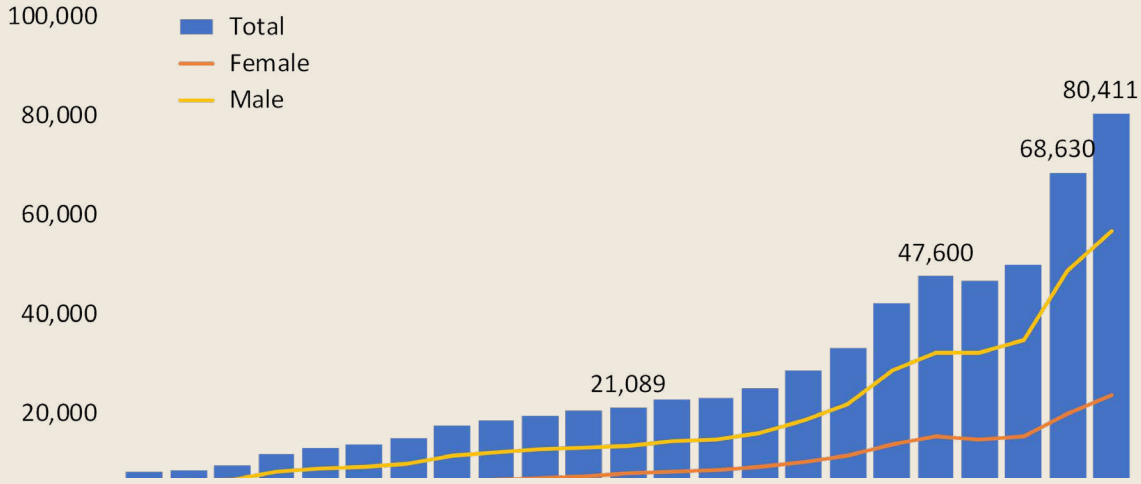
Drug Overdoses in New Jersey, 2015-2022



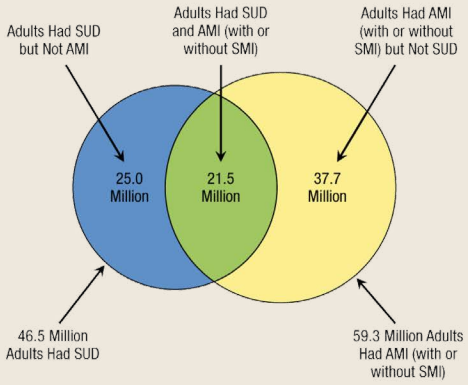
Drug Overdose Deaths in New Jersey, 2015-2019



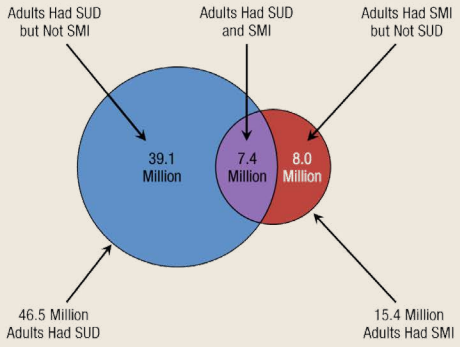
National Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2021



Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2022

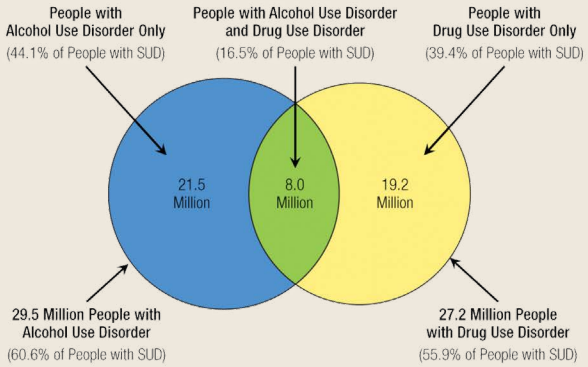


84.2 Million Adults Had Either SUD or AMI (with or without SMI)



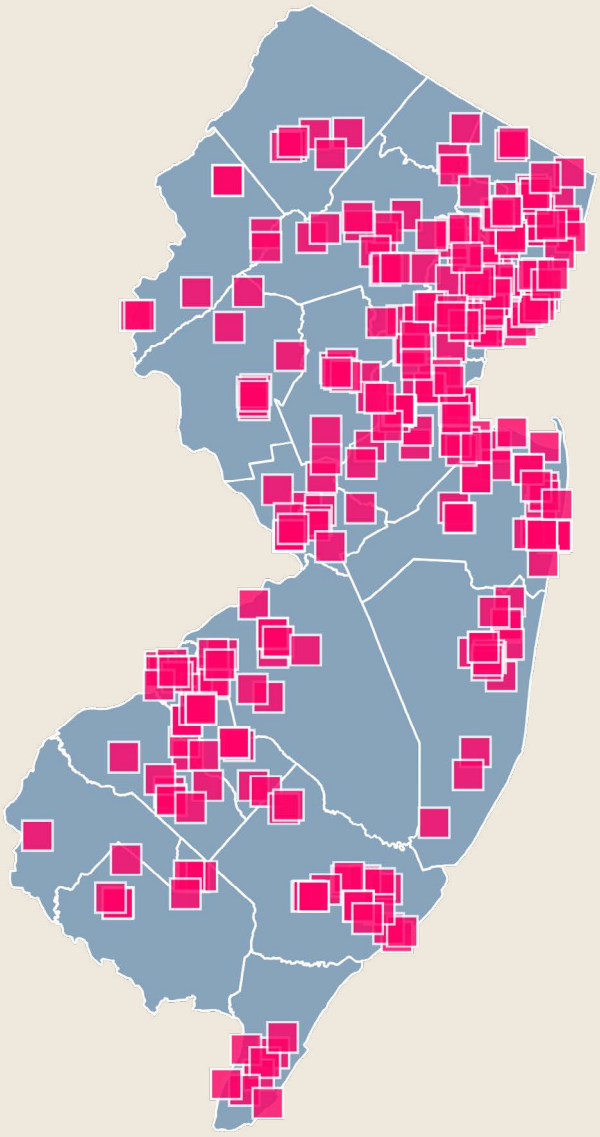
54.4 Million Adults Had Either SUD or SMI

Alcohol Use Disorder or Drug Use Disorder in the Past Year: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2022



48.7 Million People Aged 12 or Older with Past Year SUD

Addiction Treatment in New Jersey



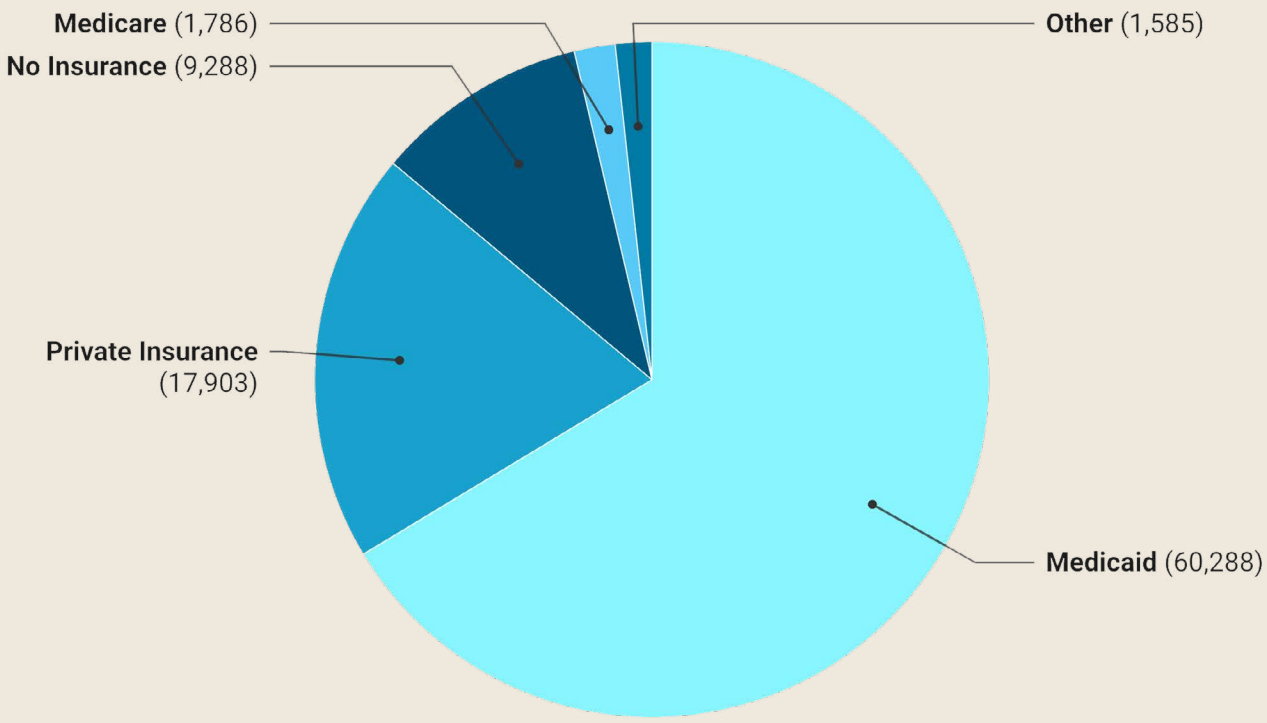
Treatment Facilities in New Jersey, 2022

The behavioral health care system in New Jersey consists of hundreds of mental health and substance use treatment providers, which vary in size, structure, and offering of services. Providers may be community-based non-profit organizations, large for-profit entities, opioid treatment providers, community hospitals, or large hospital networks with community services. In addition to providing mental health and substance use disorder treatment services, many of these organizations also provide psychosocial rehabilitation services and social services, such as transportation, housing, peer recovery supports, and case management. Yet, persons in need of treatment experience gaps both in access to providers and in the services provided.

According to the 2022 National Directory of Drug and Alcohol Abuse Treatment Facilities, there are 318 treatment facilities in New Jersey.[13] Of this total number, 263 offer regular outpatient treatment, 206 provide intensive outpatient services, 56 provide detoxification, 49 offer residential treatment, and eight offer hospital inpatient treatment. Transitional housing, halfway housing, and sober housing constituted 20 of these treatment facilities. Furthermore, 233 facilities, or 73.3 percent, offer a comprehensive mental health assessment. Only 73 facilities, or 23.0 percent, offer STD testing; 255 treatment providers, or 80.2 percent, offer mental health services; 280 treatment providers, or 88.1 percent, offer case management; 186 facilities, or 58.5 percent, offer housing services; 223, or 70.1 percent, help with obtaining social services; and 145 facilities, or 45.6 percent, provide employment counseling and training.[14]

Treatment services may be paid through Medicare, Medicaid, private insurance, or federal, state, county, and private contracts. According to the New Jersey Substance Abuse Monitoring Systems (NJSAMS), for persons who received substance abuse treatment in New Jersey in 2022, 10.8 percent had no insurance, 70.2 percent had Medicaid, 2.1 percent had Medicare, and 20.9 percent had private insurance. For persons who received substance abuse treatment for opioids specifically, 8.1 percent had no insurance, 83.7 percent had Medicaid, 2.2 percent had Medicare, and 9.5 percent had private insurance.,[15,16] Evidently, the vast majority of persons who seek addiction treatment in New Jersey either do not have any insurance coverage or have insurance coverage through a publicly funded program.

Health Insurance at Admission in New Jersey, 2022



Unmet Demand of Addiction Treatment in New Jersey

According to the 2021 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health, 475,000 New Jerseyans, or 6.04 percent of the population needed but did not receive treatment at a specialty facility for illicit drug use in the past year. Despite this sizable number, according to the Substance Abuse Overview from the New Jersey Department of Human Services, only 126,582 persons in 2021 actually sought substance abuse treatment, and only 46,898 persons actually received such treatment.[17] As such, there was an unmet demand of 60.7 percent for substance abuse addiction treatment in New Jersey.[18] In other words, for those persons who sought addiction treatment services in 2021, only 40.3 percent of them were actually able to obtain it. Evidently, there are significant variations in the number of persons who need, seek, and actually receive treatment in New Jersey.

As drug overdoses continued to rise and an increasing percentage of persons developed substance use disorders (SUDs), the structure of treatment providers in the State has not been able to accommodate the growing numbers of persons in need of treatment. Historically, the unmet demand for substance abuse treatment in New Jersey has been around 40 percent. However, in 2020, as a result of adverse consequences of the COVID-19 pandemic (e.g., reduced staffing, reduced operating hours, providers closing down, non-traditional users engaging in alcohol and illicit drug use), there was a notable growth in the number of persons seeking substance abuse treatment and a corresponding increase in the percentage of unmet demand of treatment. From 2019 to 2020, the number of persons seeking treatment increased from 94,050 persons to 119,284 persons, an increase of 26.8 percent, with those actually receiving such treatment decreasing from 56,374 to 46,768 persons, a 17.0 percent decrease from the year prior. Consequently, the unmet demand increased by 51.6 percent from 40.1 percent to 60.8 percent, where it has approximately remained since then.[19,20]

Overdose Deaths, Hospital Visits, and Treatment Admissions in Southern New Jersey

In New Jersey, overdose death rates, drug-related hospital visits, and substance use treatment admission rates are and have been historically concentrated in the southern region in the state. In terms of the highest rates of suspected overdose deaths in 2022, the top five counties were: (1) Atlantic, at 92.9 suspected overdose deaths per 100,000 residents; (2) Camden, 67.6 deaths per 100,000; (3) Essex, at 52.2 deaths per 100,000; (4) Cumberland, at 49.3 deaths per 100,000; and (5) Cape May, at 46.2 deaths per 100,000.[21,22] With the exception of Essex County, those counties with the highest rate of overdose deaths were all located in southern New Jersey. Furthermore, based on the population and number of overdose death rates in each county, in 2022, southern New Jersey had an overdose death rate of 46.7 per 100,000 persons, while northern New Jersey had an overdose death rate of 25.4 per 100,000. As such, southern New Jersey has an 84.3 percent higher overdose death rate than northern New Jersey. Although 27.1 percent of the population is located in southern New Jersey, this region is experiencing 40.6 percent of the overdose deaths.[23]

Overdose Deaths in New Jersey, 2022

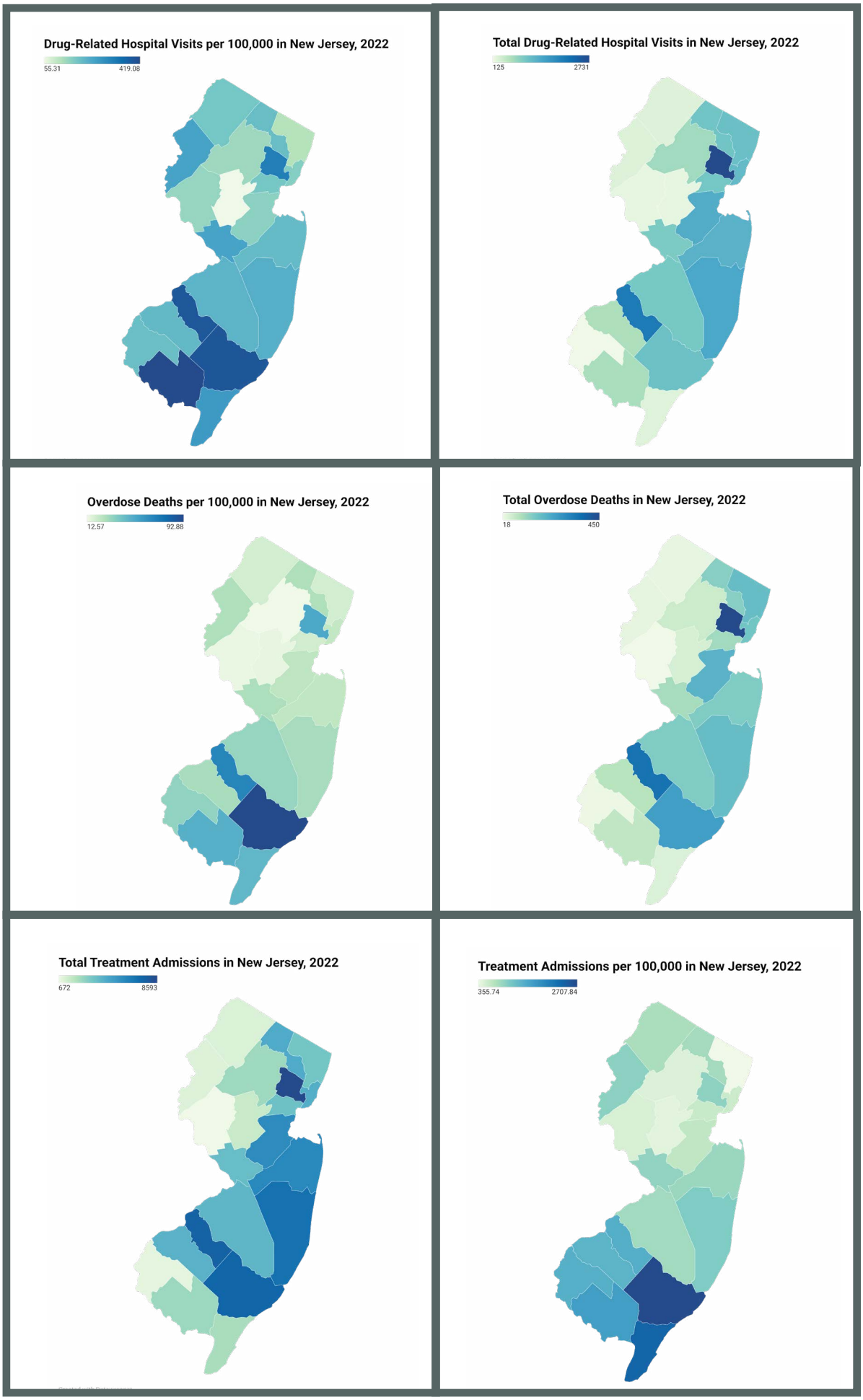
County	Overdose Deaths, Rate per 100,000	Overdose Deaths, Total
Atlantic	92.88	255
Bergen	19.46	186
Burlington	32.69	151
Camden	67.62	354
Cape May	46.19	44
Cumberland	49.30	76
Essex	52.16	450
Gloucester	28.78	87
Hudson	23.04	167
Hunterdon	13.96	18
Mercer	27.88	108
Middlesex	24.21	209
Monmouth	23.46	151
Morris	12.57	64
Ocean	29.19	186
Passaic	27.24	143
Salem	33.93	22
Somerset	14.48	50
Sussex	19.41	28
Union	19.81	114
Warren	27.36	30

Drug-Related Hospital Visits in New Jersey, 2022

County	Treatment Admissions, Rate per 100,000	Treatment Admissions, Total
Atlantic	394.85	1,084
Bergen	115.72	1,106
Burlington	213.27	985
Camden	393.71	2,061
Cape May	263.47	251
Cumberland	419.08	646
Essex	316.53	2,731
Gloucester	204.11	617
Hudson	163.34	1,184
Hunterdon	148.11	191
Mercer	244.23	946
Middlesex	157.32	1,358
Monmouth	200.28	1,289
Morris	139.41	710
Ocean	223.62	1,425
Passaic	196.55	1,032
Salem	192.80	125
Somerset	55.31	191
Sussex	177.49	256
Union	175.72	1,011
Warren	246.26	270

Substance Use Treatment Admissions in New Jersey, 2022

County	Treatment Admissions, Rate per 100,000	Treatment Admissions, Total
Atlantic	2707.8	7,434
Bergen	355.7	3,400
Burlington	881.0	4,069
Camden	1449.1	7,586
Cape May	2381.8	2,269
Cumberland	1654.3	2,550
Essex	996.0	8,593
Gloucester	1389.1	4,199
Hudson	604.0	4,378
Hunterdon	521.1	672
Mercer	973.6	3,771
Middlesex	672.3	5,803
Monmouth	924.3	5,949
Morris	491.1	2,501
Ocean	1085.2	6,915
Passaic	856.7	4,498
Salem	1436.0	931
Somerset	453.4	1,566
Sussex	816.1	1,177
Union	627.1	3,608
Warren	1010.6	1,108


Drug-Related Hospital Visits per 100,000 in New Jersey, 2022
55.31
419.08
Total Drug-Related Hospital Visits in New Jersey, 2022
125
2731
Overdose Deaths per 100,000 in New Jersey, 2022
12.57
92.88
Total Overdose Deaths in New Jersey, 2022
18
450
Total Treatment Admissions in New Jersey, 2022
672
8593
Treatment Admissions per 100,000 in New Jersey, 2022
355.74
2707.84

Similarly, in New Jersey, the rate of drug-related hospital visits is higher in southern New Jersey than northern New Jersey. In 2021, New Jersey exhibited a rate of drug-related hospital visits of 209.6 visits per 100,000 persons. However, in southern New Jersey, this statistic is appreciably higher at 286.2 visits per 100,000 persons, compared to a rate of 181.2 drug-related hospital visits per 100,000 residents in northern New Jersey. The two counties with the highest drug-related hospital visits are Cumberland County at 432.6 visits per 100,000 residents and Atlantic County at 420.5 visits per 100,000 persons.[24]

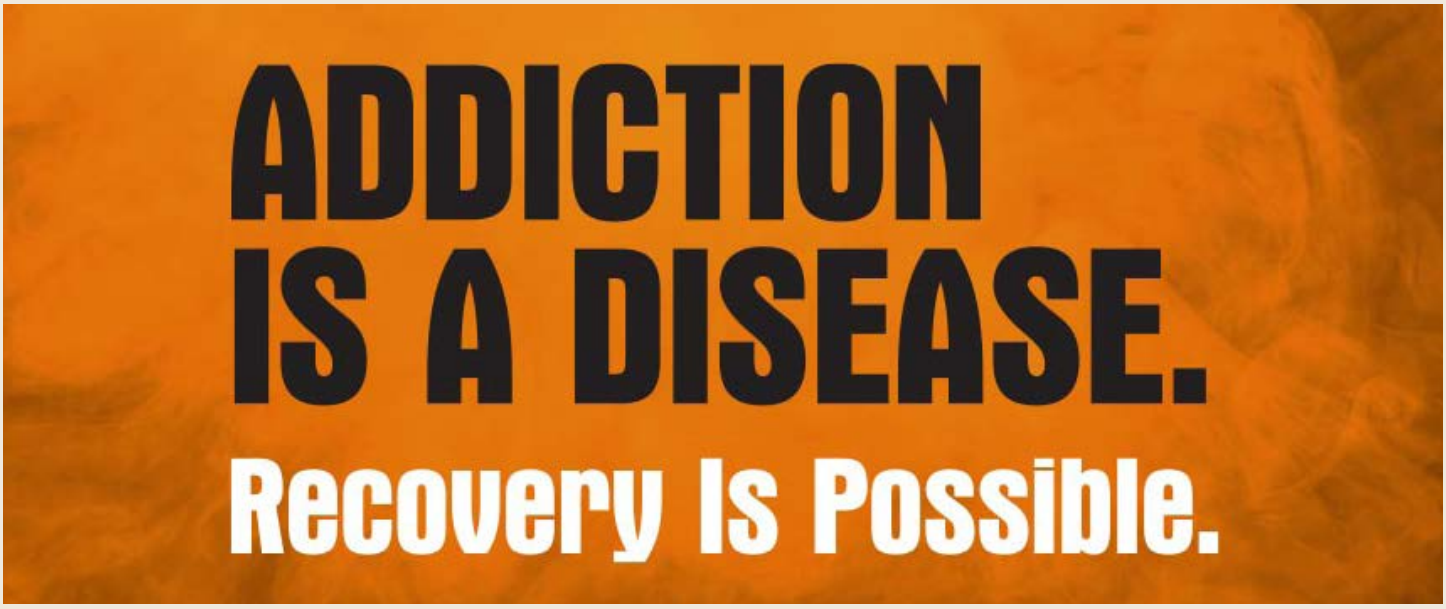
This concentration is also observed for substance use treatment admissions. In 2021, the top five counties with the highest treatment admission rate were: Atlantic, at 2,704 admissions per 100,000 residents; Cape May, at 2,372 admissions per 100,000; Cumberland, at 1,660 admissions per 100,000; Camden, at 1,448 admissions per 100,000; and Salem, at 1,431 admissions per 10,000.[25] Furthermore, in 2021, southern New Jersey had an overall treatment admission rate of 1,430 per 100,000 residents, and northern New Jersey had an overall admission rate of 694 per 100,000 residents. Thus, southern New Jersey has a 106.1 percent higher admission rate than northern New Jersey. In total, 43.3 percent of treatment admissions were located in southern New Jersey, although only 27.1 percent of New Jerseyans are located in the region.

Racial Disparities Among Overdose Deaths and Treatment Admissions

There is a racial disparity in New Jersey among those persons dying from drug overdoses and those persons admitted to treatment, in comparison to the general population. The population of New Jersey is 52.9 percent White, 21.9 percent Hispanic, and 13.1 percent Black.[26] However, in 2022, 54 percent of persons who died due to a drug overdose were White; 27 percent were Black; and 15 percent were Hispanic.[27] Although White persons comprise a similar percentage of overdose deaths as the general population, there is a stark disparity among Black persons, where they make up over twice the percentage of drug overdose than the general population.

This racial disparity is more clearly reflected in the rate of overdose deaths in the State. While there has been some success, with a decrease in overdose death rates among White persons in New Jersey from 37.7 to 34.9 per 100,000 persons from 2020 to 2021, there has unfortunately not been a commensurate change in overdose death rates for other racial groups. From 2020 to 2021, the rate of overdose deaths among Black persons rose from 54.6 per 100,000 persons to 65.9 per 100,000 persons. For Hispanic persons, the overdose death rate rose from 24.6 per 100,000 to 25.9 per 100,000.[28] It is notable that the rate of overdose deaths actually *decreased* for White persons while still increasing for racial minorities.

This racial disparity remains for SUD treatment admissions. According to the New Jersey Substance Abuse Monitoring System (NJSAMS), 58.3 percent of persons admitted to substance abuse treatment were White, 24 percent were Black, and 15 percent were Hispanic. Again, Black persons comprise a significantly greater percentage of treatment admissions than they do in the general population.



There are 67 SAMHSA-certified Opioid Treatment Programs (OTPs) in New Jersey.[29] OTPs are the only setting in which methadone, an FDA-approved medication to treat opioid use disorder (OUD), may be legally prescribed. As such, compared to the total number of treatment providers in the State, only a relatively low percentage of them offer methadone, one of three FDA-approved medications for the treatment of OUD, the other two being buprenorphine and naltrexone.[30] Although it is a best practice for persons to be offered access to an OUD, according to the aforementioned National Directory, only 13 facilities offer all three medications approved for MAT. Furthermore, of the 310 treatment facilities that treat OUD, only 40 providers offer methadone; 163 offer buprenorphine; and 171 offer naltrexone.[31]

This relative lack of access to Medication-Assisted Treatment (MAT) is reflected in statistics on treatment admissions in New Jersey. In 2021, there were 87,745 treatment admissions and 86,626 treatment discharges in New Jersey.[32] Of these admissions, 46,898 were unduplicated. According to NJSAMS, 45 percent of admissions were due to primary drug use of opioids. Nonetheless, data indicates that only 15 percent of patients admitted to treatment received methadone; 12 percent received buprenorphine; and 2 percent receive naltrexone (vivitrol).[33] It is necessary to expand access to MAT, a best practice for treating OUD.

Although New Jersey has made substantial progress in addressing the opioid epidemic and ensuring that persons have coordinated care, there are still many gaps in the behavioral health care system today, as the aforementioned analysis of access to addiction treatment in the State briefly describes. The recommendations contained herein are made in recognition of these and other observations of the present structure of addiction treatment in New Jersey. The objective of this report is to present detailed policy recommendations that fill these and other gaps to ensure that substance abuse treatment is readily accessible throughout New Jersey and that persons receive comprehensive, integrated and holistic care.

Policy Recommendations and Best Practices

The recommendations presented in this report address several aspects of the addiction treatment system in New Jersey. Behavioral health care is particularly complicated and siloed, which engenders a fragmented system. While the State of New Jersey has taken significant steps to improve the accessibility and comprehensiveness of substance use treatment, the purpose of this report is to address specifically those areas in which there remains deficiencies and a corresponding need for attention and improvement. This report will focus upon five particular aspects of the behavioral health care system in New Jersey: (1) Fee-for-Service Managed Care; (2) Certified Community Behavioral Health Clinics (CCBHCs); (3) Interoperability; (4) Court-Involvement; and (5) Prevention and Intervention.

Fee-for-Service and Managed Care

New Jersey operates its Medicaid program, known as NJ FamilyCare, under the Section 1115 demonstration waiver. The New Jersey FamilyCare Comprehensive Demonstration was recently approved for its third five-year demonstration period, effective April 1, 2023 through June 30, 2023. As part of this demonstration, which was first approved by the Centers for Medicare & Medicaid Services (CMS) in 2012, New Jersey has sought to enroll nearly all Medicaid beneficiaries into managed care, a type of delivery system in which the State contracts with managed care organizations (MCOs) to provide high quality Medicaid healthcare services, while reducing costs and ensuring proper utilizations of such services.[34]

The behavioral health care system has been and currently is largely carved out from managed care and instead delivered on a fee-for-service (FFS) basis. However, in the most recent proposal, which CMS approved on March 30, 2023, New Jersey has made clear its intention to "carve-in additional behavioral health services to managed care over time, a process the State has indicated to CMS will take place gradually over [the] demonstration renewal period, after extensive stakeholder input." Such stakeholder input is now underway. The objective of integrated and coordinated care for patients is highly commendable. Nonetheless, as New Jersey prepares for this behavioral health carve-in, it is imperative that New Jersey takes the opportunity to address outstanding issues and concerns, implement evidence-based recommendations, and not compromise the provision of addiction treatment in this state.[36,37]

(1) Provider Credentialing and Licensing under Managed Care

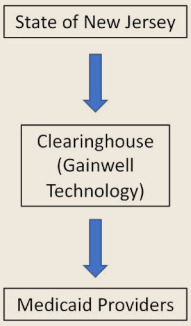
The current contract between the State of New Jersey and the respective Managed Care Organization (MCO) states each MCO is responsible for developing its own provider network. In order for a provider to be able to provide services to all Medicaid beneficiaries, each provider must negotiate contracts separately with each MCO, which places considerable administrative requirements upon providers. Since each MCO has its own application, credentialing procedures, and timetables, the process of negotiating with MCOs is overly complicated and time-intensive. It is recommended that New Jersey institute a universal application and credentialing process for all MCOs.

In addition, each individual staff member must be credentialed with each MCO in order to provide services to patients. Providers must then follow the credentialing requirements, which differ among the MCOs, and credentialing may take over 90 days from the date the staff are hired. Provider employees must then be paid but nonetheless are unable to provide services until they receive credentialing approval. MCOs should then credential each provider as opposed to each employee.

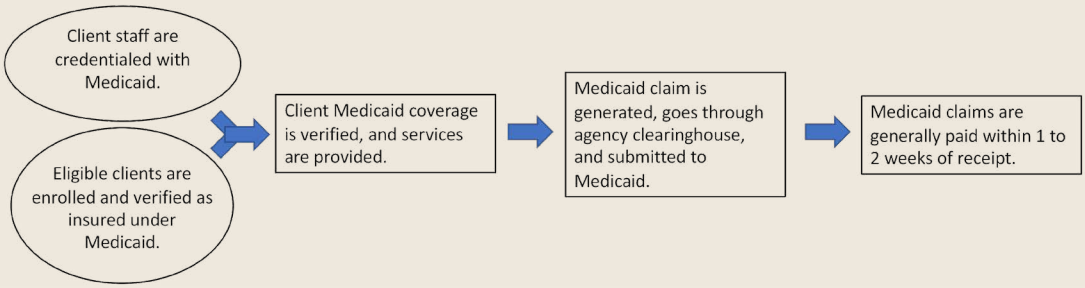
(2) Authorization under Managed Care

Managed care requires pre-authorizations for the provision of services, to ensure that patients are receiving the appropriate treatment at the appropriate time. When a provider seeks to provide a service to a Medicaid beneficiary, the provider must submit an authorization request to the MCO and receive approval in order to provide that service. This goal is commendable. Yet, in practice, pre-authorization unfortunately often creates bureaucratic barriers to necessary treatment, which is time-sensitive for

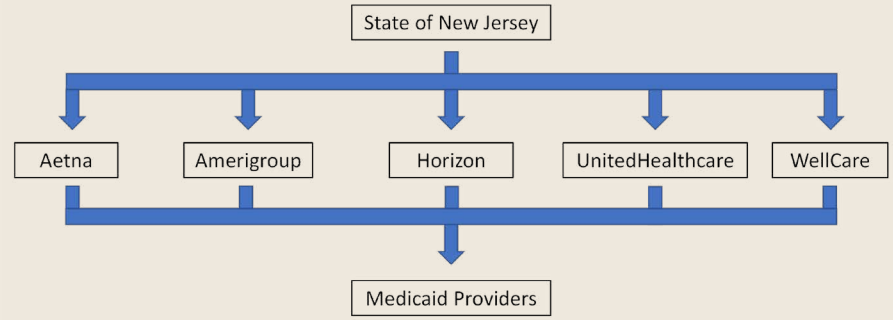
New Jersey Medicaid Payment Process under Straight Medicaid



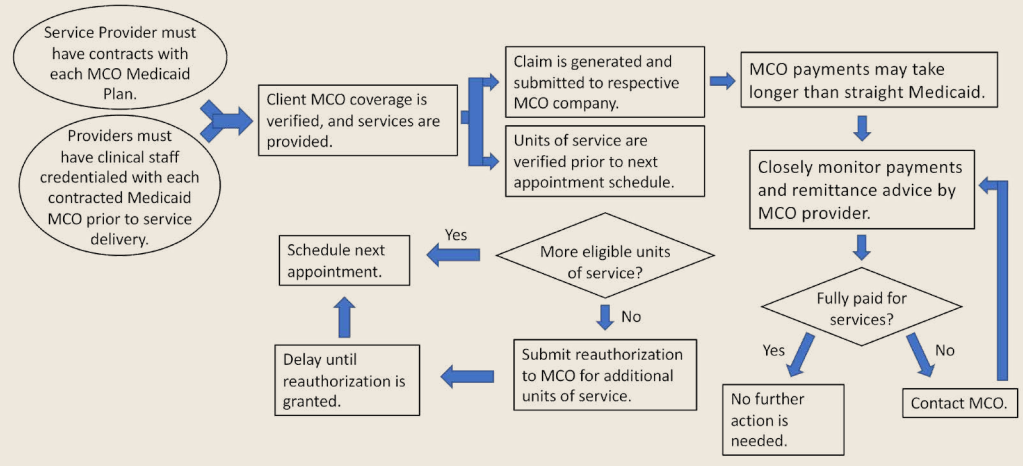
Service Delivery and Payment Under Straight Medicaid



New Jersey Managed Care Medicaid Payment Process



Service Delivery and Payment Under Managed Care



behavioral health services. Providers have experienced many challenges with obtaining authorization for the provision of services. For this reason, in 2019, the Murphy Administration announced the removal of the prior authorization requirement for Medication Assisted Treatment (MAT).[38]

According to the U.S. Department of Health and Human Services, Office of Inspector General, Medicaid MCOs deny approximately one out of every eight prior authorization requests. New Jersey had an MCO prior authorization denial rate of 27 percent. In addition, the State does not use denial data for oversight and does not regularly review a sample of denial to determine the appropriateness of such denials.[39]

Furthermore, there may be substantial delays in MCOs providing authorizations. MCOs have 14 calendar days to render a decision on a prior authorization request for non-emergency services.[40] Yet, providers have noted that, compared to the Interim Managing Entity (IME), MCOs often take a significantly greater amount of time to approve or deny authorizations, sometimes taking days to provide authorization. MCOs may be unresponsive to phone calls and emails. Treatments may also not be authorized for the appropriate length of time, resulting in providers requesting multiple authorizations. Since MCOs often have a more restrictive view of medical necessity than the provider, authorization for certain services and treatments may be denied when they are medically necessary.

New Jersey should take certain steps to guarantee that MCOs approve authorization when appropriate and do so in a timely manner:

1. The State should require MCOs to report MCO prior authorization data on a regular basis to provide oversight over MCO prior authorization decisions.

2. The State ought to review a sample of MCO prior authorization denials on at least monthly basis to ensure that MCOs are appropriately approving and denying authorization requests. The New Jersey Division of Medical Assistance and Health Services (DMAHS) currently requires MCOs to submit a quarterly report of all utilization management (UM) appeal requests and dispositions.[41] It is recommended that this requirement be supplemented with a monthly report of all authorization denials, irrespective of whether an appeal was made to the denial.

3. The State should require MCOs to use a standard prior authorization system, so that there is consistency of decisions across all MCOs and providers have a reasonable expectation of which authorization requests will be approved and which will be denied.

4. The state should likewise require MCOs to use the same standards and guidelines, e.g., ASAM Levels of Care, when making authorization decisions. MCOs should be using the same methodology and criteria as NJ Medicaid, the Department of Health, and the Division of Certification of Need and Licensing Standards.

5. In accordance with recommendations from the American Medical Association, the State should restrict the use of prior authorization for behavioral health services (determining on a service-by-service basis) or otherwise require that the prior authorization decision is made within an appropriate time frame.[42]

6. The State also ought to implement a universal appeal process for all five MCOs for the review of authorization denials.
These basic requirements for MCOs would allow for consistency of authorization decisions and reasonable uniformity across the five different MCOs, as well as place greater oversight over these companies to ensure best outcomes for patients and providers.

(3) Rate Adequacy under FFS and Managed Care

Behavioral health providers have experienced and continue to experience significant change in the manner in which their services are reimbursed, whether by Medicaid or by the state. Prior to 2016, behavioral health providers operated under a cost reimbursement system, which paid a monthly payment at a rate set forth in the contract. In 2016, the New Jersey Division of Mental Health and Addiction Services (DMHAS) began transitioning providers to a fee-for-service (FFS) delivery system, where providers either billed the State or Medicaid directly for each service rendered to a patient. Now, New Jersey has begun the process of moving behavioral services to a managed care delivery system, where providers contract with and bill each MCO.

DMHAS has specified the order in which providers ought to bill for services. NJ FamilyCare is the "payor of last resort," which means that providers

must first pursue all other programs for payment before billing NJ FamilyCare. In order to be eligible for NJ FamilyCare reimbursement, the provider, client, and service must all be eligible. The exception to NJ FamilyCare as the payor of last resort is for New Jersey government agencies. Providers should bill NJ FamilyCare before billing state and/or county-only funded programs. Providers thus bill in the following order: (1) third party insurance; (2) Work First New Jersey/Substance Abuse Initiative—Behavioral Health Initiative; (3) NJ FamilyCare; and (4) state and/or county programs, if the previous three coverages do not exist.[43]

The rates at which providers are reimbursed for the provision of services are determined by the source of funding. As such, the State determines the rates for services funded solely by the State and also sets rates for reimbursement of services provided to Medicaid beneficiaries. Although behavioral health services have been mostly "carved-out" of managed care, the Section 1115 waiver allows NJ FamilyCare to reimburse providers for certain services that are not normally permitted under the standard parameters of Medicaid. Other services are reimbursed through state-only funds. It has been well-documented that Medicaid reimbursement rates are substantially less than the Medicare reimbursement rates, which themselves are less than that of private insurance.[44] According to the KFF, Medicaid reimbursement rates were approximately 50 percent of that of Medicare.[45] In addition, for regular methadone treatment at Opioid Treatment Programs (OTPs) in New Jersey, for example, the Medicaid reimbursement rate was 40 percent of that of Medicare.[46] For services that are Medicaid-eligible, the State of New Jersey sets its state reimbursement rates at 90 percent of the Medicaid rate.[47]

A concern for behavioral health providers during the transition to FFS has been that the reimbursement rates are not sufficient to guarantee the financial stability of behavioral health providers. According to a survey conducted by the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA) in 2018, 27 behavioral health providers that were reimbursed through FFS had a total annualized deficit of $18,359,475.[48] Given these inadequate reimbursement rates, physicians are less likely to accept Medicaid, which creates significant barriers to behavioral healthcare for Medicaid beneficiaries. In New Jersey, from 2014 to 2017, only 42.2 percent of physicians accept new patients with Medicaid, a relatively small percentage compared to the national average of 73 percent.[49] The adequacy of FFS reimbursement rates are thus an integral component of ensuring that providers are financially stable and able to provide necessary services to patients.

This concern remains as behavioral health services are carved-in to managed care. The State must set fair rates that truly cover the full costs of care of behavioral health providers in the state. As with other aspects of service delivery, managed care complicates the reimbursement system for providers. Under managed care, each provider must negotiate a contract separately with each MCO, and the contract will detail the specific rates at which providers are reimbursed for provider services to beneficiaries under the MCO's health plan. It is thus certainly possible that a provider will be reimbursed different amounts for the same service provided, depending on the respective contracts with the MCOs. Furthermore, the State of New Jersey currently does not require MCOs to pay the prevailing Medicaid rate to providers.[50] As such, the burden is on the providers to ensure that the MCOs pay at least the Medicaid rate, which is already largely inadequate.

The State must play a more direct role in the contracting process and establish general uniformity of reimbursement rates across the MCOs. Currently, as per the contract between the State and MCO, MCOs are required to submit all proposed provider contracts to DMAHS for review and approval. However, MCOs are only required to submit the rate schedules to DMAHS upon request.[51] In addition, the State currently does not specify verbatim language for the provider contract/subcontract for reimbursement. The State should require MCOs to automatically submit rate schedules to DMAHS when seeking approval for the contract, and it is recommended that the State provide at least some specifications as to the reimbursement schedule for providers, so as to ensure their financial stability. Without such recommendations, providers will encounter variability and uncertainty as to their cash flows, which are necessary for providers to provide needed behavioral health services on a long-term basis.

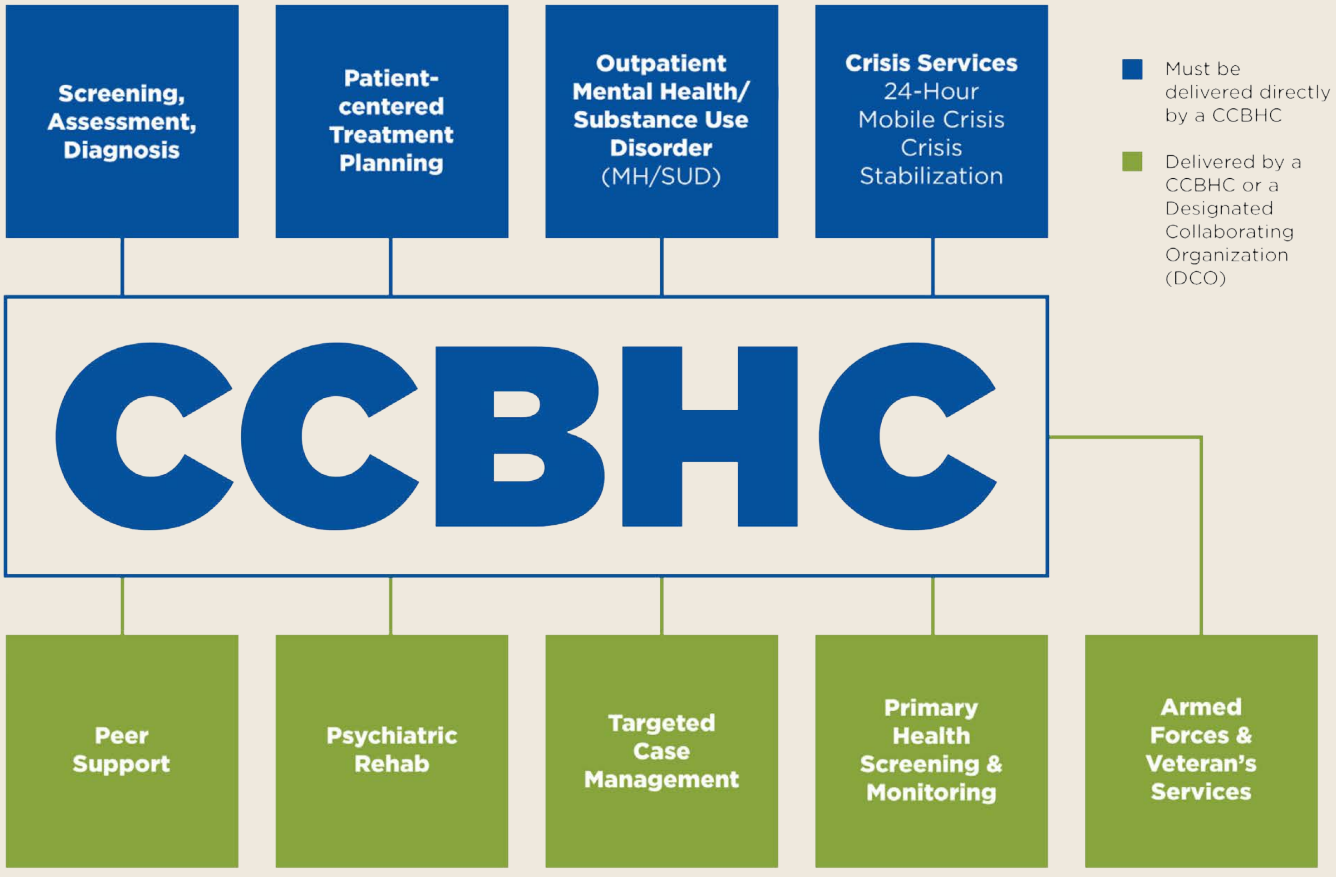
(4) Claims Processing under Managed Care

Under FFS, the process for provider payment is initiated through the submission of claims by a provider to Medicaid that indicates that a service has been provided to a patient. Claims are submitted

directly, either electronically or manually, to Medicaid, via a clearinghouse, in a standardized format consistent with federal regulations. Medicaid then processes the claims in batches and then adjudicates them, either approving, denying, or suspending for further review. Reasons for denial of a claim may include that the patient was not eligible for Medicaid, the service was not authorized, or the claim was submitted too late. Medicaid usually processes claims and remits payments within 10 days.

Under managed care, the process for payment is more complex and places a greater administrative burden on both the MCOs as well as the providers. Each provider must negotiate a contract with each of the five MCOs in order to provide services to the enrollees of each respective MCO's health plan. As such, providers also negotiate rates with the MCOs directly, which creates a significant burden and places a disadvantage upon smaller providers to negotiate sustainable reimbursement rates. After services have been provided, the provider then generates a claim and submits them to the MCO, depending upon the health plan of the enrollee. Providers must also carefully track authorizations and changes in client coverage, so that claims are properly generated and submitted and that payments are properly received.

Because providers must submit claims separately to each MCO, they are required to separate their billing process accordingly, which creates a fragmented process and requires considerable administrative time and effort. Furthermore, there is significant delay in MCOs remitting payment to providers. For claims that are not disputed, MCOs will process payments within 45 to 60 days, as opposed to 10 days for Medicaid. For the processing of claims, the State should implement a common clearinghouse to which providers submit claims. MCOs should batch process these claims, which allow for the payment to be remitted in a timely fashion. For those claims that are not disputed, MCOs should process them within 10 days to match the 10-day turnaround for Medicaid. It is inevitable that a certain number of claims will be incorrectly filled out or will not match MCO requirements, which understandably delays their processing. Nonetheless, within 20 days, MCOs should be required to inform providers of claims with delayed processing and specifically detail the reason for the delay. It is also recommended that there be regular submission of data by the MCOs to DMAHS on the status of claims.



Certified Community Behavioral Health Clinics (CCBHCs)

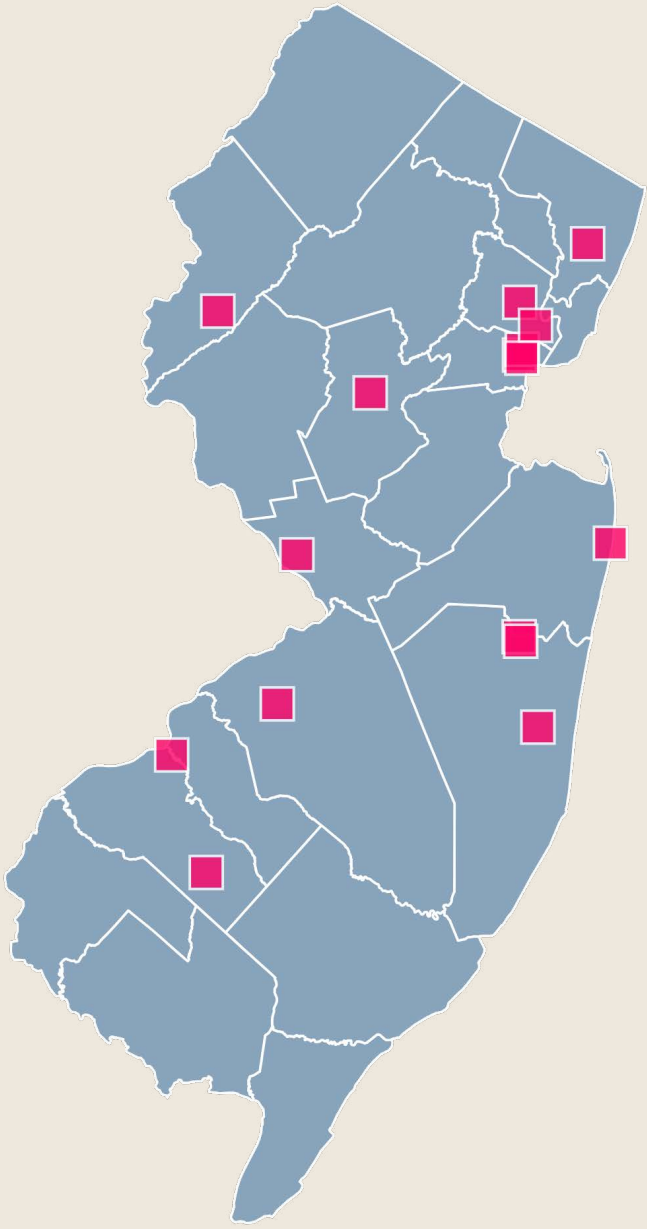
Certified Community Behavioral Health Clinics (CCBHCs) seek to improve the behavioral health of persons; provide community-based services for mental health and substance use; advance integration of behavioral and physical health care; employ evidence-based practices for behavioral health care; and improve access to such care.[52] Authorized through the Protecting Access to Medicare Act of 2014 (PAMA) and with seven demonstration projects in the state, the CCBHC model has transformed New Jersey's ability to serve people in their communities by providing greater coordination of care, expanding access to addiction treatment services and MAT, and requiring providing services to any person in need, regardless of their place of residence, age, condition, or ability to pay.

CCBHCS are required to provide the follow services, either directly or through Designated Collaborating Organizations (DCOs): (1) crisis services; (2) treatment planning; (3) screening, assessment, diagnosis, and risk assessment; (4) outpatient mental health and substance use services; (5) targeted case management; (6) outpatient primary care screening and monitoring; (7) community-based mental health care for veterans; (8) peer, family support, and counselor services; and (9) psychiatric rehabilitation services.[53] These services must be patient-centered, trauma-informed, and recovery-oriented.[54] CCBHCs offer a full continuum of services to patients.

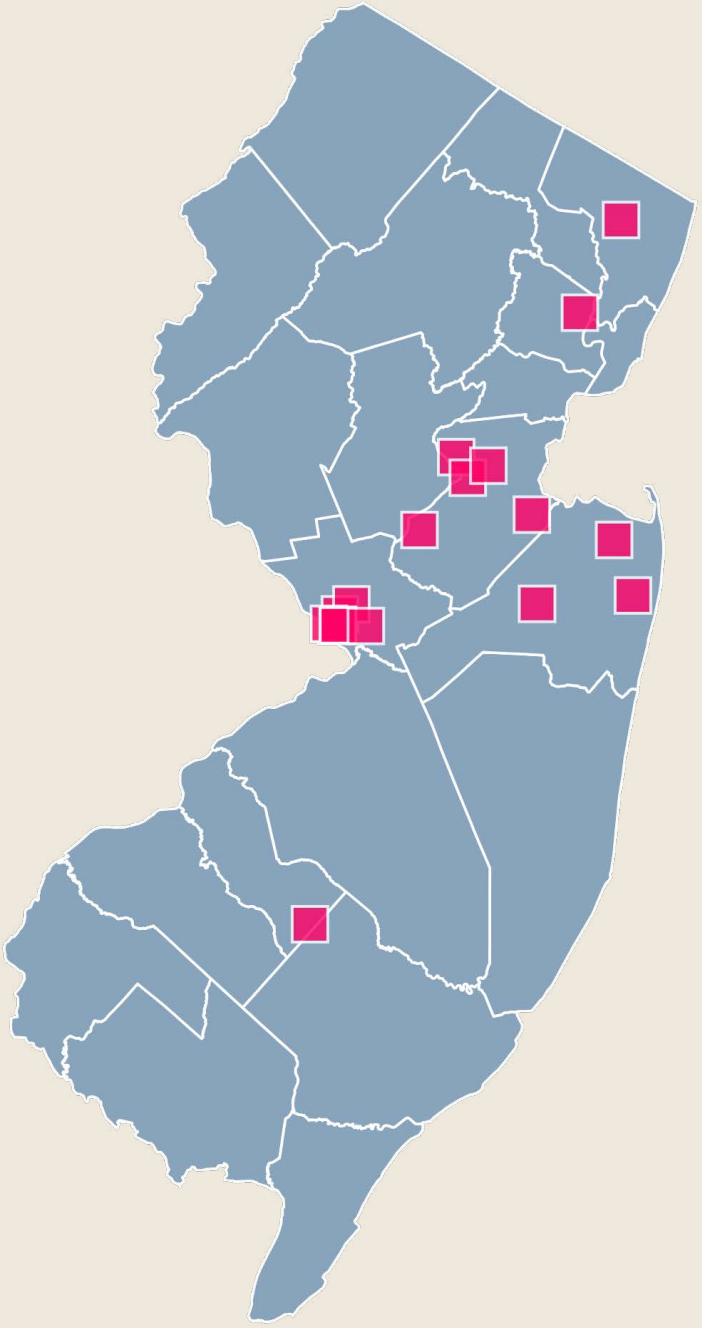
This report fully endorses and supports the CCBHC model, which has improved access to substance use and mental health treatment and enables the delivery of holistic, integrated care. The comprehensive range of services which CCBHCs provide and the requirement that these clinics serve anyone who requests care make it a best practice for substance use and mental health treatment. The State of New Jersey should preserve the CCBHC model and seek to expand it throughout the state. Indeed, this report identifies the CCBHC model as a best practice due to the full continuum of comprehensive mental health and substance use treatment services, as well as its sustaining funding structure.

(1) Expansion of CCBHCs

There are seven provider agencies in New Jersey that operate the original demonstration CCBHCs and thus provide integrated mental health and substance use services.[55] The CCBHCs in New Jersey are: Northwest Essex County Healthcare Network (Essex County); Oaks Integrated Care (Mercer County); Catholic Charities Diocese of Trenton (Mercer County); Rutgers University Behavioral Health Care (Middlesex County); CPC Behavioral Health Care (Monmouth County); Care Plus NJ (Bergen County); and AtlantiCare Behavioral Health (Atlantic County).[56] These CCBHCs are located in six counties, five of which are urban and one of which is mixed urban and rural.[57]



CCBHC Demonstrations in New Jersey, 2023



CCBHC Grantees in New Jersey, 2023

The Substance Abuse and Mental Health Services Administration (SAMHSA) has also provided CCBHC expansion grants to 15 providers in the state: Acenda, Inc. (Gloucester County); Bridgeway Rehabilitation Services, Inc. (Union County); Family Connections (Essex County); Family Guidance Center of Warren County (Warren County); Integrity House (Essex County); Lakewood Community Services Corp. (Ocean County); Legacy Treatment Services (Burlington County); Maryville Addiction Treatment Center (Gloucester County); Monmouth Medical Center (Monmouth County); Ocean Mental Health Services, Inc. (Ocean County); Preferred Behavioral Health of New Jersey (Ocean County); Richard Hall CMHC of Somerset County (Somerset County); SERV Centers of New Jersey, Inc. (Mercer County); Team Management 2000, Inc. (Bergen County); and Trinitas Regional Medical Center (Union County).[58]

There is a CCBHC demonstration or grantee in only 12 of 21 counties in New Jersey. As such, there are nine counties in New Jersey without either a CCBHC demonstration or CCBHC expansion grantee. For those persons who seek CCBHC services in any of these nine counties, they must travel to another county to do so. Of the nine counties in which there is a CCBHC expansion grantee, there is also demonstration program in four of them. Furthermore, despite the concentration of drug overdose deaths, drug-related hospital visits, and substance use treatment admissions in southern New Jersey, the majority of CCBHCs, whether a demonstration project or an expansion grantee, are located in the northern half of New Jersey. There is only one CCBHC demonstration project (14.3 percent) and six CCBHC expansion grantees (40 percent) in southern New Jersey.

In February 2023, SAMHSA issued guidance to states participating in the CCBHC Demonstration Program on the addition of new CCBHCs to their respective programs.[59] At this juncture, New Jersey has the ability to certify clinics which meet the certification criteria for CCBHCs. It is strongly urged that the State pursue the addition of CCBHCs throughout New Jersey to expand access to their comprehensive services. In particular, the State ought to focus on expanding CCBHCs to meet the demand for substance use treatment in southern New Jersey. It is critical that CCBHCs are expanded to reflect the distribution of overdose deaths and treatment admissions.

(2) Statutory Authority

Under the NJ FamilyCare Comprehensive Demonstration Renewal Proposal, the State of New Jersey proposed transitioning the CCBHC demonstration from PAMA Section 223 authority to SSA Section 1115 authority.[60] The purpose of this transition of statutory authority was to provide stability to the CCBHC demonstration, since it would guarantee five years of continuity during the waiver period. Although the Centers for Medicare &

Medicaid Services (CMS) ultimately declined to grant New Jersey permission to proceed under the 1115 waiver, it is useful to address the specific changes that New Jersey delineated in its 1115 waiver proposal.

Specifically, New Jersey stated that participation in the CCBHC model would be limited to the seven demonstration provider agencies that already have CCBHCs. DMHAS would still have the ability to add additional sites to the demonstration on a competitive basis. The State should not limit its ability to add new CCBHCs. Although this proposal was made prior to the aforementioned guidance from SAMHSA and is thus reflective of the regulatory environment at the time, it is nonetheless important to underscore that New Jersey should have the ability to certify new provider agencies as CCBHCs for those that qualify.

New Jersey further proposed to introduce a value-based payment methodology for CCBHCs during the 1115 demonstration renewal period. Under this payment model, CCBHCs would be required to meet certain quantitative and qualitative benchmarks in their delivery of services; often, value-based payments are tied to bonus payments and penalties, depending upon outcomes. As with any payment model, it is imperative that the State ensure that providers receive reimbursement rates that provide financial sustainability.

In its final approval for the Medicaid 1115 waiver extension, CMS "agreed to overlay a section 1115 waiver of statewideness in the event the state later decides to pursue the CCBHC program through state plan authority."[61] A State Plan Amendment (SPA) is the process by which states make changes to its Medicaid policies and operational approach, though such changes must be made a on a statewide basis. In addition, a SPA represents a permanent change to the way in which a state runs its Medicaid program, and a waiver of statewideness allows states to implement pilots and local programs before eventualled being expanded statewide.

The waiver of statewideness from CMS allows New Jersey to further develop the CCBHC demonstration project, without requiring them to do so on a statewide basis immediately. Expanding the CCBHC program throughout the state should be done on a gradual basis, which a waiver of statewideness allows. Although CMS noted that the waiver of statewideness will only be effective through the end of the demonstration period, a CCBHC SPA would nonetheless provide notable stability to the program, since the State would have ongoing authority to oversee and expand CCBHCs. It is thus recommended that New Jersey pursues a CCBHC SPA, so as to guarantee the long-term sustainability of the program, even if such a process would be time-intensive.

Integration of Behavioral Health Care and Physical Care

Expanding access to evidence-based treatments for substance use disorder (SUD) is an integral component of addressing the opioid epidemic in the state. Unfortunately, only a small percentage of persons who need substance abuse treatment actually receive it. According to the 2021 National Survey on Drug Use and Health, approximately 1,122,000 New Jerseys needed but did not receive treatment at a specialist facility for substance use in the past year.[62] With only 126,582 persons seeking and 46,898 persons receiving substance abuse treatment in 2021, behavioral health providers are evidently interacting with only a small percentage of those persons with substance use disorder.[63]

In order to expand access to behavioral health services in New Jersey, the integration of physical care and behavioral health allows for an increased coordination of services, by identifying persons with SUD and linking them appropriately to treatment. Under the traditional model of care, physical care providers, such as primary care providers (PCPs), refer patients to behavioral health providers as needed, though there is no ongoing coordination of care. Under this integrated model, PCPs and behavioral health providers work collaboratively to provide delivered care that address both physical and behavioral needs. This model has been shown to improve the delivery of patient care, reduce healthcare costs, lower rates of emergency department visits, and improve health outcomes.[64,65] As such, the integration of physical care and behavioral health care is a best practice.

(1) Universal Screening in Primary Care Settings

This report recommends that screenings for behavioral health needs be implemented in primary care settings. Given the low rates of persons with SUD receiving treatment services, the primary care setting represents a crucial opportunity to provide linkage. The U.S. Preventive Services Task Force (USPSTF) recommends the implementation of screenings (i.e., asking questions about unhealthy drug use) when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. The Surgeon General likewise recommends routine screening for alcohol and other substance use in primary care settings. Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA) also recommends that healthcare professionals screen patients for alcohol, tobacco, prescription drug, and illicit drug use at least annually. When adults are screened for mental health or substance use problems, it is critical that PCPs require behavioral health clinicians to conduct appropriate diagnostic follow-up.

There are important considerations when seeking to implement substance use screenings in primary care settings. First, data shows that a self-administered screening tool produces more accurate reporting among patients with substance use needs than a staff-administered screening.[69] Indeed, patients are likely to be more comfortable disclosing behavioral problems when it is self-reported instead of being asked face-to-face. Second, it is recommended that screenings are conducted on an electronic platform, so that results are properly transmitted and recorded in the patient's medical record. Third, it is important that PCPs conduct a behavioral health screening for patients at any type of visit (as opposed to restricting screenings to annual check-ups, for example). PCPs should utilize any opportunity to identify behavioral health needs for patients.[70]

PCPs may utilize a variety of screening tools, each differing in length, specificity of questions, and populations screened. For example, one type of screen may only consist of one item, inquiring how many times a patient used an illegal drug or prescription medication for nonmedical reasons.[71] Alternatively, clinics may use the Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool, which consists of a combined screening component followed by a brief assessment for positive screens.[72] Other tools only screen specific substance types (e.g., alcohol, opioids) and populations (e.g., adolescents, adults).[73]

Selection of a screening tool must include consideration of the population served by the clinic. Often, ultra-short screenings (one or two questions) are only useful in order to rule out a diagnosis (not confirm a diagnosis), and there may be a high number of false-positives. For PCPs that serve a population with a high rate of substance use, a tool that screens alcohol and illicit drug use separately may be preferable. In any case, it is important that the screening tool employed properly screen for substance use and particularly opioid use disorder (OUD).[74] For those persons who screen positive, clinics must have sufficient resources for a second-stage assessment for behavioral health needs.

(2) Office-Based Addiction Treatment (OBAT)

In 2019, the New Jersey Division of Medical Assistance and Health Services (DMAHS) and Division of Mental Health and Addiction Services (DMHAS) developed the Office-Based Addiction Treatment (OBAT) program to expand access and improve utilization of non-methadone Medication-Assisted Treatment (MAT) services for Medicaid beneficiaries. Providers have traditionally experienced barriers to providing SUD services, such as the prohibitive reimbursement rates, lack of knowledge on treating behavioral conditions, and prior authorization requirements to provide MAT services. In developing the OBAT program, NJ FamilyCare announced increased rates for specific services and removed the prior authorization requirement for MAT. Since this model was submitted to and approved by the Centers for Medicare & Medicaid Services (CMS) through a State Plan Amendment, the OBAT program is offered on a state-wide basis.[75]

This model, known as the "MATrx Model," consists of three types of providers. First, Office-Based Addiction Treatment providers provide MAT induction, stabilization, and maintenance, as well as navigation and care coordination services. These providers consist of physicians (primary care and specialty), Advanced Practice Nurses (APNs), and Physician Assistants (PAs). Second, premier providers are independent clinics or DOH-licensed physician practices (e.g., Federally Qualified Health Centers, Opioid Treatment Programs, Certified Community Behavioral Health Centers) that provide fully integrated care, i.e., MAT, counseling, and primary medical care. Third, Centers of Excellence (COEs) are state-contracted providers that, in addition to OBAT services, provide mentorship, peer services, and trainings to OBAT and premier providers. All three tiers work collaboratively to promote integrated care.

This model of treatment represents a significant enhancement in expanding access to MAT services and is highly commended. Indeed, SAMHSA recommends that MAT should be accessible across all settings and levels of care. Challenges in linking patients to behavioral health resources should not prevent practitioners from prescribing buprenorphine.[77] Since PCPs may be the first healthcare professional with whom a person with SUD or OUD may interact, they are uniquely positioned to provide patients with linkage to treatment almost immediately. The following recommendations are presented to increase the efficacy and value of the OBAT program.

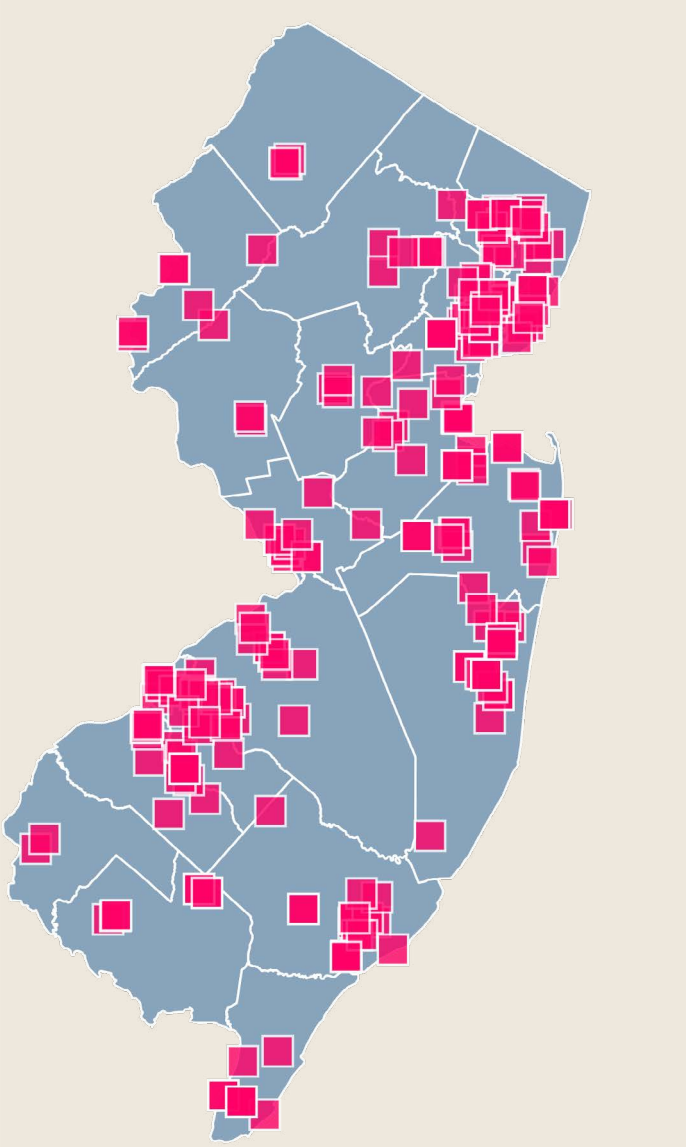
First, the OBAT program must be significantly expanded. According to the New Jersey Department of Human Services, from the beginning of 2022 through July 2023, the OBAT program consisted of

only 48 physicians, 169 independent clinics, and 49 advanced practice nurses and mid-level practitioners. These statistics demonstrate that the OBAT program has not been adequately implemented throughout New Jersey. Notably, many of the healthcare practitioners and providers that are billing as part of the OBAT program are SUD and mental health clinics. The intention of the OBAT program is for primary care providers and family medicine providers to integrate MAT and navigator services into their practices. The State should thus seek to expand the number of primary care and family medicine providers that are part of the program with an appropriate distribution throughout the state.

Second, OBAT providers should conduct universal screenings of all patients, regardless of the specific reason for the visit. Any visit should be utilized as an opportunity to identify those persons who have behavioral health needs and provide linkage to the appropriate modality of care. As previously mentioned, universal screenings would allow for primary care providers to utilize a critical point of intervention.

Third, the required behavioral services should be strengthened. Currently, OBAT providers must have at least one navigator, who can be any licensed individual (e.g., Registered Nurse, Licensed Practical Nurse, Social Worker); any individual with a Baccalaureate degree with two years clinical or lived experienced; or any individual with an Associate degree or a certified medical assistant with four years clinical or lived experience. In order to qualify for reimbursement, navigators must address the psychosocial needs of the patient with SUD and establish a comprehensive, individualized treatment plan.

In order to strengthen behavioral services at OBAT providers, the State should institute new staffing requirements to accommodate the greater needs that patients with SUD have. To that end, OBAT providers should employ one nurse and one licensed mental health or addictions counselor per 100 patients. This staffing requirement allows providers to provide team-based care and balance MAT patient care with the needs of all other patients. Since requiring every OBAT provider to have these two positions may not be immediately feasible due to workforce challenges, the State should raise reimbursement rates for OBAT providers to cover the cost of employing the recommended staff. Since these costs differ throughout New jersey



OBAT Providers in New Jersey, 2023

(e.g., the cost to employ a nurse is different in Hudson County and Camden County), the State should accommodate these disparities in the reimbursement rates for behavioral health services.

Fourth, in order to implement team-based care and allowing PCPs to balance MAT patient care with the needs of all patients, behavioral staff members should provide the following services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care between treatment settings, including follow-up; (5) patient and family support; and (6) referral to community and support services. These services, some of which are now required as part of the OBAT program, would expand access to comprehensive, integrated care.

Interoperability

Interoperability refers to the ability of two more systems to exchange medical information and use the information once received.[79] Achieving interoperability is a primary objective among health-care providers and allows for efficient, patient-centered, and effective care. In New Jersey, there has been meaningful efforts and substantial progress to integrate interoperability among health care providers. The New Jersey Health Information Network (NJHIN), owned by the New Jersey Department of Health and operated by the New Jersey Innovation Institute (NJII), is the only state-designated information network that allows for the electronic exchange of medical information across the state. This network is connected to local Health Information Exchanges (HIEs), regional health hubs, all 71 acute-care hospitals, over 6,000 physicians and care teams, long-term care organizations, over 21,000 providers, non-hospital facilities, Federally Qualified Health Centers (FQHCs), and New Jersey public health registries.[80]

Yet, interoperability has not been integrated among behavioral health providers to the same degree. There are approximately 200 providers that are generally interoperable, a statistic which demonstrates that there has been significant progress. Nonetheless, of those behavioral health facilities that are interoperable, there are only 40 that are currently connected to the NJHIN.[81] There is a clear discrepancy between providers that are interoperable and those that are connected to the NJHIN. The State of New Jersey must respond to these deficiencies in promoting interoperability among substance use disorder (SUD) and mental health providers. The following recommendations aim to enhance the capabilities of the NJHIN and increase the number of providers connected to it.

(1) Appropriate Levels of Funding

There are considerable costs associated with the implementation of electronic health records (EHRs). There have been multiple studies to determine the costs of integrating EHRs into a health-care practice. According to one study, the total cost of a four-month planning period and the first year of EHR use is $233,297 for the average five-physician practice. After one year of implementation, the monthly costs to support the EHR dropped to $1,650 per physician. Another study found that the implementation cost of EHRs for an average five-per-

son practice had a cost of $162,000, with a yearly maintenance expense of $85,500.[83] The significant resources required are a necessary consideration in achieving the intended goals of implementing EHRs among healthcare providers, including those who treat behavioral health.

In order for SUD providers to achieve interoperability and connect to the NJHIN, the State must provide the necessary funds. Interoperability is a highly expensive endeavor, and if providers do not have the necessary funds, they will simply not become interoperable. As such, the State must devote more resources to achieving interoperability among SUD providers. In so doing, the State will allow for SUD providers to have access to the most complete medical information available to them and that they have a consistent system of communication with other healthcare providers in the community and throughout the state.

(2) Substance Use Disorder Promoting Interoperability Program (SUD PIP)

NJHIN has made efforts to integrate interoperability among SUD providers through its Substance Use Disorder Treatment Provider Promoting Interoperability Program (SUD PIP).[84] Funded by the New Jersey Department of Health and New Jersey Department of Human Services, this program was launched in 2019 and, although set to conclude on June 30, 2023, has been extended. This program is a $6 million grant initiative aimed to provide funding to qualified SUD providers to implement or upgrade to EHR technology. Providers could receive up to $42,500 in incentive payments for achieving certain milestones.

Unfortunately, the SUD PIP is not able to fully cover the costs of implementing EHRs for behavioral health providers. The incentive payments, though certainly helpful and a considerable step towards the goal of interoperability, are not large enough to fully fund the transition to certified electronic health record technology (CEHRT) for providers. Indeed, the size of the grant itself limited the number of SUD providers that could achieve interoperability. Although the SUD PIP is a meaningful first step, it simply does not have the requisite funds to guarantee its effectiveness. The State must add substantial funding to this program.

Furthermore, the State must require providers to achieve all milestones that it sets forth. The SUD PIP only requires providers to achieve two out of five milestones, and this decision contributed to providers developing limited interoperability when participating in the program. As such, based on this rule, providers are not required to connect to the NJHIN (Milestone 3), something that should be required of all providers that participate in this program. It is critical that providers achieve all milestones and that interoperability necessarily means being interoperable with the NJHIN.

An important factor for the SUD PIP program is all providers that participate in the program will have to integrate interoperability through systems that are certified by the Office of the National Coordinator for Health Information Technology (ONC), because the program uses federal funds. However, the NJHIN does not require providers to have ONC-certified systems in order to connect to and use the network. Unfortunately, the requirement that providers participating in the SUD PIP program must use ONC-certified systems creates a barrier for some providers in achieving interoperability. There are numerous interoperable systems that are well-designed and well-functioning but that are not ONC-certified.

New Jersey must recognize that ONC-certified platforms are not a necessary condition for achieving interoperability in the state. Although the SUD PIP will certainly allow providers to become interoperable, the State will have to use its own funds to further increase the level of interoperability among behavioral health providers in New Jersey. The SUD PIP should only be one component of the State's overall efforts to improve interoperability throughout New Jersey.

(3) Bi-Directionality

NJHIN has two primary capabilities: (a) transmission of Admission, Discharge, and Transfer (ADT) Alerts statewide to providers and care management teams regarding medical information and updates on patients; and (b) transmission of Continuity of Care Documents (CCDs), which summarize patient information (e.g., medical history and current condition) in a concise format.[85] These functions of the NJHIN are particularly valuable to SUD providers. For example, if a patient receives treatment from a SUD provider that is connected to the HIN, when the patients enters the Emergency Department (ED) of an acute-care hospital due, the hospital will send an alert (i.e., push notification) to

the NJHIN that will be transmitted to the provider, who will be notified that the patient is in the ED. Since persons with SUD are at risk of overdose and other emergency situations, the notification of an ED arrival is particularly valuable to the provider.

Yet, interoperability is only as valuable as how much information providers are able to provide to the NJHIN. A significant limitation of interoperability in New Jersey is that the majority of providers are not bi-directionally interoperable; they are only able to receive information but cannot send any. Since acute-care hospitals and long-term care facilities are predominantly the only entities capable of sending information to the NJHIN, the network is only useful as a means of interoperability for those patients that receive medical care from these facilities. Indeed, the NJHIN is unable to provide any communication between providers that are not bidirectionally interoperable. As such, patients that do not seek care or interact from acute-care hospitals or long-term care facilities will not benefit from the NJHIN.

The State must require that bidirectionality is a condition of achieving interoperability. Indeed, the bidirectional transfer of information is essential in ensuring that all healthcare providers base their medical decisions on the same set of information. Furthermore, the integrity of the NJHIN itself will be strengthened through a requirement that all providers that join the network are capable of the bidirectional transfer of information. Yet, achieving bidirectional interoperability is a time-intensive and resource-intensive process. For SUD providers to achieve this level of interoperability, they will need to have qualified Information Technology (IT) staff and the necessary funding. As such, the State must couple the implementation of this requirement with adequate funding and staff to achieve it.

(4) Record Updating

Interoperable providers must provide the most updated information to the NJHIN. Since providers will likely stop providing care to certain patients and will start serving other patients in a given period of time, those providers must properly reflect those changes in the information provided to the HIN. The Common Key Service/Master Person Index, a component of the NJHIN, provides the ability to match patients across multiple organizations and applications. If the data that this component has is not accurate or incomplete, the NJHIN will not be able to properly transmit information to the appropriate providers. Thus, as a standard practice, the State must require providers to regularly, at least once a month, update the patient records in the NJHIN.

(5) Bi-Directional Connectivity to NJSAMS

The New Jersey Substance Abuse Monitoring System (NJSAMS) is the administrative data collection system for the Division of Mental Health and Addiction Services (DMHAS). This database is used by all licensed SUD treatment providers in New Jersey and collects demographic, financial, clinical, behavioral, and service information of clients who receive substance use treatment in the state. In addition, NJSAMS is the database through which behavioral health providers contact the Interim Managing Entity (IME) and receive prior authorization approvals or denails, conduct screening assessments, and complete the Division of Addiction Services Income Eligible (DASIE) form. NJSAMS plays an integral role in the operations of SUD providers in New Jersey by aiming for timely reporting on SUD treatment episodes, improved monitoring of outcomes, improved client placement, and treatment utilization.[86]

There are unfortunately notable technical limitations to NJSAMS. While behavioral health providers are able to receive information from NJSAMS, they are unable to send information to the database directly from the EHR. Instead, in order to submit information, which they are required to do so per state policies and regulations, providers must follow a cumbersome process of exporting information from the EHR and then submitting the exported file to NJSAMS.

The State of New Jersey must invest substantially in its technical expertise and upgrade the technological proficiency of its state reporting systems. Because behavioral health providers interact with NJSAMS to complete and comply with a wide range of requirements and regulations, developing bi-directional connectivity between behavioral health providers and NJSAMS is an important policy objective.

Court-Involvement

Correctional institutions, courts, and other criminal justice apparatuses are well-positioned at critical points of intervention to provide necessary treatment to persons with substance use disorder (SUD) and opioid use disorder (OUD). Indeed, each point of contact across the criminal justice system is an opportunity to increase access to evidence-based treatment, reduce the number of persons with OUD in the justice system, and move towards a more rehabilitative approach to criminal justice. In New Jersey, similar to the rest of the country, there is a convergence between persons with SUD and persons who are court-involved. Estimates show that the percentage of prisoners with an active SUD is upwards of 65 percent.[87] Given this correlation between court-involvement and substance abuse, access to evidence-based treatment must be expanded across the criminal justice system.

New Jersey has made significant progress to ensure that court-involved persons have access to substance abuse and mental health services. These initiatives and programs include diversion programs, where persons with SUD and/or mental illness are diverted to behavioral health programs at initial stages of court-involvement; statewide Recovery Courts (previously known as Drug Courts) at the Superior Court level; behavioral services offered during incarceration in state prisons and county jails; and programs to provide linkage to behavioral services upon release. In recognition of the progress that has been made, the recommendations presented herein respond to those continued deficiencies and gaps in behavioral health services for court-involved persons.

(1) Medication-Assisted Treatment (MAT) in State Prisons

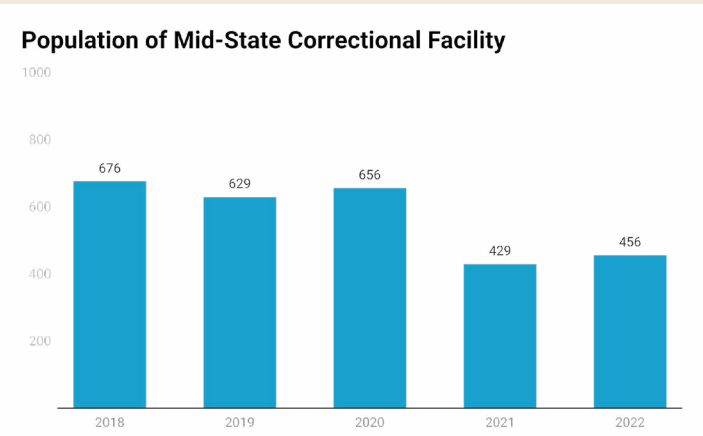
The New Jersey Department of Corrections (NJDOC) offers all Food and Drug Administration (FDA)-approved medications for the treatment OUD at all state prisons. Access to MAT programs in correctional settings is a best practice and ensures that incarcerated persons are receiving the necessary treatment during a crucial opportunity for intervention. The National Sheriffs' Association (NSA), the National Commission on Correctional Health Care (NCCHC), and the American Society of Addiction Medicine (ASAM) all fully support increasing access to addiction treatment medications, particularly MAT, and psychosocial support services in correctional settings.

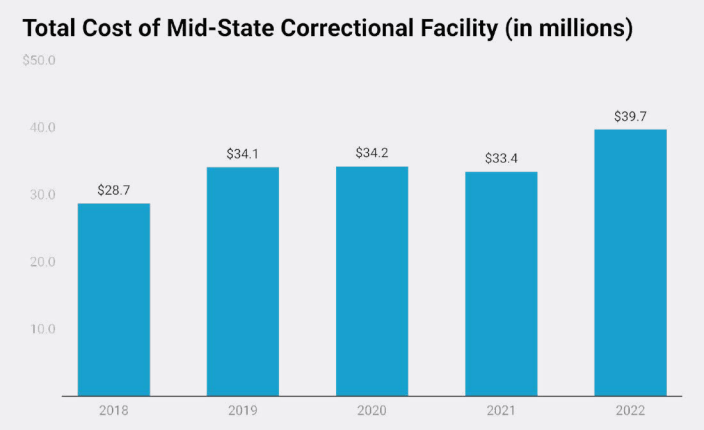
However, the policies that NJDOC has adopted and implemented to provide MAT to

incarcerated persons do not constitute a best practice. According to the NJDOC Internal Management Procedure for MAT, which was developed in 2017 and revised in March 2023,[88] NJDOC employs separate procedures for whether persons were admitted already on MAT or if they should be provided with this treatment during their incarceration. If persons were already on MAT when admitted to NJDOC, they will have their medications continued for at least 30 days, as required by state law.[89] The determination to continue MAT past the initial 30 days is determined by the expected duration of incarceration and, if applicable, the patient's history of illicit substance use during previous incarcerations. If an individual's sentence exceeds two years, they will be considered for "taper-to-abstinence with continued counselling therapy." If an individual's sentence is less than two years, "taper-to-abstinence" will still be considered, though only if there is no clinical benefit to the continued use of MAT.

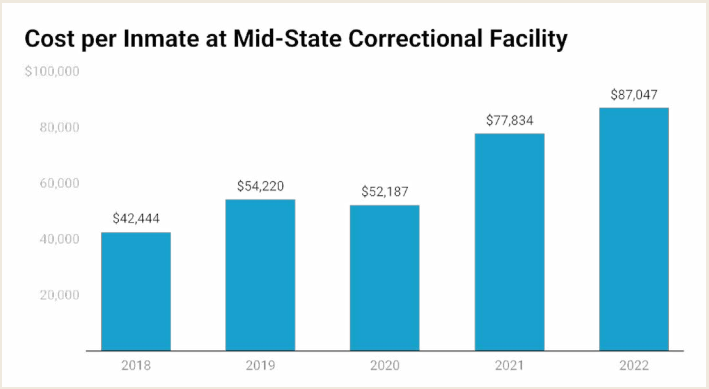
In order to induct an incarcerated individual into MAT during their incarceration, there must be a clinically documented rationale for doing so, such as objective evidence of consistent substance use in prison or high risk of death in the absence of MAT intervention. For those who will be released within 60 days, in order to be inducted into MAT, NJDOC must have a reliable post-release appointment and linkage to a community provider. If no such appointment is secured, induction to MAT is delayed until after the individual is released from prison.

These policies are not evidence-based and should be revised to ensure that incarcerated individuals who have behavioral health needs are receiving the appropriate treatment services. The Internal Management Procedure falsely assumes that incarcerated persons do not have access to illicit drugs during their incarceration; prisons are unfortunately not drug-free. NJDOC should implement the following changes to its procedures for administering MAT to incarcerated persons.





First, NJDOC should not have a "taper-to-abstinence" policy. Studies have repeatedly documented that retention in MAT results in better outcomes, such as reduced rates of mortality and reduced utilization of high-intensity treatment.[90, 91] In its National Practice Guideline for the Treatment of Opioid Use Disorder, the American Society of Addiction Medicine (ASAM) states that "patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly." For methadone, ASAM advises, "While the optimal duration of treatment with methadone has not been established, it is known that relapse rates are high for most patients who drop out; thus, long-term treatment is often needed."[92] MAT should not be disrupted, except in unique circumstances, for incarcerated persons.



Second, NJDOC should not make a distinction between persons who are serving sentences longer than two years and those who are not. Rather, NJDOC policy should be revised to require a determination of the necessity of MAT services on an individualized basis. If a person is presently on a treatment plan during their admittance to NJDOC, a

healthcare provider should make an individualized, clinical judgement as to whether the plan should be continued or altered.

MAT is often an essential component of a person's recovery from OUD. NJDOC should thus implement evidence-based policies that promote the long-term health of its incarcerated population. Indeed, providing adequate access can contribute to a safe and secure facility for inmates and staff, reduce costs, minimize the risk of overdose and death following release, and facilitate a path to recovery for persons with SUD.

(2) Mid-State Correctional Facility

Mid-State Correctional Facility, one of nine state prisons operated by NJDOC, is a 696-bed, medium security institution for male inmates in Burlington County. This facility, which reopened in 2017, is dedicated to providing treatment to New Jersey inmates who have SUD. The treatment program is administered by Gateway Foundation, a contracted vendor, and is licensed by the Department of Health. In 2017, the inmate population at Mid-State Correctional Facility was 676 inmates, with a $42,444 cost per inmate. In 2022, the inmate population declined to 456 inmates, while the cost per inmate grew substantially to $87,047, a 105.1 percent increase from 2017.[93]

The Office of the State Auditor, in the legislative branch of government, conducted an audit of the Mid-State Correctional Facility for the period of July 1, 2018 to July 31, 2022. This audit, which was released in May 2023, found the facility's provision of SUD treatment and counseling services to have several deficiencies and to be in violation of contract requirements. It is critically important that NJDOC rectify the problems identified in this state audit and ensure that the SUD treatment program is following proper standards.

First, the audit found that counseling services and treatment plan reviews were not being conducted in accordance with contract requirements. NJDOC must first implement monitoring procedures to guarantee that Gateway, the contracted vendor, is complying with its contract and following established procedures for providing counseling services and treatment plan reviews. For all programming periods reviewed by the State Auditor, half of all inmates at Mid-State did not receive the required counseling/education, and 45 percent did not receive the required number of individual sessions. Moreover, 47 percent of all treatment plan reviews were not completed every 60 days, as contractually required.

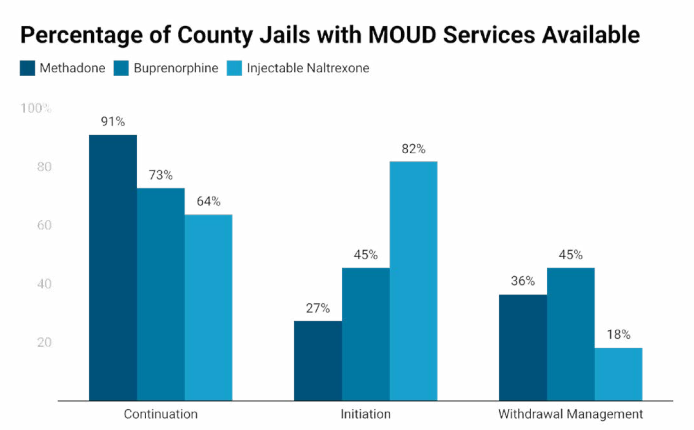
Second, NJDOC must enforce requirements that assessments for referred inmates are conducted in a timely manner. If there is capacity at the Mid-State Correctional Facility, assessment and placement should be expedited. As of April 2022, there were 300 inmates who were referred to the program but had not yet received a SUD assessment; 125 inmates were referred in 2022, 153 in 2021, and 22 during the calendar years 2018 through 2020. These delays in providing an assessment are unacceptable. It is imperative that the SUD assessments be completed within five business days of referral, as the contract requires.

Third, NJDOC should adjust the admitting process to allow eligible inmates to be transferred to the treatment facility in a reasonable timeframe and allow SUD assessments to be conducted there. Currently, assessments are not conducted in one central facility, and the vendor must travel to different facilities throughout the state, contributing to significant delays in assessing inmates for SUD and transferring them to Mid-State Correctional Facility. The Department of Corrections should thus seek to adjust the process to allow transferring inmates to the treatment facility for a SUD assessment immediately following referral and the completion of the classification process.

Fourth, if there are few beds available, NJDOC should use the length of an inmate's sentence as a factor in considering admittance into the SUD program. Indeed, while all persons with behavioral needs must be certainly provided with the appropriate treatment, when there are issues of capacity, NJDOC should prioritize those persons with shorter sentences to ensure that their needs are properly addressed prior to their release.[94]

Fifth, NJDOC must strengthen internal controls and oversight and confirm that its expenditures are in accordance with department policy. The department did not comply with department policy regarding procurement and the Department of the Treasury Circular in regards to delegated purchasing authority (DPA) transactions. The audit found that transactions lacked proper documentation and incomplete requisition forms. Furthermore, the department does not review vendor invoices for SUD treatment services. The audit

discovered, for example, that during a four-month period, the vendor overbilled the department, resulting in a net overpayment of $7,115. The department must therefore follow proper protocols for expenditures to guarantee that invoices for SUD treatment services are accurate.



(3) NJDOC Audit of Behavioral Health Services

In recognition of the several deficiencies found by the Office of the State Auditor in its audit of the provision of SUD services at Mid-State Correctional Facility, the Department of Corrections must conduct and make publicly available a yearly audit of its behavioral health services throughout all of its facilities. A yearly audit would provide the Department of Corrections with the necessary information to identify deficiencies in services and compliance with policies, as well as the opportunity to rectify them. It is also important that the audit be made available to the public, such as in the case of the audit of Mid-State Correctional Facility, to ensure that incarcerated persons are receiving the behavioral health services they need in a timely manner.

(4) Expansion of MAT in County Jails

Although all state prisons offer all three medications for MAT, there is variation among the provision of and access to MAT in county jails. Indeed, most county jails have historically lacked such treatment services. In 2019, the New Jersey Department of Human Services, Division of Mental Health and Addiction Services, and the Departments of Corrections and Health led a statewide effort to expand MAT in jails by providing financial support and technical assistance.[95] Although this $8 million initiative has expanded access to MAT and provided significant support to ensuring that county jails are able to respond to the treatment needs of its detained population, gaps unfortunately still remain.

According to a 2022 study on county jails in New Jersey, approximately 23 percent of the detained population had OUD, based on existing assessments used to screen for OUD. For persons who were already in treatment prior to jail entry, 91 percent of county jails are able to continue methadone treatment; 73 percent are able to continue buprenorphine treatment; and 64 percent were able to continue naltrexone treatment. For those persons who initiated MAT during their detainment, 27 percent of county jails are able to initiate methadone treatment; 45 percent are able to initiate buprenorphine, and 82 percent are able to initiate naltrexone. For withdrawal management, 36 percent, 45 percent, and 18 percent of county jails respectively used methadone, buprenorphine, and naltrexone.[96]

County jails must offer MAT services to all detained persons that need such services. New Jersey should adopt the following recommendations to improve the provision of MAT services across all jails in the state:

1. The State must require county jails to employ the same set of evidence-based, clinical criteria to determine eligibility to receive MAT during detainment. Currently, county jails employ different criteria and clinical guidelines to delivering SUD treatment to detained persons. In some cases, clinical care is not aligned with best practices.[97] These differences include practices to determine eligibility for MAT, protocols for delivering such medications, and the manner in which MAT services are recorded and tracked. It is imperative that county jails follow consistent and standardized clinical guidelines in connecting persons to the appropriate treatment.

2. All county jails should offer all three-FDA medications for continuation, induction, and withdrawal management. Since federal and state regulations may complicate the delivery of MAT services, county jails must develop partnerships with community providers, such as OTPs and CCBHCs, and implement proper protocols to guarantee timely linkage to MAT.

3. The State must expand its grant program to provide all county jails with adequate funding to employ qualified and dedicated staff and resources and ensure timely access to SUD treatment services.

4. Persons detained in jail vary significantly in terms of their length of stay. Particularly for persons

with short lengths of day, county jails must expedite intake, initiation, and linkage to treatment. In order to so, all persons entering county jail must be systematically screened for SUD in a timely manner.

5. For those persons receiving MAT and will soon be released, county jails should provide access to those medications during their transition back into the community. As such, it is highly recommended that, at the time of release, persons be provided with a 30-day supply of all prescription medications that have been prescribed. In addition, county jails should ensure that there is a coordinated follow-up procedure to ensure that persons continue receive MAT as needed.

6. The State must require county jails to activate insurance coverage when released from jail. Reactivation of Medicaid upon release varies by individual jails and depends on their relationship with local Medicaid offices. Currently, only 64 percent of county jails in New Jersey assist in reactivating Medicaid at release. It is imperative that insurance coverage is reactivated for persons released from county jail to allow for the continuity of treatment services in the community.

Implementing these recommendations would ensure that the current gaps in county jails in delivering effective OUD treatment are properly addressed. These recommendations are best practices for county jails to implement in providing MAT services to detained persons.

(5) Pre-entry Services

The pretrial period is a critical opportunity to identify biopsychosocial needs of defendants and connect them to appropriate services, such as addiction treatment, mental health services, housing, licenses, training, and linkage to employment. Currently, New Jersey's pretrial services do not have an existing framework to provide supportive services to defendants following arrest and prior to adjudication. The pretrial assessment employed by the court system does not consider mental health or substance abuse issues, community relationships, current or past employment, or housing status. This lack of support has a negative effect, since many released defendants may return to the same environment that contributed to their court-involvement.

In January 2023, the New Jersey Reentry Corporation (NJRC) released the *Pre-Entry Report: A Research Examination of Best Practices*, which details recommendations to enhance the pretrial services offered in New Jersey, as well as proposing a pilot program to implement these changes.[98] This report presents similar recommendations, as the pretrial period is one of the earliest stages in the criminal justice process in which a defendant can be connected to evidence-based and effective treatment for persons identified with SUD.

First, there must be universal screening for all defendants prior to the initial court appearance. In addition to allowing pretrial services officers to make "informed, individualized, and risk-based recommendations to the court regarding release, supervision, and detention decisions," the screening must also help determine whether the defendant should be referred to social services or behavioral health treatment. Offering these services increases the likelihood of compliance with conditions of release. As such, the assessment that is used by the courts must properly identify substance abuse, mental health, and other behavioral problems in defendants.

Second, for defendants who screen positive for substance abuse or mental health issues, there should be immediate referral to the appropriate provider who can address those behavioral problems. Indeed, pretrial services officers should utilize the pretrial period as an opportunity to correct the behavior of persons re-entering society following arrests. Officers may direct defendants to services and mandate enrollment in treatment programs, including substance abuse and mental health treatment. The criminal justice system, starting at the pretrial period, must identify those persons with behavioral needs and address them through linkage to appropriate treatment. During the pretrial period, court officials can provide opportunities to stabilize persons, who will be better able to make healthy and productive decisions.

(6) Section 1115 Waiver Demonstration

NJ FamilyCare does not cover services that beneficiaries receive during their incarceration. In the NJ FamilyCare Comprehensive Demonstration Renewal Proposal, the State requested expenditure authority to provide Medicaid reimbursement for up to four behavioral health care management visits for incarcerated Medicaid beneficiaries. The propos-

al was limited to those incarcerated persons who were expected to be released within 60 days and was meant to ensure continuity of care between the provision of service inside the correctional facility and services received following release. Unfortunately, in its approval letter, CMS delayed pre-release services for incarcerated individuals as part of the demonstration extension.

Nonetheless, CMS indicated its commitment to work with New Jersey on this initiative to increase pre-release services for court-involved persons. Indeed, in April 2023, the U.S. Department of Health and Human Services (HHS) released new guidance for states to apply under their Section 1115 demonstration to provide increased care for individuals who are about to be released from incarceration. This demonstration opportunity will allow states to cover a set of pre-release services up to 90 days prior to an individual's expected release date. This guidance is a significant development, given the longstanding federal statutory exclusion that prohibited persons from receiving Medicaid coverage for most services while in a state or county incarceration. [100]

As part of this demonstration opportunity, CMS will require the State to provide at a minimum: (1) case management to address physical and behavioral health needs and health-related social needs; (2) MAT services for all types of SUD as appropriate, with counseling; and (3) a 30-day supply of all prescribed medications at the time of release. The State will also have to demonstrate certain milestones, including: (1) increasing coverage and ensuring continuity of care for incarcerated persons;

(2) covering and ensuring access to pre-release services for incarcerated persons upon release to the community; (3) connecting persons to services available post-release; and (4) allowing for cross-system collaboration. These and other requirements of the Section 1115 Demonstration Opportunity are highly welcome and valued.[101]

It is strongly recommended that the State of New Jersey submit a demonstration proposal to implement this reentry demonstration. As part of the application to CMS, the State should adopt the following provisions:

1. The demonstration should apply to all state prisons and county jails. In addition, although CMS has indicated that federal prisons should not be included in this demonstration, the State should still seek to assist federal prisoners in submitting Medicaid applications, as the CMS will permit under the demonstration.

2. The State should ensure that eligibility for this program applies to as many persons as permitted.

3. The pre-release timeframe should be 90 days. Although CMS will require services to begin at a minimum of 30 days prior to the individual's expected date of release, the State should seek to provide incarcerated persons with a longer period of Medicaid covered services.

4. As part of the Administrative Information Technology (IT) System Costs component of the demonstration, the State should seek to make all state prisons and all county jails interoperable with the New Jersey Health Information Network.

Offering services to incarcerated persons in the time immediately prior to their release is essential to ensure that such persons are able to receive needed services at such an important juncture, namely, when they are transitioning back into the community. Assisting persons during this transition, which is often fraught with barriers and a dearth of resources, will decrease the likelihood of recidivism and promote linkage to and continuation of needed behavioral health treatment.

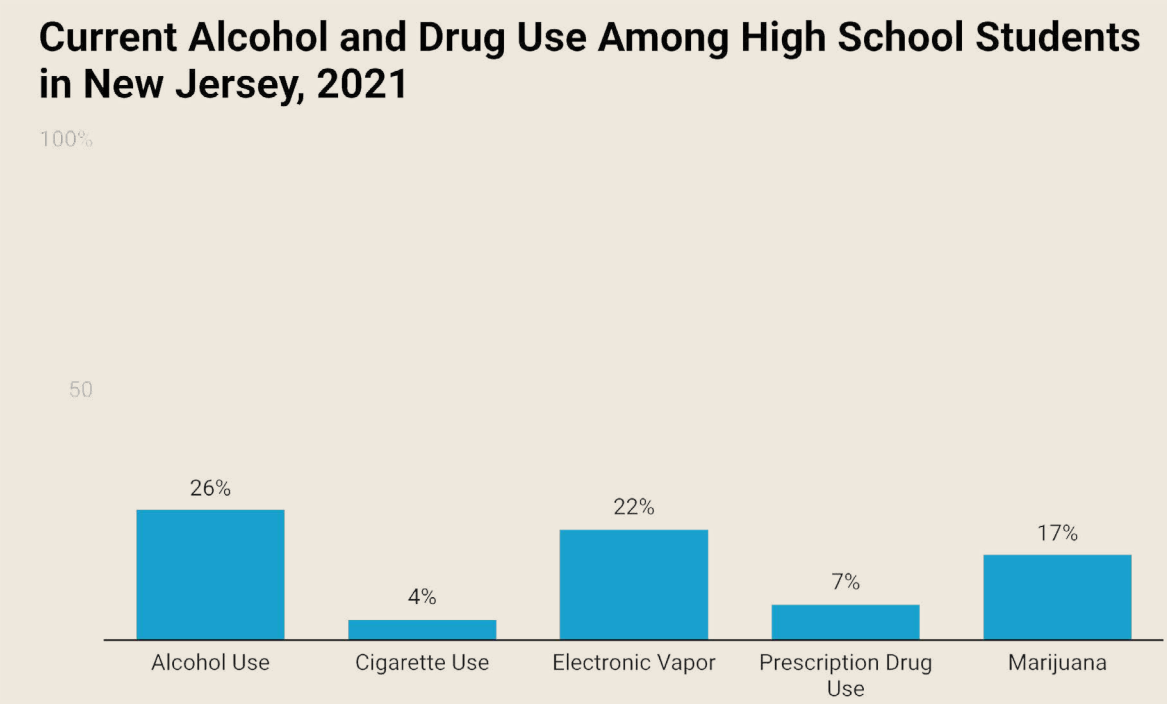
(7) Reentry Services

In addition to substance abuse and mental health issues, court-involvement is associated with higher rates of chronic and other physical health care needs, including hypertension, asthma, tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hepatitis B and C, arthritis, and sexual transmitted diseases, when compared to the general population.[120] These physical and behavioral health conditions complicate an incarcerated person's return to the community. Furthermore, court-involved persons experience numerous barriers to successful reentry. There are substantial difficulties in obtaining housing, education (e.g., GED), identification (e.g., birth certificates, driver's licenses, social security cards), state and federal benefits (e.g., Supplemental Nutrition Assistance Program, General Assistance), health care coverage, training, and employment.

In addressing the behavioral needs of court-involved persons, it is critically necessary that

the social determinants of health be properly addressed. If the myriad of challenges that court-involved persons face when returning from incarceration goes unmet, the likelihood that they will be able to access and continue behavioral health treatment diminishes. Indeed, the risk of opioid-related overdose death among persons following release from prison and jail is increased through poverty, disruptions in health care access, and other social needs. The social determinants of health cannot be separated from treating a person's behavioral problems. Behavioral health providers which treat court-involved persons and reentry programs which assist persons with behavioral health needs must be fully equipped with the necessary resources and partnerships to address health-related social needs and respond effectively with a whole-person, wraparound approach.

Prevention and Intervention



In order to address the opioid epidemic, it is necessary to ensure that persons who currently have substance use disorders (SUDs) and other behavioral health needs have access to holistic and comprehensive care. Indeed, a necessary component of any effort to address this epidemic is to treat those persons with SUD and place them on the path of recovery and healthy living. Yet, for the opioid epidemic to fully abate and for the United States and New Jersey to see a long-term decrease in overdose deaths and rates of addiction, the State of New Jersey must continue to prioritize prevention and education. Thus, in addition to providing services and resources to persons after they have developed SUD, there must also be a corresponding commitment to interventions prior to their interactions with illicit drugs and high-risk situations.

There are generally three types of interventions: (1) universal interventions, which seek to decrease certain health problems across all persons in a given population by reducing risk factors and promoting protective factors; (2) selective interventions, which are delivered to a particular subset of a population who have specific factors that put them at increased risk of drug use; and (3) indicated interventions, which are directed towards persons who already engage in illicit drug use but have not yet developed a SUD.[104] These three types of interventions represent areas in which the State should develop prevention and intervention strategies to limit illicit drug use and the development of addiction. The recommendations presented herein pertain to these three areas of intervention as important stages in prevention.

Alcohol, Tobacco and other Drugs

By the end of grade 2	By the end of grade 5	By the end of grade 8	By the end of grade 12
The use of alcohol, tobacco, and other drugs in unsafe ways is harmful to one's health.	• The use of alcohol, tobacco, and drugs may affect the user, family, and community members in negative ways and have unintended consequences. • Drug misuse and abuse can affect one's relationship with friends, family, and community members in unhealthy ways.	The use of alcohol, tobacco (including e-cigarettes, vaping), and other drugs (including cannabis products) can result in social, emotional, and physical harm to oneself and others.	Long-term and short-term consequences of risky behavior associated with substance use and abuse can be damaging physically, emotionally, socially and financially to oneself, family members and others.

Dependency, Substances Disorder and Treatment

By the end of grade 2	By the end of grade 5	By the end of grade 8	By the end of grade 12
Substance abuse is caused by a variety of factors. There are many ways to obtain help for treatment of alcohol, tobacco, and other substance abuse problems.	• The short- and long-term effects of substance abuse are dangerous and harmful to one's health. • The use/abuse of alcohol, tobacco, and drugs can have unintended consequences but there are resources available for individuals and others affected by these situations.	• A variety of factors can contribute to alcohol, tobacco, and drug disorders (e.g., mental health, genetics, environment) and a wide variety of treatment options are available depending on the needs of the individual. • The use of alcohol and drugs can affect the social, emotional, and physical behaviors of individuals and their families.	• Alcohol and drug dependency can impact the social, emotional, and financial wellbeing of individuals, families, and communities. • Substance abuse, dependency, and substance disorder treatment facilities and treatment methods require long-term or repeated care for recovery.

(1) Education in School Settings

Education on substance use, the risk involved, and its harm is essential in efforts to prevent and diminish the misuse and abuse of substances, whether among children, adolescents, or adults. In addressing the opioid epidemic, schools play a fundamental role in providing drug education to students and ensuring that they have the necessary information to make healthy decisions. Education programs in middle and high schools are particularly important, as drug use is higher among adolescents than older people. In 2022, 11 percent of eighth graders, 21.5 percent of tenth graders, and 32.6 percent of twelfth graders reported illicit drug use in the past year in the United States.[105] In New Jersey, 26 percent of high school students in 2021 were drinking alcohol at the time the survey was taken; 22 percent were using an electronic vapor product; 7 percent reported ever taking a prescription drug without a doctor's prescription; and 17 percent were currently using marijuana.[106] These trends demonstrate the need for robust educational programs on substance use and addiction for students in elementary, middle, and high schools.

The New Jersey Department of Education is required to provide New Jersey Student Learning Standards that delineate expectations on what students should know and be able to do at benchmark grade levels. All school districts in New Jersey are required to deliver the curriculum and instruction that these standards set forth. The 2020 New Jersey Student Learning Standards (NJSLS) for Comprehensive Health and Physical Education detail the performance expectations regarding alcohol, tobacco, and other drugs as well as dependency, substance use disorder, and treatment by the second, fifth, eighth, and twelfth grades.[107] These standards are well-developed and provide school districts with an evidence-based platform to teach students about substance use, substance abuse, and the substantial harms that may result. Nonetheless, there are certain steps that the State should take to further ensure a robust education in behavioral health.

First, the NJSLS should be updated to specifically address the opioid epidemic and the emergence of synthetic opioids, particularly fentanyl, as a significant factor in this public health crisis. In addition, the standards should require students to understand how the illicit drug supply in New Jersey has evolved and continues to do so, such as the recent entrance of fentanyl-adulterated xylazine. Students should know how the specific trajectory of the opioid epidemic has affected New Jersey.

Second, the State should require that private schools adhere to the standards pertaining to substance use, substance abuse, and addiction treatment set forth in the NJSLS. The NJSLS currently only apply to students enrolled in public elementary, secondary, and adult high school education programs within the State of New Jersey; they do not apply to non-public schools. There is precedent for such a policy, as the State currently requires private schools to provide education on accident and fire prevention.[109]

Third, the Department of Education should report on the progress of students in achieving the NJSLS for Comprehensive Health and Physical Education. The Department is currently required to report annually to the State Board of Education and the public on the progress of students in meeting NJSLS, as measured by a statewide assessment system. This assessment, however, only evaluates student achievement in mathematics, English language arts, and science.[110] The public should have access to how these health education standards are implemented throughout New Jersey and the level of proficiency that students have attained.

Fourth, the Department of Education should have a comprehensive record of all education programs on behavioral health in New Jersey. According to an Open Public Records Act (OPRA) request, the New Jersey Department of Education does not maintain such records. In order for the State to effectively respond to gaps and deficiencies in the prevention education provided to children and adolescents, that the State must have a basic understanding of what programs are offered in the school districts throughout New Jersey.

(2) Social Determinants of Health

The social determinants of health refer to those conditions in which people are born, grow, live, and work that affect a person's health. These factors comprise five major categories: healthcare access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment.[112] It is important to recognize that improving health outcomes requires broader approaches that address the social, economic, and environmental factors that affect health.

These social determinants play a significant role in determining a person's risk of developing addiction and the likelihood of recovery from it. Persons are at a greater risk for opioid use disorder (OUD) and opioid overdose if they are unemployed,[113]homeless,[114] or have a low education level.[115] A 2019 study, based on data from 2002 to 2014 from 17 states, including New Jersey, found that prescription opioid and heroin overdoses are more concentrated in communities that are economically disadvantaged, which are associated with higher rates of poverty and unemployment, lower quality education systems, and lower median household incomes.[116]

Given the well-documented effect that these factors have on a person's risk of developing addiction, addressing the social determinants of health is essential in not only assisting those persons who currently have SUD but also as an intervention for those persons who may be at risk or predisposed for substance misuse and SUD. The following recommendations seek to improve the ability of behavioral health and community providers to properly address these social, economic, and environmental factors.

First, behavioral health facilities should offer comprehensive, wraparound services to patients, such as enrollment in state and federal benefit programs (e.g., Supplemental Nutrition Assistance Program, General Assistance, Division of Vocational Rehabilitation), identification retrieval and restoration, housing assistance, training, and employment. According to the aforementioned 2022 National Directory of Drug and Alcohol Abuse Treatment Facilities, in New Jersey, 85.8 percent offer case management; 57.1 percent offer housing services; 68.4 percent help with obtaining social services; and 45.1 percent offer employment counseling and training.[117] Since many patients have various needs that extend well beyond behavioral health and medical care, it is critically important that behavioral health providers have the capability to provide targeted case management services that respond to the wide range of needs that patients may have. Those behavioral health providers that do not have the capability to offer these services that address a patient's various needs should develop partnerships with local community providers to ensure that there is access to these wraparound services.

Second, the State must devote significant resources to ensuring that persons have access to sober, structured housing. There are only 20 facilities that constitute transitional housing, halfway housing,

or sober housing in the state.[118] Sober housing has been shown to be effective in promoting long-term outcomes for persons who are several addicted.[119] Persons are often in sober housing during a crucial period in their recovery, and, without access to sober housing, persons are likely to return from intensive treatment immediately to the same environments that contributed to the development of addiction. In further developing sober housing for persons with behavioral health needs, the State must work to ensure housing facilities are distributed evenly throughout the state.

Third, beyond sober housing, access to safe, stable, and affordable housing is an essential component of long-term recovery. People who are homeless exhibit higher rates of physical health problems, mental health issues, and SUDs.[120] Furthermore, longer periods of homelessness are associated with lower rates of recovery and higher rates of serious mental illness.[121] It must be a priority that when persons with SUD complete treatment, they are placed in environments that do not encourage relapse and further substance use. Ensuring that persons have access to stable and affordable housing would support them in their recovery from SUD. Furthermore, while recognizing that the State must make affordable housing generally available, which requires considerable effort and resources, ensuring that persons, whether or not they presently have a SUD, have safe and stable housing would decrease the likelihood that they would later develop a SUD or mental illness.

Prevention and intervention are necessary in addressing the opioid epidemic and the significant rates of addiction in New Jersey. The State must ensure that persons have access to quality education on behavioral health in school and access to embedded services. Adolescence is a period of time where persons are at particular risk of illicit drug use; ensuring that adolescents have access to the necessary information and services will allow them to make healthy decisions. Furthermore, the State must recognize the importance of responding to the social determinants of health and how doing so increases the likelihood that treatment will be effective and that recovery will be lasting.

Present Avenues in Addressing the Opioid Epidemic

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical Bills	Playground	Higher education			
Support	Walkability				

The recommendations presented in this report address areas of insufficiency in the provision of behavioral health services in New Jersey and present policy recommendations that will promote holistic, integrated behavioral health care. These proposed recommendations address varied aspects of the structure of behavioral health treatment in the state. The State of New Jersey has significant opportunities at its disposal to implement these recommendations and effectively address the opioid epidemic, namely the Opioid Recovery and Remediation Fund and the pursuit of legislation through the Legislature.

Opioid Recovery and Remediation Fund

In August 2022, Governor Murphy established the Opioid Recovery and Remediation Advisory Council under Executive Order No. 305 and, in March 2023, signed legislation into law that established the Opioid Recovery and Remediation Fund. In 2021, Johnson & Johnson and McKesson, Cardinal, and Amerisource-Bergen entered into nationwide settlement agreements that will pay the State of New Jersey and eligible counties and municipalities a total of $641 million over the next two decades.[122] Furthermore, New Jersey is also set to receive approximately $508.1 million from another nationwide settlement agreement with the pharmacy chains CVS, Walgreens, and Walmart, and drug makers Teva Pharmaceuticals and Allergan.[123] Thus, if the latter settlement is approved, the Murphy Administration will have secured over $1 billion in total opioid settlement funds.

The purpose of the Opioid Recovery and Remediation Advisory Council is to provide recommendations to the State of New Jersey on how these funds should be used to address the opioid epidemic. The settlement funds may be used for a wide range of activities to arrange the opioid epidemic, including: treatment; recovery supports; prevention; harm reduction; education and awareness; evidence-based data collection and research; and serving specialty populations. The Advisory Council is reviewing proposals, data, and analysis, as well as engaging stakeholders and community members. In recognition of the unprecedented opportunity that these opioid settlement funds provide New Jersey, the Advisory Council should consider the following recommendations.

First, it is recommended that the Advisory Council seek the allocation of at least $10 million

annually for at least a period of three years to further develop the interoperability of substance use disorder (SUD) providers throughout the state. As has been discussed, there are considerable and indeed prohibitive costs in behavioral health providers becoming interoperable. It is necessary that providers have the necessary funds as well as qualified Information Technology (IT) staff to become interoperable with the New Jersey Health Information Network (NJHIN).

Second, the opioid settlement funds should be used to invest in the physical infrastructure of behavioral health facilities, particularly those evidence-based, integrated facilities located in geographically high-need areas. There are many treatment providers whose facilities are in urgent need of renovation and improvement. The opioid settlement funds present a substantial opportunity to ensure that New Jersey's treatment providers have the necessary infrastructure to continue providing effective SUD treatment.

Third, the Advisory Council should r ecommend to the State that the opioid settlement funds should be used to address the social determinants of health, including housing, legal issues, access to healthcare, family issues such as domestic violence and child support, court-involvement, and transportation. Sober housing is particularly important and in need of funding; this evidence-based strategy is often essential in the recovery process and allows for a continuity of care from intensive modalities of care, such as residential treatment and in-patient hospitalization, to less-intensive ones, such as outpatient services. Furthermore, behavioral health providers should be equipped with the capability to address the social determinants of health by connecting persons to housing, disability insurance, government benefits, and legal assistance.

Fourth, the Advisory Council should recommend that these funds be used to expand the operational hours of certain behavioral providers, particularly Opioid Treatment Programs (OTPs), throughout New Jersey. In 2021, the Division of Mental Health and Addiction Services (DMHAS) launched a grant initiative of $4 million to expand the operating hours of OTPs in New Jersey.[124] However, this initiative was only available for five OTPs and was only available for two years. Although this program represents a significant advancement in expanding access to OTPs, this report recommends that New Jersey continue this program. There should be a focus on providing access to 24/7, walk-in MAT programs, with at least one such provider in each county. Of course, in concert with this initiative, the State must ensure that providers have the resources and staffing required to expand their operating hours.

Fifth, these opioid settlement funds should be used to substantially increase reimbursement rates for substance use treatment services in New Jersey. Noncompetitive reimbursement rates constrain the ability of providers to recruit and retain qualified staffing to treat patients; consequently, providers are unable to properly respond to patients' needs. The Advisory Council should thus seek a reimbursement rate increase for the full continuum of substance use treatment services of at least 35 percent. Moreover, these reimbursement rates should have an annual cost-of-living adjustment, based on the Consumer Price Index, to guarantee the long-term stability of providers.

Sixth, the State of New Jersey must devote substantial funding for workforce development. A sizable portion of SUD providers, particularly those in southern New Jersey, experience staffing shortages and difficulty retaining qualified professionals, which contributes to a constrained ability to provide appropriate treatment to persons in need. The State has made some investment to strengthen the workforce for behavioral health providers, particularly a $39 million investment, consisting of $27 million in state dollars and $12 million in federal dollars, in FY2023 and another $37.5 million, consisting of $27 million in state dollars and $10.5 million in federal dollars, in FY2024 for rate and contract increases. However, these funds do not adequately resolve the years-long workforce challenges; providers are still unable to offer competitive salaries to their employees. It is imperative that the State devote extensive funding to workforce development, so that SUD providers able to hire and retain the necessary staff to the meet the increasing demand for behavioral health services.

The foregoing recommendations as to the use of the opioid settlements funds are certainly not exhaustive. The more than $1 billion that New Jersey is set to receive is a rare and significant opportunity to address the opioid epidemic in the state. As the State aims to increase the effectiveness of behavioral health services in New Jersey, it is essential that the State prioritize both immediate needs as well as long-term prevention strategies, both of which are necessary to adequately address the opioid epidemic and save lives.

Legislative Efforts

The New Jersey State Legislature will continue to play a integral role in improving the provision of behavioral health services in the State. Indeed, the Legislature has the authority to pursue many, if not the majority, of recommendations presented in this report through legislation. As there are a number of bills regarding behavioral health currently under consideration, the Legislature must swiftly pass the following bills:

1. S2668/A508: This bill will require that the terms of a contract entered into between a program providing mental health services, substance use disorder treatment services, or services to persons with developmental disabilities and the State must include an annual increase in the cost-of-living adjustment, based on the Consumer Price Index, that the provider receives.

2. S136/A1456: This bill stipulates that the terms of a contract entered into between a child, youth, and family organization and the Department of Children and Families (DCF) must include an annual increase in the cost-of-living adjustment, based on the Consumer Price Index, that the provider receives.

3. S2792/A4223: This bill will require the Medicaid rates for primary care and mental health services to be equal to the Medicare payment rate for the same services.

4. S1895/A3792: This bill will increase the Medicaid reimbursement rates for partial care behavioral health and SUD treatment services by 35 percent, when those services are provided to an adult Medicaid beneficiary on an in-person basis. This bill would also increase the aggregate Medicaid reimbursement rate for transportation services to or from a partial care services provider to be increased from $7 to no less than $10.

Conclusion

The opioid epidemic continues to result in the death of thousands of New Jerseyans each year, and the total death toll increases every day. However, these tragic deaths do not fully convey the actual depth of this public health crisis. In 2021, the latest year for which data is available, 15.51 percent of the population in New Jersey had a substance disorder, a startling statistic that demonstrates how this epidemic affects almost everyone in the state, whether personally or through family and friends.

In recent years, the State has taken formidable steps to strengthen the behavioral healthcare system in New Jersey. The Murphy Administration, as well as past Administrations, have advanced evidence-based treatment, such as the expansion of Medication-Assisted Treatment (MAT) and the integration of behavioral health care and primary care, to guarantee that persons who have substance use disorder (SUD) are able to receive comprehensive, holistic services in a timely manner. In many respects, the State of New Jersey has pursued policies and initiatives that are positive and highly valued improvements and reflect evidence-based strategies in addressing the opioid epidemic.

Nonetheless, deficiencies and gaps in services affect the effective and efficient provision of behavioral healthcare to persons with SUD. Notably, in 2021, 60.7 percent of persons who sought SUD treatment in New Jersey were unable to receive it.[125] With a significantly larger number of persons not even seeking treatment, the State must work with SUD providers throughout New Jersey, so that they can accommodate the demand for treatment. It is crucial that those persons who need but do not seek treatment are properly identified and accordingly referred to the appropriate modality and intensity of treatment.

In recognition of the progress that the State has accomplished and that which remains to be done, this report has outlined several policy recommendations and best practices to improve the behavioral healthcare system in New Jersey. The recommendations pertain specifically to: (1) the behavioral health carve-in to managed care; (2) Certified Community Behavioral Health Clinics (CCBHCs); (3) the integration of behavioral health care and physical care; (4) interoperability; (5) the behavioral health challenges that court-involved persons face; and (6) prevention and intervention. The Opioid Recovery and Remediation Fund and the passage of bills currently proposed in the Legislature are among the avenues to implement the recommendations contained in this report.

It is important to note that the recommendations presented herein are not exhaustive. They do not address all solutions to the opioid epidemic in New Jersey. Rather, the purpose of this report is to identify those areas in behavioral health care that need to be further expanded and enhanced to better address SUDs and improve access.
Properly responding to the opioid epidemic will require years-long coordination and efforts among all federal, state, and local levels of government, as well as that of the private and non-profit sectors and communities.

These recommendations are meant to advance the efforts of the State of New Jersey in addressing this public health crisis that has already taken the lives of so many persons and affected countless other individuals, families, and communities. Access and linkage to comprehensive, holistic, and integrated behavioral health treatment are essential to a robust response to the scourge of addiction in this State. The foremost objective of these recommendations is to
connect persons to treatment at critical points of intervention; place them on the path of long-term recovery and health living; and, ultimately, save lives.

Appendix A: Opioids, Addiction, and the Opioid Epidemic

Opioids are a broad category of pain-relieving drugs that are naturally found in the opium poppy plant. These drugs are either produced directly from the plant, such as morphine and codeine, or synthetically produced using the same chemical structure in a laboratory, e.g., fentanyl and tramadol. Opioids are often used medically to relieve pain and function by interacting with opioid receptors on nerve cells in the body and brain. When opioids bind to opioid receptors on cells, they block pain signals and release large amounts of dopamine throughout the body. Side effects include drowsiness, constipation, vomiting, nausea, and slowed breathing (which may lead to hypoxia or cause an overdose).[126]

Although there are serious risks and significant side effects to such opioids, they are a legitimate course of treatment for pain for some patients. In 2022, 142.8 million prescriptions were dispended to American patients. Common prescription opioids include hydrocodone (Vicodin®), oxycodone (OxyContin®, Percocet®), oxymorphone (Opana®), morphine (Kadian®, Avinza®), codeine, and fentanyl.[128]

Although prescription opioids have a legitimate healthcare value, these drugs are prone to misuse due to their incredibly high addictive nature. Opioids, when consumed, bind to opioid receptors (mu, delta, and kappa) on nerve cells, which causes a cascade of neural signals that reduce pain, activate the reward centers, and produce sensations of pleasure and euphoria. In this process, endorphin and dopamine production are dramatically increased.[129] As a result of the sense of euphoria which results from the consumption of opioids, persons are motivated to repeatedly use the drug, even in the absence of considerable pain, simply to reproduce this sensation.[130]

Development of Addiction

Repeated exposure to drug use affects three major neurocircuits in the brain: (1) the basal ganglia, which involve processes such as motivation, habits, and emotions; (2) the extended amygdala, which plays a role in stress, anxiety, and unease; and (3) the prefrontal cortex, which involves complex behavior, decision making, planning, self-control, and other executive functions.[131] Each brain region is generally associated with a particular stage in addiction: (1) binge/intoxication, where the basal ganglia's reward system produces the intense pleasurable effects of the drug and promote its continued use; (2) withdrawal/negative affect, where the reward systems experience a decrease in function and stress neurotransmitters are produced in the extended amygdala; and (3) the preoccupation/anticipation stage, where the executive functions of the prefrontal cortex are compromised and substance use habits and craving are promoted. Addictive substances produce positive feelings and also relieve subsequent negative feelings, both of which drive the progression to addiction.[132]

Normally, the dopamine receptors in the brain receive a low and stable level of dopamine from the dopamine-producing neurons.[133] However, the consumption of a drug of abuse, such as an opioid, dramatically and rapidly increases the production of dopamine neurons. This "burst firing" and the accompanying high level of dopamine are able to active multiple kinds of dopamine receptors, heightening the effects of the reward.[134] Indeed, the neurons responsible for the production of dopamine will repeatedly fire not only in response to the opioid itself but also in response to stimuli that have consistently preceded the drug's consumption.[135]

As such, the environmental characteristics that are associated with the consumption of a drug (e.g., a person consumes an opioid consistently at a particular location and time of day) may serve as a vehicle for further drug consumption. Environmental stimuli become conditioned and, as the use of drug is continued to be accompanied by the same environmental stimuli, they will trigger increased dopamine production, as there is now an expectation of a reward, i.e., the drug. Consequently, the individual is motivated to engage in the behavior that will secure the reinforcer, namely consuming the drug. Yet, whereas non-pharmacolog-

ical reinforcers do not increase dopamine production, drugs do. This two-fold dopamine production further reinforces the behavior of drug consumption.[136] For certain drugs, however, such as cocaine, the increase in dopamine production is modulated by downstream inhibition of dopamine neuron cell firing and dopamine release. Such an observation may explain why the "high" of cocaine is reduced with subsequent episodes of cocaine consumption.

As persons consume opioids repeatedly over time, tolerance is developed to the drug, as the nerve cells gradually become less responsive to the same opioid stimulation. As such, over time, one will need to consume an increasingly greater amount of the drug in order to produce the same level of euphoria produced from prior episodes of drug consumption.[137] Unfortunately, opioid tolerance can lead to opioid dependence, which can develop in a few weeks of repeated use. As a person continues to consume opioids, the person begins to physiologically adapt to the continued stimulation of the opioid. The brain begins to treat the repeated exposure of opioids as its new "normal," adjusting its production of neurotransmitters and other chemical signals in accord with the presence of opioids in the body. The sudden cessation or abrupt reduction of opioid consumption can thus cause opioid withdrawal.[138] Withdrawal symptoms include muscle ache, bone pain, yawning, diarrhea, cramps, agitation, sweating, anxiety, and other negative emotional states.[139]

For example, neurons in the locus coeruleus are involved in the production of noradrenaline, a chemical that stimulates blood pressure, wakefulness, and alertness. The introduction of opioids into the body and brain causes the production of this chemical to be suppressed. As a person consumes opioids for an extended period of time, the locus coeruleus compensates by returning its activity to relatively normal levels, likewise producing noradrenaline at a normal level. When a person ceases or significantly reduces the consumption of opioids, the neurons in the locus coeruleus compensates by producing high amounts of the chemical, which causes anxiety, muscle cramps, and diarrhea, the characteristic systems of withdrawal. The pleasurable sensations produced from the activation of the brain's reward system promotes the continued use of opioids. Yet, repeated opioid use will also induce the development of negative withdrawal symptoms when such use is discontinued. The onset of these withdrawal symptoms in turn prompts the person to continue drug consumption as a result of the natural tendency to avoid pain. If the person continues to consume opioids on a long-term basis, addiction to the drug may, if not will, develop.[140]

An addiction is a chronic disorder that is characterized by compulsive behavior of drug seeking despite the presence of negative consequences. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, defines a substance use disorder[141] as characteristically "a cluster of cognitive, behavioral, and physiological symptoms indicated that the individual continues using the substance despite substance-related problems."[142] More specifically, addiction causes a compulsion of seeking and consuming the drug, inability to limit intake, and negative emotional states when access to the drug is limited or restricted. Addiction does not develop as the result of a singular instance of drug consumption but rather follows the repeated consumption over a significant period of time, i.e., on the order of weeks or months.

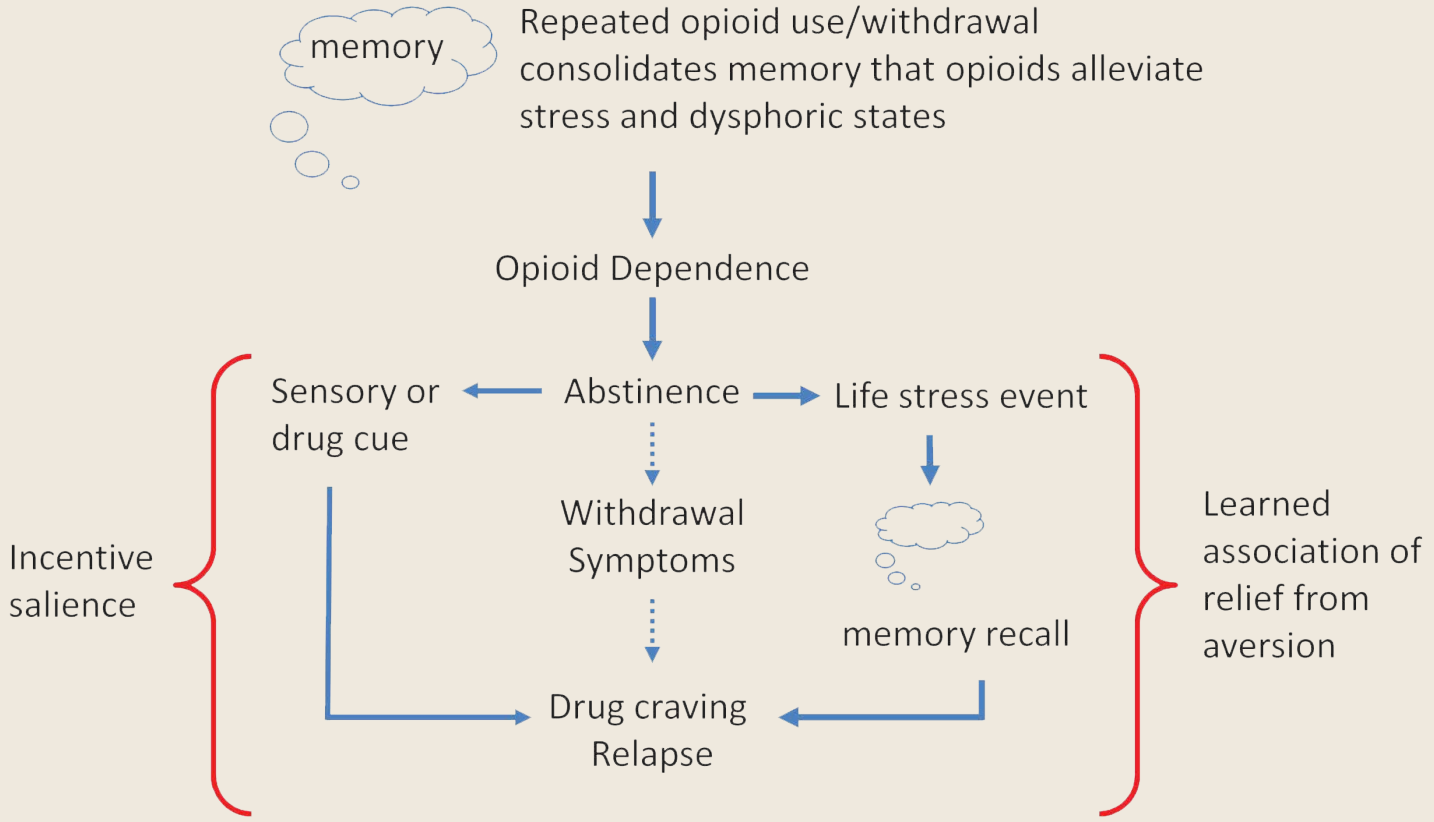
People who suffer from addiction experience behavioral changes that adversely affect their ability to function. Such behaviors persist in the face of a professed desire to reduce or eliminate drug consumption. The transition from proper drug usage to dependence to addiction is based upon many factors, including the type of drug, pattern of usage, genetics, age, and environment. The development of addiction involves impulsivity, positive reinforcement, negative reinforcement, and compulsivity. As drug use becomes habitual, a person no longer exhibits impulsive behavior but rather compulsivity. Indeed, instead of the positive reinforcement that initially characterized the drug consumption, a person's habitual use of an addictive system is reflective of negative reinforcement, where the person uses the drug to feel relief from withdrawal systems. At this point, the person no longer consumes the drug to feel the "high" but instead to escape the "low" feelings. Compulsive behavior, such as seeking the drug at the expense of responsibilities and relationships, now characterizes the drug user.[144]

Recovery is offset with the likelihood of relapse. A person relapses when they return to a previous pattern of substance use. Evidence shows that relapse will be a likely phenomenon in a person's path of treatment. Relapse rate following detoxification ranged from 72 percent to 88 percent after 12 to 36 months.[145] Another study of opioid dependent patients discharged from detoxification treatment reported a relapse rate of up to 91 percent in persons with OUD, and the initial relapse occurred during the first week of discharge for 59 percent of cases.[146] Given the potential for relapse following discharge from

inpatient treatment, when tolerance is lowered, if such a relapse occurs, the likelihood of opioid overdose is significantly heightened.[147]

Negative moods and attitudes, external pressures from the environment, and lessened vigilance constitute high risk factors for relapse. The degree of craving versus self-efficacy (respectively, the desire to use the drug versus the perceived ability to resist it) are also notable psychosocial factors. Early relapse after inpatient detoxification was found to be associated with younger age, history of injecting, and failure to enter aftercare services (i.e., a lack of continuum of care). Other factors also include withdrawal, lack of a protective environment, drug availability, social encouragement, and drug-related cues.

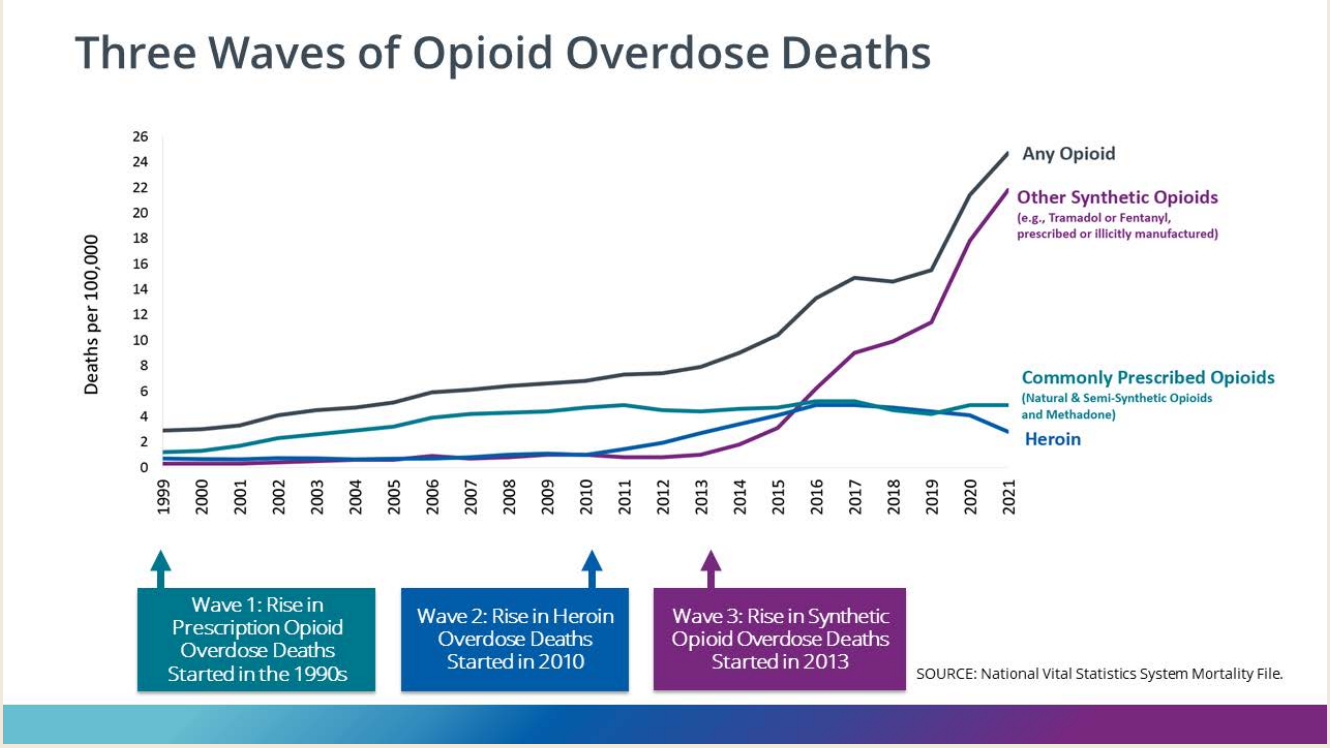
Persons who use opioids are at risk for opioid overdose, which occurs when a person's opiate pathways are excessively stimulated. Opioid use generally stimulates opiate receptors in the central nervous system, causing sedation and respiratory depression. During an overdose, the portion of the brain that regulates the respiration rate is excessively affected, which results in respiratory depression, hypoxia, and eventually death. The "opioid overdose triad" of symptoms is pinpoint pupils, respiratory depression, and a decreased level of consciousness. Risks for opioid overdose include escalating doses, returning opioid use after cessation, and combining the use of opioids with other drugs (e.g., other opioids, alcohol, sedative medications).[148]



History of the Opioid Epidemic in the United States

The opioid epidemic in the United States is often identified as containing three distinct waves, each of which is fueled due to the dominance of a particular class of opioids.[149] Accordingly, the United States experienced this epidemic due to: (a) prescription opioid pills, (b) heroin, and (c) synthetic opioids, particularly fentanyl.[150] The United States is currently experiencing the "third wave" of the opioid epidemic, as fentanyl now dominates the opioid drug supply and is responsible for the vast majority of the opioid overdoses in New Jersey and United States at large.[151]

The "first wave" began in the 1990s, when the prescription of opioids increased for the purposes of relieving pain in patients. In 1995, the American Pain Society launched a "pain as the fifth vital sign" campaign to encourage physicians and other healthcare providers to focus on pain as a key metric for treating patients.[152] In 2000, the Joint Commission



published standards for pain management, underscoring the need for quantitative assessments of pain in patients.[153] The emphasis on pain management in the healthcare community nonetheless had unwanted consequences. Physicians, with the intention of fulfilling the mandate to provide adequate pain management to patients, began to quite strongly rely on opioid medications. Pharmaceutical companies likewise encouraged the use of opioids as a humane, safe, and effective means of pain management.[154] OxyContin prescriptions, for example, increased from 670,000 to 6.2 million in the span of five years, from 1997 to 2002.[155]

Concerns as to the overaggressive prescription of opioids emerged. According to one study from 2005, during the midst of this first wave, there was more than double the incidence of adverse drug reactions to opioid over-sedation after a numerical pain treatment algorithm was implemented.[156] Pharmaceutical companies were also noted to have contributed substantially to the opioid epidemic. In 2007. Purdue Pharma pleaded guilty to charges of misbranding Oxycontin, agreeing to pay $634.5 million to resolve ongoing investigation as well as $19.5 million for settlement with 26 states and the District of Columbia.[157] Numerous investigations, lawsuits, and settlements have since taken place. The total number of dispensed prescriptions in the United States peaked in 2012 at more than 255 million.[158] As opioid prescriptions decreased, the epidemic entered its second wave and began to be defined by the increasing presence of heroin.

The second wave of the opioid epidemic began around the early 2010s due to misuse of heroin and its increasing availability.[159] Heroin is an illicitly produced semisynthetic opioid made from morphine, a natural substance derived from opium poppies.[160] As efforts increased to inform the public and the healthcare community about the ill effects of overprescribing opioids as pain relievers, access to prescription opioids was limited. There has been a documented pathway between prescription opioid use and heroin.[161] In 2011, about 80 percent of persons who used heroin had first misused prescription opioids.[162] For persons who had developed a dependence and addiction to opioids, heroin was seen as the economic and even logical choice, given greater difficulty in obtaining prescription opioids and the higher cost associated with it. Nonetheless, over time, heroin increasingly became a person's initial opioid, from 8.7 percent in 2005 to 31.6 percent in 2015.[164] Furthermore, from 2010 to 2012, the death rate from heroin overdose in 28 states increased from 1.0 to 2.1 per 100,000 persons, a 110 increase in two years.

The use of heroin as opposed to prescription opioids also had other concerning medical consequences. While prescription opioids were routinely ingested orally, heroin can be smoked, insufflated, or intravenously injected. The tendency to consume heroin via injection through the use of needles has contributed to the transmission of blood-borne viruses such as hepatis C or HIV. The United States has

experienced two documented HIV outbreaks due to the use of shared needles in Indiana and Massachusetts.[166,167]

It is important to note that there was a significant difference in age groups affected by these two respective waves of the opioid epidemic. In the years 2012 to 2014, the age distribution of persons hospitalized for opioid prescription overdose had its largest peak in the 50- to 64-year-old age group, whereas the peak age group for heroin overdoses was 20- to 34-year-olds.[168] This statistic reflects that the transition of dependence from opioid prescriptions to heroin use created an environment where younger persons began using heroin directly, without any prior opioid use.

The third wave of the opioid epidemic began in 2013 when there was a marked increase in the misuse, abuse, and overdose of synthetic opioids, particularly illicitly-produced fentanyl.[169] Fentanyl is approximately 100 times more potent than morphine and 50 times more potent than heroin.[170] Although fentanyl can be legitimately prescribed to patients to treat severe pain, it is illicitly-produced fentanyl that has sustained the opioid epidemic during this third wave. There are also fentanyl analogues that differ in potency, as well as other novel synthetic opioids in the illicit drug supply that contribute to overdose deaths.

The primary source of fentanyl in the United States is China, according to the United States Drug Enforcement Administration (DEA). The flow of fentanyl into the United States is complex and may take a number of routes, such as via Canada or Mexico. Mexico and India are expected to play an increasingly greater role as sources of fentanyl. Notably, whereas DEA seizures of fentanyl produced in Mexico contain less than a 10 percent concentration, DEA seizures of fentanyl sourced from China contain a more than 90 percent concentration, highlighting that the Chinese supply has an extremely high purity.[171]

Fentanyl continues to dominate the illicit drug supply in New Jersey and throughout the country. Indeed, this power synthetic opioid accounts for an increasingly larger supply of overdose deaths in the state. In 2015, 26.28 percent of drug deaths in New Jersey were due to fentanyl in 2015; in 2019, that percentage was 77.7 percent.[172] Since fentanyl is often sold as heroin or counterfeit opioid pills,[173] overdose deaths now often occur due to a person unwittingly using fentanyl, where a potentially lethal dose is only two milligrams.[174] In 2021, nearly 75 percent of overdose deaths that involved heroin also involved synthetic opioids such as fentanyl.[175] Fentanyl has made the opioid epidemic even deadlier and severely complicated the ability of the state, counties, and community to effectively respond to substance abuse.

There is also concern for the emergence of new drugs in the illicit drug supply. Notably, xylazine, a non-opioid veterinary tranquilizer known as "tranq," has increasingly been used in conjunction with fentanyl and plays a greater role in overdose deaths.[176] According to the DEA, between 2020 and 2021, xylazine-related overdose deaths increased more than 100 percent in the Northeast, 500 percent in the Midwest, 750 percent in the West, and 1,127 percent in the South.[177] On April 12, 2023, the White House Office of National Drug Control Policy designated fentanyl adulterated with xylazine as an emerging threat in the United States.[178]

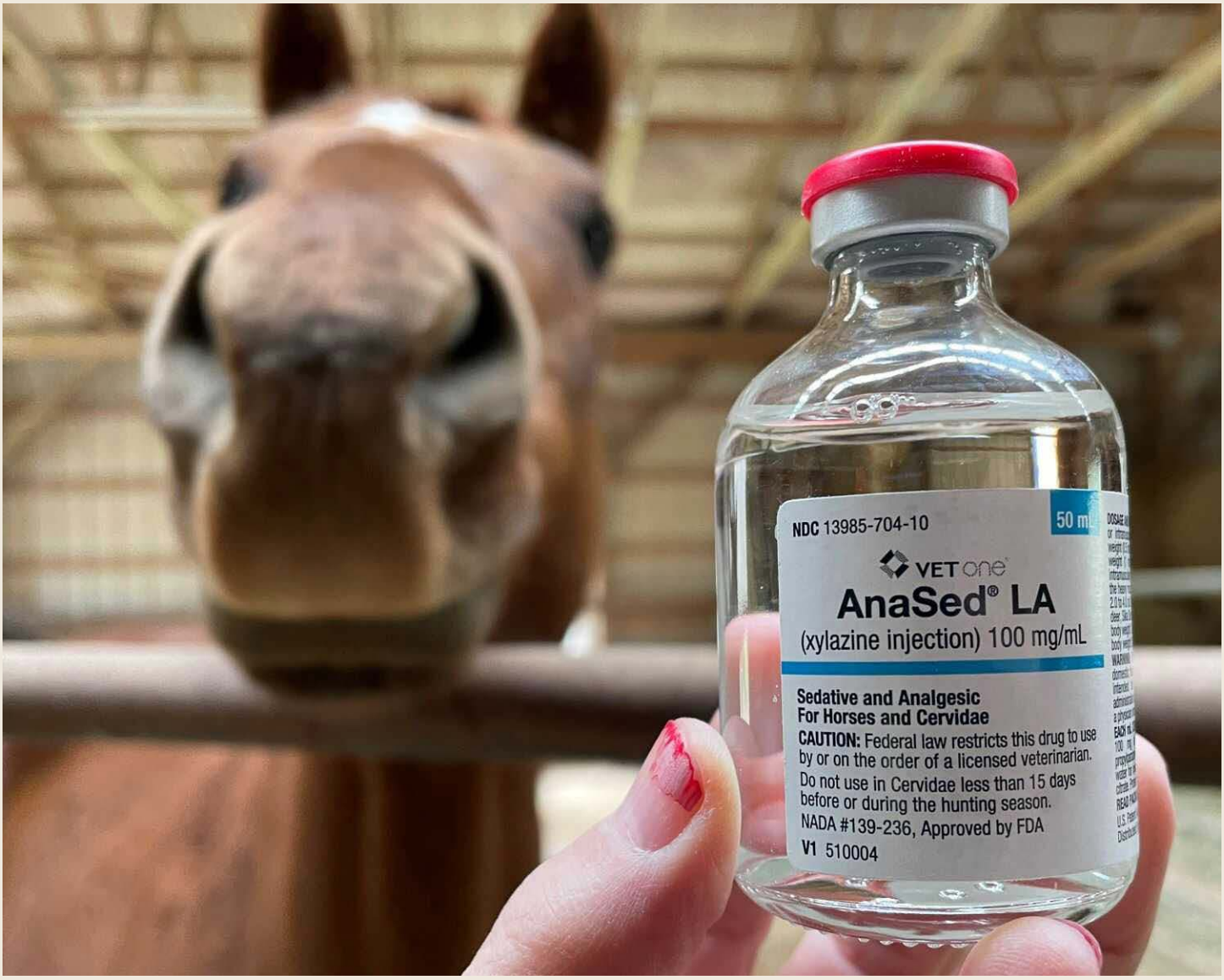
This drug has been increasingly prevalent in the illicit drug supply in New Jersey. In 2022, 36 percent of suspected heroin and fentanyl seizures contained xylazine, and 99 percent of all drug seizures containing xylazine also contained fentanyl.[179] Evidently, those persons using xylazine are primarily persons are using fentanyl. Deaths involved xylazine are also sizable: in 2021, nearly 8 percent of overdose deaths involved xylazine and during the six months of 2022, this proportion increased to 10 percent. Unfortunately, xylazine may complicated an existing opioid overdose, because it does not respond to naloxone and symptoms from exposure to xylazine may mimic an opioid overdose. As such, it may be difficult to determine whether a person is experiencing an overdose due to opioids or xylazine.

The changing landscape of the illicit drug supply in the United States and New Jersey warrants continuous monitoring. It is necessary that efforts to address the opioid epidemic and the ill effect of fentanyl also includes addressing the presence of other illicit drugs such as xylazine. A proper response to the addiction crisis requires a complete understanding of how the drug supply evolves and how the dangers of addiction is significantly augmented by their combination.

Economic Costs of the Opioid Epidemic

The opioid epidemic in the United States has had massive economic costs. According to the White House Council of Economic Advisors, the burden of opioid use disorder and overdose deaths was estimated to be $684.6 billion in 2017, which is 3.5 percent of the U.S.'s total GDP. This statistic is a 35.8 percent increase from the 2015 estimate of $504 billion. The Centers for Disease Control and Prevention found the economic cost of the opioid epidemic to be far higher: in 2017, costs totaled approximately $1.02 trillion, 54 percent of which was due to overdose deaths and 46 percent of which was due to opioid use disorder.[180] According to the 2021 estimates, each year, the opioid epidemic account for $35 billion in healthcare costs, $14.8 billion in criminal justice costs, and $92 billion in lost productivity.[181]

Many studies have documented the relationship between a region's high exposure to opioid prescription and significant declines in participation in the labor force.[182] In a 2016 survey of men aged 25- to 54-years-old who were not in the labor force, nearly half took pain medications daily, two-thirds of whom took prescription pain medications.[183] The increase in opioid prescriptions from 1999 to 2015 may be responsible for 43 percent of the documented decline in labor force participation among prime age men. [184] Furthermore, the opioid epidemic has, in addition to reducing the labor force participation, also increasing applications for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).[185]



Appendix B: Treatment

Treatment is the process in which persons struggling with addiction receive intervention and comprehensive services to address their physical, mental, and behavioral health challenges and ensure long-term, sustainable recovery. Opioid addiction, known as opioid use disorder (OUD), is a chronic and relapsing disease that is treatable.[186] The characteristics of treatment vary depending on a person's individual needs, circumstances, and the particular drug(s) used. Treatment is the critical juncture at which a person struggling with addiction is placed upon a path of recovery and must constitute a comprehensive plan of care.

Levels of Care

Treatment for substance use disorder is often preceded by detoxification, during which a person who is acutely intoxicated and dependent on a substance is cleared of toxins. Detoxification thus manages acute intoxication and withdrawal. Although detoxification programs do not themselves resolve the psychological, behavioral, and social problems associated with substance use disorder, it is nonetheless a necessary treatment for addressing them. During detoxification, persons are stabilized and prepared for entry into treatment. Detoxification itself will likely not produce long-term recovery. Treatment must succinctly follow detoxification, as the reduction in tolerance to opioids that occurs during detoxification may increase the risk of overdose. [187]

Substance abuse treatment is offered in either
inpatient or outpatient settings. Treatment programs continue to diversify and may take many approaches and modalities. The American Society of Addiction Medicine (ASAM) Criteria is a comprehensive set of guidelines used for placement, continued stay, and discharge for persons with addiction and co-occurring disorders. Many states, including New Jersey, use these criteria as the basis for clinical guidelines and medical review. The New Jersey Administrative Code, for example, states that the "evidence-based and peer-review clinical practices appropriate to review the medically necessity of substance use disorders [are] the ASAM criteria."[188]

ASAM has defined five major levels of care in treating substance use disorders, with defined intermediary levels of care as well:

- Level 0.5: Early Intervention Services
- Level 1: Outpatient Services
- Level 2.1: Intensive Outpatient Services
- Level 2.5: Partial Hospitalization Services
- Level 3.1: Clinically Managed Low-Intensity Residential Services
- Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services
- Level 3.5: Clinically Managed High-Intensity Residential Services
- Level 3.7: Medically Monitored Intensive Inpatient Services
- Level 4: Medically Managed Intensive Inpatient Services [188]

Persons may require more than one of these treatment modalities, depending on the severity of their addiction and their progress in recovery.[190]

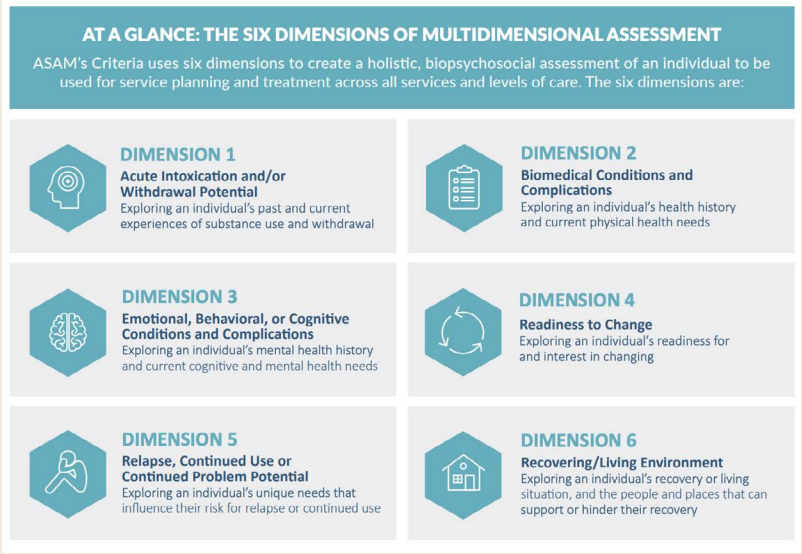
Intensive inpatient services include continuous supervision and treatment in a hospital setting that seeks to medically manage detoxification and medical/psychiatric crisis. This inpatient hospitalization usually lasts a short period of time and is restricted to patients with (a) severe overdoses; (b) severe withdrawal symptoms; (c) acute medical conditions that may complicate withdrawal; (d) mental health comorbidities who are a danger to themselves or others; and (e) acute substance dependence and failure to respond to less intensive treatment modalities.

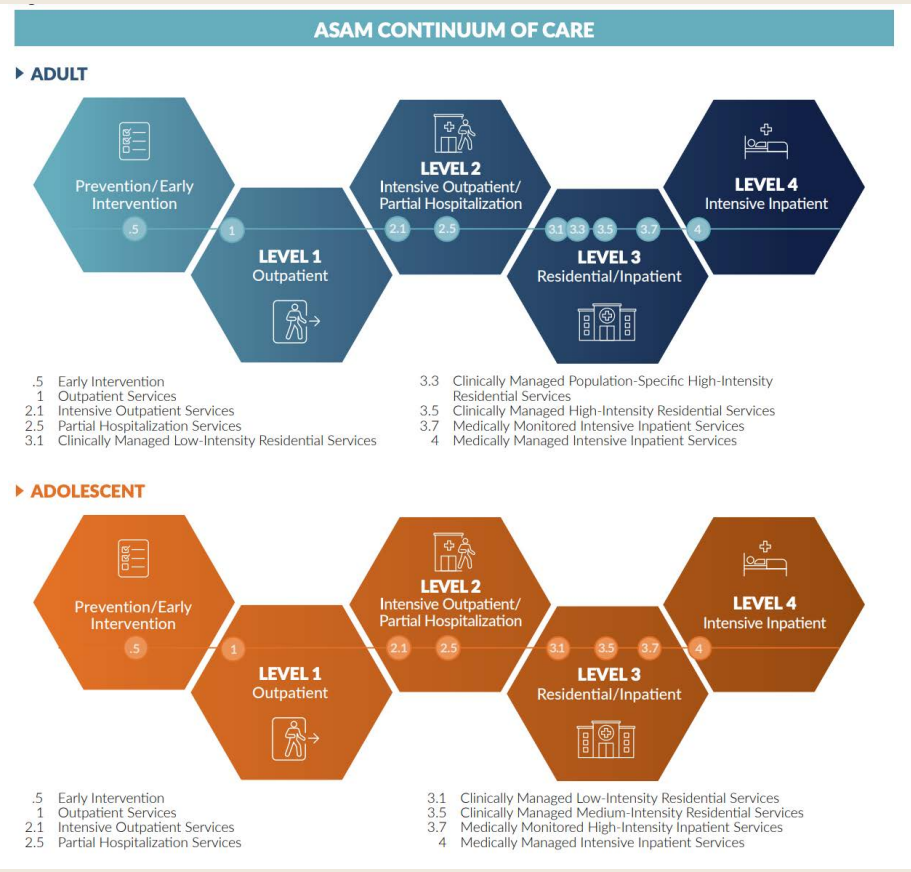
Residential treatment provides intensive care in a live-in facility with 24-hour supervision. This form of treatment is suited for persons who have a significant substance use disorder and do not have the proper motivation and social supports for successful recovery but nonetheless do not warrant inpatient hospitalization. Residential treatment offers monitoring of detoxification, withdrawal or maintenance management, psychological support such as behavioral cognitive counseling, and

community support. The length of stay may be short-term, such as four weeks, or long term, such as a year.[191]

Intensive outpatient services (IOPs) required a specified number of hours of weekly attendance (usually a minimum of 9 hours). This treatment is best suited for persons beginning treatment or transitioning from a more intensive modality such as residential treatment. IOPs provide a full range of services while allowing the patient to remain living in their homes and community. IOPs may be located in hospitals, community behavioral health centers, or day treatment programs.[192]

Outpatient treatment refers to treatment settings that require a weekly attendance of less than nine hours a week. Services may include medication-assisted treatment, behavioral cognitive therapy, and community support. Given that this form of treatment is the least intensive, patients in outpatient treatment should have appropriate support systems and living arrangements, access to transportation, and motivation to attend the services.[193]





Relapse prevention may include a variety of strategies, including identifying high-risk situations and antecedent factors, circumstances, and decisions that may contribute to the likelihood of relapse. An important psychological phenomenon is "abstinence violation effect," where a person's relapse precipitates the desire to maximize it. Another phenomenon is the "problem of immediate gratification" where persons choose smaller rewards in the short term instead of larger rewards in the long term. These phenomena must be addressed in employing relapse prevention efforts.

The aim of substance abuse treatment is to ensure that patients are treated in the least restrictive environment that is nonetheless still effective and safe. As patients undergo treatment, they may be moved to a less structured setting as may be appropriate. Nonetheless, relapse or failure to respond to a particular treatment setting may require placing a patient in a more restrictive and intensive environment.

Medication-Assisted Treatment

Medication-assisted treatment (MAT), the combination of psychosocial therapy and an approved medication, is a best practice for treating opioid use disorder. The National Institute on Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration (SAMHSA), ASAM, the Centers for Disease Control and Prevention (CDC), and the American Medical Association (AMA) all recommend MAT as a best practice for treatment of OUD.[194]

The Food and Drug Administration has approved the use of three drugs for the treatment of opioid use disorder: methadone, buprenorphine, and naltrexone. Buprenorphine and methadone are opioid agonists; since these medications are still opioids, they allow the patient to substitute these medications for the stronger full agonist opioid such as heroin. Naltrexone is an opioid antagonist (not an opioid) that blocks the effect of opioids.[195]

Methadone is a long-acting, synthetic opioid agonist and thus fully binds to the mu-opioid receptors in the brain, the same receptors to which prescription and illicit opioids bind. The binding to the opioid receptors allows methadone to lessen the effect of withdrawal symptoms and does not produce euphoria.[196] Notably, since methadone is an opioid itself, individuals do not first have to undergo opioid withdrawal before taking this medication. Nonetheless, methadone sustains opioid tolerance and dependence, so failing to take this medication as prescribed may cause withdrawal and overdose. Indeed, there is an elevated risk of opioid overdose death during the first two weeks of methadone treatment; that risk is substantially lowered after this period.[197] By law, methadone may only be dispensed through a state- and federally-certified opioid treatment program (OTP).[198]

Buprenorphine is a partial opioid agonist and thus only partially binds to the mu receptor, activating it less strongly than full agonists do. Similarly to methadone, buprenorphine lessens the effect of withdrawal symptom. This medication also has a lesser effect on respiratory depression due to its "ceiling effect" (where doses above 24 mg do not increase effects on respiratory function) and is thus safer than methadone for agonist substitution treatment. In order for an OUD patient to use buprenorphine, they must abstain from using opioids for at least 12 to 24 hours. Buprenorphine may be provided at an OTP but is commonly prescribed in office settings. Buprenorphine is also commonly formulated with naloxone, an opioid antagonist that assisting in preventing the misuse of the medication.[200]

Naltrexone is a mu opioid receptor antagonist that alters the reinforcing effect of euphoria produced from opioids. This medication blocks the activation of opioid receptors. Given its function, this medication is used to prevent relapse by blocking the euphoric and sedative effects of opioids. Naltrexone is long-acting, allowing for consistent medication levels for a month. Yet, naltrexone can cause withdrawal symptoms, and thus patients must have already undergone withdrawal and four to seven days without any opioids prior to initiation. Any practitioner licensed to prescribe medications can prescribe naltrexone.[201]

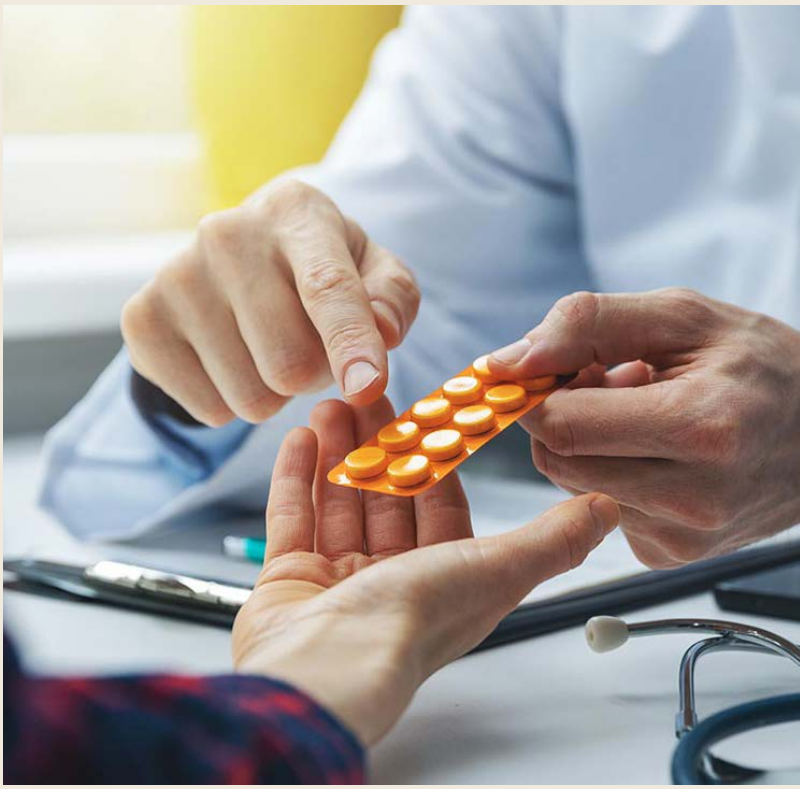
Abundant evidence and research demonstrate that these three medications are safe and effective. Medication-assisted treatment reduces opioid use, opioid use cravings, and opioid use disorder symptoms. Treatment using agonist medication such as methadone, for example, is associated with a 50 percent reduced mortality among persons with OUD. Methadone and buprenorphine have been demonstrated to reduce all-cause and overdose-related mortality among persons with OUD. Medication-assisted treatment has also been shown to decrease criminal activity, decrease injection drug use, reduce HIV and hepatitis C infections,[207,208] improve social functioning,[209] and result in a better quality of life for persons with OUD who do not receive treatment.[210]

In conjunction with the aforementioned medications, MAT also comprises counseling and behavioral therapies. This psychosocial intervention encompasses a variety of methods and components, including motivational interviewing, contingency management, and individual, group, and/or family counseling.[211] Federal law requires that patients in an Opioid Treatment Program (OTP) be able to receive counseling and behavioral therapies.[212]

Yet, there are many challenges to MAT. These medications are controlled substances and while effective and safe, they nonetheless do have risks and side effects, some of which are serious when these medications are not taken as directed. Common side effects of methadone include, for example, dizziness, nausea, vomiting, constipation, sweating, and slow breathing; serious side effects include difficulty breathing, chest pain, and fainting. If persons add illicit opioids to their prescribed methadone, for example, their risk of death is increaed. It is imperative that patients follow directions given by physicians and healthcare providers when taking these valuable and often necessary medications. [213]

Furthermore, controversy and stigma remain concerning the use of medications to treat persons with OUD. Indeed, many persons do not understand why a person suffering from OUD should be given a potent opioid, methadone, as treatment. A persistent and false attitude toward MAT is that it is simply replacing one addiction with another.[214] In addition to the stigma and stereotypes associated with OUD itself, the misconceptions of MAT among the general public have shown to reduce treatment seeking.[215]

There is also a lack of access to MAT. Despite its documented effectiveness, only 11 percent of persons with OUD are estimated to receive a Food and Drug Administration (FDA)-approved medication for treatment.[216] This underutilization may be attributed to a number of factors. Evidence shows that concerns about misuse of OUD medications from prescribers serve as a barrier to providing patients with this treatment; about one-third of respondents to a national survey of buprenorphine providers viewed diversion as a significant concern.[217] Nonetheless, these concerns are not consistent with the evidence. The diversion of methadone, for example, has been in decline by 13 percent each year since 2010.[218] Furthermore, studies show that rates of misuse decline as the availability of buprenorphine increases.[219] It is a best practice to expand access to MAT while employing efforts to ensure that patients properly use their medications as directed.



Naloxone

Naloxone is an opioid antagonist that rapidly reverses an opioid overdose. By attaching to opioid receptors, it can reverse and block the effect of other opioids, such as heroin, morphine, oxycodone, and fentanyl. If given in time, naloxone is able to restore normal breathing within two to three minutes to a person who has slowed or no breathing as a result of overdose.[220] This medicine should be given to any person who shows signs of an overdose. Since naloxone has no effect on someone who has not consumed any opioids, it is highly recommended that naloxone be administered even if there is doubt as to the occurrence of an opioid overdose. The FDA has approved the use of naloxone in two forms: injectable and nasal spray.[221]

The use of naloxone lasts for only 30 to 90 minutes. Since opioids may remain in the body longer than that duration, an overdose may still occur after a dose of naloxone wears off. It is imperative that persons who have received naloxone are monitored until emergency care arrives and for two hours following the last administered dose of naloxone. Multiple doses may be required for stronger opioids, such as fentanyl. Naloxone may produce serious side effects, including causing symptoms of opioid withdrawal. Medical assistance must be obtained if such symptoms emerge. These withdrawal symptoms include nervousness, body aches, diarrhea, stomach pain, fever, chills, and dizziness.[222]

There have been considerable efforts to expand access to naloxone. In March 2023, the FDA approved Narcan, 4 milligram naloxone hydrochloride nasal spray, for over-the-counter use.[223] This approval is the first naloxone product available for use without a prescription. Narcan nasal spray was first approved as a prescription drug in 2015 by the FDA. This change will allow persons to purchase naloxone directly from drug stores, grocery stories, convenience stores, and online.

Evidence demonstrates that greater access to naloxone will save lives. According to a national study, there was 14 percent reduction in opioid overdose deaths when states enacted laws that provided greater access to naloxone.[224] Another study suggested that 21 percent of opioid overdose deaths could be prevented through distribution of naloxone among emergency personnel and the general public.[225]

Appendix C: Fee-for-Service and Managed Care

Medicaid under Managed Care

Medicaid is a public health insurance program for low-income persons that is jointly funded by the federal and state governments with each state operating its own program. Medicaid today provides medical insurance to 86.7 million people, including low-income adults, children, pregnant women, persons with disabilities, and persons who need long-term care.[226] New Jersey's Medicaid program, NJ FamilyCare, is administered through the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and provides health insurance to low-income adults, pregnant women, parents, and dependent children.[227] According to the New Jersey Department of Human Services, there are now 2,315,868 persons, or 24.9 percent of the population, enrolled in NJ FamilyCare.[228]

A state must follow federal rules and regulations in order to receive federal funding for its respective Medicaid program. The Centers for Medicare and Medicaid Services, Department of Health and Human Services, is the federal agency with which states work in partnership to administer their Medicaid programs. The Social Security Act, the underlying statute which authorizes the Medicaid program, allows the federal government to approve waivers and demonstrations (e.g., a Section 1115 waiver) that allow states to operate their Medicaid programs outside of certain federal regulations. Given the broadness of federal rules and the ability for states to secure certain waivers, state Medicaid programs vary considerably.[229]

Medicaid enrollees receive benefits through one of two service delivery systems: fee-for-service (FFS) or managed care. Historically, most Medicaid programs in the United States were delivered on an FFS basis, whereby providers bill Medicaid directly for each covered service received by a Medicaid beneficiary.[230] This delivery system incentivizes healthcare providers to provide a higher volume of services, even when such services are unnecessary to ensure quality of care or positive health outcomes. In addition, states set the FFS rates that Medicaid pays healthcare providers. Generally, Medicaid rates are less than Medicare rates, which are also well below commercial (i.e., private insurance) rates. The difference in reimbursement rates disincentivizes healthcare providers from accepting Medicaid due to the decrease in payment for their services.[231]

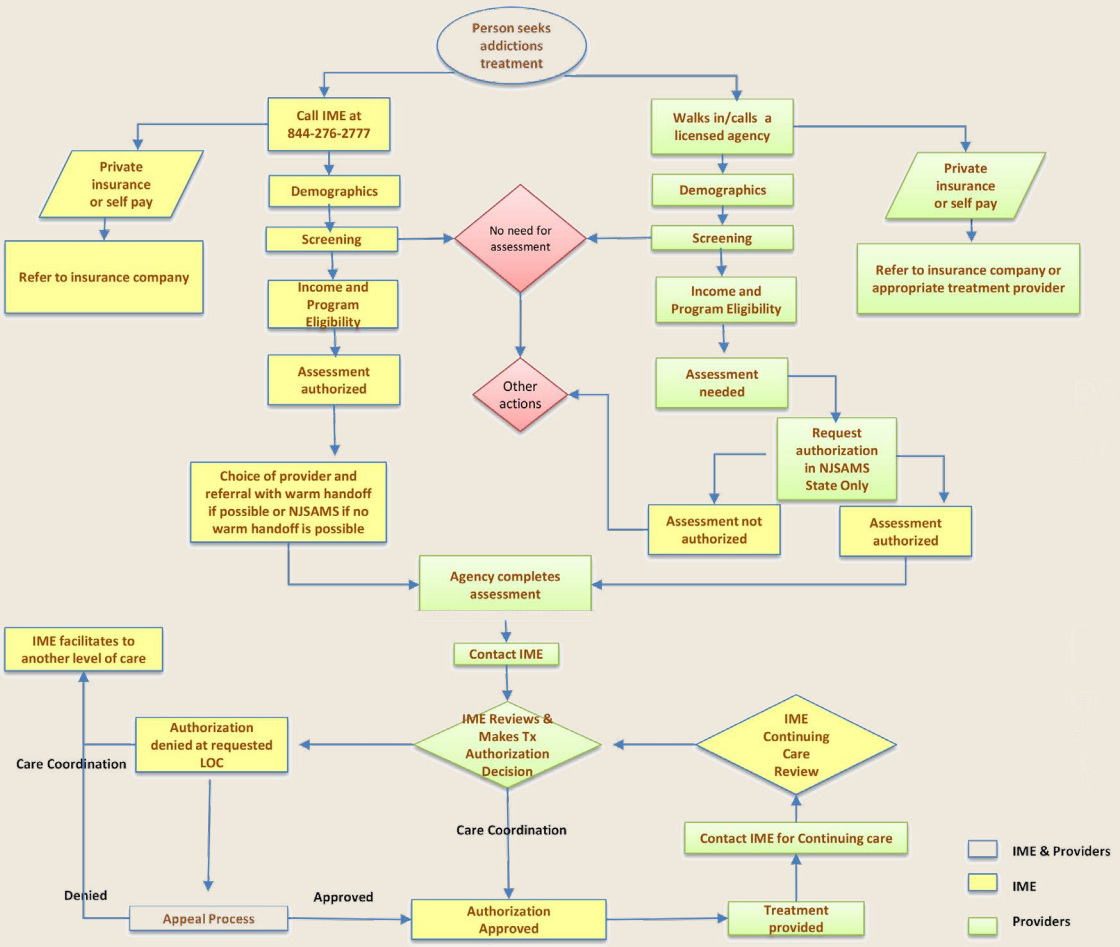
In an effort to respond to these deficiencies, states have largely turned to a managed care delivery system. States may implement managed care in their Medicaid program through four types of federal authorities: sections 1915(a), 1915(b), 1932(a), and 1115(b) of the Social Security Act.[232] This transition from FFS to managed care began in the 1990s, and the share of Medicaid enrollees covered by a managed care delivery system has increased significantly. In 2020, 83.94 percent of all Medicaid enrollees were in some form of managed care. There are three main types of Medicaid managed care: (1) comprehensive risk-based managed care, where states contract with managed care organizations (MCOs) to provide comprehensive benefits and oftentimes pay them a fixed monthly rate per persons; (2) primary care case management, where states contract with primary care providers to provide case management to Medicaid beneficiaries for a monthly fee, while other services remain fee-for-service; and (3) limited benefit plans, where states contract with plans to provide coverage for one or two Medicaid services. Comprehensive-risk based managed care is the most commonly used type of managed care. In 2020, 72.41 percent of Medicaid enrollees were in comprehensive-risk based managed care.[233]

Managed care seeks to manage cost, utilization, and quality. A managed care delivery systems seeks to provide the following functions: (a) assessment of risk factors; (b) development of a plan of care; (c) referrals and assistance to ensure timely access to providers; (d) coordination of care linking enrollee to providers, medical services, and other support services; (e) monitoring; (f) continuing of care; and (g) follow-up and documentation.[234] With managed care, states seek to provide timely access to high-quality and cost-effective health care services that are tailored to the enrollees' needs.

New Jersey began transitioning Medicaid beneficiations into statewide managed care from a traditional fee-for-service model in 1995. Beginning with enrolling children through the KidCare program, New Jersey expanded managed care to parents and some childless adults under NJ Family Care.[235] New Jersey subsequently sought to place most Medicaid beneficiaries into managed care. By 2011, about 75 percent of all NJ FamilyCare clients were enrolled in a managed care plan for their physical health care.[236] Today, 94.4 percent of all Medicaid beneficiaries in New Jersey are enrolled in managed care, all of which is provided under the comprehensive-risk based model.[237] In October 2012, New Jersey received federal approval from the Centers for Medicare and Medicaid Services to reform and expand its managed care system through a Section 1115(b) demonstration waiver.[238] Through the New Jersey Comprehensive 1115(b) Demonstration waiver, nearly all Medicaid and Children's Health Insurance Program (CHIP) beneficiaries are required to receive their benefits through managed care.[239]

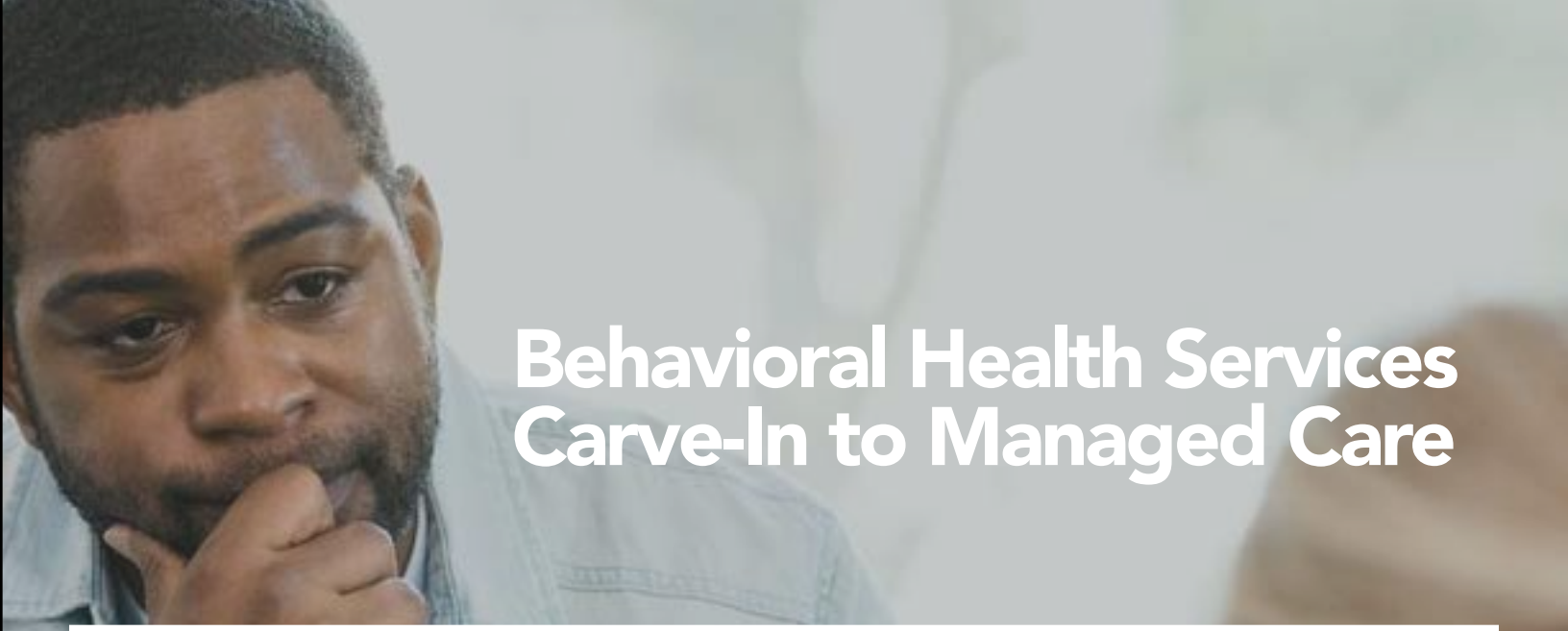
In New Jerseys, persons enrolled in Medicaid receive benefits by enrolling in a managed care organization (MCO), which coordinates the person's healthcare and management of services. There are currently five MCOs that participate in New Jersey's NJ FamilyCare Medicaid program: (1) Aetna Better Health of New Jersey, (2) Amerigroup New Jersey, (3) Horizon NJ Health, (4) UnitedHealthcare Community Plan, and (5) WellCare of New Jersey.[240] The State uses one contract, which each MCO signs in order to participate in the Medicaid programs. MCOs are not reimbursed on a fee-for-service schedule but rather through a capitation rate, which is the fixed monthly amount that the State pays the MCO for each enrollee. Capitation rates are required to be actuarily sound, so as to cover the costs of the provided services.[241] The contract also specifies supplemental payment for pregnancy, certain blood products, and certain medication drugs. MCOs are responsible for paying providers, with whom they contract, for the services provided to enrollees.[242] MCOs determine the method of reimbursement (often on an FFS basis) and exact rates when contracting with the providers. As part of its care management, providers must receive prior authorization from MCOs to provide certain services. If prior authorization is not granted, enrollees may be required to pay for the services directly.[243] The services that require prior authorization varies among the five health plans.

Behavioral Health Services Carve-In to Managed Care



Behavioral health services have been the subject of significant attention and reform over the past decade in New Jersey. The New Jersey Division of Mental Health and Addiction Services (DMHAS), operated under the Department of Human Services, historically used a contract, net deficit funded payment system for mental health and substance use disorder treatment services. Each provider would negotiate its own contract with DMHAS, in order to receive reimbursement for services provided to eligible patients. As such, there were disparate reimbursement methodologies between mental health and substance use disorder service contracts.[244] Under this cost reimbursement system, community-based providers received a monthly payment at a predetermined rate set forth in the contract, regardless of specific services provided. In 2016, New Jersey began to transition to a fee-for-service (FFS) delivery model for behavioral health services. DMHAS sought to: (1) increase system capacity; (2) create greater access for individuals seeking treatment; (3) standardize reimbursement across mental health and substance use disorder providers; and (4) create greater budgeting and expenditure flexibility for providers.[245]

The contract that MCOs sign with New Jersey's Department of Human Services, Division of Medical Assistance and Health Services, states that the "State shall retain a separate Mental Health/ Substance Use Disorder system for the coordination and monitoring of most mental health/substance use disorder conditions."[246] There are currently two categories of excepted services: (1) behavioral services "carved-out" for all beneficiaries and (2) behavioral services provided via managed care for certain populations (i.e., Managed Long Term Services and Supports beneficiaries, Division of Developmental Disabilities beneficiaries, and Fully Integrated Dual Eligible Special Needs Plan beneficiaries). (BH) services that are covered under NJ FamilyCare through either FFS or Managed Care.[248]



Behavioral Health Services Carve-In to Managed Care

Covered by MCOs	Covered by MCOs for certain populations and otherwise FFS	Provided through FFS only
• Hospital emergency department visits and inpatient stays with behavioral health diagnosis • Specialty psychiatric hospital admissions provided on an "in lieu of" basis • Autism services up to age 21 • Prescription drugs • Office-Based Addiction Treatment (OBAT) for Medication Assisted Treatment (MAT)	• Mental Health • Outpatient hospital or independent clinic services • Independent clinician (psychiatrist or psychologist) • MH partial hospitalization • Adult MH rehabilitation (level A+, A, B group homes) • MH and SUD partial care • Substance Use Disorder • Long- and Short-Term Residential • Non-hospital detox • Opioid Treatment Programs (OTPs) • Outpatient and Intensive Outpatient (OP/IOP)	• Psychiatric Emergency Services (Screening Centers) • Behavioral Health Homes • Programs in Assertive Community Treatment • Community Support Services • Targeted Case Management • Children's System of Care Management Organizations • SUD Residential Treatment (Youth Only) • Targeted Case Management • Integrated Case Management Services (ICMS) • Projects for Assistance in Transition from Homelessness (PATH)

Although most behavioral services are currently carved out of managed care, there are still some services that are under managed care (left column on page []). In 2018, the State carved in behavioral health services for certain populations, specifically Medicaid beneficiaries enrolled in Managed Long-Term Services and Supports (MLTSS), Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), and the Division of Development Disabilities (DDD). Covered services include hospital-based services, outpatient mental health and substance use disorder (SUD) services, Intensive Outpatient SUD services, SUD partial care, residential detox, adult mental health rehabilitation, short term residential treatment, Ambulatory Withdrawal Management, and Medication-Assisted Treatment. In addition, the State also carved in all acute-care hospital and psychiatric unit admissions to managed care.[249] Other behavioral services and those services not for the aforementioned populations remain carved out of managed care.

Currently, behavioral health services are managed through the Interim Managing Entity (IME), which was established by DMHAS in January 2015.[250] Rutgers University Behavioral Health Care (UBHC) was selected as the IME, now known as the UBHC IME Addictions Access Center. In many ways, the IME operates similarly to an MCO. Indeed, the purpose of the IME is to develop a coordinated point of entry, where persons seeking substance abuse treatment are immediately connected to the appropriate level of treatment for the correct length of time. The IME provides 24/7 availability to callers, screening and assessment, referrals to addiction treatment providers, care coordination, and utilization management.[251] Managed care organizations are directed by the State to contact the IME to connect Medicaid beneficiaries to SUD and mental health services. Nonetheless, the IME is meant as a point of entry ("no wrong door") for all persons who seeks addiction treatment.

For a person who seeks substance abuse treatment, they may either call the Interim Managing Entity at their hotline phone number (1-844-276-2777) or call an addiction treatment provider directly.[252] When a caller seeks services through the IME, a number of steps must be completed prior to referral to an appropriate provider, including a complete clinical and fiscal screening. Persons are then referred to a provider based on preference, provider availability, and financial aid availability. For persons who seek services from a provider directly, similar steps are taken. The IME then authorizes assessment for the individual seeking treatment, whether they are screened by IME or the provider. If the individual had contacted the IME directly, they would then be referred to a treatment provider at this stage.[253]

In addition to furnishing an initial linkage to addiction treatment providers, the IME also plays a substantial role in the administration of substance abuse treatment. The IME must approve addiction treatment placement, treatment plans, and continuing care of stays for individuals served through IME managed state initiatives and Medicaid covered services and providers.[254] Appropriate documentation must be submitted to establish the clinical necessary for the recommendation. Denials for authorization may be appealed through an established appeal process. The intended purpose of the IME is to remove barriers to treatment, assist clients in moving to other levels of treatment care, allow for the maximal use of available resource through centralization, ensure the appropriate treatment for persons for appropriate lengths of time, and create a more organized system of care.[255]

On March 30, 2023, the Centers for Medicare & Medicaid Services (CMS) approved the State's renewal proposal for the New Jersey FamilyCare Comprehensive Demonstration, in which the State seeks to have additional behavioral health services gradually carved in managed care over the demonstration period, i.e., April 1, 2023 through June 30, 2028. New Jersey has indicated two distinct phases for integration of behavioral health services under managed care. First, New Jersey proposes that all behavioral services currently carved in for MLTSS, DDD, and FIDE-SNP beneficiaries (middle column) be likewise carved in for all or most Medicaid beneficiaries. New Jersey envisions that the placement of these services under managed care will allow for a single point of accountability, namely the MCO, facilitate coordination between services, and improve access to care. Second, New Jersey seeks to systematically review services that are currently FFS for all beneficiaries (see chart on page []) to determine whether it is appropriate to carve in a particular service to managed care. During this phase, the State will engage stakeholders throughout the process and request guidance, comments, and recommendations from them. Given that CMS recently approved the Comprehensive Demonstration, New Jersey is just beginning the process of extensive integration discussions with community stakeholders.

Appendix D: Certified Community Behavioral Health Clinics (CCBHCs)

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA), passed by the 113th Congress and signed into law by President Obama, required the establishment of federal Certified Community Behavioral Health Clinic (CCBHC) demonstrations to ensure access to coordinated comprehensive behavioral health care.[256] CBBHCs, a new provider type in Medicaid, provide comprehensive substance use and mental health services to vulnerable populations. The CCBHC demonstration is overseen primarily at the state level within guidelines and specifications set by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS). The law allowed for eight states to participate in a two-year demonstration program of this model: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania. As one of the selected states, New Jersey began its demonstration program in 2017.

Since the passage of PAMA, the federal government has expanded CCBHCs throughout the country. Since 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA) has provided numerous expansion grants to dozens of states to implement CCBHC activities and services. In 2020, two more states, Kentucky and Michigan, were added to the demonstration program. Furthermore, the Bipartisan Safer Communities Act of 2022, passed by the 117th Congress and signed into law by President Biden, authorized the expansion of the CCBHC model to include, beginning in 2024, ten new states every two years.[257] In March 2023, SAMHSA announced that 15 new states were chosen to receive CCBHC planning grants, which assist states and providers in the implementation of the CCBHC model, such as establishing new payment systems. In July 2024, ten of these states will be selected to join the CCBHC demonstration program. As such, the federal government has made clear its intention to expand this demonstration program nation-wide.

PAMA states that CCBHCs are to provide services to any person seeking mental health or substance use treatment, regardless of their place of residence, age, condition, or ability to pay. Persons with serious mental illness (SMI), substance use disorder (SUD), opioid use disorder (OUD), and/or co-occurring mental health and substance disorders (COD); children and adolescents with serious emotional disturbance (SED); and persons experiencing a mental health or substance use crisis are able to receive services from a CCBHC.

In addition to required services, PAMA states six criteria for CCBHCs to participate in the demonstrations. These criteria fall into six areas: (1) staffing, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and other reporting, and (6) organizational authority.[258] In 2015, the United States Department of Health and Human Services provided specifications to these criteria. In March 2023, SAMHSA released updated criteria for CCBHCs to respond to new developments in behavioral health care; update criteria that are outdated; and address other areas of concerns, as suggested by CCBHCs, states, and other entities.[259]

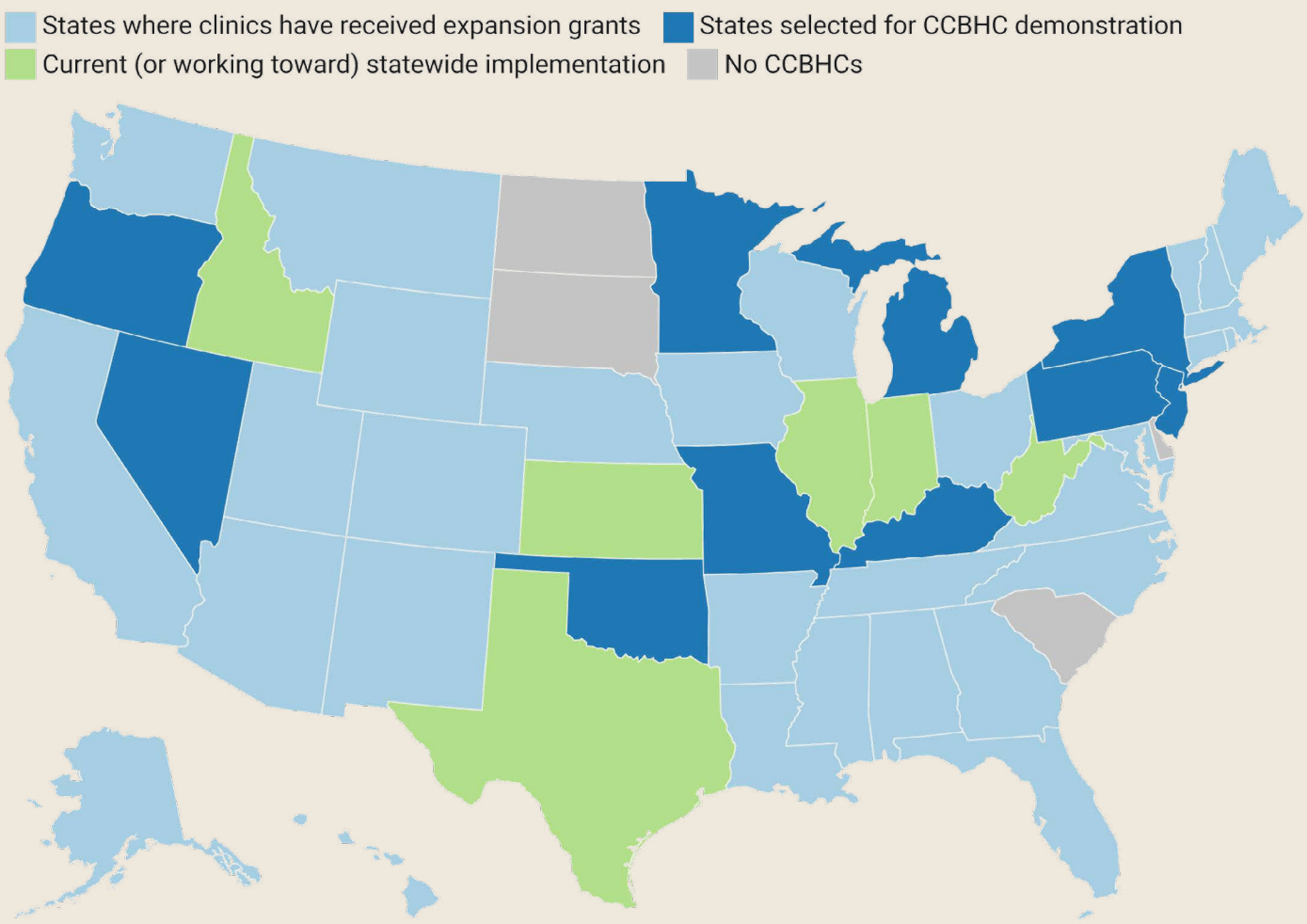
Notably, CCBHCs must abide by the following guidelines from SAMHSA: (a) provision of services for routine needs within 10 business days following assessment; (b) crisis management services available and accessible 24/7; (c) working relationships with local hospital emergency departments (EDs); (d) no refusal of services due to inability to pay and employ a sliding scale for payment; (e) access to high-quality physical health and behavioral health care, as well as social services, housing, education, and employment opportunities; (f) establish and maintain a health information technology (IT) system that includes electronic health records; (g) partnerships with Federally Qualified Health Centers for services not directly provided through the CCBHC; (h) partnerships with substance use and mental health treatment providers, e.g., inpatient psychiatric treatment, Opioid Treatment Program (OTP) services, medical withdrawal management facilities; (i) develop partnerships with hospitals, schools, child welfare agencies, juvenile and criminal justice agencies and facilities, and other social and human services within the service area; (j) partnership with the nearest Department of Veterans Affairs' medical center or other facilities; (k) cultural competence, particularly when

treating persons with limited English proficiency, military service members, and veterans; and (l) person-centered and family-centered treatment planning.

CCBHCs are required to use a prospective payment system (PPS) for the provision of services, which are reimbursed by Medicaid. Under the demonstration, states may select one of two PPS rate systems. New Jersey uses the monthly (as opposed to daily) unit of payment, whereby there is a standard monthly rate per beneficiary served. The Medicaid per-encounter rate is based on a cost report that documents a particular clinic's costs and patient encounters. This cost-based, per clinic rate also provides for bonus payments for CCBHCs that meet defined quality standards. In addition, there is a separate monthly rate payment for certain populations served by the clinic, e.g., persons with mental health or substance use problems. This separate rate seeks to reimburse CCBHCs for the higher costs associated with providing necessary services for certain populations.[261] Furthermore, the State sets the payment rates and can vary them across CCBHCs within New Jersey.

The total Medicaid/CHIP expenditures for the CCBHC demonstrations in New Jersey were $21,606,853 during the first demonstration year, of which the federal government covered $17,255,195, and $32,352,448 during the second demonstration year, of which the federal government covered $25,578,398. Per CCBHC, the average total expenditures were $3,086,693 during the first year and $4,621,778 during the second year; the average total CCBHC expenditures per beneficiary were $2,005 and $2,786 during the first and second years of the demonstration, respectively.[262]

Status of Participation in the CCBHC Model



CCBHC Outcomes

The CCBHC demonstration program has shown notable success nationwide and in New Jersey. Today, there are more than 500 CCBHCs and CCBHC grantees, operating in 46 states, as well as Puerto Rico, Washington, D.C., and Guam. In 2022, this demonstration model served approximately 2.2 million persons nationwide, an increase of about 600,000 clients from 2021. The CCBHC model has alleviated the behavioral health workforce shortage by allowing clinics to increase hiring. According to the National Council for Mental Wellbeing, CCBHCs have hired an estimated 11,240 new staff positions, representing an average of 27 new staff positions per clinic, since becoming a demonstration.[263] Given their Medicaid payment structure and grant funding, CCBHCs have been able to recruit and retain highly qualified staff.

The CCBHC model has also dramatically increased access to Medication-Assisted Treatment (MAT). Compared to the nationwide rate of 56 percent of clinics providing any form of MAT, 82 percent of CCBHCs and grantees provided MAT services. As of August 2022, 69,400 clients were engaged in MAT in the country. Because CCBHCs work closely with primary care providers, 81 percent of CCBHC respondents reports an increase in the number of referrals to primary care. Furthermore, 87 percent of CCBHCs report seeing patients for routine needs within 10 days of referral; 71 percent offer access within one week or less; and 32 percent offer same-day access to services. Nationally, the average length of time between a client's first referral and first appointment is 48 days. Furthermore, 98 percent of respondents offer 24/7 hotlines for emergency situations; 97 percent offer access to mobile crisis response; and 94 percent offer access to crisis stabilization services. The majority of CCBHCs have initiated, continued, or expanded efforts to improve access to care for underserved populations. For example, 58 percent of respondents deliver services at a site that provides affordable housing, and 18 percent plan on doing so in the future. Furthermore, persons who receive care at CCBHCs also experience a 72 percent reduction in hospitalization, 40.7 reduction in homelessness, and 60.3 percent less time in jails.[264]

CCBHCs in New Jersey saw a total of 17,851 clients in 2017; 19,133 clients in 2018; and 20,396 clients in 2020. During the first demonstration year, 19 percent of clients were under the age of 18; 56 percent were female; and 44 percent were male. Furthermore, 17 percent of clients were Hispanic; 55 percent were White; and 15 percent were African American. In terms of clients' insurance status, 52 percent of clients had Medicaid; 9 percent had Medicare; 7 percent were dually enrolled in Medicaid and Medicaid; 5 percent were uninsured; and 23 percent had commercial insurance.[265]

Appendix E: Interoperability

Interoperability refers to when separate information systems employ consistent standards to enable the electronic sharing of information across systems and networks. There are two primary components of any interoperable system: (1) the ability to exchange information among two or more systems; and (2) the ability to use the information that has been exchanged. In improving the efficiency, quality, effectiveness, and cost of health care, interoperability helps avoid medication errors, readmissions, and duplicate testing and medications, as well as improve diagnosis and treatment. Although there is widespread availability of secure electronic transfer of data, most medical information in the United States is stored on paper and manually shared between providers. Interoperability allows providers to have complete medical records, including past history, current medications, and other pertinent information.[266]

An interoperable system provides significant benefits to healthcare providers by: (1) improving integrated and coordinated patient care; (2) allowing for patients' involvement in their own health care; (3) increasing efficiency, e.g., through the elimination of unnecessary paperwork; (4) facilitating public health reporting and monitoring; (5) reducing health care costs; (6) reducing medical errors; (7) providing more effective methods of communication of medical information among providers; and (8) allowing for improved quality and safety of patient care. An HIE allows all health care providers with whom a patient interacts to have access to the same, complete information, from which to make medical decisions.

Since there is data, medical and otherwise, that accumulates among various facilities and providers with whom a patient interacts (e.g., primary care physician's office, physician specialists, pharmacies, emergency departments), interoperability ensures that such information is not stored in silos but rather available to all parties involved.

A requirement of interoperability is a Health Information Exchange (HIE), which is the electronic platform that allows patients' medical information and data to be shared securely among healthcare locations and providers. An HIE has three primary forms: (a) directed exchange, where providers can easily and securely send patient information to another health care providers; (b) query-based exchange, which allows providers to search and access patients' medical records and is often used when delivery unplanned care (e.g., Emergency Room visit); and (c) consumer-mediated exchange, where patients are able to access and managed their own medical information, including sending to other providers. It is important that an HIE has these three main
capabilities.[267]

Electronic health records (EHRs) are a necessary component of interoperability. An EHR is an electronic record of a patient's current medical and health-related information, including medical history, diagnoses, medications, treatment plans, and laboratory and test results. An integral feature of interoperable EHRs is the ability for health information to be managed by authorized providers in a standardized format that is capable of being shared with providers from multiple health care organizations, such as laboratories, specialists, emergency facilities, and pharmacies.[267]

Today, interoperability is essential for the delivery of appropriate care, reducing the cost of healthcare, and improving its efficiency. According to The Office of the National Coordinator for Health Information Technology (ONC), in 2021, 62 percent of hospitals in the United States engaged in all four primary domains of health information exchange (i.e., sending, receiving, finding, and integrating), an increase from 41 percent in 2017. Furthermore, 88 percent of hospitals engaged in electronically sending and receiving patient health information, and 74 percent of hospitals reported the ability to integrate information into EHRs.[268]

Despite these efforts, gaps remain to widespread interoperability. In 2018, 32 percent of persons who went to a doctor at some point during the year reported experiencing a gap in health information exchange, including needing to bring a test result to an appointment (19 percent), waiting for results longer than reasonable (14 percent), repeatedly providing medical history to due to inability to access medical history (5 percent), and redoing a test due to unavailability of earlier results (5 percent).[269] Furthermore, in 2019, among physicians engaged in HIE, 85 percent found that electronic exchange information was challenging when the other provider used a different EHR vendor.[270] Barriers to interoperability may include lack of organizational preparation, unavailable technology, deficient funding, and lack of Information Technology (IT) personnel necessary for interoperability.

Behavioral health providers have encountered particular difficulty in achieving interoperability. Indeed, very few providers have interoperable systems due to prohibitive costs, limited resources, and extensive administrative requirements. According to the Office of the National Coordinator for Health Information Technology, as of 2017, less than 10 percent of substance abuse centers in the country use electronic methods to send or receive client information. Furthermore, three in ten substance abuse centers use only electronic methods to store and manage medical records.[271] While centers affiliated with hospitals use electronic methods to store records at higher rates than non-affiliated centers, there is still remains a significant disparity of the rates of electronic storage and management of medical information between behavioral health providers and non-behavioral health providers. Of course, the electronic storage of medical information is a necessary component of interoperability and does not itself presuppose its achievement. While there has been some progress in such electronic storage, the adoption of interoperability itself is far more lacking.

Appendix F: Court-Involvement

Court-involved persons are disproportionately burdened by illicit drug use, substance abuse, and overdose deaths. According to the Bureau of Justice Statistics, U.S. Department of Justice, 38 percent of all federal and state prisoners in 2016 reported using drugs at the time of the offence for which they had been committed, and 64 percent of all prisoners reported using at least one drug in the 30 days prior to their arrest.[272] Indeed, 49 percent of state prisoners and 32 percent of federal prisoners met the criteria for having a substance use disorder in the past twelve months. In addition, illicit drug users are themselves more likely to become court-involved. According to one study, 51.7 percent of persons with prescription opioid use disorder in the past year and 76.8 percent of persons who have used heroin in the past year became court-involved.[273]

Court-involved persons are at a considerably higher risk of overdose deaths compared to the general population. Indeed, drug overdose is the leading cause of death after release from prison and the third leading cause of death while in correctional custody.[274] Since persons with SUD often undergo withdrawal during their incarceration, the consequently low tolerance for illicit drug use notably increases their risk of fatal overdose, if they return to drug use upon release from prison or jail. Indeed, the risk of drug overdose is increased manyfold, as much as 12 to 40 times according to estimates,[275,276] during the first two weeks following release. Given the significantly high rates of substance use among court-involved persons, prisons, jails, and other correctional institutions must have the capability to provide persons with or refer persons to treatment when needed and appropriate and that such treatment is continued after persons are released.

(1) Health Care in Correctional Settings

All correctional institutions are constitutionally required to provide needed health care for incarcerated persons in their custody. However, the provision of health care to incarcerated persons varies widely across settings and jurisdictions. State, counties, and even facilities may differ in standards of adequate

care, and health care screenings and life-sustaining services may be implemented differently as well. Indeed, health care in correctional settings differs considerably in practices, including in the services provided (e.g., assessment, care management, delivery of care), setting (e.g., availability of care onsite, coordination of services while in custody), providers (e.g., contracted vendors or state agency staff), and dedicated staff per facility. This variation among the provision of health care leaves many correctional institutions providing only the most basic care for illnesses and injuries.

Incarceration status does not itself render a person ineligible for Medicaid. Individuals involuntarily held in a public institution may be enrolled in Medicaid, for example. However, according to Section 1905 of the Social Security Act, federal Medicaid funds may not be used to pay for services for individuals while they are incarcerated, except when they are inpatients in a medical institution. In 2016, the Centers for Medicare & Medicaid Services (CMS) provided guidance to states regarding facilitating access to Medicaid services during and following incarceration, including states' authority to suspend rather than terminate Medicaid eligibility.

There are six general types of Medication-Assisted Treatment (MAT) models in correctional settings: (1) off-site medication administration, where patients are transported to community providers for medication; (2) on-site medication administration by an external provider, where external OTPs or other prescribers administer medication to patients within the correctional facility; (3) on-site extended-release naltrexone; (4) licensed correctional prescribers provide buprenorphine on-site; (5) facility becomes a licensed OTP, where the correctional facility obtains an OTP licenses permitting use of methadone for treatment of OUD; and (6) facility becomes a licensed health care facility, where state and DEA licensing is obtained that entitles the facility with the same regulatory exceptions as hospitals for OUD treatment.[277]

(2) Behavioral Health Services in the New Jersey Department of Corrections

The New Jersey Department of Corrections, which is responsible for operating and managing all New Jersey state prison facilities, provides access to substance use disorder (SUD) treatment and mental health services at all state prisons. These services are offered in partnership with contracted vendors Rutgers University Correctional Health Care (UCHC), Rutgers University Behavioral Health Care (UBHC), and Gateway, as well as through the Office of Substance Abuse Programming and Addiction Services (OSAPAS). For mental health, services are provided by Rutgers UCHC, and NJDOC's Health Services oversees and audits the provided care. All state prisons in New Jersey offer all three Food and Drug Administration (FDA)-approved medications for treating opioid use disorder (OUD), and all correctional officers carry naloxone. Upon arrival to a state correctional facility, all individuals are screened for substance use and mental health issues. If a screen indicates the need for further evaluation, they are then referred for a comprehensive assessment. In addition, incarcerated persons may request treatment at any time. Persons with a moderate to severe substance use disorder may receive licensed SUD treatment (i.e., Long-Term Residential, Short-Term Residential, Intensive Outpatient, and Outpatient) at either the Mid-State Correctional Facility, which has approximately 700 beds, or Edna Mahan Correctional Facility for Women, which as 65 beds.

All persons receiving mental health services at DOC are placed on a Mental Health Special Needs Roster (MHSNR), and all persons on this roster receive an individualized, comprehensive treatment plan. According to the DOC, 23 percent of incarcerated persons are on the MHSNR (21 percent of male inmates and 67 percent of female inmates). Outpatient mental health services, including individual psychotherapy and psychiatry, are offered at all state prisons. For persons in need of more intensive mental health services, DOC may place them in a Transitional Care Unit (located at four prisons), Residential Treatment Unit (located at four prisons), or a Stabilization Unit (located at three prisons). These separate units have 24/7 nursing coverage.

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New Jersey Reentry Corporation (NJRC)

Program Data

NJ REENTRY CORPORATION

NJRC is committed to providing critically needed services to court-involved individuals. Case management and legal services link clients to addiction treatment, structured sober housing, job training and employment, mental health and medical care; thereby, assisting clients to achieve healthy self-sufficiency, reducing recidivism, and fostering safer communities.

10 Locations

- Bergen County • Essex County
- Hudson County • Middlesex County
- Monmouth County • Ocean County
- Passaic County • Union County

22,203 NJRC Program Participants

11,053 NJRC Jobs Secured *

840 NJRC Veterans Served

Sources: Salesforce, CDC; NJCares 2020
** Individuals may have more than single employer.*

NJRC Stats - Salesforce

19.7%
Rearrest

10%
Reincarceration

55%
Employment (adjusted seasonally)

4,577
The Women's Project Enrollment

16,260
Medicaid Enrollment

11,445
Addiction Treatment Referrals

10,836
Medical Treatment

6,831
Psychiatric Treatment Facilities Behavioral/Mental Health

5,279
Medication Assisted Treatment

4,021
Birth Certificates Obtained

3,848
MVC Identification Drivers Licenses

73
Pro Bono Attorneys

2,680
Emergency Kits Delivered in Prison

13,684
Training

5,935
Participants Enrolled During PHE

17
Latin American Nations Documents

This report was written by Matthew Harper, Research Associate, NJRC, who is indebted for its completion to Debra Wentz, PhD, President and Chief Executive Officer, NJAMHAA; Mary Abrams, Senior Health Policy Analyst, NJAMHAA; Governor James McGreevey, Executive Director and Chairman, NJRC; Robert Carter, Chief Operating Officer, NJRC; and Nickoy Ellis, Media, NJRC.

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