The Shift to Fee-for-Service: Neoliberalism and Behavioral Health Services

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Abstract: The rise of neoliberalism has influenced both policy and practice. With an emphasis on the economic market, performance, and efficiency, practitioners must re-examine their role and ethical responsibility to the individual receiving services. The aim of this reflection is to examine the role of fee-for-service in behavioral health and the unintended consequences that occur on the frontlines as practitioners negotiate the need to meet regulatory standards that are, at times, in conflict with providing person-centered care. The author concludes by emphasizing the need for more research on policy implementation and highlights the importance of cultivating a supportive environment while simultaneously advocating for policies that both empower service recipients and allow for service flexibility.

***Keywords*:** neoliberalism, person-centered care, fee-for-service, behavioral health, policy

Introduction

In 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment allowing New Jersey to provide Medicaid reimbursable mental health Community Support Services. Community Support Services (CSS) consist of rehabilitative services that support an individual in restoring skills necessary to achieve recovery goals and integrate into the community (Centers for Medicare and Medicaid Services, 2011). While state plans vary, each agreement allows a state to receive a federal match for each valid service provided (Smith et al., 2000). In this case, maximizing Medicaid dollars can help offset behavioral health costs. New Jersey's state mental health authority identified supportive housing as the program element that would implement CSS as a fee-for-service (FFS) model.

New Jersey's supportive housing providers historically operated on cost-based contracts. However, this funding structure did not necessarily ensure nor monitor high quality service delivery or agency spending. In many ways, I believe, the cost-based contract system was set up for failure. It was inevitable that the burden of supporting behavioral health programs exclusively with cost-based contracts would become unsustainable. At any time, state legislatures could make fiscal decisions that significantly reduce or eliminate the funding allocated for behavioral health contracts. Additionally, states do not have enough fiscal resources to indefinitely support the rising needs of behavioral healthcare.

Transitioning to FFS, in many ways, also means a shift to neoliberal governance. Neoliberalism endorses efficiency, performance, and free market (Harvey, 2007). In New Jersey, although agencies will be independently billing Medicaid for the services they deliver, the state would still maintain regulatory authority over CSS programs. This new arrangement ultimately reveals a hierarchal power between the state and agencies responsible for delivering this rehabilitative service. Further, neoliberalism forces agencies to become more entrepreneurial since they will

rely heavily on FFS reimbursement (Evans, Richmond, & Shields, 2005). For many agencies, shifting to a business model may conflict with their mission to provide person-centered care. For example, implementing a market model can give health insurers and administrators more fiscal power and influence over the types of services delivered (Verhaeghe, 2014). As such, agencies may structure services based on what insurers will pay for rather than what an individual may want to work towards.

New Jersey's mental health authority funded the Rutgers University Department of Psychiatric Rehabilitation and Counseling Professions to provide training and technical assistance to supportive housing agencies transitioning to FFS. As a faculty member on the training and consultation team, I was uniquely positioned to explore the impact of FFS on supportive housing. I also worked in supportive housing for several years, which gave me a good understanding of the previous program policies and practices. As part of my current role, I conduct on-site visits with agencies and speak with staff and the individuals receiving their services. I will share some excerpts from these visits in hopes that policy makers and behavioral health programs can gain insight into the experiences of those directly affected by the change to FFS. Additionally, the aim of this reflection is to examine the role of FFS in behavioral health and the unintended consequences that occur on the frontline as practitioners negotiate the need to meet regulatory standards that are, at times, in conflict with providing person-centered care. I have also been able to explore the neoliberal influences of adopting this model. I will share the stories of front-line practitioners in supportive housing programs and a service recipient to specifically illustrate these unintended consequences and neoliberal influences.

The Transition to Fee-for-Service

New Jersey's transition to FFS means that payment is based on services that fit billable standards. In this case, reimbursement is based on the interventions outlined on an individual's approved rehabilitation plan. Under New Jersey's rehabilitative FFS model, these interventions must address skill deficits and promote independence. The services also need to be documented in a progress note. Prior to Medicaid FFS, agencies provided services that were less formal and not always outlined on an individual's plan. In my experience, a practitioner could spend several months engaging an individual by taking trips to a coffee shop or spend countless hours assisting someone with skills they have already mastered. However, under the new billing infrastructure, Medicaid will not reimburse for providing such services.

The new standardized practice requirements for the rehabilitative FFS model, CSS, also focus on practitioner credentials. Only registered nurses, practitioners with a clinical license, or psychiatrists can complete the formal assessment that drives the reimbursable plan. This is a stark contrast from years past. When I worked in supportive housing, agencies employed individuals with a high school diploma or a bachelor's degree. Furthermore, agencies hired peer providers with a mental health diagnosis. Under cost-based contracts, peers and staff with a high school diploma or bachelor's degree could complete assessments. Aside from new staffing requirements, CSS also mandates that an outside entity authorize individualized rehabilitation plans. Previously these plans were reviewed and approved by supervisors within an agency. The transition to FFS forces agencies to adopt a new practice approach that places greater oversight

on the services practitioners deliver. Practitioners with higher credentials generate higher reimbursement rates for an agency, which, in this case, will influence staff recruitment. From a fiscal standpoint, it would be nearly impossible for an agency to remain profitable if they continued to employ primarily high school level staff or peers due to their lower reimbursement rate.

In the case of Medicaid FFS, agencies are forced to increasingly regulate and monitor practitioners to ensure that their work proves profitable to cover overhead costs. This places much more accountability on the individual practitioner. I believe that a neoliberal approach calls for practitioners to be more rigid in the way they work with individuals and more focused on maintaining higher caseloads. As a result of such systemic changes, practitioners become demoralized and alienated (Wallace & Pease, 2011). In speaking with practitioners, in many ways, they lose their professional identity due to enmeshment in a business model that undoubtedly guides their practice. Rather than focusing on providing quality services, practitioners may be expected to structure their work on the services that will generate the most reimbursement.

I could not help but consider that, on a broader scale, neoliberalism significantly affects individuals receiving services. In my opinion, their relationship with practitioners takes a different form. The reconstruction of the therapeutic relationship can result in pathologizing service recipients for financial gain (Wallace & Pease, 2011). I began to consider the possibility of individuals who were independent in many areas of their life getting frequent visits from a practitioner to meet monthly quotas. I wondered if practitioners would focus on a person's deficits rather than strengths so they would be able to maintain the volume needed to remain financially stable. Treating individuals like nothing more than dollar signs goes against the values of the helping profession. On the other hand, I was curious about the benefits of adopting an FFS cost structure. I was excited at the opportunity to visit agencies and hear directly from those contending with the changes.

"Pat": Transportation

I met with a frontline practitioner who began to talk about her work with service recipients and the various goals they work on together to achieve. One task that took up most of her time was driving. She reported that the individuals in the program needed help getting to and from different places in the community. I listened intently as she described one such visit.

Pat: "I sit in the car while he's in the grocery store since he doesn't need my help."

I asked her why she bothers to go if she simply sits in the car and he can shop independently. I also inquired about the possibility of teaching the person how to use public transportation. She explained,

Pat: "He would have no other way to get there. There is no public transportation in his area, he can't afford to buy a car, and none of the people he knows has a car. I know they really don't want us to be driving people around, and truthfully I didn't go to school to be a taxi driver, but

what's the alternative, leaving people without a way to get food?"

I could sense Pat's frustration and could understand her dilemma. During my time in supportive housing, providing transportation was a normal occurrence. I often felt like the "taxi driver" Pat described. However, I never questioned it because I thought it was part of my job.

Cartwright and Hardie (2012) highlight that implementing a policy may indeed produce the positive contributions it was aimed to achieve, but it also produces what Lipsky (2010) calls "unintended consequences" that may not have been initially considered. Pat acknowledged that "they don't want us to be driving people around," likely because transportation is not a billable service under the CSS FFS model. Yet, it has been my experience that practitioners use transportation time with individuals in the program to discuss goals or to build rapport and trust that it will ultimately benefit that individual's well-being. Pat also mentioned that there were no public transportation options available, which made it difficult to teach the person she was working with alternative ways of getting to the store on his own. While discouraging practitioners from transporting individuals may support an agency's fiscal agenda, it, perhaps, unintentionally ignores the needs of individuals receiving services. Pat later stated that she felt that the decision to continue taking the person she was working with to the grocery store week after week was the right thing to do, even if it was not a billable service. She went on to share that she believed that what she was doing was in the best interest of the individual she was working with, which speaks to delivering person-centered care. Though the CSS guidelines specify the need to provide services that foster independence, Pat exercised "discretionary measures" (Lipsky, 2010). She deviated from the agency's new neoliberal guidelines to meet the needs of the person she was working with.

I think most in the helping profession would agree that service recipients have unique needs and practitioners will always be faced with different scenarios that require in-the-moment decisions. Further, I would assert that flexibility is needed to cope with an ever-changing environment, but if practitioners continue to make exceptions to the rules, then what are the "unintended consequences" (Lipsky, 2010) for practice? Often, when system reforms alter organizational demands, frontline practitioners make adjustments that are functional for their agency, but dysfunctional for the individuals they serve (Brodkin, 2011). While well-intentioned, I believe that Pat's decision to routinely accompany an individual to the grocery store could have negative implications.

In my opinion, continuing to take an individual grocery shopping without a plan to teach the skills necessary to get there independently fosters dependent behaviors. An individual will continue to be reliant on the agency to meet his or her transportation needs and perhaps never realize the importance of acquiring such skills. In this case, Pat may be able to work with the service recipient to build relationships with people in the community that can assist him with getting to the grocery store. I wondered if Pat explored vocational goals with the individual so he could one day save money to purchase a car to drive to and from the store on his own. I believe without exploration a person receiving services may not see the alternative possibilities. They may never feel empowered to be more independent and may remain content with others doing for them. Pat's role as an everyday gatekeeper determines whether the individuals she serves

gain access to the services to meet their needs (Spitzmueller, 2016). In this case, I think the person Pat is working with has the right to services that would allow him to reach his optimal potential. Further, Pat could be denying him access by imposing her own rules that are not reflective of the agency's standards. Nevertheless, if Pat's decision to provide transportation to the grocery store addresses the service recipient's needs, then how does this decision fit into the neoliberal approach that her agency is adopting? While this example demonstrates one of the many dilemmas that have emerged from introducing neoliberalism into behavioral health practice, I knew there was much more discourse that existed.

"Anthony": No More "Check-Ins"

I found myself eager to speak with individuals receiving services. Speaking with practitioners is helpful, but people on the receiving end of services give a different perspective. I met with Anthony who has been receiving services for five years. He explained that he was grateful for all the help he has received from the supportive housing staff.

Anthony: "These people really saved my life. I was at my lowest point and they helped pull me out. They would come visit me every day, just to talk."

When asked if he noticed any changes in the services he was receiving he shared,

Anthony: "Now they say they can't really do that (come by to talk) anymore. My worker said with the new rules, they're not allowed to do a lot of the things they used to because they'll lose a lot of money. They can only come to do things that are on my treatment plan."

I could sense the disappointment in his voice and began to feel a sense of guilt. I thought of my role in the FFS transition. I was tasked with training the supportive housing workforce about rehabilitative services, but inherent in that was also teaching staff to focus more on what was billable and what was not.

The change to FFS will hold practitioners accountable for the services they deliver. Spitzmueller (2016) suggests that FFS arrangements direct a practitioner's energy away from the stated needs of service recipients and toward what agencies are paid to produce. As I reflected back to the feelings I had when meeting with Anthony, I now see that my guilt was rooted in the apparent loss in humanity. To me, what Anthony described was a blatant focus on reimbursement. In some cases, I think there is value in "just talking." However, in looking more deeply, I recognize that practitioners should be just as focused on what agencies are paid to produce. Most agencies would lose funding if they did not abide by regulatory guidelines. While Anthony was disappointed in the need to shift focus, it was a necessary measure for the agency to ensure sustainability in the changing environment. If there was no focus on revenue, agencies would go out of business and practitioners would lose their jobs. The new CSS FSS model requires practitioners to actively work with individuals on their identified goals if they want to be paid. These standards encourage proactive behaviors. If there were no rules, then a practitioner could presumably continue to visit service recipients day after day, week after week, year after year to "just talk." A review of agency records showed that frontline practitioners, in large part, were

not addressing goals that were outlined on plans during visits. "Check-in" and "follow-up" were common words used in many of the progress notes. However, these were the types of visits that Anthony explained were necessary for his recovery.

For Anthony, having someone to talk to helped him through a difficult time. He believes that there will be no allowances for the things the agency "used to do" because the agency will lose money. One could argue that, in this case, the organizational practices of managerialism undermine the ability of a practitioner to address and support an individual's need (Wallace & Pease, 2011). As I mentioned, even though Anthony viewed his time with practitioners as an opportunity to simply talk, it was clear that it played a meaningful role in his life. The new neoliberal approach provides practitioners with a limited menu of care options that may not always include what a service recipient needs and can be perceived as a "devaluation of caring work" (Healy & Meagher, 2004). I wondered, if the agencies' focus shifts to fiscal compliance, where do service recipients fit?

In my opinion, a compliant agency with compliant workers does not necessarily mean that the care that is being provided is of high quality. Thus, in this case, providing quality services comes with balancing the delivery of person-centered care in a neoliberal environment. However, I think this is difficult. I have spoken to practitioners working in FFS arrangements that report feeling pressured to sustain service volume to reap financial gains for their agency. Such demands, even if unintentional, change the therapeutic relationship. I believe practitioners may begin to see service recipients as dollar signs, and individuals will see practitioners as obedient soldiers out on an agency mission to make money.

In many ways, a neoliberal environment encourages practitioners to push service recipients out of their comfort zone. Simply helping an individual maintain his or her stability or level of functioning may not aid in moving someone along the continuum of care. In this regard, if practitioners are not empowering individuals to be self-sufficient, then they are contributing to a larger systemic issue. I have found that the old way of doing business, reliance on cost-based contracts, did not always hold agencies accountable for poor outcomes. In some neoliberal systems, services can be reduced or cut off to manage costs (Wallace & Pease, 2011). If this were to occur, the impact on service recipients would be significant. As such, agencies need to monitor programmatic outcomes while continuing to provide a supportive environment for service recipients that don't feel fiscally driven.

"Michelle": The Role of Supervision

Michelle, a frontline practitioner, brought her lunch into the conference room and explained that she never has time to eat on a regular day, so our meeting was a welcomed relief from her non-stop schedule. I asked her how she felt about the transition to FFS and was surprised by her response.

Michelle: "Look, my supervisor says that we are required to do things one way, but then our director comes and says the opposite. I can't make myself crazy trying to figure it out. It's on them—that's why they get paid the big bucks."

Michelle had been with the agency for two years. I found her honesty both amusing and refreshing. Most staff seemed to be walking on eggshells and unsettled by the uncertainty, but Michelle seemed committed to being stress-free during the transition to FFS. I asked her how she viewed her role and she said,

Michelle: "I just do what I'm told and hopefully help a few clients along the way."

It was clear that Michelle did not see herself as someone who had power. Initially she seemed unaffected by the changes; she wasn't going to make herself "crazy trying to figure it out." On the other hand, I believe it was important for Michelle to help the individuals she works with in some way. Michelle did not believe that it was her responsibility to find out about CSS, but rather her supervisor's job to know. Lipsky (2010) states that the focus on more accountability means that frontline practitioners are less controllable. Yet in this case, Michelle is allowing this new form of accountability, which has neoliberal implications, to control how she approaches her work. Michelle's admission that she simply does what she's told implies that she does not always take the time to ask questions about why she is expected to do things a certain way. She also mentioned receiving mixed messages, but later admitted that she does not make the effort to get clarification from her supervisor.

I asked Michelle about the type of supervision she received.

Michelle: "I don't really get supervision unless there's something wrong with my paperwork. There's no time."

Supervision in a neoliberal environment focuses on making sure practitioners hit targets. This method of supervision focuses mainly on assuring that administrative tasks are completed rather than helping practitioners develop skills. For Michelle, her supervisor only meets with her when there is "something wrong" with her paperwork. I knew from other onsite visits and trainings that Michelle was not alone. The transition to FFS, in my opinion, deprioritizes supervision. In the CSS FFS model, supervision time is not reimbursable. Therefore, there is limited time, if any, to support a practitioner with professional development goals and the enhancement of skill competencies.

Hasson (2010) explains that fidelity can be optimized by using facilitation strategies that include manuals, training, and feedback. In this case, Michelle is receiving feedback, but it is fraught with inconsistencies and focuses on problems. As such, I think it is important for mental health authorities to provide opportunities for agencies to learn about the changes and explore ways for agencies to manage tasks they are not paid for, such as supervision. I have found that if supervisors and administrators do not feel supported by the state, then it will be difficult for them to adopt a new approach and guide their frontline staff successfully. Conversely, practitioners should be able to rely on their supervisors to have the correct answers; otherwise, a supervisor's credibility will be diminished. In this case, supervisors hold a position that comes with the responsibility of evaluating implementation and using a communication mechanism that will inform the mental health authority about the new FFS model and its effectiveness on the frontlines.

Some supervisors use disciplinary action as a means to deter unsatisfactory job performance. However, Lipsky (2010) points out that "agencies are constrained from controlling workers too much, particularly in challenging their performance...for fear of generating opposition to management policies and diminishing accountability even further" (p. 163). In this case, I think it is important for Michelle's supervisor to assess whether she is effectively providing CSS and offer further in-vivo training as needed. The absence of such evaluative measures leaves frontline practitioners with the power to enforce rules and practice in ways that may compromise the integrity of CSS. I believe if supervisors allow fear of opposition to dictate their relationship with frontline practitioners, then they are inherently becoming a part of the problem. Without consistent supervision, it will be difficult to implement the FFS model, CSS, as intended. I have seen supervisors, for the most part, rely heavily on frontline practitioners' self-report to evaluate the work being done with service recipients. I do not believe that a practitioner's self-report alone is an adequate monitoring strategy. Although supervision is not reimbursable in the CSS cost structure, I believe it's a task that still needs to be done. Providing supervision, in my opinion, is part of best practices. To me, if frontline staff feel supported and receive consistent supervision then it's likely to have a positive impact on their work. The new neoliberal approach of FFS requires practitioners and supervisors to work closely to ensure a balance between the values of neoliberalism and practice.

Discussion and Implications

In many ways, the cost-based contract system for funding supportive housing services in New Jersey was not empowering or sustainable. There were no consequences for agencies that did not deliver services that led to positive outcomes. I believe the emergence of neoliberalism in behavioral health through new policies like FFS could create many positive changes for agencies. Wallace and Pease (2011) argue that, despite being exposed to neoliberal discourse, practitioners have the ability to resist. Instead of feeling constrained by fiscal demands, practitioners can make their work with individuals more meaningful. I saw firsthand how the old system facilitated dependency on multiple levels: agencies dependent on contracts for funding and service recipients dependent on service providers for help. Shifting to CSS could mean more efforts to empower stakeholders. If practitioners focus their practice on teaching individuals the knowledge and skills necessary to be successful members of the community, then they could have an improved quality of life.

Policies are created to serve as a framework that structure the way practitioners provide services; however, one can argue that some policies are ineffective, either by design or implementation. Practitioners often feel the need to exercise discretion when regulatory requirements are in conflict with the needs of service recipients (Lipsky, 2010). Gaps in policy implementation will exist in perpetuity as long as policymakers make decisions that do not take into consideration the nuances of service delivery. I have seen how policies can diminish the individual experience. For example, policies do not always take into account the individual needs of a person or the efforts that a practitioner may need to take to support someone in their recovery. Instead, policies address broader issues. Additionally, when new policies affect practice, service recipients can be left feeling abandoned.

Under this FFS model, practitioners are urged to focus on delivering the services outlined on an individual's rehabilitation plan. The services or interventions that are delineated on the plan are what the agency will get reimbursed to provide. While, in many cases, practitioners are free to provide support that falls outside of an individual's rehabilitation plan, financial ramifications discourage this type of flexibility. I think agencies that take a rigid stance and begin limiting the services they provide risk alienating the individuals who receive their services. Vasquez, Bingham, and Barnett (2008) explain that the American Mental Health Association firmly discourages abandonment of service recipients. Furthermore, abandonment is considered a form of inappropriate termination.

In this case, service recipients should be made aware of the limitations of an agency given the transition to FFS and work with other stakeholders to find solutions. In doing so, I believe, individuals stay abreast of changes and their needs remain a priority for practitioners. It is not uncommon for service recipients to be unaware of changes that influence their care. Policy makers, mental health authorities, agencies, and practitioners should work to disseminate information to these individuals more readily. Lipsky (2010) describes a system where efforts are made to help "guide a [service recipient] through bureaucracy, and to obtain answers they are otherwise unable to get" (p. 195). Such guidance would not only make the system more manageable for individuals but foster a more transparent therapeutic relationship and empower individuals to make life changes.

If there was more dialogue about what was happening on the frontlines, there may be fewer gaps during implementation. Policy makers and mental health authorities may not be aware of the challenges that exist on the frontlines that would make it, in most cases, nearly impossible to maintain the integrity of new models of service delivery. Creating forums that are accessible to frontline practitioners and the individuals they serve would allow policymakers and mental health authorities to gain the perspectives needed for successful implementation. Additionally, when there are significant changes in approaches to care that impact many community stakeholders, states should consider adopting a process that would support agencies and service recipients during the change. In New Jersey, the state mental health authority has invested in a state-wide training and technical assistance initiative for the agencies affected by the change to FFS. This strategic plan allows an entire workforce to be educated about the FFS changes while teaching practitioners the critical skills necessary to still provide quality rehabilitative services. This type of training initiative can serve as a helpful guide for those creating policy and the frontline staff who have to adhere to the requirements.

Conflict will always exist for practitioners as they manage the needs of their agency versus the needs of the individuals they serve. However, creating a supportive environment where practitioners can turn for support is critical. "Street-level" (Lipsky, 2010) work can leave practitioners feeling overwhelmed and isolated. As such, policy makers and state mental health authorities should consider incorporating supervision into FFS models. Consistent supervision and encouraging peer support could work to cultivate a supportive environment where frontline staff can openly discuss their challenges and receive feedback as they continue to negotiate needs in a neoliberal system that does not always consider the practitioner.

As I look back on writing this reflection, I must acknowledge my initial apprehension. Due to my role in the training and consultation team funded by the state mental health authority, I wondered if my critique of the new FFS model would be met with resistance. I also questioned if I could offer a balanced view of the change. Thus, throughout this process, I was mindful to examine the role of FFS from all angles. I also committed to being transparent about my experiences and offered excerpts from the visits I conducted. For me, this process highlighted the need for more scholarship on policy implementation. Gaining a better understanding of these policies, how they are implemented, and their effect is critical. There is often much more of an emphasis on researching direct practice rather than on the structures and policies in which direct practice operates. By conducting more research on policy implementation, we can identify strategies that could contribute to successful transitions. Ultimately this will create a healthier environment for agency staff and the individuals receiving their services.

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