
Committee Meeting

Of
SENATE HEALTH, HUMAN SERVICES,
AND SENIOR CITIZENS COMMITTEE

ASSEMBLY HUMAN SERVICES COMMITTEE

“The Committees will hear testimony from invited guests on the Governor’s Reorganization Plan No. 001-2017, ‘A Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health’”

LOCATION: Committee Room 4
State House Annex
Trenton, New Jersey

DATE: July 25, 2017
11:00 a.m.

MEMBERS OF COMMITTEES PRESENT:

Senator Joseph F. Vitale, Chair
Senator Fred H. Madden, Vice Chair
Senator Richard J. Codey
Senator Robert M. Gordon
Senator Dawn Marie Addiego
Assemblywoman Valerie Vainieri Huttle, Chair
Assemblywoman Cleopatra G. Tucker, Vice Chair
Assemblyman Herb Conaway Jr.
Assemblywoman Patricia Egan Jones
Assemblyman Angela V. McKnight
Assemblywoman BettyLou DeCroce
Assemblyman Joe Howarth



ALSO PRESENT:

Adaline B. Kaser
Margaret A. Roberts
Office of Legislative Services
Committee Aides

Marcela Ospina Maziarz
Senate Majority
Andrea Katz
Assembly Majority
Committee Aides

John Gorman
Senate Republican
Natalie Ghaul
Assembly Republican
Committee Aides

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Hearing Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

JOSEPH F. VITALE
Chairman

FRED H. MADDEN, JR.
Vice-Chairman

RICHARD J. CODEY
ROBERT M. GORDON
RONALD L. RICE
JIM WHELAN
DAWN MARIE ADDIEGO
DIANE B. ALLEN
ROBERT W. SINGER



New Jersey State Legislature
SENATE HEALTH, HUMAN SERVICES AND
SENIOR CITIZENS COMMITTEE
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COMMITTEE NOTICE

TO: MEMBERS OF THE SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE

FROM: SENATOR JOSEPH F. VITALE, CHAIRMAN

SUBJECT: JOINT COMMITTEE MEETING - JULY 25, 2017

The public may address comments and questions to David Drescher, Adaline B. Kaser, Committee Aides, or make bill status and scheduling inquiries to Kimberly L. Prihoda, Secretary, at (609)847-3860, fax (609)943-5996, or e-mail: OLSAideSHH@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The Senate Health, Human Services and Senior Citizens Committee and the Assembly Human Services Committee will meet on Tuesday, July 25, 2017 at 11:00 AM in Committee Room 4, 1st Floor, State House Annex, Trenton, New Jersey.

The committees will hear testimony from invited guests on the Governor's Reorganization Plan No. 001-2017 "A Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health."

Issued 7/18/17

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New Jersey State Legislature
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COMMITTEE NOTICE

TO: MEMBERS OF THE ASSEMBLY HUMAN SERVICES COMMITTEE
FROM: ASSEMBLYWOMAN VALERIE VAINIERI HUTTLE, CHAIRWOMAN
SUBJECT: JOINT COMMITTEE MEETING - JULY 25, 2017

The public may address comments and questions to Robin C. Ford, Margaret A. Roberts, Committee Aides, or make bill status and scheduling inquiries to Lisa DeRosa, Secretary, at (609)847-3860, fax (609)943-5996, or e-mail: OLSAide.AHU@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

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SENATOR JOSEPH F. VITALE (Chair): Good morning, everyone.

I will call to order a joint hearing of the Senate Health, Human Services, and Senior Citizens Committee; and the Assembly Human Services Committee.

With us this morning are our members; thank you for coming; and specifically Chairwoman Vainieri Huttle, and Health Chairman, Herb Conaway -- Dr. Conaway.

First, can we call the roll, please?

MS. KASER (Committee Aide): Chairman Vitale.

SENATOR VITALE: Here.

MS. KASER: Chairwoman Vainieri Huttle.

ASSEMBLYWOMAN VALERIE VAINIERI HUTTLE (Chair): Here.

MS. KASER: Vice Chair Madden.

SENATOR FRED H. MADDEN Jr. (Vice Chair): Here.

MS. KASER: Senator Codey.

SENATOR CODEY: Here.

MS. KASER: Senator Gordon.

SENATOR GORDON: Here.

MS. KASER: Senator Whelan.

SENATOR VITALE: He's not coming; he's--

MS. KASER: Not coming; sorry about that.

SENATOR VITALE: He's under the weather.

MS. KASER: Okay.

Assemblywoman Jones.

ASSEMBLYWOMAN JONES: Here.

MS. KASER: Assemblywoman McKnight. (no response)

Senator Addiego.

SENATOR ADDIEGO: Here.

MS. KASER: Assemblyman Howarth.

ASSEMBLYMAN HOWARTH: Here.

MS. KASER: Assemblywoman DeCroce.

ASSEMBLYWOMAN DeCROCE: Here.

Thank you.

Vice Chairwoman Tucker is present; she's on her way.

SENATOR VITALE: Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: And I'd like to add Chair Herb Conaway, of Health, who is substituting in this morning. Welcome, Assemblyman.

Good morning, and welcome to the joint meeting of the Assembly Human Services Committee and the Senate Health. Forgive me; I'm not used to this room, and I feel like I need binoculars. (laughter) I'm used to my small, humble room in Human Services where I can, kind of, reach out and touch everyone. So I need glasses to even see to the end of the room.

But with that being said, you know, it's not often that we have these joint meetings; and it's even rarer to have them in July. And so this shows the importance of the issue before us today.

I want to also thank the members who are here today, and the stakeholders who we will hear from.

There is certainly no question that mental health and substance abuse are public health issues. However, there's -- the transitioning of addiction services and mental health into the Department of Health is a significant shift, and something that we as legislators have the responsibility to vet.

We received the letter on the Governor's Reorganization Plan on June 29; I wasn't able to read it, because we had a small problem in the State House during -- afterwards, and I think I read it on July 3 or 4. And with that being said, we had 60 days to either agree with it or oppose it. And so that's why we have this hearing, so we can hear from the stakeholders and, hopefully, have it thoroughly vetted and have our questions answered today.

And so with that, I will turn it over to Chairman Vitale.

SENATOR VITALE: Thank you, Chairwoman.

I echo your comments. And this is -- we're now nearly 30 days into the 60-day period by which we have an opportunity to discuss this issue and ultimately agree or disagree with the reorganization proposed by the Governor. There are a lot of questions that we are going to ask today. We're going to hear from, as the Chairwoman said, experts in the field; the stakeholders who would be impacted by this.

In addition, we'll spend more time, of course, after today speaking amongst each other, and also with additional stakeholders to get their feedback.

What the Governor has proposed is a significant change in the way in which the Department of Human Services provides these services, and how there is this proposal to move it to the Department of Health --

which is a very significant change for a number of reasons that we'll talk about today -- and whether or not we think all of that or part of that is a good idea; and, more specifically, meets the needs of those individuals who the Division serves.

So with that, we have our first witness. And I'd like, if we can -- to be able to get as many people in, that we've invited to speak, to have that opportunity -- to try to limit their comments to 5, 8, 10 minutes. Because there will be, certainly, questions that the members will have, and follow-up after their testimony.

So with that, I'd like to call, as our first witness, John Jacobi from Seton Hall; the Seton Hall School of Law.

John, if you want to, just introduce yourself for the record, please.

JOHN V. JACOBI, Esq.: Thank you.

My name is John Jacobi; I am a Professor at Seton Hall Law School, and a Director of the Health Law and Policy Program at Seton Hall Law School.

I want to thank the Chairs and the Committee for inviting me to provide some information today. I'm hoping that my testimony will be of some assistance. My Center has been working on behavioral health and, particularly, behavioral health integration issues for a number of years. I will describe that process and tell you what our findings -- our tentative findings have been. They will go to some, but not all, of the issues that are before the Committees today.

As the Chairs indicated at the beginning of this hearing, the fragmentation of the healthcare delivery system is one of the biggest issues

that these Committees and the Legislature as a whole have dealt with in recent years. And that fragmentation takes many forms. But one of the most important is the fragmentation of behavioral health and physical health.

Just to give a quick punchline, I believe that I can say from our research -- some of this is obvious to everyone in this room -- that behavioral health integration saves lives; that the reform of New Jersey's licensure system for outpatient care is a necessary, although not a sufficient method or means of achieving integration; and that the process of achieving that integration is a long one. It's a problem that has been recognized for decades in New Jersey. I believe that there is a window of opportunity now to move forward. And however this Committee resolves the issues raised by the Resolution, I hope that the progress that's been made to try to integrate physical and behavioral health care isn't stopped.

So a couple of years ago, my Center was asked by the Nicholson Foundation to look into problems of licensure and financing of integrated care, in part because there were many reports in New Jersey that caregivers were being told that it was forbidden to provide more than one of those modalities of care in the same setting. Now, some of the subsequent legislation that members of these Committee are responsible for have taken care of some of those problems; although not all of them, obviously. To respond to that problem, we were asked to interview people from the two departments -- Health and Human Services, caregivers and advocates -- which we did. We produced a report last year, recommending significant changes in the licensure system and in the funding system for behavioral health and physical health care in order to encourage integration. We

talked to people, from leadership on down, in the two departments, and to many caregivers and advocates. Our recommendation included changing the licensure system to permit a caregiver to provide all three modalities -- that is, substance use disorder, mental health, and primary care -- in the same setting; and to address the problems in the Medicaid system that were frustrating the attempts by caregivers to integrate care.

We ended up describing, in some detail, how the licensure system might be fixed. After the passage of some time, we were invited by the Department of Health and the Department of Human Services to provide technical assistance, to work with them to try to implement some of the recommendations that we made. We have, for the last six months or so, been engaged in that technical assistance project, meeting with folks from both agencies -- and, again, with caregivers and advocates -- in order to try to put some flesh on the bones in order to try to describe exactly how the regulatory and sub-regulatory systems in New Jersey could be adjusted, in order to encourage patient-centered care for people with behavioral health and physical issues.

The process of working through the changes that would have to be taken has been somewhat complex. It has involved hearing from folks -- many of whom are in this room -- about what their frustrations have been; talking to people in the agencies about what their perceptions are about what the reasons are for some of the problems. We have been-- I think it's fair to say we have made a fair amount of progress in driving consensus between the two agencies, and among the workers in those two agencies, in order to move forward with an administrative method to create a single license for all three modalities of care. I can tell you that the process, while

far from glamorous -- as legal issues go, maybe no legal issues are glamorous -- but from my perspective, the work that would have to be done in order to accomplish what we have recommended is technical; it is extensive; and it would stretch over a period of a couple of years, probably.

I will say this. Leaving aside -- and I realize this is a funny thing to say, given what you're here for -- leaving aside the Resolution, the progress that could be made to allow for the integration of the licensure system in order to permit a single license, could, I believe, be accomplished in two stages; the first stage, which could be done by the end of this calendar, to allow caregivers to apply for and receive a license for all three, or any of the three, modalities of care. That leaves aside the problem that our regulatory system is antiquated; it doesn't always jibe -- that is, the Department of Health regulations don't jibe with the Department of Human Services regulations. That could be papered over in the short run, in ways that would make your eyes glaze if I described it. But in the long run, the right thing to do is to update our regulations, many of which go back two or three decades, in order to allow for patient-centered care -- that clinicians understand to be the right way to provide care -- for people with behavioral health needs to flourish in New Jersey.

So I hope that however this joint body and the Legislature generally addresses the resolution, that it does so with an understanding of the background that behavioral health integration is absolutely necessary. I don't have to tell the members of this joint Committee that you have done yeoman's work over a number of years on these issues. But we can't separate what the resolution is attempting to do from the efforts to move forward with behavioral health integration.

I wish I had more wisdom on the steps forward in that regard, but I do think that it is fair to say that any solution to creating a single license for caregivers to provide behavioral health -- that is substance abuse disorder or mental health -- and primary care would require some reorganization of the two agencies. Whether it should be done in the way -- whether the agency is sliced the way that the Resolution purports to slice it; whether that is the right way to do it or not, is one question. It would have to be, though, that the powers of one of the two agencies would have to be transferred to the other agency in order for a single license to be granted and overseen by the same licensing and inspections services.

I would be remiss if I didn't say what I say to the folks in the agencies every time that I meet with them, and that is that fixing the licensure system is only half of the battle. That if the licensure system is updated to the 21st century -- maybe even to 2017 -- that would be great. It would allow caregivers to have truly integrated care. But that will not happen if the financing system is not also addressed so that Medicaid reimbursement is available to caregivers who are providing services under a modern, integrated form of care; and not in the old fashioned, piecemeal system that the Medicaid system was designed to address.

So those are my comments. I'd be happy to take questions; or to be available to the members of these Committees at any point in the future, if you'd find that useful.

SENATOR VITALE: Great; thank you, John.

I appreciate that, and the work that you've done over the past few years.

We had this conversation about the legislation that a lot of the members here voted for, that would create a single license. And back when we began to talk about a legislative strategy to combat the opioid epidemic, one of my frustrations that I found was, sort of, the simple example of: FQHC was providing primary care; dental primary care; but could not truly offer behavioral health services. Because the way that the regs were written, the law was written -- at the time -- is, you had to have a separate entrance, a separate waiting facility, separate waiting rooms, separate treatment areas for people with behavioral health needs. And that struck me as being a real barrier to care, to integrating that care -- so to be able to provide both behavioral health services and physical health services in the same place at the same time.

And why those regs were written, why someone thought that it was a good idea to have a separate entrance and a separate waiting room for people with behavioral health issues is a conversation for another day. But it's part of the stigma that we're all trying to overcome, I think.

And so that sort of got the discussion going, departmentally. Because I had heard from both Commissioners, at the time, saying that, "Oh, that's really difficult, because we have one license to do physical health, and another department that has a license to do the behavioral piece. And it's a *thing* if we try to integrate this. It's very comp--" And it is complicated; I don't mean to say that it's not.

So eventually that sort of took some seed on a department level, and the Commissioners at the time began to work, hopefully, in cooperation with one another, to try to advance that idea.

What we did talk about was having a facility that provided behavioral health services and, at the same time, be able to provide physical health -- so it was sort of going both ways.

Your work, and through the grant that Nicholson -- is helping us get to that place, we think.

It seems to me that -- and this is-- Maybe it's a simple comment; then I'll ask for your response, and then I'll pass the mike to other members -- it seems to me that if we were to -- and I'll use the word *simply* -- but put the licensure issue, the licensure element of all of this in one department. And I, you know -- whether it's the Department of Health, for example, which currently is very good at doing licensing; it is what they do. On the operational side, in terms of what the scope of the work the DHS does and DMAHS provides, it is very complicated -- DD, long-term care, Medicaid-- I mean, there are scores of services they provide that are currently being provided and, I think in a manner that-- With the resources that they have, and the mission that they have, they are doing a good job.

So how, in your view -- and I know you don't want to take a position; I don't expect you to take a position on this issue. But if, for example, the Department of Health, at some point in time, when we put all these pieces together -- they handle the licensure element of all of this. And the Department of Human Services and its division, DMAHS, can continue to do their work without having to bifurcate the system. Is that one way in which we can look at this, going forward?

MR. JACOBI: I certainly agree with your premise -- that having the licensing authority -- if I understood you correctly -- that having the

licensing authority in one department is crucial. I think it is crucial that the licensing responsibility be in one department, if the license is going to be a single license. I just think it's unworkable, practically, to do it otherwise. It's possible to do it otherwise, but not well.

As for whether any other aspect of the Department of Human Services would naturally or necessarily also be shifted has not been a part of our work. And I think for the purposes of the outpatient integration that I've been describing, it is a separate issue. What really needs to be in one place, in order for outpatient integration to work, is licensing authority. And if we were, or anyone was coming up with a regulatory system in 2017 to deal with outpatient therapeutic services, we would never develop it the way it's currently in place. It's a legacy problem; it's a problem of the regulations, going back to a time when mental health and substance abuse disorder care were thought of differently and not in an integrated fashion. So we would create a single licensing authority to provide, certainly, the outpatient care.

And if I understand your question correctly, that is what our work has been focusing on; that is, the outpatient services and not the other services that you mentioned.

I hope that's responsive.

SENATOR VITALE: Great; thank you.

Senator Gordon.

SENATOR GORDON: Thank you, Mr. Chairman.

And thank you for your testimony and the work you've done in this area.

I don't think any of us here are questioning the benefits of integrating the three modalities of care at the site of care, and the patient benefits of doing that.

But what we're talking about with this Reorganization Plan is changing the organization charts in Trenton. And if I were looking at this problem, as I'm trying to, from an MBA perspective -- I'll put it that way -- and looking at a problem in organization design, I would want to know, what are the compelling reasons for integrating agencies? Is there a coordination activity that is being impeded now? I mean, let's say we fix the licensing problem, and just put that in one agency. Is there still a coordination problem? Are there some failings in the flow of information from one agency to another? What is the compelling reason to integrate agencies that, at one time, were together in another era?

That's one question I had.

The other is the question of timing. Why now? We're about four months from what I'm confident will be a transition process, with a Committee devoted to organization design of the State government. Why should we make these changes now, when it might be better to put those decisions off for at least four months, when they may be part of a larger change in organization structure?

And so I would appreciate whatever thoughts you have in response.

MR. JACOBI: Thank you; two excellent questions. I would be happy to answer them.

First, I want to make sure that it's clear that I wasn't suggesting that anyone on these Committees was opposing behavioral health

integration. I certainly didn't mean that. The purpose of my comments is to try to put in context how that work moves forward against a background of the Resolution.

So from the organizational dynamics perspective, my colleagues and I have thought a lot about that; and I will tell you what our conclusion is. And our conclusion is that, from a legal perspective, it's important for there to be a single authority to approve licenses. I don't want to end with that, because I think your organizational dynamics question is an excellent one. And we are of the view that it is inevitable -- if you have two different agencies responsible for coordinating pieces of a single license or a conjoined license, that inevitably there will be mission drift; that there will be disagreements between them; that one agency's people will understand a piece of language differently than the other agency does.

And that happens now. For example, Senator Vitale raised the issue of needing two separate entrances for behavioral health and physical health. I've looked through those regulations; there is no such regulatory requirement. It is what is -- the agencies interpret their regulations to require that. And that is always something that happens with agencies. They develop their own interpretations, as they have to, of regulations. And if they are separately supervised there would inevitably be mission drift; that inspectors for one agency would inspect (*sic*) against a different understanding of the same regulation than their sister agency.

And I just don't think it would work. I think it is legally problematic; but more importantly to your point, I do think that it is organizationally fraught with peril.

On the timing issue -- I've been working on these issues for a long time; but not as long as many members of these Committees have been working on this issue -- that is the issue of behavioral health integration. And members of this Committee are aware, perhaps painfully aware, of the ebbs and flows of the ability of the Legislature to bring administrative agencies along, to get them to actually be on the same page as the Legislature; let me put it that way. And I believe -- I could be wrong -- but I believe that there is a window of opportunity here where -- it would be overstating it to say the stars are aligning; but I do think that there are people in both agencies who have expressed a willingness to work on these issues and a willingness to see the project through. If I am correct on that, then we can make some progress; and I'm the kind of guy who likes to take progress when you can get it.

That said, I am aware of the calendar, and I think that you raise an interesting point. I am simply reluctant to let go of the possibility of making substantial progress in the present. And I don't think, given the way that agencies work, that the progress that we would make would interfere in any way with the next Governor's ability to organize whatever the Governor wants to organize. Because I don't think anybody would disagree with the goal of creating a single license for those outpatient services, which is really what we are focusing on.

I hope that's responsive.

SENATOR GORDON: A follow-up question.

Short of redrawing the organization chart, is it possible that we can achieve the coordination and synchronization that we're looking for by simply making sure that, by rewriting the regulations, for example -- to

make sure that they're congruent and not in conflict, or not open to misinterpretation or a different interpretation by the two agencies?

MR. JACOBI: I would respectfully say "no;" that we can do our best to fix the regulations so that they read the same, but as you know, the work of agencies is complicated, and particular issues are often not squarely answered by the plain language of a regulation, and some interpretation is necessary.

And I will say that other states have tried to leave the agencies separate and tried to create some joint regulations. New York has done that. I think it works imperfectly; I think that there are -- that bringing the authority together in one place is more certain to allow for a caregiver to be able to understand clearly what they need to have if they're going to get a license for either services.

SENATOR VITALE: Senator Codey.

SENATOR CODEY: Thank you, Chairman.

My concerns Senator Gordon has already said -- and I echo them -- in terms of "Why now? Why this?" So forth and so on. We have something like 40-something days left to overturn this. And I kind of hate to say this, but I feel the thing may be wired already, unfortunately. Hopefully this Committee can recommend to the full Legislature not to allow this to go through.

And how many stakeholders were sat down over the past year and spoken to about this change and how it would affect their operations? Would it best for the people who we serve? I say, "None." If a person decides to do this -- the Governor is not here; the person who is going to implement this, the Commissioner, is not here. Why now; it's absolutely

ridiculous to be here when we're going to have a new Governor in just a few months, as Senator Godson said.

So hopefully, we can, very firmly and loudly, say, "Not now, Governor; not now."

Thank you.

SENATOR VITALE: Chairman Conaway, did you have a comment?

ASSEMBLYMAN CONAWAY: Let me-- Thank you, Chairman.

I'll just take a moment to congratulate our members here on -- a little off-topic -- on getting smoking -- the age to buy cigarettes up to 21. That's great public health work.

UNIDENTIFIED MEMBER OF COMMITTEE: (off mike)
(Indiscernible)

ASSEMBLYMAN CONAWAY: Well, it was not me wanting to put it up, I can tell you.

But, congratulations to everyone here, particularly Senator Codey, and Assemblywoman Vainieri Huttle, and Chairman Vitale for their great work on that Bill.

Mr. Jacobi, I read your report from stem to stern, and jumped out to the footnotes and the other things that were referenced in your report.

And I want to congratulate you on a very fine piece of work with respect to one of the large questions that face our society today -- and that is what we're going to do about -- and, really, what we should have

been doing for some time, one would argue -- in the area of mental health, its treatment, and those who also suffer from issues related to addiction.

Your report, I read, is calling for integration of services -- I think, as you've referenced here, I think probably broadly shared in this room by, certainly, Committee members; but I would think also by members in the audience, many of whom we'll hear from today -- that we need to integrate these services and deal with the stigma that has been a barrier for so many people in getting service.

Now, I read your report, and I just want to put a point on it. I thought I heard you say that single licensure would require reorganization of the agencies. I mean, when you read the Governor's message -- Executive Order -- are there things in the Executive Order that you find objectionable, given the report that you wrote?

MR. JACOBI: Well, I think that if I'm to respond directly to your question--

ASSEMBLYMAN CONAWAY: Please.

MR. JACOBI: --with respect to the substance of our report, what was important to us was that there be a single authority for the licensing of outpatient therapeutic services; and the Resolution accomplishes that. So to that extent, the Resolution is consistent with our recommendations.

Of course, the Resolution goes beyond that. And we didn't address the other aspects of the modification of the structure of the Department of Human Services in our report. So the--

ASSEMBLYMAN CONAWAY: So you've said, I gather -- I take it that -- and you'll answer this directly, I guess -- and that is that a

single line of authority -- I thought I heard you use that word -- that a single line of authority-- And I would think common sense would say that a single line of authority, generally, is more efficient than having multiple lines of authority, or inchoate or unclear lines of authority when you're trying to get anything done. So the basis of your argument is that a single line of authority -- in this licensing area, at least -- is something that would bring efficiency, and allow and remove many of the barriers that you outlined in your report. And I think that they are understood by many people here on the Committee -- remove those barriers so that we could do a better job of getting care to people who need it. Was that a true statement?

MR. JACOBI: Yes; I agree with that.

ASSEMBLYMAN CONAWAY: Now, you also mentioned in your report -- and you went on quite extensively, as I recall -- on the question of coding and payment. Because as you know, in health care, you don't get what you don't pay for. And if there are issues around how people will be paid, people are going to think twice about investing their time and their energy in a service if they don't know that they are going to actually be reimbursed for that service. And you spent quite an amount of time in your report talking about the various problems that exist with respect to coding, code sets, paying for services; and for the regulators on the one hand to have -- to state clearly how things are going to be paid, on the one hand; and for those who would be doing the services, understanding how they're going to be paid.

So given that you have cited -- and I think, quite rightly -- that a single line of authority would make sense with respect to the licensure end, doesn't the same logic carry forward in this question of coding and

how things are going to be paid? That having a single authority, a single entity making decisions on how services will be reimbursed -- that that would be something that would bring efficiencies, and would allow people to make considered judgements in investment of their time and labor to bring these services on line? And indeed, I think to help the agencies, even, to decide how they're going to regulate in this area, since the government is going to be paying for a lot of this service?

Doesn't the same logic apply here on the payment side?

MR. JACOBI: Respectfully, I think not; I think not, certainly to the same extent as you suggested, Doctor. It is true that if New Jersey Medicaid doesn't conform its payment system to encourage the patient-centered care that you describe, then the care is not going to happen. And I certainly agree with that, and we describe that at some length.

I guess I am less clear, and we did not say in our report, that we thought that the Medicaid authority had to be in the same department as the licensing authority in order for those changes in Medicaid payment to take place. I don't think that it would be harmful for them to be in the same agency; but the logic, I don't think, runs as strongly with respect to payment in licensing as it does with respect to bringing all of the licensing together in one agency.

ASSEMBLYMAN CONAWAY: Again, through the Chair. In the FQHC context -- I think you went into some length in talking about that -- is that it's unclear exactly how mental health services are going to be provided in those settings. There a number of clinics; they are in well-placed positions across the state to deal with populations in need. And there is, quite frankly, confusion about whether or not they can offer service

and how that is going to be paid. Now, it's your -- and you might now have taken a position on this; I sort of inferred, so I will say that I *inferred* that getting a code set together around these services, and making some decisions about using a few FQHCs in this context might go a very long way to making sure people actually get the service they need. Because they're there in the community already, providing a host of other services to people in need.

MR. JACOBI: I certainly agree. I don't want to lose the mundane issue that they have to be able to be licensed to provide those services, before they can be paid for them. But I certainly agree with your point.

ASSEMBLYMAN CONAWAY: And lastly, there is -- I think you referenced in your report, as well, and we've certainly heard a lot about this over the years -- and the Chairman just referenced it -- this question of stigma, and the separation -- the bifurcation between mental health services, addiction services, if you will, and physical health. And one of the things that I was encouraged by in reading your report is that the government actually will -- might very well be in a position to make a statement about that very troubling issue, and the barriers that it places before people in getting this needed care. And that one might argue that, after all, if the government behaves or structures itself in a way that bifurcates physical and mental health, then we shouldn't be surprised if that same kind of structure carries itself right down in the ground and into the field, where this bifurcation is causing so many problems for people getting the health care they need, and getting good outcomes across the spectrum, in terms of one's health.

Thank you, Mr. Chairman.

You don't have to answer that one. (laughter)

MR. JACOBI: You said it better than I could.

SENATOR VITALE: It didn't answer the question mark; that was sort of--

Would any other members like to question the witness?

Yes; Assemblywoman.

ASSEMBLYWOMAN DeCROCE: Thank you, Senator. I appreciate it; thank you.

When Assemblyman Conaway was talking about Medicaid, and talking about the Department of Health -- I don't normally serve on this Committee, but I do sit on Health and Senior Services, so I feel I have some knowledge on it. But the Department of Health, right now -- don't they deal with DHS pertaining to nursing homes and Medicaid?

MR. JACOBI: There is certainly a lot of cooperation between the two agencies--

ASSEMBLYWOMAN DeCROCE: Okay.

MR. JACOBI: --on a number of issues.

ASSEMBLYWOMAN DeCROCE: Okay. But the Department of Health -- they license nursing homes and assisted living facilities. So the license is over here, but they're working with Medicaid over here with AHS; am I correct?

MR. JACOBI: That's true.

ASSEMBLYWOMAN DeCROCE: Okay. So if the Division in AHS is taken out of that Department, and that whole Division, with all

their employees, with all the experience, and knowledge, and ability is brought over to the Department of Health, how does that hurt?

MR. JACOBI: I'm sorry; if DMHAS -- if Division of Mental Health and Addiction Services--

ASSEMBLYWOMAN DeCROCE: Right.

MR. JACOBI: --is brought over to the Department of Health--

ASSEMBLYWOMAN DeCROCE: Right. If all the employees-- Because that's my understanding, and that was a question I had this morning with the Departments. It was made clear to me that every one of those employees would be moved over to the Department of Health to implement the program.

One thing we know -- and I agree with you -- is regulations are antiquated. There are gray areas. I believe in some of the reports that I read -- and I was brought up to speed quickly on this -- there is a regulation that could have three different interpretations by three different individuals because there are gray areas. So we all know that regulations need to be rewritten to bring them up to today. So does it matter if it's at AHS, or if it's at the Division of Health? They have to be rewritten; they have to be redeveloped and brought up to today's standards so that these gray areas can go away. Because the gray areas are what cause the problems within the departments; because they fight within themselves. And I can tell you, I was the Deputy Commissioner for the Department of Community Affairs -- which many of my colleagues hear me say that all the time -- and on a regular basis we had to deal with regulations. And I had directors in departments-- And within the division, there would be individuals reading interpretations and arguing amongst themselves that it was wrong.

Now, I know it's a long process to write a regulation and go through the process, through the Attorney General process, and everything that we have to do to make it into a formal regulation. But if we have to do that over here, how does it hurt us if we're doing it within the Department of Health when it needs to be done anyway? And we have all those employees implementing it. So if they come over here right now, it's really not going to interrupt any of the services, because they are all going to be within the Department of Health; they're going to be moved over.

Either way, whether they're moved over and this Plan is put into place, even if it's not -- we still have to rewrite the regulations, which has to be done. So whether it's done on this side, or this side, or done all together as one, it has to happen. I would think that's better for everyone involved; for interpretation of what our departments and divisions need to do to help the people of New Jersey.

MR. JACOBI: Well, just a couple of quick thoughts.

One is that I don't want to soft-pedal the fact that there would inevitably be dislocation when one agency is reorganized and some of their employees and functions go to another agency. So I don't want to -- I think we have to acknowledge that there will be some dislocation, no matter how things move from one agency to another -- if they do. That's one thing.

The second thing is, that it's certainly true that if antiquated or outdated regulations have to be rewritten, they could be rewritten by either agency, or both.

And then, the third thing is that you would be putting lawyers out of a job if it were true that you could write regulations so clearly that there would never have to be an interpretation. I think that there always --

there's always going to have to be an interpretation. That's why I think it's so important to have -- in the narrow area that I'm talking about -- outpatient services -- for there to be one authority that has the final say on the interpretation of the regulations.

ASSEMBLYWOMAN DeCROCE: You know, I agree; you know, there's always going to be an area of interpretation in some areas of it. But it doesn't need to be at the weight that it is right now, because it's intense.

Now, I can tell you that-- I oversaw the Division on Women in the Department of Community Affairs. And we went through a process where it was moved over to the Department of Children and Family Services. And there was pullback; there were individuals who did not want it to happen. They were very upset. They thought it was going to be the worst thing in the world. I'm no longer, obviously, there; I'm here in the Legislature. But when I see individuals who worked with me in the Division on Women, they are happy where they are; and it worked, and it wasn't the disruptive, confused thing that happened within the Department. And it was basically -- one Department didn't want to let go of what another Department was going to get. But when they moved the whole Department, with all the employees from the Division on Women over, it worked, and they're doing better.

So I don't think it's not something we-- I think it can work; but, yes, a discussion needs to take place. But I don't see it as a doomsday thing. And I think having everything in one place to handle it-- And by the way, if I'm correct, Addiction was within the Department of Health 20 years ago, and it was moved over to where it is now. So, you know, that

wasn't such a good choice back then. So it shows when you do singular things like that, it isn't good; but if you put everything together to be addressed -- with licensure in one place, and implementing the regulations and the requirements -- within the Department, it should be more streamlined for the public.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

I'll conclude the questioning for you.

Oh, okay. Let me just get my-- Okay; go ahead, Senator Gordon.

SENATOR GORDON: Thank you, Madam Chair.

I just have a quick question.

Getting back to the timing issue again -- as you know, another thing that's going on now is the transition for many of these mental health providers from contract-based reimbursement to fee-for-service. Do you see that as a complicating factor affecting a reorganization?

MR. JACOBI: Yes. I think that agencies that are undergoing the shift to fee-for-service are, to a greater or lesser extent, having a lot of their staff time taken up sorting that out.

And to the extent that this shift affected them in their day-to-day operations, it would have an effect-- I don't see how an agency that is currently providing services would be affected in their day-to-day operations by this shift. The regulations would -- at least, in the first instance -- remain identical, and they would be responsible for complying with the same regulations. They would simply be organized under a different agency.

So yes, potentially; but not -- I don't think a lot. But you'll hear from many people today who would have better views on that.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

Actually, a follow-up on that fee-for-service. Most of the providers are still having challenges now; and they're working daily with the Department of Human Services. And so to, sort of, throw something differently now into that area would certainly, I think, possibly hinder some of that delivery of care.

But I have just a couple of questions to conclude with you; and I thank you for your research.

But did your research conclude that all mental health and addictions services should be transferred to DOH, or just the licensure part? And I ask this because -- did you keep in mind the consumer with the wrap-around services? Because as you know, DHS and DHMAS provide supportive housing, the employment programs and services for the consumers. And all of these wrap-around services aside, do you think that DOH -- the Department of Health -- has the wherewithal, or the expertise, in regard to those services -- which would be the housing and employment issues? And I don't know if you can answer that, but I think that's the other piece we need to look at. Because again -- and we'll reiterate it, time and time again -- integration is crucial; we believe that. However, if you're in the process of integrating now, is there really a need to integrate all under the Department of Health?

MR. JACOBI: An excellent question. Let me just say that unless the two agencies were completely joined, there would have to be a breakpoint at some place within the Department of Human Services. I think that members of these Committee have been heard many times saying that the licensure of outpatient therapeutic settings should be integrated.

And if that means that part of the Department of Human Services would have to come over to the Department of Health -- if that's what it means -- then of course, those functions that formerly were the Department of Human Services' would now be separated from other services that the Department of Human Services provides.

So there would be some dislocation either way; and I think that there's a good argument that getting the therapeutic licensure in one agency is extremely important. As important as supportive housing and employment supports are, I think that they can be provided by sister agencies more effectively than a separate licensing system for therapeutic services.

But I certainly take your point; but that's my opinion.

ASSEMBLYWOMAN VAINIERI HUTTLE: Okay; thank you.

Seeing no further questions, we appreciate your work, and your testimony, and your time.

And I will call up the next panel of witnesses.

MR. JACOBI: Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

Next, we have Terry O'Connor, former Director of Addiction Services.

(confers with staff)

Oh, wait a minute; hold on.

Terry, sit back down. (laughter) No, no -- I called the wrong panel up. Someone has to leave, so I'm just switching order; I apologize.

We're calling up Barb Johnston, right? Panel three? Mental Health Association. Sorry, Terry.

Debra Wentz, New Jersey Association of Mental Health and Addiction; Patricia DeCotiis, New Jersey Psychiatry Association; and Robert Davison, Mental Health Association of Essex.

Patricia, I'm sorry; you're on the next panel as well. I'm calling a little out of order.

So we have Barb Johnston, Debra Wentz, and Robert Davison.

Thank you.

And whoever would like to begin; welcome.

BARBARA JOHNSTON: Sure.

Good morning; I'm Barb Johnston. I'm here representing the Mental Health Association in New Jersey.

Thank you for hearing our testimony today.

MHANJ is a statewide, not-for-profit organization that's dedicated to improving the lives of individuals living with mental illness.

And we have serious concerns, and we oppose the shifting of oversight of the Division of Mental Health and Addiction Services -- the *Division* -- from the Department of Human Services to the Department of Health. And while we strongly believe that the integration of both mental health and substance use are critical, it's also critical to have the integration along with physical health care. And we've done a lot of advocacy in this regard.

However, we believe that this move is not a viable way of making this happen. And you heard Professor Jacobi talking about some of the reasons. And we believe that regulatory is a small portion of what's blocking integration right now; that even if we addressed the regulatory

issues, sustainability is a huge issue in order for these programs to continue to integrate care.

We believe also that DHS and the Department of Health have vastly different roles and functions. DOH performs a predominantly regulatory function, as well as oversight of health policies and programs; and DHS, on the other hand, has a strength and history to conduct wide-scale operational programs, and they serve tens of thousands individuals -- residents in institutional and community settings.

So just put very simply, one has a regulatory role -- and that's the Department of Health -- and DHS has much more of an operational role around services. And we think that's very important to note.

Also, as we've heard, this is a fragile time in DHS, in the Division, for these organizations that are transitioning from a contract-type to a fee-for-service. So previously, they received contractual dollars from the Division, and now they're billing under fee-for-service and, specifically, community support services. And this is a very fragile time. Without a safety net in place, many agencies are really struggling to get this done. And there is very good communication between the Division and the providers, and they're working it out as they go along, with the Department really supporting this initiative. And that's very important to note that as well.

Then, of course, the issue with Medicaid came up. And it is our belief that large numbers of individuals who are served by Medicaid also need to be close to the services they receive; and many of the individuals have behavioral health conditions, many living in poverty. It is very important to keep those together. And today, even, the Division and

Medicaid have really made some great strides around innovations, like behavioral health homes and integrating through CCBHCs. There is a lot of work to be done, but we believe having them together really helps with innovation.

Then, of course, if it were to move, those divisions that would stay under DHS -- like Developmental Disabilities -- they would be separated from the services that those individuals really need so much.

So again, you're splintering further if you make that kind of a move.

I think also very important is that the Division works closely with community providers, consumers and their families. And they really have developed a terrific philosophy of *Wellness and Recovery*, and it has taken a long time to get there, through a lot of community input. But the philosophy of the Department and the Division is really one of recovery and wellness. And we want to make sure that this remains.

So the Department of Health really has much more of a medical model focus; and they should, because that's what they're about. But we think moving it could possibly erode the recovery model in the Division that we have worked so hard to maintain.

Thank you.

DEBRA L. WENTZ, Ph.D.: Thank you.

I would echo and agree with everything that Barb said.

And on behalf of the New Jersey Association of Mental Health and Addiction Agencies--

ASSEMBLYWOMAN VAINIERI HUTTLE: Excuse me, Debra; would you introduce yourself for the record, please?

DR. WENTZ: Oh, I'm sorry.

I'm Debra Wentz; I'm President and CEO of the New Jersey Association of Mental Health and Addiction Agencies. And I thank you and Chairman Vitale for holding this hearing today.

NJAMHAA has long supported and worked toward integrated care, because the physical comorbidities that plague the population served by our members have left them with a 25- to 37-year shorter life expectancy than the rest of the population.

We've also held that mental health is *health*, and we've participated in anti-stigma campaigns throughout our history.

The rationale that's presented in the Plan matches these positions. However, we have very serious concerns about the Plan that cannot be ignored.

The most disconcerting aspects of the Plan are, as have been mentioned, the timing of the move; the rapidity of its implementation; the lack of both vetting for impact and stakeholder input; and the disconnect from the Division of Medical Assistance and Health Services. The community-based behavioral system, as others have noted, is just now, largely, transitioning to fee-for-service. Due to the negative fiscal impact, staff have just recently been laid off, psychiatric time has been reduced, and changes have been made to business models. Yet many agencies are still facing deficits for the current year.

Undertaking another major, systemic change, while there is already such uncertainty and difficulty, could be a significant disruption to addressing ongoing transition issues.

We are also concerned that the staff disruption that's caused by physical and administrative moves at the State level, potential layoffs, and job-shifting cannot be afforded at this critical juncture.

Moving the Division of Mental Health and Addiction Services without moving Medicaid could also potentially be a serious setback. Medicaid is an integral component of the community-based system of care, and the major player and the major payer in the current transition to fee-for-service. Our members' programs are, for the most part, licensed by the Division of Mental Health and Addiction Services, but they also hold Medicaid licenses in order to be able to bill Medicaid; and they must adhere to Medicaid regulations throughout their programs.

Because of the full involvement of both Divisions in mental health and substance use treatment programs, the majority of meetings that we hold have staff from Medicaid. The Department of Human Services wisely also established a number of new positions for senior staff to serve as a bridge between Medicaid and the Division of Mental Health and Addiction Services. These strong collaborations, overlapping experiences, and historical knowledge are vital to seeing the community-based system of care maintained, especially during these early stages of transition.

A recent study by the Commonwealth Fund explored the merging of Arizona's Medicaid agency with its Division for Behavioral Health Services. The report noted that separating Medicaid from behavioral health responsibilities -- into different agencies -- inevitably leads to different and sometimes misaligned policy goals, program priorities, and purchasing strategies. This can impede the delivery of integrated care to enrollees and the implementation of value-based purchasing.

There are other concerns, as well. True integrated care happens at the consumer level. For instance, NJAMHAA has been advocating for several years for changes to regulations that would allow agencies to more easily bring primary care services to their clients. Breaking down barriers to that would have a much more immediate impact on those served. It is also necessary to fully explore the integration and coordination of critical social and supportive services that are an integral part of promoting the health and wellness of individuals with mental health and substance use disorders

While such a move, as it is proposed, could be logical, it should be done in a *planful* manner, with extensive input from all stakeholders, legislators, and the public. NJAMHAA, therefore, recommends delaying such a move until such time that it can be fully vetted and its impacts fully known. We urge all legislators to lend their support to resolutions that would stop the current plan, in order to allow time for full study and a more reasonable transition timeline, should the Plan ultimately be implemented.

But should you go forward now, I think it would just add another moving part into many other systemic changes that are taking place, including on the Federal level, which is the major payer. And we don't know, from day to day, the outcome of that and the impact on New Jersey.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you, Debra.

And we do have copies of your written testimony, and others who may be testifying.

So just, for the record, we have the written testimony. If you could possibly summarize it, and then there will be an opportunity for questions; because we have quite a full agenda today.

Thank you.

Please identify yourself, Robert.

ROBERT N. DAVISON: Good afternoon.

My name is Bob Davison; I'm the Executive Director of the Mental Health Association of Essex and Morris. And thank you very much for having me.

In theory, transferring the Division of Mental Health and Addiction Services to the Department of Health, for the purposes of integrating behavioral and physical health, has great merit. Mental illnesses and addictions are real diseases and chronic conditions that require lifetime management.

In practice, to do so requires a deliberative process that seriously considers the goals and, just as importantly, the unintended consequences of such an endeavor.

New Jersey citizens who currently suffer from mental illness and addictions deserve such a process. The only body that can guarantee such a process is the New Jersey State Legislature.

While the ideal is worthy, the proposal to transfer the Division of Mental Health and Addictions in less than 60 days, without that deliberative process, is irresponsible at best and reckless at worst. Serious issues must be considered first prior to any hasty action; issues such as, has the Department of Health demonstrated any understanding of mental illnesses and addictions, and do they have any practical experience

overseeing a public system that is responsible to citizens with mental illness and addictions, and their families? Frankly, as alluded to earlier by both Chair people, the sum and substance of my discussion with well-meaning Department of Health officials over the years concerns their proposals for separate and segregated emergency rooms -- the implications of which is to cast those with mental illness and addictions as a *less-than*.

The Division of Mental Health and Addictions currently enjoys a close relationship with Medicaid, the largest funder of mental health and addiction services. What will be the impact of the Division being re-siloed in the Department of Health? The Department of Human Services has done groundbreaking work ensuring that the consumer and family voice is an essential aspect of the mental health and addiction system in New Jersey. What assurances do we have that these voices will continue to be heard?

What is the impact on individuals with a dual diagnosis of a developmental disability and of a mental illness? This already woefully underserved population, and their families, deserves consideration.

The Department of Human Services has worked closely with the local county mental health boards to ensure that the citizen voice and the local voice is reflected in the system. Will those voices continue to be heard after the transfer?

Has the proposal considered what would be the impact on the providers of mental health and addiction services? The community-based system is already in the midst of a disruptive transition to fee-for-service. Believe me, I know, because at the Mental Health Association we volunteered to go early in many aspects of the transition. And while I

support the transition, and believe the Department is doing a good job, it is extremely disruptive. It is a very heavy lift, and now is not the time to add additional bricks on the load.

During this transition, it is critical that both the community-based providers and the Division of Mental Health and Addiction Services focus solely on ensuring that community providers maintain their commitment to providing services to individuals with mental illnesses and addictions. Now is not the time to rearrange the bureaucratic deck chairs.

Finally, I'll follow up on what Governor Codey and Senator Gordon asked -- "Why now?" The people charged with providing the essential leadership to such a major effort will likely not be here after Governor Christie leaves office. Leadership requires a sustained effort, not a policy hit-and-run in the waning days of an Administration.

Our time and this Legislature's time would be better spent fighting the Draconian proposals that are happening this morning in Washington, D.C. Again, while some aspects of this proposal have merit, the timing and the haste of it strikes me as the shiny object to distract us from the real work of ensuring that individuals with mental illnesses and addictions get the integrated care that they and their families deserve.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you for your testimony.

Just a general question to any of you. Were any of your organizations consulted in advance of this Reorganizational Plan? And did anyone ask for any of your input, thoughts, or concerns?

DR. WENTZ: No.

ASSEMBLYWOMAN VAINIERI HUTTLE: No?

DR. WENTZ: No.

MR. DAVISON: No.

MS. JOHNSTON: No.

ASSEMBLYWOMAN VAINIERI HUTTLE: Okay; thank you.

And another question -- I don't know how many of your consumers who receive Medicaid receive other services, including housing, food stamps, and other services that DHS may provide. So I would think that out of almost--

MS. JOHNSTON: Almost all.

ASSEMBLYWOMAN VAINIERI HUTTLE: All?

MR. DAVISON: Yes.

MS. JOHNSTON: Almost all.

ASSEMBLYWOMAN VAINIERI HUTTLE: Okay; all right.

Those were, sort of, questions that--

MR. DAVISON: Chairwoman, in my experience, those links are absolutely essential.

ASSEMBLYWOMAN VAINIERI HUTTLE: And so that's why the questions are asked -- obviously for the fact that it's going to be very difficult, then, for consumers receiving Medicaid as well.

Any questions from the Committee?

Chairman Conaway.

ASSEMBLYMAN CONAWAY: Just a thought. You said that links-- And the Chair mentioned -- I think you mentioned food stamps and housing.

So Housing First -- I know it's another big concept. And I don't think anybody would expect the Department of Health is necessarily going to be on point on that. But explain to me why this Reorganization Plan would impact the ability of individuals who need those services -- or I should say, negatively impact the ongoing ability of people who need housing services or food stamps. How does that get disrupted in this Reorganization Plan?

MR. DAVISON: Well, sir, I think that's a fair question. And the answer is, it may or may not. But what I've learned as a provider working with State government -- that State government always operates better when they measure twice and cut once.

ASSEMBLYMAN CONAWAY: I think that's everybody, whether it's State government or not.

MR. DAVISON: Right, right.

ASSEMBLYMAN CONAWAY: Just one other question.

MR. DAVISON: And to do this in the next 30 days is doing neither.

ASSEMBLYMAN CONAWAY: Now, just --- this is really a question for, I think, a number of people, I suspect, who are going to come up -- so that I can understand it.

My understanding is -- if I am wrong, I apologize -- is that the Department -- that is personnel; the same persons that you are dealing with today are going to move-- Well, I don't know if they are going to physically move; some may physically move. But the leadership is going to change in the near-term -- a leadership that's going to change in the next year anyway, by the way. There's going to be a change in leadership in both of those

Departments, I would expect, and policymaking staff at the high levels. But that is sort of -- that next level of staff down there, the people with whom you deal every day, who manage your questions of payment, and how to do the regulations -- those persons, unless there is some wholesale retirement -- aren't they going to be there, still working with you to achieve the things that need to be achieved for this population? Or are they all going to retire or something? Is that-- I'm trying to understand where they go, or why they're going to go away, or why things are going to get worse or better when the same people are going to -- with whom you have relationships; you mentioned that -- aren't they going to be there, in any case, even when the Administration changes?

MS. JOHNSTON: Well, I think you're right -- that the Division would move intact. But we also know that there are two points to be made here. One, is the culture can change in a Department. And the Department of Human Services is very involved in the Division. And that when you change leadership, we all know that that is a cultural change, and we all know that the Department of Health has a different culture than the Department of Human Services. And we're not saying that's good or bad; but we are saying that would be a change, and that's not a good thing right now.

The second thing is that you are moving people who need to communicate, very directly, with their colleagues in Medicaid. And while it makes sense from a theoretical point of view -- that Medicaid can and does work with anybody and everybody -- there is a practical point of view, which is that when they are in the same department, communication and collaboration is enhanced. And I have been told that by Deputy

Commissioners who have retired; who, when I spoke with one this morning, said, "In theory, yes; in practicality, no."

SENATOR VITALE: Thank you; thank you for being here. And if you would like to stay, there may be some follow-up questions later.

Our next panel is -- we have Mr. Terry O'Connor, the former Director of Addiction Services; Dr. Spitalnik, from Rutgers; and Mr. Ray Castro, from the New Jersey Policy Perspective.

T E R R E N C E O ' C O N N O R: Good morning.

My name is Terrence O'Connor. I am appearing here today as the former Assistant Commissioner--

SENATOR VITALE: Terry, hold on one second, until we get the full panel up.

MR. O'CONNER: Sorry.

SENATOR VITALE: That's okay.

ASSEMBLYWOMAN VAINIERI HUTTLE: That's because I called him earlier; he was anxious.

SENATOR VITALE: And Ray, if you could turn your button off, please. Thank you.

Now, Terry; you can continue.

And by the way, just if-- We have three more panels, four more panels who would like to testify today. And we would like to complete this within the hour. So, again, if we can summarize your testimony; if you know it, fine. If not, read part of it. But if you could summarize it, it would be better, so we can also get some questions from the members.

Thank you.

MR. O'CONNER: Good morning.

My name is Terrence O'Connor. I'm appearing here today as the former Assistant Commissioner of the Addiction Services Division, Department of Health, for a 10-year period in the 1990s; in addition to another 20 years serving at other senior level positions, including Chief of Staff, within the Department of Health.

My entire professional career has been dedicated to improving health outcomes, especially for individuals with substance abuse and mental health disorders.

I thank the Chairs of both the Senate Health Committee, Senator Joseph Vitale; and Assemblywoman Valerie Huttle, Assembly Human Services Committee, for the opportunity to speak and provide testimony on the Reorganization Plan 001.2017.

I am in strong support of the Plan's main goals, "To improve health care, remove bureaucratic obstacles to the integration of physical and behavioral health care, and effectively address substance use disorder as the public health crisis that it is." I am not convinced, however, that a major organizational transfer at this time will accomplish those stated goals.

Clients affected by these disorders are not only served by the Department of Health and the Department of Human Services, but by other departments within the branches of State government. Specifically, initiatives developed before, during, and after my tenure, with the Departments of Corrections, Community Affairs, Juvenile Justice, and the Judiciary -- through the Drug Court Initiative -- have continued within the Human Services Division of Mental Health and Addiction Services.

County governments also have a critical role in serving these clients. It is necessary that these programs and relationships be maintained;

and it is not clear on whether this will occur by shifting DMHAS to the Health Department.

During my tenure as Assistant Commissioner, my principle goal was to develop a client-focused, evidence-based prevention and treatment service model for individuals affected by these disorders. Among the strategies considered and discussed with the Department of Human Services to accomplish these goals was the transfer of the Division of Mental Health and parts of the associated Medicaid funding to the Department of Health. After careful and lengthy deliberations, it was decided not to proceed with this option because of the complexity, timing, and difficulty of making such a large organizational change without a reasonable assurance that we would be improving client outcomes. This is still the case today.

I strongly urge the Committees to elicit more input from stakeholders from New Jersey affected by this change. I would also suggest that other states be contacted with similar reorganizations, to determine if the promised or expected outcomes that would benefit clients would (*sic*) occur. Connecticut, most recently, has served as an example where this process resulted in the establishment of a separate department that would try to achieve these goals -- as an example for further discussion.

Thank you very much.

SENATOR VITALE: Thank you, Terry.

Doctor.

DEBORAH M. SPITALNIK, Ph. D.: Thank you.

Good morning; I'm Deborah Spitalnik, Executive Director of the Boggs Center on Developmental Disabilities, and Professor of Pediatrics--

SENATOR VITALE: One more time, please.

DR. SPITALNIK: Thank you.

So I will start with Senator Vitale, Assemblywoman Huttle, and distinguished Committee Members; thank you so much for this invitation.

I'm Deborah Spitalnik, Executive Director of The Boggs Center on Developmental Disabilities; and Professor of Pediatrics and Family Medicine at Robert Wood Johnson Medical School.

My comments today are from multiple perspectives, and include specific concerns related to people with intellectual disabilities; but, more broadly, the health policy considerations from my experience here in New Jersey and nationally.

There is clearly broad evidence of the importance of the integration of behavioral and physical health. Ezekiel Emanuel, in his new book on transforming health care, talks about the integration of behavioral health and physical health at the individual patient level. Clearly, the Nicholson Foundation has been a leader in that; and certainly our colleague Professor Jacobi's report addresses that. However, a lot of those issues are not service delivery issues at this point; they are regulatory issues.

I also want to speak about the distinction between population health and the delivery of individual healthcare services.

The efficacy of the New Jersey's Department of Health, as a public health entity, is well-demonstrated by its recent accreditation by the Public Health Accreditation Board. But for the concerns raised in this

reorganization, I would propose, for the Committees' deliberations, that the integration of the physical and behavioral health services to individuals is an issue of the structure of the delivery system, and is outside of what is generally construed as the *fabric and role* of public health.

Although behavioral health has many public health implications, I am concerned that the movement to the Department of Health does not address the service delivery challenges.

I want to speak specifically -- as Mr. Davison did -- to the mental illness needs of people with developmental disabilities; those with severe disabilities that originate early in life. The evidence is that 50 percent of people with intellectual disabilities, and 50 to 70 percent of people with autism, have co-occurring mental health diagnoses and disorders. And the service systems for these individuals fall squarely within the Department of Human Services.

For families seeking care, often due to a psychiatric emergency, finding services from two divisions within the same department continues to be challenging. The reorganization, I think, would put an insurmountable burden on families in seeking care.

There continues to be adults with developmental disabilities in psychiatric hospitals, due to the inadequate supply of community services. To build the services needed to enable people with co-occurring conditions to live in the community, there needs to be collaboration across DD support providers and behavioral health providers. This needed coordination would be further challenged and, really, mitigated by having two departments.

For people with disabilities and co-occurring disorders, the service delivery challenges are provider education and training, coordination of care, and adequate reimbursement. Changing the administrative location of these services will not address those issues.

I also want to speak to the centrality of Medicaid in the delivery of behavioral health services.

New Jersey Family Care serves almost a million adults in New Jersey; 16.9 percent of these adults are in the Aged/Blind/Disabled category. For all adults on Medicaid, according to the National Health inventory, there's a high incidence of mental health disorders and other disabilities.

When New Jersey transferred Senior Services from the Department of Health, back to the Department of Human Services -- I think that demonstrates the efficacious role of leaving these services in the Department of Human Services. At that time, in his 2013 budget address, Governor Christie cited, "The improvement of health outcomes, appropriate care in the appropriate setting, coordination of wrap-around services, and the ability to create opportunities for aging adults to remain at home" as guiding that move to Human Services. This shift created a single point of access for older adults, people with disabilities, and their caregivers, regardless of Medicaid eligibility. So this is both a Medicaid issue, but also sets the tone, and the pace, and the structure for all services. These analogous experiences in the aging system, I think, speak to the importance of retaining the Division of Mental Health and Addiction Services within the Department of Human Services.

Also, the issue of managed long-term services and supports -- the 36,000 Medicaid beneficiaries who are receiving their long-term care

through managed long-term services. And these individuals represent the *dual eligibles* -- those who are Medicaid and Medicare eligible. They have high and complex needs. For them, behavioral services are carved into the Medicaid contract, and are provided through managed care organizations which contract with Medicaid. For these MCOs, similar to DD providers and mental health providers, it would create additional burdens, as well as increased difficulty, I believe, in integrating behavioral and physical care.

I also want to speak to the experience of the Department of Human Services in delivering direct services to individuals, and patients, and clients.

The Assemblywoman, earlier, asked about the impact of moving the whole staff of the Division of Mental Health. What I would say is that the experience of Human Services, first and foremost, as the centralized Medicaid agency-- But also, the experience of the Department in the administration of State mental hospitals is also bolstered by Human Services' experience in maintaining service delivery in State-operated Developmental Centers. Although the reorganization proposes to transfer all staff and all operating authority, there is a body of departmental-wide experience and functions that I believe would be eroded if the transfer were effectuated. The role of the DHS Office of Program Integrity and Accountability, which monitors individual safety and health -- I think that duplicating those services would create inefficiency, duplication, and the loss of interoperability.

These problems -- the obstacles to integration, as I think Professor Jacobi indicated -- I believe they are regulatory, not service delivery. And in fact, referring to his and his colleagues' report from Seton

Hall -- out of their eight recommendations, four are recommendations about licensing and regulation; three are about payment; and one is about program innovation, including behavioral health homes, which the Department of Human Services is now providing on a pilot basis.

I think that the Reorganization Plan refers to conflicting and duplicative licensing statutes and requirements. I believe that those can be resolved and reconciled through collaboration and interagency planning, as exemplified by the successful development of the Shared Space Waiver, which eased the way for Federally Qualified Health Centers to provide care.

I think that we cannot ignore the tumult; and, even as we speak right now, in Congress -- the tumult in health care delivery and the uncertain future facing health insurance, generally, and Medicaid most specifically.

I think to make changes at the State level now rests upon an unpredictable future, compounding uncertainty with administrative dislocation and disruption. That speaks to Senator Codey's point of, "Why now?"

And to speak to Senator Gordon's point -- any major shift in the administrative location of services has a minimum of two to five years of disruption and dislocation. We know that the system, as has been spoken about earlier, is going through tremendous changes with fee-for-service. New Jersey's citizens in need of behavioral services -- and that really includes 80 percent of us -- would be best served by maintaining the present administrative location of State services, and working towards the integration of behavioral and physical health through -- to Senator Codey's

point -- engaging stakeholders and interagency planning to eliminate barriers and obstacles, and create coherence and access.

Thank you so much.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

And I just want to interject.

I guess it was a few years ago -- the Human Services Committee -- we went on a tour of all -- of the five psychiatric hospitals; I think there are four left now, with the closing of Hagedorn. And you bring up a very excellent point, because the work of psychiatric hospitals is certainly different than the work of acute care hospitals.

And so my question to the Health Department -- who isn't here to answer today -- but how do they intend to preserve the role of the State psychiatric hospitals when its experience is primarily in general hospitals? So that would be a question to ponder and think about.

So you did bring up an excellent point; and that is one of the questions that I would like the Health Department to answer.

DR. SPITALNIK: May I also speak to that -- in that the goal for hospitalization is stabilization and helping people return to their communities. And those community services are funded by Medicaid. The experience in creating Human Services-- And in fact the Rutgers Biomedical and Health Services' Medicaid High Utilizers Stakeholder Advisory Group (*sic*), which was commissioned by the Governor to address the highest utilizers of Medicaid services -- and individuals with behavioral health needs were among the top one percent in a persistent way, over time. And one of the clear findings from that group -- on which I had the honor to serve -- was that there is the need not only for mental health services, but

physical health services and other wrap-around services that are coordinated on an individual basis. And the experience for that is resident within Human Services and supported by the Medicaid program; and now even more embedded through managed, long-term services and support.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

Ray, would you state your name for the record, please?

Did you want to hold that until -- or do you have one--

Assemblyman Madden -- Senator Madden. I'm used to my Assembly Committee.

SENATOR MADDEN: Yes; thank you, thank you.

Doctor, I just-- In your testimony, in actually written and, both, verbal-- If we can just talk about-- Here's a statement in your report. "The role of the DHS Office of Program Integrity and Accountability would need to be replicated, creating inefficiency, duplication, and the loss of interoperability."

If the people are being transferred with the program, is that not true of either some or all of the people in this Program of Integrity and Accountability?

DR. SPITALNIK: Thank you for that question.

I think that the Office of Program Integrity and Accountability in DHS monitors community services, hospitals, and developmental centers in terms of licensing and quality issues. And I think there is -- that was what I was referring to from the issue of interoperability -- that I think there are issues of quality and accountability that are synergistic by having that within one entity.

Also, because of the co-occurring of disorders, both in people who are presently in State hospitals -- both people with developmental, intellectual disabilities, or autism -- who are waiting for community placement, I think it is duplicative to set up the same kind of unit; and this is monitoring at the individual, service delivery level. So that is my sense, that initiatives around quality improvement, quality enhancement -- that they transcend the separation of mental health and developmental disabilities; and also aging and managed long-term services and supports. So populations are not distinct, and there is, I think, an efficiency, both financially and also in terms of competence, within a single unit.

Thank you.

SENATOR MADDEN: So Doctor -- if I may, Madam Chair -- the Department of-- Let's talk about the Department of Health, if we can think about those for a minute -- regarding the medical providers, the hospital networks, and what have you -- they go out into dialysis units, they go out and inspect these facilities, correct--

DR. SPITALNIK: Yes.

SENATOR MADDEN: --for all these different variables that you are referring about -- efficiencies, low infection rates, and successes, and ratios of patients and things of this nature? So they have an oversight entity within the Department of Health now. There's an oversight accountability unit in the Department of Human Services. So because there are two oversight units in these departments, do you say that we currently have a duplication of services? The answer is "no."

DR. SPITALNIK: No.

SENATOR MADDEN: Because they are all focused on a particular entity.

The departments within State government have oversight and professional standard units throughout either the Department of Law and Public Safety; Transportation has its piece; things of this nature. So when -- if this was to occur, where the services went over to Health, we would expect -- at least I would, as a legislator -- that there is going to be an oversight mechanism that will go with that. And what needs to go, would go to make it successful; I would believe that the Commissioners would see that happen.

But I just -- if I can just jump to one other question.

DR. SPITALNIK: And they could be--

SENATOR MADDEN: That's okay; I'm just--

DR. SPITALNIK: Thank you.

SENATOR MADDEN: --bringing on record where I am on this, because a lot of this is-- I'm trying to make sure-- Like, here's a statement. When you openly-- You say that there's going to be a two- to five-year transition of disruption. That's a long time -- of taking an existing program and, on a table of organization, physically moving it under a different set of hierarchy. Yet the Directors, the day-to-day operations people, the people who do this for a living, the people who we actually hope to hear from at different times when we have problems, or constituents -- they're all still going with these services. And I'm trying to get my arms around how you can say that it's going to take two years, to upwards of five years, for them to fall back in place and keep their piece of the pie running, so to speak.

DR. SPITALNIK: Well, I certainly -- I very much appreciate both questions.

I think that we have some experience within Human Services, within the population, generally, of the movement of children from the Division of Developmental Disabilities to the Department of Children and Families. And that it takes-- There's a literature on that, but I'm not saying that in an academic sense. It takes a long time to readjust services. Even though the boxes move, even though the positions move, the cultures of the Department, the ways of operating-- And again, I think we're also facing leadership changes within -- certainly the next -- potentially within the next six months.

So that's one of my concerns. And again, I think there are functions around Medicaid that would create some of that disruption.

To speak to your prior point about the oversight and regulatory issues: While there is this structure of oversight, I think the issues here, in monitoring, accountability, and oversight, are really related to populations of people; and that there is a unity among the vulnerabilities of the people who are served directly by Human Services -- served through managed care; served through managed long-term supports.

Additionally, the aging population who are in managed, long-term services and supports, behavioral health, is carved into managed long-term services and supports. And I think that would create additional challenges. I think that the quality management and quality improvement that's done by the Division of Medical Assistance and Health Services -- Medicaid -- brings value to the oversight of both; first the safety and well-being of the population; and the efficient use of resources.

So that would be my response to that really excellent question.

Thank you so much.

SENATOR MADDEN: Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you, Senator.

Ray Castro.

RAYMOND J. CASTRO: I'm the Director of Health Policy at New Jersey Policy Perspective. But before that, I worked for the Department of Human Services for over 30 years in the Commissioner's Office.

So I'm going to take a little bit of a historical perspective on this issue.

In my view, the Governor's Plan represents one of the most radical changes in the organization of State government in a century, and deserves much more study than the allotted 60 days.

We're also very concerned that even though these problems have been going on for many years, the Governor chose to wait until the very end of his Administration to rush through these changes, all of which have to be carried out by the next Governor. Gubernatorial transitions are already complicated enough; adding a significant change like this -- which could have life and death consequences for New Jersey residents -- would make it even more so.

To some extent, this issue is *deja vu* all over again. It wasn't that many years ago that we transferred Addiction Services from the Department of Health to the Department of Human Services. And I look at the Reorganization Plan, and it was the same arguments that they're now

giving for why to go back to the Department of Health. At some point, we have to recognize that bouncing these services back and forth between departments is not the issue; there are a lot of other issues that have been raised at this hearing today.

One of the main reasons that the DHS was created in 1919 was to oversee psychiatric care. Ever since then, psychiatric hospitals and community mental health have always been within the Department. What we know from this extensive experience is that managing inpatient and community mental health services is very complex and, if it is not done properly, it can have disastrous consequences for the consumers' mental health and safety.

And I was in the Department when psychiatry hospitals -- when suicides, abuses, and so on, were not uncommon. That was decades ago. We've made a lot of improvements.

For, frankly, Senator Codey was a very strong advocate for those changes. And I would be very concerned about going back and doing this management all over again. I am not aware of the Department of Health ever having any experiencing managing a huge institution directly. It's entirely different than licensing.

We are also extremely concerned that adding such a major new function to the Department of Health will divert it from its core mission as a regulatory and planning agency, which oversees health in New Jersey. We believe that function is critical, and will be especially needed in the future, given the many changes that are going on in the health sector. We are concerned that these critical functions will be reduced, rather than

strengthened, as a result of adding an entirely new function to the Department of Health.

A good example of this -- you know, the Department of Health has to monitor the health outcomes in the state. So if they are the administrative agency for mental health, are they really going to objectively evaluate whether they are doing a good job or not? They need to have this overall role of overseer, not become an administrative agency.

We disagree with the Governor's suggestion that since the DHS has a lot of staff and the Department of Health does not, that there should be more of a balance. The DHS is half what it used to be; and most research in organizational theory shows that the size of an organization has very little to do with its effectiveness.

Lastly, such a major change in State government should not be made in the face of such uncertainty at the Federal level. We all know there is a major effort to greatly reduce the amount of Federal support the states receive, particularly for health care. Until we know what those changes are going to be, it would be premature to make organizational changes in State government.

In conclusion, we believe the Governor's Plan could create many more problems than it solves, if it solves any. On the other hand, we recognize that there may be some merit to this, so we suggest further research on this issue.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you; those are great points.

I just wanted to add -- you started to talk about moving back and forth.

The recent Olmstead Settlement, as we've discussed so many times -- an agreement based on the progress made by DHS to secure community-based services for people. And I'm thinking -- otherwise they may be institutionalized -- as we are moving them back into the community, I wonder if DOH has a plan to sustain this progress; that's another question to be thought about.

Any questions from my colleagues?

Chairman Conaway.

ASSEMBLYMAN CONAWAY: I can't help, as I listen -- I heard *disaster*, and then I heard *the plan may have merit*. If it's a disaster, then I suppose--

These chairs drive me crazy. I always curl my legs up underneath the thing; and I put the chair down--

SENATOR VITALE: (Indiscernible) for the chairs.

ASSEMBLYMAN CONAWAY: Yes. Well, we need something with less moving parts -- might work for me.

But you hear disaster on one hand; then you hear-- And I think, from many on the panel who have spoken, that there are merits to the things that need to be considered. And yet, there's a rejection out-of-hand.

I guess my principle-- And I would also make this other observation. Change in paradigms of care shift over time. Years ago, when you went into the hospital, if you had a mental illness you were in the hospital for 30 days. You didn't have, you know, a lot of medications to

help keep people out of the hospital -- you know, the way we're organizing and delivering care, and moving to an outpatient setting versus an inpatient one. We're seeing now this, sort of, what I call a *paradigm shift* in how we ought to deliver mental health services. And indeed, the relationship between physical and mental illness -- why shouldn't the government-- And I think the government's trying to recognize these shifts and respond to them. And to listen to some of the arguments, it's going to take forever to make any changes -- culture-- You'd never do anything. I mean, when would be the time to do anything to take on these challenges that you all admit exist?

And so this is rhetorical; you don't have to respond. But I'm sort of baffled by that point.

When do you make a change? I've heard a lot of concern about things that are going on now that are disagreeable; and I would think change is exactly -- if they are so disagreeable, change is exactly what's needed to deal with some of the problems that you have cited here before this Committee today.

So I'm a little confused by that. I'm one of those people who thinks, "If there's a problem, let's address it, let's move forward" But let's not sit in the water and not move; you have to get to shore somehow, and that means you have to start rowing. Now, not rowing in every which direction; but plan, and take a direction, and get moving to higher ground and dry land.

When do you decide if you ought to make a change? Because all I hear is, "Delay, delay, delay; change is hard, so we're not going to do it."

DR. SPITALNIK: To speak to that point, I think there is a tremendous amount of positive change in the services that are administered through the Department of Human Services. I think, through the 2011-2015 Comprehensive Medicaid Waiver, which is just being renewed for the second five years -- we've seen a rebalancing towards community care, both for people with mental health needs, people with substance -- with addiction problems, and people with disabilities, as well as older individuals.

And I think that system is becoming more robust; I think there are challenges in any human or health services. So my points -- at least, and I defer to my colleagues -- are not that we shouldn't make change because change takes time. But I think we are on a good path, and I would not like to see us disrupt that. But I do think that intruding upon us, from the perspective of the changes that are being proposed in Medicaid and in health insurance, generally -- I think we're not sure where the balance is shifting.

The expansion of Medicaid -- which was clearly an important leadership by the Governor -- has made it possible for another half-million New Jerseyans to have coverage, many of whom have behavioral health and addiction needs.

I think that we are on a path; I think our challenge is to improve those services, to make sure we have reasonable rates, to make sure we have adequate financing; and, as was said by the first panel, to make sure we have a regulatory structure that supports these positive changes, including seeing the Olmstead agreements -- both in mental health and disability -- being fulfilled. I don't think that changing service delivery at that point speaks to any of those challenges, or makes it any easier for

families or individuals to negotiate a complex system, particularly for people with very complex needs for our services.

MR. CASTRO: Yes, and I think that -- there is a lot that could be done soon. And I think that John Jacobi's report is excellent, and there are many recommendations in there, particularly relating to the single-licensing agency.

I'm just concerned about creating such massive changes that we create other problems. To be very frank, I don't think the Department of Health is doing an adequate job of its mission now. I think, particularly in the future, they need to take much more of an oversight and an aggressive role in terms of planning and overseeing health services. And I am concerned about this whole new function of having them supervise institutional placements in psychiatric hospitals.

So I think there is a lot-- I don't think we have to wait until January to do a lot of these things. I think that, as I said, many of the recommendations in John's report could be proceeding soon.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

No further questions?

Assemblywoman Jones.

ASSEMBLYWOMAN JONES: Thank you, Chairwoman.

I think this is almost a rhetorical question -- and we have heard it from other panels -- that further study-- What's the point of the timing at this point? Was there anything done to come to the conclusion that we should move this large piece from DHS to the Department of Health?

MR. CASTRO: I'm not aware of any at all. And I think, as you noted, they didn't seem to get very much -- or any input on this. This came out of the blue, frankly; I have no idea.

And that's what-- I mean, there was lot of study, obviously, that was done on this whole licensing issue. There is no study, as far I can see, in terms of this huge change in organizational structure. And I would love to see a study done before any decision is made in that area.

DR. SPITALNIK: In addition to the issue of study, I think the whole issue of stakeholder input -- first and foremost, individuals directly affected, family members, people who provide care on behalf of individuals in need. Medicaid, both federally and within New Jersey, has very strong stakeholder requirements for making any change in the program, whether it's waivers or anything.

And chairing the Medical Assistance Advisory Committee -- we repeatedly seek stakeholder input in any change in the structure of service delivery, change in the structure of assessment, change in the benefits package. We haven't seen the parallel processes around that. And yet, at the same time -- particularly in both the mental health community and the addictions community -- we know that peer support, stakeholder, and individual and family engagement -- as well as in disabilities and aging -- have been really the primary source of shaping services.

So, it's absent that-- And I really tried to find that out, and I certainly have combed the Seton Hall report. And it doesn't speak to the change in service delivery; it speaks to the regulatory issues. And I think we need to think of them separately, and act upon the regulatory issues. And that is within our present purview.

ASSEMBLYWOMAN JONES: Just a further point on that.

Since the U.S. government -- the Department of Health and Human Services-- Have we ever thought about putting the two together, so that we have the regulatory agency with the real human service component; and they are both in the same place? It seems to me we're moving one large component to a department that is not used to direct, hands-on service to people.

So I don't know.

MR. CASTRO: I think there's -- I would have some concerns about that. I mean, having worked in the State-- When you're an administrative agency, you become very vested in what you're doing, obviously. It becomes, frankly, a bit of a (indiscernible) issue.

And I think it's really important that we have a department, like the Department of Health, to look at the big picture--

ASSEMBLYWOMAN JONES: Separate.

MR. CASTRO: --and ask the very basic question, "Are people healthier or not?" And frankly, that question is rarely asked, and it's almost never answered.

And that's what the role of the Department of Health is. So I would like to see that function strengthened in that Department, and take more of an overview in terms of evaluating not only community services, but State services as well.

DR. SPITALNIK: And within the Federal Department of Health and Human Services, there really are two separate Departments. There is, really, the side that delivers services, the Administration on Community Living for People with Disabilities, the Administration on

Aging; and then the Health Resources Services Administration and the regulatory agency. And at this point, I would not hold that up as a model of either efficiency-- And the distinction is, they don't deliver direct services. That devolves down to the State, through funding from those streams.

So I think our mandates and responsibilities are better served-- And again, now we have the experience of the Senior Services having moved to Health; in addition to the movement of Addiction Services -- moved to Health, and moved back to Human Services, for precisely the reasons we're concerned about people with mental health issues: wrap-around services, community services, coordinated services, and care delivered in local communities.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

Seeing no further questions, I will call up the next panel.

Before I do that, though, I just want to acknowledge a young group of students who joined us; and I would like to acknowledge them. They are the New Jersey Young Democrats High School Leadership Academy; wow. They are in Trenton for three days to learn about government and policy; and later today they will have their own mock legislative hearing here in the State House. So hopefully they'll get some pointers from us; and we welcome all of you and wish you the best of luck.

Next panel.

SENATOR VITALE: Phil Lubitz of the National Alliance on Mental Illness New Jersey; Kim Higgs, New Jersey Psychiatric Rehabilitation Association; and Patricia DeCotiis, New Jersey Psychiatric Organization.

KIMBERLY HIGGS: Good afternoon.

My name is Kim Higgs; I'm with the New Jersey Psychiatric Rehabilitation Association.

Thank you all for hearing our testimony today.

Certainly, you've heard from lots of people already; and so much of what I have to share on behalf of our association is certainly aligned with that.

For those of you who I've not had the opportunity to meet, the New Jersey Psych Rehab Association represents providers of community mental health services. And when I say *community mental health services*, I'm talking very specifically about those services that are provided in people's homes -- supportive housing, intensive supportive housing, programs and assertive community treatment, outreach programs; services to the types of individuals -- who you've heard from others who have spoken today -- referred to as people who are some of the highest-cost utilizers of services.

And so as a result, we have a slightly different perspective on this than some others do, but certainly similar to others who have spoken to you so far today. We have significant concerns about making this change at this time. And without reading all of the testimony that I've prepared, in the interest of time I want to go through a few sections of it.

And we certainly understand that DHS and DOH share the responsibility of ensuring quality health care for residents of New Jersey. However, each approaches its scope and responsibility from its own perspective, focus, and orientation of care. So I can't stress enough -- it's not clear to us how making this transition quickly, at this time, increases

access to service of people who are served in the Department of Human Services.

You heard a few moments ago about a two- to five-year transition for departmental changes. That's absolutely the case. Our partners at the Division of Mental Health and Addiction Services -- and that became a singular division in 2011 -- they are still operating under multiple sets of licensing regulations. So providers who serve both communities of individuals within their programs are still working under two sets of rules.

So again, moving that into the Department of Health, layering in additional perspectives, new leadership, just creates that much more challenge, especially with this fee-for-service transition.

Under the Department of Human Services, mental health services are focused around rehabilitation, recovery, integration, and human services components. These are not in the wheelhouse of the Department of Health. The Department of Health, and rightfully so, is focused on health, medication, disease management, symptom reduction. The Department of Health licenses facilities; the Department of Human Services licenses services. That's a significant difference in orientation.

The Department of Health does not license, again, the wrap-around components of service that I'm referring to and that my Association's providers provide.

The timing of this is, of course, of great concern. We have a new Administration coming in. There are a multitude of things that need to be considered, and I'm going to walk as quickly as I can through this list of things that you see in our full testimony -- and that's the formal and

informal relationships that exist right now in DMHAS that would shift to DOH -- the Department of Children and Families, the Judiciary, the Department of Corrections, the Department of Labor, and the Division of Voc Rehab, the County Mental Health Boards. You have to consider the effects of separating DDD and DMHAS under DHS; the management of the comprehensive waiver, the management of the joint programs between Mental Health and DD. The continuing Olmstead compliance; splitting of licensing -- we talked about the Office of Program Integrity and Accountability; you've heard about that.

Think also, too, that as this shifts under the Department of Health, the number of physical plant waivers you would have to have for programs and services that are licensed in DMHAS to fit, so to speak, into DOH. That would be a very long list that would be very time consuming to get to that.

Separating DMHAS from State hospital management; the effects of moving the certified Community Behavioral Health Center initiative out of DHS. As you probably know, we're one of seven states that are involved in this Federal waiver. Not a good time to shuffle -- again, as Bob Davison said -- to shuffle the deck chairs on this one.

While the communication from the Governor's Office does talk about this being a process that would increase access and would improve services, this is probably not the time -- we know this is not the time to do this.

This is a business decision. And certainly on the providers' side, we've heard for a number of years, as we've gotten close to our fee-for-service transition, that providers need to look at their environment, they

need to weigh their environment, and they need to make sound business decisions. We don't see the sound business decision here.

So this order has certainly not included deliberation -- the assessment of the pros and cons; the viability of the options; consideration of the intended and unintended consequences. To presume that this could -- that these departments -- that DMAHS could easily integrate into the Department of Health, frankly, is exceedingly optimistic and blissfully ignorant of the reality in which these systems are operating.

I should-- I'd like to add, just as another point related to this -- having looked a couple of times over the last six or so months at the Department of Health's *Healthy New Jersey 2020* webpage -- there's no mention of behavioral health, there's no mention of mental health, there's no mention of substance use, of addictions. So the groundwork just isn't there; the shared language isn't there.

And as a last point, I can't say strongly enough that our position is *not* to not do it; our position is simply, "Let's not do it at this time." As an association, as we've watched the State marching towards this fee-for-service transition, ours has not been one of the voices that has said, "Don't do it;" ours has consistently been one of the voices that says, "If we're going to do this, we have to do it in a way that makes sense. We have to be smart about it; we have to be prepared for problems that could arise down the road so that we can get to the endpoint." We maintain the same position with this.

This might be the right thing to do; the right thing to do might be to create a whole other department. We don't know yet, because that assessment process has not occurred; and we strongly urge, encourage, and

ask that a vote is taken on this, and that this can be delayed until we have a new Administration in place after January.

Thank you.

PHILLIP LUBITZ: Good morning.

Phil Lubitz from NAMI New Jersey. NAMI is the nation's and state's oldest organization -- grassroots organization advocating for people with mental illness, and their families. We were started by families in 1985; and although we are predominantly still made up of family members, we now represent people with mental illness, friends of people with mental illness, and professionals.

So one of the things we do at NAMI, under the State Family Support Act, is adopt a plan -- the State plan that is meant to support family caregivers. And since 1996, we've been writing about the needs to integrate physical health care with mental health care. That was one of the eye-openers for me, coming from a provider of mental health services where we were, pretty much, just concerned with psychiatric symptoms; and then meeting and hearing what was a concern of family members of people with mental illness. And of course, like you or I -- we're concerned about the health of our families.

So, you know, that again -- we're happy that there's more attention to the integration; we're not surprised that it's been elevated.

But listening to the hearing, I haven't really gotten the sense that what the Department of Human Services has been doing in terms of integration has been fully conveyed. Again, we have developed, as part of the Affordable Care Act, behavioral health homes that integrate behavioral health care and physical health care. I think in New Jersey, in particular,

our Medicaid agency has really been a national leader in expanding this integration under our Medicaid program.

Kim also mentioned that we are one of, I believe, eight states, actually, that have received a Federal demonstration grant for certified community behavioral health clinics that not only integrate mental health care, substance abuse care, and physical health care; but integrate the funding for those. People liken this, really, to what we are doing with FQHCs; it's the behavioral health side of really having one-stop shopping for all those services. So there are seven of those sites. So all together, New Jersey, in just the last couple of years, has developed 13 sites that coordinate behavioral health care and physical health care.

So these initiatives have come out of the Department of Human Services; and I guess we're talking about transferring a lot of these. But, you know, one of the things that's been lost in our discussion today is what really leads to good health. And, you know, some of that clearly is getting to see a doctor; but there are so many other things in psychiatric care that we've learned, in terms of things like supported employment, or supported education, or mutual support, peer support, giving people the feeling that having a mental illness isn't a dead end in their life. And these things are really the specialty of the Department of Human Services, and very little of that occurs in the Department of Health.

You know, another thing is when you ask family members what impedes their care -- of course the integration is a problem. But more often than not, the things they identify are inhibiting the physical health care to people with mental illness. It's just the availability of providers who will see them. Because most of the people are on Medicaid; so the reimbursement

rates in Medicaid are so poor that we have a really small provider network. I don't see where transferring the mental health care from Human Services to the Department of Health is really going to help them. In fact, I think it's likely to hinder that since, again, Medicaid becomes the key element in this.

Quite frankly, we haven't talked at all about the discrimination against people with mental illness. And it's no surprise to me, because I hear it from families and people with mental illness all the time. There is a good deal of discrimination against people with mental illness on the physical healthcare side. People don't like people with mental illness sitting in their emergency room. Often when people with mental illness come to see a practitioner -- physical healthcare practitioner -- their complaints aren't taken seriously; their symptoms are thought of as being symptoms of their mental illness, rather than symptoms of a physical ailment.

And so, again, when we look at what contributes to health -- again, there's more to it than the programs that we would traditionally think of as being under the Department of Health. Again, losing the connections that we've done to housing would be -- make it extraordinarily difficult for people. You know, we're learning more and more that a person's housing situation, stability in their life, really plays a large part in their physical health. I think we're making a mistake, then, if we separate Human Services for people with mental illness -- going over to Health and leaving behind, say, people with developmental disabilities. And we lose that synergistic connection that the housing has for both those populations.

So we have a number of relationships that exist in the department level. And by just shifting the staff of the Division of Mental

Health and Addiction Services, we're not going to take the people who do the connections, say, with criminal justice. I wish Senator Madden was here, because there is a lot of work being done diverting people with mental illness from the criminal justice system into the treatment system. Well, the same holds true for people with developmental disabilities. And that doesn't take place at the division level; that takes place at the department level. And then, so switching people over to another department is really going to disrupt those.

SENATOR VITALE: Thank you, Phil.

Thank you.

Do the members have any questions? (no response)

Great; thank you both.

Next, Cory Storch, Bridgeway Rehabilitation; and Heather Simms, Peer, Collaborative Support Programs of New Jersey.

Come up to the next table, if you'd like. Come on up; both of you, come on up.

ASSEMBLYWOMAN VAINIERI HUTTLE: I can't see you back there.

SENATOR VITALE: A little closer.

C O R Y S T O R C H: Thank you, Senator.

SENATOR VITALE: We've asked of all the other -- the witnesses if you could try to refrain from reading your testimony. We have about another 20 minutes left, and we have two more panels.

MR. STORCH: Thank you, Senators, for the opportunity to share our concerns about this proposed departmental transfer.

My name is Cory Storch; I started work in the community mental health field 40 years ago. So I started as a rehabilitation counselor, and I now serve as the CEO of Bridgeway Rehabilitation Services.

The Bridgeway is a specialty mental health organization. Our mission is to work with folks who have severe and persistent mental health conditions. Many of them have co-occurring chronic medical problems and substance abuse. We're dealing with people who have frequent hospitalizations, some of whom experience homelessness, and also have criminal justice involvement.

So you've heard a lot of arguments about the fee-for-service disruption being a reason to not act right now on this departmental transfer. So I'm not going to get into that; you've heard that argument over and over again. But I will share with you -- just so you can get a sense of what it looks like in the field, on the ground -- these disruptions.

So service organizations -- these are mostly nonprofit organizations -- are doing their budget projections for this year, in this new fee-for-service system. And many of them are contemplating giving programs back to the State because they are not sustainable. One example: There are two counties in rural New Jersey where the service provider gave back a PATH program -- that's the homeless outreach team that serves people with psychiatric conditions. The State had a bidders' conference; nobody showed up for the bidders' conference. So I got a phone call, and I was asked if Bridgeway would take on these programs. We are negotiating with the State on it, but it's -- we can't afford to take a program that's going to lose us money, because we're having a hard enough time balancing our budget under this new fee-for-service arrangement.

I anticipate that this will be a trend that will increase, where organizations will continue to give back services to the State that will have to be re-bid. Maybe some of that will turn out okay; I think some of it won't. I think people are going to be hurt by this. Right now, in those two rural counties, there are no homeless outreach services to people with psychiatric conditions. So I do think that the timing is important.

And I'd also just like to make one other point, and this is about the integration of care.

I applaud the Jacobi report, because it did point out the importance of regulatory reform. But regulatory reform, by itself, is completely not sufficient to actually have integrated primary and behavioral health care. The main problem is that it is not financially sustainable; the rates are inadequate.

Even the Federally Qualified Health Centers in this state have a much enhanced rate that's much higher than the Medicaid rate. But even those centers are very reluctant to serve people who have a serious and persistent mental illness.

So the State, through the Department of Human Services, has created some initiatives, as well as the Federal government. Bridgeway is a participant in the pilot project to integrate primary care and behavioral health care. And I can tell you, it is extremely difficult to sustain these services. They do save lives, but even if we have regulatory reform, I think the State will see a lack of service partners to actually do the work. I think if we actually enhance the rates and actually made this sustainable, even without regulatory reform as the next step, I think you would find partners

who would work with State government, who would actually figure out a way to make everything happen, including the regulations.

I think it would be a mistake to think that doing the regulations first is going to trigger the reform, because I don't think it will.

I just want to conclude by just reinforcing that there are tremendous changes and pressures on service providers. These pressures do trickle down and trickle up to families and people who have lived the experience of mental illness. And we have to be very careful that as we proceed we get this right, because we have a lot of people who are filling up emergency rooms and who have preventable hospitalizations. And if we can get this right, then I think we can make big inroads into that, and it would also be very beneficial to the taxpayers, as well as the people who need the services.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you, Cory.

Heather, would you please state your name again, for the record?

H E A T H E R S I M M S: (off mike) My name is Heather Simms; good afternoon.

I'd like to thank you all for taking the time to consider my perspective on the proposed transfer of DMHAS from the Department of Human Services to the Department of Health.

I, personally, both have lived experienced and professional experience on the topic of addressing mental and physical healthcare needs, and the stigma associated.

I want to express my concerns with the move at such a critical time, when both individuals receiving behavioral health services and providers are currently learning how to navigate the new fee-for-services billing, specifically for community support services.

I feel that it is imperative to carefully consider the timing and planning of such a move, and carefully evaluate the impact of all parties involved.

I must say that it has been both a benefit and challenge to implement and provide services in the CSS environment. As a provider, we are learning to implement the services under the new requirements; and at the same time we were also educating the recipients of the services about what this is and how to utilize the services. We have helped them learn the skills, gain the knowledge, and be linked to resources that help empower them to reach their valued life goals. I feel that to add more change now, at a department level, would be detrimental to the strides and the successes that I have seen in the lives of the people who we provide services to.

I personally was diagnosed with bipolar disorder shortly after the birth of my second child, and received supportive housing services before returning to work. I have provided these housing services at Collaborative Support Programs of New Jersey for almost the past 15 years. Using the wellness and recovery focused approach during this time, I have experienced and worked with individuals who have faced challenges of addressing both mental and physical health. I have seen the impact that not addressing both can have on a person's quality of life and ability to be a fully involved community member.

I personally was isolated, cycling from being overweight to being underweight, experiencing horrific side effects of medication, alone and scared before receiving the support services that focused on my overall wellness. From having both the benefit of receiving services and ongoing education on the best practices for addressing wellness and recovery, I have become a healthier, happier, more productive community member.

I'm now a peer provider, wife, mother, and very active in youth sports in my community. I'm more active and mentally healthier than ever. This was all achieved by learning skills on how to advocate and effectively communicate both my mental health and medical needs to providers. I've been able to achieve these things in my life as the result of learning the wellness and recovery approach to address areas where I felt most confident and ready to make those changes. This is what provided the environment for success.

There have been many benefits to being able to both share my personal and professional knowledge when working with individuals to identify and plan their own path for recovery. I have been able to see not only more progress, but progress that has been maintained.

The culture of recovery starts at the top of an organization, and Human Services supports that culture now.

It is imperative that we continue the collaboration with DMHS, service recipients, and community-based agencies in ensuring we do not lose the voice of the individuals receiving these services -- especially regarding the management of both their mental and physical healthcare needs during this time of transition. An organizational change into a new department

threatens the continuity of services, and would put peer inclusion and recovery at risk.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you for your testimony.

Any questions for the panel? (no response)

Thank you very much.

MR. STORCH: Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: And we have two panels left. I'd like to call up Joe Young, Disability Rights New Jersey; Valerie Sellers, New Jersey Association of Community Providers; and Seth Hahn, CWA.

Welcome.

Joe, do you want to start? And state your name.

Thank you.

J O E Y O U N G: Yes; Valerie has deferred. (laughter)

So I'm at the end of the day again.

So, very briefly -- obviously you have my testimony. I hope someone will take the time to at least look at the footnotes.

I do want to answer some questions that have been asked.

First of all, I think it's very important that -- we're asking the wrong-- If you're asking-- If the only question that you're asking is how to solve the licensing problem for people with mental illness and substance abuse, this might be the right answer. But you have to look at the larger picture. That's not the question we should be asking; that's not the only service delivery system that exists, right?

So there is more to the question. What are the important things that are going on? And as even John indicated in his testimony, there's more even to this one integrated -- the delivery system question than just licensure. So this is an axe to solve a much smaller problem. And my hope would have been that after John issued his report, some people at the Department would have gotten their heads knocked together and solved the problem. That didn't happen; and I guess, John, it's a little bit more complicated than just that. But this is a problem that can be solved without doing this kind of major surgery.

Two: One question was on, again, the five- to ten-year thing. So I was involved in a transition from a government agency to-- It is a traumatic event. Even if you tell everybody that this is what the situation now is, and on the next day it's not going to change, there is trauma, and disruption, and concern, and all this kind of stuff for the entire time it plays out.

So at this time -- when we're having this massive transition in services; when people need to be focused on who's getting paid, and whether people are getting paid enough; and whether the services are going to be there the next day -- this is not the right time to distract them about moving offices, or will they have to move offices, or change stationery, or whatever else may be going on.

Another really fast question was this idea of the Office of Program Integrity and Accountability; there is also supportive housing, there's also the Human Services Police -- now we're going to have two Human Services Police Departments, or two police departments that (indiscernible)?

The Office of Program Integrity gets tens of thousands of complaints. The inspectors in the Department of Health go out, take a look, check the furniture, check the temperature in the faucet, and stuff like that. It's a wholly different system. It has taken years to merge the Division of Developmental Disabilities inspection system, or monitoring system, because we're looking at abuse and neglect, unusual incidents, medication errors, and all kinds of things occurring in institutions and in the hospitals on a daily basis; dozens and dozens of these incidences on a daily basis. They finally merged themselves within the Department, and now have effective, again, synergy of collected effort. All this kind of stuff is working. Now the idea of splitting them off again doesn't make sense.

There's more to mental health than just getting services in a doctor's office, as Cory very well indicated. Mental health, now, is wellness and recovery; a whole branch of supportive education, supportive housing, supportive employment. These are multiple things that the Human Services Department is better able to deliver than the Department of Health. As John indicated in his report, when there is overlapping jurisdiction, there's always a tendency to want to consolidate. But separate agencies exist in State government in order to allow the aggregation of expertise. And reorganization should take place carefully and with some degree of planning before we jump into the mix.

Let me also indicate my skepticism of the Department of Health. We've been moving things *out* of the Department of Health -- the Children's Catastrophic Care Commission, the Department of Addiction Services before, and the Department of Aging. It was the Department of Health that did the regulations about separate bathrooms and separate

entrances -- not *did* the regulations because, again, they don't exist. They're enforcing nonexistent regulations about separate bathrooms and separate health-- And they are still enforcing them against mental health agencies, even though they may not be enforcing against ambulatory care facilities.

And still one of my pet peeves: The Advanced -- the Assemblywoman will remember -- we talked about the Advanced Directive for Mental Health Care Act that was passed in 2005. The Department of Health still has not promulgated regulations implementing that Act since 2005, all right?

So within the disability community -- we talk about *nothing about us without us*. Until today, there's been no public discussion of this Plan; there's no reason -- the Plan should not go ahead until it has been explained to the community, and the community understands the consequences of this Plan. And particularly, I'm concerned about the effect on people with developmental disabilities, autism. Do their services -- health services not matter in this thing? They're going to be separated, if you're going to move somebody someplace. And the integration of the people with developmental disabilities, and mental health, and physical health is as important as what's being discussed here.

Thank you.

V A L E R I E S E L L E R S: Thank you, Joe. I deferred to Joe so he would not be the last person testifying today.

Assemblywoman Huttie, Senator Vitale, members of the Committees, thank you for the opportunity to testify today.

I'm Valerie Sellers; I'm the CEO of the New Jersey Association of Community Providers, representing 54 agencies in the state.

You have my testimony; you've heard all the arguments. I think -- I would just ask that we not lose sight-- And I think Assemblywoman Huttle, you said this. We're talking about consumers; we're talking about people, their lives, their families, their loved ones. And we cannot lose sight of that.

If over 50 percent -- I think Dr. Spitalnik said -- over 50 percent of individuals with intellectual and developmental disabilities also have a dual-diagnosis of mental illness; that is a large population. And it is complicated enough to navigate DHS, DCA for housing, and now the Department of Health for mental health. It is daunting for families; it is daunting for consumers to try and figure out this system. And making it more complex is not going to address those issues.

So I would just ask that we do take into consideration the impact and the unintended consequences such a move would have on the very people who we serve and we're here to represent today.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: I just have a quick question, Valerie.

I asked, I think, to one of the panels before; but since you serve, or represent many organizations -- were any of those organizations notified of the reorg plan?

MS. SELLERS: Were-- I'm sorry?

ASSEMBLYWOMAN VAINIERI HUTTLE: Were any of your providers--

MS. SELLERS: No, no. In fact, we were all caught off guard, and many of my providers do offer mental health services.

ASSEMBLYWOMAN VAINIERI HUTTLE: How did you hear about this?

MS. SELLERS: Joe Young sent me the copy of the letter. And I was very concerned, and actually sent out a query to all my members saying, "Has anybody heard about this?" Which they had not. And then there was a flurry of activity after that.

So there is genuine concern about trying to do case management in Human Services; case management in the Department of Health; and they can't figure out how they can do this efficiently.

So no, we did not have any input.

ASSEMBLYWOMAN VAINIERI HUTTLE: But if Joe didn't get his hand on that letter -- ahold of that letter -- you would not know.

MS. SELLERS: No.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

S E T H H A H N: Thank you to both the Chairs.

My name is Seth Hahn; I represent the Communication Workers of America.

I have with me Carolyn Wade, who is the President of Local 1040. She has submitted written testimony; but if there are questions, she is certainly our in-house expert, and I would defer to her on any questions, with your permission.

The CWA represents workers at both the Division of Mental Health and Addiction Services and the Department of Health, and so we have a somewhat unique perspective and expertise at both agencies here.

And we do share the goal of treating substance abuse as a public health crisis. But we have real concerns about whether this Plan is going to effectively do that.

If you read the Order-- So for decades, it's been the Department of Human Services that is structured to provide 24/7, round-the-clock intensive care. And the result is that the Department of Health currently has no expertise or experience providing this type of care, let alone the expertise warranted to provide the quality type of care.

And certainly nothing would prevent that from changing; but the process by which this Plan is being effectuated so far is not one that will successfully allow that expertise to be developed.

Next, we'd like to point out that the overwhelming majority of patients at the psychiatric hospitals in New Jersey are not suffering from drug addiction. If you read the report, it really places -- it reads like the whole Plan is to provide a greater level of care on drug addiction, and that that is sort of the impetus for all of these changes.

But those people are the minority at the psychiatric institutions. There are people there suffering from mental illnesses, or have developmental disabilities; many of who have violent tendencies. There's been discussion today about a great many of them having dual-diagnosis. And reorganizing the entirety of those services to prioritize those at the institutions who are suffering from drug addiction, we believe, poses a real threat to the majority of patients currently in institutions for reasons unrelated to drug addiction. And we have concerns that they will suffer as a result, as already lean budgets are refocused and stretched even more thinly to divert money towards drug addiction.

There are also concerns about licensing and inspections; that has been discussed today. We have concerns about putting the institutions into the DOH, and having DOH workers conducting any inspections of the institutions. It would probably be inappropriate for workers inspecting their peers at the DOH, and we have found that there can often be bureaucratic pressure from politically appointed leadership to influence the outcomes that workers are seeing when they conduct inspections.

There has been a lot of discussion today about licensing and inspections. But we can tell you that the DOH is stretched so thin that inspections are really no longer happening. Rather than provide workers for inspections of hospitals, the Administration, early in the Administration, just simply stopped doing inspections of the State's hospitals. And now hospitals are allowed to self-certify on their inspections.

And so if you are adding inspection work -- and we're talking about licensing and re-doing some of this -- if you're adding that work to the Department of Health without addressing the resources issues, you have a real concern that other things that the DOH does -- such as inspections of hospitals and facilities -- will suffer; and you'll have secondary effects of this that aren't really related to the Division of Mental Health.

Finally, if the goal were to improve drug addiction services -- as people have pointed out today -- it's hard to imagine a process that could be worse. This has not been publicly discussed; this seems to be the first gathering of stakeholders. The Plan, as the Chair mentioned, was unveiled the day before a government shutdown, as one house of the Legislature was preparing to go on recess. And leaving aside whether there is a legitimate reason these services could be under the Department of Health, there is not

a compelling reason to have a major reorganization hastily completed, four months before a new Governor takes office. And certainly, the Plan offers no emergent reason for such a significant transfer of functions at this time.

CWA requests that the Administration abandon this proposal; and, if it will not do so, we request the Legislature make use of its veto power by passing a concurrent resolution to stop the Plan by August 27 -- I believe, is the deadline.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you, Seth.

Since there's no one here from Health to answer some questions, and since you have employees in both -- members in both DHS and DOH, maybe you can answer this. Do you think the transfer will impact the ability of the employees' promotions or titles? Do you think there will be -- departments will share the same titles? Do you think they will be having the same requirements from one department to the next? How is the staffing involved, as far as assuring that there won't be any layoffs, or impacting if they need to relocate, or even retain their current schedule? I mean, these are questions that should be asked to the departments, I guess; but since you're, sort of, in both, I don't know if you have any answers or any thoughts on that.

MR. HAHN: Could I allow President Wade to answer that question?

CAROLYN C. WADE: The Department of Health uses--

ASSEMBLYWOMAN VAINIERI HUTTLE: Could you state your name again for the record, please?

MS. WADE: I'm Carolyn C. Wade, President of CWA Local 1040.

The Department of Human Services and the Department of Health utilize different titles. If the Division of Mental Health would go over to the Department of Health, and if there is a layoff, many of my member's rights will be just cut off because there is no place for them to move. They have more rights in the Department of Human Services because of the commonality of the titles that are used there.

May I just emphasize something that I believe needs to be emphasized?

We've heard about all of the different aspects that Human Services has that could be going over to the Department of Health. But one aspect I feel that is very interesting -- that should be emphasized and really considered by this Committee -- and that is a unit they call the *STU*; that's the *Special Treatment Unit*. This is a unit where -- when a sex offender completes their term in prison and is not ready for the community, this unit offers intensified special treatment -- so that if they can be reentered into the community, then it would be from this unit. And no one has mentioned this group of people; it's not a large group of people, but it's a group that needs to be considered because they are a part of the forensic hospital. And the forensic hospital takes care of the criminally insane, which no one has mentioned -- that we do have people in the Department of Human Services, in the Division that we're speaking of, who are civilly committed.

SENATOR VITALE: Any questions from members?

Assemblywoman.

ASSEMBLYWOMAN DeCROCE: It's only curiosity.

If that should take place, wouldn't it have to go through Civil Service approval because of the change from department to department, and the titles within each department -- of each position?

MS. WADE: Well, the Department of Health will have -- they can make the decision to not utilize those titles, but change them. But, you know, people who are already in the titles who are coming from Human Services -- my assumption is that they would take that title with them, unless there is some change. And of course, if there is some change, then Civil Service will have something to do with it. But titles are grouped together by functions--

ASSEMBLYWOMAN DeCROCE: Right.

MS. WADE: --and we're not talking about a function change here. So the assumption is that they would not change.

ASSEMBLYWOMAN DeCROCE: Yes, I just do have a concern that I think Civil Service would be involved, and it may get a little complicated because of that. And I just have a feeling that they would, so I would hope that maybe we could find that out as well.

Thank you.

SENATOR VITALE: Thank you very much for your testimony today.

Our last panel is Wayne Wirta, National Council on Alcohol and Drug Dependence-New Jersey; Walter Kalman, National Association of Social Workers, New Jersey Chapter; and Susan Loughery -- I'm sorry; it sounds like an Irish name, and I can't do that -- Catholic Charities, Diocese of Trenton. (laughter)

How do you pronounce that? L-O-U-G-H-E-R-Y.

ASSEMBLYWOMAN VAINIERI HUTTLE: I think you got it.

UNIDENTIFIED MEMBER OF AUDIENCE: (off mike)
Loughery (indicating pronunciation)

SENATOR VITALE: Loughery (indicating pronunciation)?
How did I do; did I do okay? Good.

This is the last panel; thank you.

S U S A N L O U G H E R Y: Good morning, Chairman Vitale,
Chairwoman Vainieri Huttle, and members of the Committees.

ASSEMBLYWOMAN VAINIERI HUTTLE: Good *afternoon*.

MS. LOUGHERY: Good *afternoon*; that's right (laughter).

Thank you for the opportunity to be here today.

My name is Susan Loughery; I am Director of Operations for
Catholic Charities, Diocese of Trenton.

And I will summarize my testimony in the interest of time.

A brief overview of Catholic Charities, Diocese of Trenton:
We operate in four counties -- Monmouth, Ocean, Burlington, and Mercer.
We employ 632 staff, 57 percent of whom work in behavioral health
services. We provide a variety of services, including specialized abuse and
trauma counseling; mental health and addictions treatment; domestic
violence services for victims and their families; and concrete services, such
as housing, food, and clothing, to all residents of central New Jersey,
regardless of religious affiliation.

Our programs include Outpatient, Substance Abuse Treatment,
Psychosocial Rehabilitation, Crisis Intervention, Programs for Assertive
Community Treatment -- that's PACT -- Employment, Residential Services,

and Supportive Housing. We also maintain a Behavioral Health Home, and are providing services under the State's Certified Community Behavioral Health Clinic -- CCBHC -- Demonstration Funding.

So we know that there is significant empirical evidence to support the integration of behavioral health treatment, as well as physical health. Specifically, early integration studies, such as that of the *PCARE Study* -- which is a randomized trial of medical case management for community mental health settings -- demonstrate effective, holistic approaches for management of behavioral health and physical health conditions in community settings.

Data, such as the PCARE study, shows that this integrated approach results in the reduction of symptomology for the behavioral health diagnosis, as well as the improvement of chronic conditions, such as metabolic syndrome.

This approach results in reduced cost in the overall care of the lifetime of these vulnerable consumers, and also reduces the frequency of episodes of care in acute care settings, such as emergency rooms. Therefore, integration of services is critical. However, integration must be carefully considered; it does not simply reflect a merger of systems, departments, or services. Consideration must also be given to, one, the fiscal sustainability of the services being provided by those safety net providers; and two, the ancillary systems that address social determinants and mitigate disparities that impact health outcomes.

Fiscal sustainability for services provided by those safety net providers must include payment mechanisms. Integration without Medicaid creates a new fragmentation in the overall system. Being allowed

to integrate from a regulatory perspective without having a financial structure to support payment of an integrated system, could result in impeding progress to the new system by disrupting the synergy between claims, outcomes, and measures data. Payments, services, and reporting infrastructure must move in tandem to reduce data silos and to achieve population health objectives.

Consideration must also be given to systems such as transportation and emergency housing, which address social determinants impacting health outcomes. Furthermore, care coordination is a conduit for these services, although addressed very limitedly, currently, in our payment mechanisms. It cannot be ignored that client engagement related to these ancillary systems occurs in non-traditional healthcare settings, as evidenced by the successes we see through the PACT teams. Since this type of work is done primarily in the community, it needs to be flexibly woven into the new system.

So the question is not what should be done; it's when and how. The reorganization should be addressed in a carefully planned way in order to achieve the maximum benefit of this effort.

Comprehensive stakeholder engagement should be considered; and communication should be bidirectional and at regular intervals between governmental entities and the providers of the services.

Thank you.

WALTER KALMAN: Hi.

One of the benefits, obviously, of being last -- or almost last -- is that everything's pretty much been said up to this point.

So in the interest of time, I'd rather just-- You have my written testimony, and I would just emphasize a couple of key points that have been made throughout the course of the day.

Obviously, one of them is the timing of this change, and the fragility of the system right now with the major changes that are underway with--

ASSEMBLYWOMAN VAINIERI HUTTLE: Excuse me; Susan, do you want to shut your button off, and then--

MR. KALMAN: --fee for-service, and so on, that's occurring right now.

Also, obviously, the circumstances that are changing as we speak -- literally -- in Washington--

ASSEMBLYWOMAN VAINIERI HUTTLE: And I hate to interrupt one more time.

Would you please state your name for the record?

Thank you.

MR. KALMAN: Sure. Yes, Walter Kalman, for the National Association of Social Workers. I speak on behalf of the over 20,000 social workers here in New Jersey.

The issue of the timing, certainly because of what's going on in Washington at this point in time, adds uncertainty to the system.

As social workers, we tend to separate into both looking at issues from the micro-level and the macro-level. And a lot of the concerns that have been expressed here and the changes that need to occur, have to do with the fact that -- at the micro-level, an inadequacy of looking at people in their environment, the resources, the challenges that they face;

and looking at that in a comprehensive manner. And in order to make the broad system changes -- especially this one that is being suggested here -- we think, on a macro level, we need to look along the lines of something that Governor Codey did when he was in office -- he convened the Mental Health Task Force, which looked at the entire system. And in a very short intensive period of time, we made movements towards essential changes in the system. And that's one of the ways we might approach looking at whether or not the systems that are currently in place are sufficient, and the changes that need to be made; rather than an abrupt kind of change that is being suggested in this process.

WAYNE E. WIRTA: Good morning.

My name is Wayne Wirta, and I am the President and CEO of the National Council on Alcoholism and Drug Dependence of New Jersey.

We do not represent treatment providers or treatment professionals. We represent those who are in need of recovery, or who are in recovery.

We have over 1,000 individuals who have volunteered to be advocates for issues that pertain to recovery and good treatment -- access to treatment, etc.

So I'm here to speak on behalf of the constituents who it will eventually trickle down to -- that the impact of what's being proposed could either be good or bad. As somebody mentioned earlier, this is the first hearing on this issue; it may be the only hearing on this issue within the time period.

My question is, will this be good or bad for our constituents? We hear that it might be good; we hear that it might be bad. It's a major

change that could be either, and we would just like to urge caution. I'd like to second what you said -- that we should have some task forces, some interdepartmental task forces; have opportunity for my constituents to have input -- the mental health constituents to have input. This should be a process that could result in that kind of a change. And if a process recommended this as part of a system that would improve care for our clients, then I would wholly support it. And I'm not saying I'm against it because, quite honestly, I don't know whether to be for or against it, based on the information that has been provided so far.

So I would just support the request that this be held up; that an opportunity be given to study this question, to look at alternatives, to have public input. So that when the recommendations are finally coming in terms of a piece of legislation or an Executive Order, we have some sense that it has been thought out clearly; that there are points that are made in favor of the recommendations that we can understand, that we've had a chance to look at, and have some input into; and then be able to come here and say, "Yes, we support it," or, "No, we don't support it."

I don't know which to say right now, and I would like to be in the position to be at a hearing where we can know what to say about that. So I would ask that you take caution in something that could be a major move that could have serious impact, one way or the other, on the clients who we represent.

Thank you.

ASSEMBLYWOMAN VAINIERI HUTTLE: Thank you.

Any questions for our last panel?

Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Ms. Loughery, it sounds like, if I understood you, that you are in favor of the integration; that you think it is generally a good idea -- that is, of mental, and addictions services, and physical health services?

MS. LOUGHERY: Yes, I'm in favor of integration of services, based on the empirical data that we've seen and the experience that we've seen for our consumers.

It becomes an issue of access and navigation; and I think it's critical to have the goal being the outcome for the consumer -- what can we do to provide everything that the most vulnerable within our state need. And that is integrated services.

ASSEMBLYMAN CONAWAY: And through the Chair, if I may, just another--

This was mentioned before, and I hadn't had a chance to ask the question, so I will ask it of you, here, at the end. And perhaps someone will, at the end, let me know more on this point.

And that is -- it's been mentioned that as we move forward, it's going to be important to make sure that there is sustainability of services; and I read that as *payment* for services. And the Jacobi report went on at some length about the issues related to coding -- what kinds of services may be offered; in what setting; that there are different code sets; there are differing times allotted for counseling sessions; and everything else. There is a lot of complexity and conflicting rules in coding -- that is, getting paid for services -- that needs addressing. And I suppose some might argue that it might be best addressed by having some line of authority to make a decision, one way or another, in a lot of these things.

But can you speak to this question of the sustainability question that's been mentioned here? Is there a reason why this reorganization would doom sustainability for programs, versus leaving things as they are? I mean, how does this reorganization impact the sustainability question, in your view?

MS. LOUGHERY: So with regard to payment mechanisms -- what we're looking at is, we're looking at population health, which takes into consideration lots of different services and systems based on what's needed for each individual consumer.

So that might mean collaboration between various organizations -- a hospital system and a community provider; an FQHC and a behavioral health provider. So then the question becomes, who does what under the regulatory guidance, and who gets paid for what under that regulatory guidance?

So being allowed to provide integrated services under the auspices of regulatory guidance doesn't necessarily mean that all of the providers will be paid under that system. So it really needs to be taken into consideration -- how we move forward with a payment mechanism for all of the providers who are part of that integrated, holistic care plan for that consumer.

ASSEMBLYWOMAN VAINIERI HUTTLE: Before we close, we do have written--

Thank you very much.

We have written testimony -- we'll definitely not read it, but I do want to take a piece of it -- from former Assembly member Mary Pat

Angelini, who was also a member of the Human Services Committee, and who is now CEO of Preferred Behavioral Health Group.

And she goes through the integration -- how wonderful it would be. And at the end she says, "Overall, I am not 100 percent convinced that this major move needs to happen at the same time that so many of the agencies are experiencing tremendous pressure in this new environment of fee-for-service. My main concern is that those we serve -- the most vulnerable in our communities -- will fall through the cracks and ultimately will cost our communities and the State of New Jersey substantially more due to visits to the hospital emergency rooms. That being said, if the Plan moves forward, I will commit, of course, to assisting in any way necessary for successful implementation."

But I do believe that her last paragraph speaks volumes on what we heard today -- that I think, as a Human Services Committee, our main concern should be those who are the most vulnerable in our communities.

And with that being said, I will hand it over to Chairman Vitale.

SENATOR VITALE: Thank you to everyone who came out today to testify. This was an important day for us -- to understand how deeply this issue runs for all of you, the different agencies and providers that work within both systems; and as the Legislature decides what to do about this, the Executive Order, and what our options are.

So I also want to thank the members for coming out during the summer. We still continue to be legislators; and so a day down in Trenton is always a fun experience.

So thanks for being out here today, and we look forward to seeing you again.

Senator Codey, did you want--

SENATOR CODEY: Yes, Chairman, I would like to make a motion that we have a recommendation to both the Speaker and the President of the Senate to come back in and consider this very issue before the deadline passes.

SENATOR VITALE: We have until -- August 29 is the deadline--

SENATOR CODEY: Right.

SENATOR VITALE: --by which we have to respond. The Assembly comes in on Monday for a voting session.

SENATOR CODEY: Yes, we're going to come back in for this purpose.

SENATOR VITALE: Yes. I don't know that we--

SENATOR CODEY: That we voice our concerns, and ask that the President of the Senate and the Speaker of the Assembly come in to take up this issue.

SENATOR VITALE: Well, I think-- Governor, I don't know; this is a joint hearing, and I don't know that we have the ability to make a motion, and a second, and have it be a matter in standing. So I think we all want to resolve this issue, and I think many of us are on the same page. So let's hold off on that, but let's have a conversation in the next few days with members of both these Committees, and certainly Chairman Conaway's Committee as well. I know the Assembly is meeting on Monday; I don't know whether or not they'll take up a resolution. The Senate is not

scheduled to come back, but certainly we can come back at any time. And I will speak with the Senate President to see what his opinion is on this, and what his pleasure is.

ASSEMBLYWOMAN VAINIERI HUTTLE: And I would also like to add that some of the questions that we had for the Commissioner of Health, who could not be here today, I will have in writing and send it to the Commissioner, and get back to the rest of the Committee members.

Thank you.

SENATOR VITALE: Thank you all. Have a good day.

(MEETING CONCLUDED)