Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey

John V. Jacobi, J.D.
Tara Adams Ragone, J.D.
Kate Greenwood, J.D.*

Seton Hall University School of Law
One Newark Center
Newark, NJ 07102
law.shu.edu

March 31, 2016

*Kate Greenwood served as Research Fellow & Lecturer in Law at Seton Hall University School of Law through July 24, 2015.
Executive Summary

People with behavioral health conditions suffer from missed health care opportunities. Research has shown that people with serious mental illness suffer from increased burdens of sickness and early death as a result of poorly managed physical illness. People with less significant behavioral conditions too often remain unconnected to mental health or substance use disorder care because such services are unavailable in primary care settings. Clinicians responding to these system deficits advocate care integration through bringing primary care and behavioral health under one roof.

Innovative New Jersey clinicians have worked toward behavioral health integration. The clinical difficulties such integration entails can be daunting, but models from around the country, as well as home-grown efforts, point the way toward success. The Nicholson Foundation has funded several care integration efforts around New Jersey. Clinicians reported, however, that their efforts are impeded by legal barriers in New Jersey’s licensure and reimbursement systems. The Nicholson Foundation asked Seton Hall Law School’s Center for Health & Pharmaceutical Law & Policy to examine those legal barriers, and to propose solutions that would facilitate appropriate behavioral health integration.

This Report reviews the clinical behavioral health literature and describes the statutory and regulatory law on licensure and reimbursement. It reflects extensive conversations with many primary care and behavioral health providers, academics, advocates, and government representatives. The generosity of these interlocutors greatly aided in translating the general and formal to the specific and contextual, allowing us to understand the law as applied to behavioral health integration efforts. The openness and candor of government representatives at all levels were particularly helpful.

The Nicholson Foundation

Advancing Health and Promoting Opportunity

Support for this Report was provided by a grant from The Nicholson Foundation.
Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey

The goals of this Report are several. First, the statutory and regulatory framework is complex, and the regulated community experiences confusion that impedes efforts to extend care. One goal, therefore, is to describe in clear terms both the “black letter” law and, equally as important, authoritative interpretations of that law as applied to behavioral health integration.

Second, the Report describes those instances in which current law impedes the development of integrated care. In some instances New Jersey law appears to lag the clinical developments in this area, suggesting that modifications in the law could benefit all. This Report details such areas in the licensure and reimbursement areas.

Finally, this Report offers recommendations for adjustments to the regulatory framework governing reimbursement and licensure, which recommendations are intended appropriately to balance the consumer protection missions of the Departments of Human Services and Health on the one hand with the imperative to facilitate the move to clinically integrated behavioral health and primary care services. One extremely positive development is that, during the course of the Report’s development, the New Jersey Departments of Human Services and Health announced a forward-looking policy innovation allowing the sharing of clinical space for behavioral and primary care in licensed facilities. The Departments’ movement is consistent in many regards with recommendations in this Report, and suggests continuing regulatory advances to accommodate integrated care.

The literature on clinical advances to behavioral health integration, as briefly summarized in this Report, provides both important areas of consensus and areas of continuing development.

- The drive to integrate primary and behavioral health care responds to the evidence that people with serious behavioral health conditions suffer for lack of access to primary care, while people with mild to moderate behavioral health conditions, too often unconnected to behavioral health care, could benefit from access to care in primary care settings.
- The drive to integrate care goes beyond merely increasing access; rather, studies demonstrate that behavioral health integration can improve patient outcomes.
- There is a growing body of literature indicating that integrating care is cost-neutral or cost-saving. Many high-utilizers of hospital emergency department services have behavioral health conditions, and appropriate community care of both their behavioral health and physical health needs could reduce the need for expensive hospital-based care.
- Best practices for behavioral health integration are still emerging, and various models, tailored to particular populations and settings, continue to develop.
- Development of behavioral integration faces several environmental barriers, including gaps in reimbursement, low Medicaid reimbursement rates, and onerous licensure standards.
Many New Jersey behavioral health and primary care providers regard licensure rules to be a principal barrier to integrated care. Discussions with these providers revealed that there is a great deal of confusion among the regulated community as to New Jersey's licensure rules.

- Federally Qualified Health Centers (FQHCs) and other outpatient clinics are an important source of primary care for New Jerseyans with low or moderate incomes. FQHCs are licensed by the Department of Health (DOH) as Ambulatory Care Facilities (ACFs).
- The ACF regulations list permissible services, which include some limited outpatient substance use disorder treatment but not mental health services. Mental health programs (MHPs) and outpatient substance abuse treatment facilities (SAs) are licensed by the Department of Human Services (DHS). This structure suggests that a facility attempting to provide integrated behavioral health and primary care services could be required to obtain two or three separate licenses, an onerous and time-consuming task.
- In practice, however, both DOH and DHS permit DOH-licensed FQHCs to provide limited mental health services, such as screening, brief intervention, and limited counseling and medication management, without being licensed by DHS.
- The extent to which DOH and DHS permit ACFs to provide behavioral care is quite ambiguous in New Jersey's laws and regulations.
- Mental health programs and outpatient substance use disorder treatment programs licensed by DHS are not permitted to provide most primary care services without obtaining a separate ACF license from DOH; however, DHS-licensed mental health programs are often permitted, by informal arrangement, to provide up to eight hours of primary care per week without a DOH license.
- Hospital-based outpatient facilities located away from the hospital campus must be separately licensed as ACFs by DOH. In addition, if a hospital licensed for mental health care does not offer outpatient behavioral health services on its hospital campus and operates more than one off-campus outpatient behavioral health facility, DOH will only consider one of these programs as being under the hospital's license; additional such facilities must be licensed by DHS as a MHP.
- It is unclear whether hospital-based outpatient clinics are permitted to provide integrated behavioral health and primary care services without obtaining a license from DHS, although DOH acknowledged that integration may be appropriate in certain circumstances.

A major sticking point with many facilities striving to provide integrated care has been the State's position that licensure provisions prohibited providing behavioral and primary care in the same clinical space. A memorandum released as this Report was going to press, referred to here as the Shared Space Waiver, and described in detail in Part III(B)(9a) below, substantially relaxed that requirement for ACFs.
Prior to the publication of the Shared Space Waiver, providers reported being told that they must maintain separate entrances, stairways, restrooms, waiting rooms, examination rooms, staff break rooms, and other duplicative facilities. Some, but not all, of those separation requirements were acknowledged by DOH as requirements, although it was reported that waivers were available for some of the separate facilities requirements.

Many of these "keep separate" requirements appear to run contrary to nondiscrimination requirements, including those of the Americans with Disabilities Act.

The Shared Space Waiver, issued by DOH pursuant to the Commissioner’s waiver authority, relieves many facilities of most of those "keep separate" requirements for facilities seeking licensure from both DOH and DHS. This Shared Space Waiver is described in detail in Part III(B)(9)a below.

In addition to licensure barriers, payment issues inhibit behavioral health integration in many circumstances.

The system by which FQHCs and other ACFs may be paid by Medicaid for behavioral health services is complex and poorly understood by providers. The instructions for and implementation of Medicaid billing is located in several uncodified locations, subject to interpretation by several sources, and has been reported to be inconsistently administered.

Although DHS has taken the position that DOH-licensed ACFs must also be licensed as mental health programs by DHS in order to bill Medicaid for mental health services, DHS has approved, through the distribution of informal guidance, certain limited reimbursement codes to be activated for FQHCs to provide some limited behavioral health services.

Almost all Medicaid recipients in New Jersey are now covered by Medicaid Managed Care Organizations (MCOs). Because New Jersey Medicaid operates with a behavioral health carve-out, however, some but not all behavioral health services are not reimbursed by MCOs, but by an independent contractor on a fee-for-service basis. This system has created some confusion, and DHS has shifted management of Medicaid payment for substance use disorder treatment to Rutgers University Behavioral Health Care, and is in the process of reexamining the system by which mental health care is reimbursed.

FQHCs receive Medicaid payment through a unique prospective payment system, intended to compensate them for providing a broad range of comprehensive clinical and other health-related services.

The FQHCs’ prospective payment rate is adjusted to account for medical inflation. In addition, the amount of payment is required to be adjusted when an FQHC experiences a "change in scope of services."
o If such a filing is required, DHS and regulated entities should engage in a collaborative process to ensure that regulatory requirements do not impede efforts to serve the needs of patients.

o Health care providers in New Jersey attempting to provide integrated physical and behavioral health services are confused, and appear to receive inconsistent guidance on licensure and reimbursement. DHS and DOH should provide more user-friendly tools to combat confusion in the regulated community. Such steps might include:
  o FAQs and more complete descriptions of regulatory policy on integration on agency web sites.
  o Public outreach to mental health programs; FQHCs and other primary care providers, hospitals, and their trade organizations with full descriptions of agency policy.
RECOMMENDATIONS
INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH CARE:
LICENSING AND REIMBURSEMENT BARRIERS AND OPPORTUNITIES IN NEW JERSEY
SETON HALL LAW – MARCH 31, 2016

Recommendation #1
New Jersey should move toward a system requiring only a single license for the operation of an integrated facility. Interim steps advancing DOH and DHS toward a single licensure system, such as the collaboration leading to the Shared Space Waiver, should be undertaken to minimize the impediments to implementing clinically appropriate integrated facilities.

Recommendation #2
Regulatory requirements for separation of behavioral and primary care services should be eliminated, as DOH accomplished with the Shared Services Waiver, except for those, such as records maintenance, required by law. Facilities regulations should be functional, encouraging shared space and services where not inconsistent with patient needs.

Recommendation #3
Medicaid payment rates for primary care and behavioral health services through fee-for-service and Medicaid managed care organizations should be reviewed in order to assure sufficient levels to permit sustainable integrated care.

Recommendation #4
DHS, in determining the shape of its fiscal agency model under the Comprehensive Waiver, should consider contracting with a single agent for both physical and behavioral health care claims.

Recommendation #5
DHS should continue to pursue initiatives such as Behavioral Health Homes and the NJ CCBHC project to ensure that people with serious and persistent behavioral health needs have access to necessary physical health services in an integrated setting.

Recommendation #6
DHS should use the period of transition to new agents and intermediaries to adjust the terms and conditions of Medicaid participation and payment to facilitate behavioral health integration.

Recommendation #7
FQHCs should be permitted to maintain or add behavioral health services to screen and provide services for mild to moderate behavioral health conditions without filing a Change of Scope application; the addition of services for severe and persistent behavioral health conditions should, however, trigger such a requirement.

Recommendation #8
The Departments of Human Services and Health should identify staff with responsibility for integration efforts and provide full and public disclosure of their regulatory policies for the benefit of providers and regulatory personnel in the form of 1) FAQs and more complete descriptions of regulatory policy on integration on agency websites; and 2) Public outreach to mental health programs, substance use disorder programs, FQHCs and other primary care providers, hospitals, and their trade organizations with full descriptions of agency policy.
Testimony to the Assembly Human Services & Senate Health, Human Services and Senior Citizens Committee
Tuesday, July 25, 2017; 11:00am
Committee Room 4, 1st Floor, State House Annex, Trenton, NJ

Testimony 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."

Barbara Johnston
Director, Policy and Advocacy
Mental Health Association in New Jersey

673 Morris Ave. Suite 100 · Springfield, New Jersey 07081
(973) 571-4100 · Fax: (973) 216-0336
E-mail: info@mhanj.org · Website: www.mhanj.org
Good morning, I am here today on behalf of the Mental Health Association in New Jersey (MHANJ). We would like to thank the Chairs of both the Assembly Human Services Committee, Vainieri Huttle, Vice Chair Tucker and the Senate Health, Human Services and Senior Citizens Committee, Vitale, Vice Chair Madden, for holding this joint committee meeting and for the opportunity to present our testimony.

MHANJ is a statewide private non-profit advocacy organization dedicated to improving access to treatment and opportunities for children and adults with mental illness and substance use disorder, through legislation and advocacy efforts. Our organization works with consumers and families to create a better life for those living with mental illness.

The MHANJ has serious concerns and opposes the shifting oversight of the Division of Mental Health and Addiction Services (DMHAS) from the Department of Human Services (DHS) to the Department of Health (DOH). The integration of mental health and substance abuse with each other and with physical health is a major focus of our advocacy efforts, however, we do not believe that this move is a viable way of making this happen. I would like to take a moment to outline some of our concerns:

- DHS and DOH have vastly different roles and functions. DOH performs a predominantly regulatory function, as well as oversight of health policies and programs. DHS, on the other hand, has the strength and history to conduct wide scale operations, serving tens of thousands of residents in institutional and community settings. Put simply, one has a regulatory role, the other an operational one.
- The population using the greatest amount of Medicaid funds are individuals living with behavioral health issues, who are often homeless, unemployed and frequently found in emergency rooms. Serving this vulnerable population is a mandate of DHS. Additionally, managing the use of Medicaid for that purpose, as well as controlling costs, is under DHS’s purview. These are the populations that they serve. Moving this populations to DOH, while Medicaid remains in DHS, will have a negative effect on the integration of these services that currently exists within one department.
- Populations that would remain in DHS include the Division of Developmental Disabilities (DDD) as well as families and individuals who are living in poverty. Many individuals under these designations are also living with a mental health and/or substance use problem. This move would separate the Divisions under which these individuals receive services. True integration would include them in the process, not separate them further from needed services.
- The public behavioral health system under DMHAS is currently transforming its contracting system to move to a unit cost framework and eventually to managed care; such changes are filled with extensive planning and detail. Shifting DMHAS under DOH and conducting these two major shifts in policy and function simultaneously, may be more than can be handled by an already fragile system. The result will be a disruption in services to those most in need of stable, consistent care.
- DMHAS works closely with community providers, consumers and families, and has developed a philosophy of Wellness and Recovery that includes multiple disciplines, support services and housing as part of achieving the goal of sustaining people in the community. It has taken much time and effort to expand the Division’s role to include multiple disciplines -- which now includes a housing capacity. This has been a unique development, with a great deal of input from community voices. The DOH is firmly based in the medical model, as befits their current mandate. We do not want to see the Recovery Model slowed or truncated.

Thank you for hearing our testimony today.
innovating for Progress | Partnering for Solutions
New Jersey Association of Mental Health and Addiction Agencies, Inc.

July 25, 2017

The Honorable Valerie Vainieri Huttle, Chair
Assembly Human Services and
The Honorable Joseph F. Vitale, Chair
Senate Health, Human Services and Senior Citizens

Testimony before the Joint Committee Meeting of the
Assembly Human Services Committee and the
Senate Health, Human Services and Senior Citizens Committee

Re: 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.”

On behalf of the New Jersey Association of Mental Health and Addiction
Agyencies (NJAMHAA), I wish to thank Chairwoman Vainieri Huttle, Chairman
Vitale and other members of the Committee for the opportunity to provide
testimony regarding the Governor’s reorganization plan that would transfer the
Division of Mental Health and Addiction Services (DMHAS) to the Department
of Health.

NJAMHAA has long supported, and worked toward, integrated care. The
physical comorbidities that plague the population served by our members and
that have left them with a 25 to 37 year shorter life expectancy demands it.
NJAMHAA has also held that “mental health is health”, and participated in anti-
stigma campaigns throughout its history. The rationale presented in the Plan
matches these positions. However, serious concerns about the Plan cannot be
ignored.

The most disconcerting aspects of the Plan are: 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 (Medicaid). The community based behavioral system is just
now transitioning to fee-for-service. Due to the negative fiscal impact, staff have
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 concerned that the staff disruption caused by physical
and administrative moves, potential layoffs, job-shifting, etc. cannot be afforded at this critical juncture.

Moving DMHAS 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 payor in the current transition to fee-for-service. Our members’ programs are, for the most part, licensed by DMHAS, but they also hold Medicaid licenses (in order to be able to bill Medicaid) and 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 NJAMHAA holds with DMHAS include senior staff from Medicaid. DHS also established a number of new positions for senior staff to serve as a bridge between Medicaid and DMHAS. 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.

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 a move such as 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 a full study and a more reasonable transition timeline, should the Plan ultimately be implemented.

Sincerely,

[Signature]
Debra L. Wentz, PhD
President and CEO
Testimony to the Assembly Human Services & Senate Health, Human Services and Senior Citizens Committee
Tuesday, July 25, 2017; 11:00 AM
Committee Room 4, 1st Floor, State House Annex, Trenton, NJ

Testimony 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.”

Terrence O’Connor
Former Assistant Commissioner of the Division of Addiction Services, Department of Health
Good Morning, my name is Terrence O'Connor. I am appearing here today as the former Assistant Commissioner of the Addiction Service Division, Department of Health (DOH) for a ten year period in the nineties; in addition to twenty years serving in other senior level positions, including Chief of Staff, within the DOH. 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, Joseph Vitale and Valerie Huttole, 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.

Then, as now, clients affected by these disorders are not only served by DHS and DOH, but also by other Departments and Branches within State Government. Specifically initiatives developed before, during and after my tenure, with the Department of Corrections, Community Affairs, Juvenile Justice and the Judiciary (Drug Court Initiative) have continued with DHS/DMHAS. County Governments also have a critical role in serving these clients. It is necessary that these programs and relationships be maintained. It is not clear on whether this will occur by shifting DMHAS to DOH.

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 (DHS) to accomplish this goal was the transfer of the Division of Mental Health and parts of the associated Medicaid funding to DOH. After careful and lengthy deliberations, it was decided not to proceed with that option because of the complexity, timing and difficulty of making such a large organizational change without a reasonable certainty of improving client outcomes. This is still the case today.
I strongly urge the Committees to elicit more input from stakeholders from NJ affected by this change. I would also suggest other states be contacted where similar reorganizations have occurred to determine if these changes had any improvements in client outcomes. Connecticut would be a good start as not too long ago they implemented a massive organizational change to deliver services for these individuals.

Thank You
Testimony 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”

Delivered to

Senate Health, Human Services and Senior Citizens Committee
Assembly Human Services Committee

By

Deborah M. Spitalnik, PhD
Professor of Pediatrics, Rutgers Robert Wood Johnson Medical School
Executive Director, The Boggs Center on Developmental Disabilities
Adjunct Associate Professor of Family Medicine and Community Health, Rutgers Robert Wood Johnson Medical School

July 25, 2017
Trenton, NJ
Senator Vitale, Assemblywoman Huttle, and Distinguished Committee
Members, thank you for the invitation to present testimony before you today 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". I am Deborah M. Spitalnik, PhD,
Executive Director of The Boggs Center on Developmental Disabilities and
Professor of Pediatrics and Adjunct Associate Professor of Family Medicine and
Community Health at Rutgers Robert Wood Johnson Medical School. My
comments today are from multiple perspectives and include specific concerns
related to people with intellectual and developmental disabilities, and larger
health policy considerations shaped by my experience in New Jersey and
nationally.

I also want to begin by expressing my admiration for the leadership and work
of The Department of Health and the Department of Human Services, as well
as my appreciation for the long-standing collaborations between The Boggs
Center on Developmental Disabilities and each department.

The backdrop for our considerations today are a series of important and highly
visible and valued commitments made by Governor Christie to address the
health of New Jerseyans. The Governor’s embrace of the Medicaid Expansion
has resulted in coverage for 555,099 of our most vulnerable fellow citizens. The
Governor has advocated for increased financial investment in behavioral health
care and increased recognition of behavioral health problems and opioid
addiction as illnesses, reducing stigma and encouraging individuals to seek care and treatment. The Governor has emphasized the importance of prevention and mental health as a public health concern.

The Integration of Behavioral and Physical Health

There is broad evidence of the importance and benefits of the integration of behavioral health care with physical health care. Dr. Ezekiel Emanuel in his new book, “Prescription for the Future: The Twelve Transformational Practices of Highly Effective Medical Organizations” (2017), highlights the integration of behavioral and physical health as a practice in “Transforming Provider Interactions” with patients. Dr. Emanuel promotes not just co-location of services, but “integration into actual care”. Joan Randall, the Chief Operating Officer of the Nicholson Foundation (2016), has urged the “improvement of behavioral health care in our state by integrating primary care and behavioral care”. John Jacoby, J.D. and his colleagues at Seton Hall Law School have provided extensive guidance on this issue through their 2016 Report, funded by the Nicholson Foundation, “Integration of Behavioral and Physical Health Care: Licensing and Reimbursement Barriers and Opportunities in New Jersey. The Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers in New Jersey” (2016), identified behavioral health needs as a contributor to persistent high utilization and costs, as well as also recommending the integration of behavioral health in primary care settings.
Population Health and Delivery of Individual Health Care Services

The efficacy of the New Jersey Department of Health's role in improving population health is demonstrated by the Department's accreditation by the Public Health Accreditation Board. The concerns raised in the Reorganization Plan emphasize a fragmented delivery system for behavioral and mental health services. I would propose for the Committees' deliberations, that the issues of the integration of behavioral and physical 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 incorporation of Mental Health and Addiction Services into the Department of Health, does not address what are service delivery challenges. I contend that in clarifying the problem to be solved, does not support the proposed reorganization and movement of mental health services.

The Mental Health Needs and Service Delivery Challenges for Individuals with Developmental Disabilities

The behavioral and mental health needs of people with developmental disabilities, those severe disabilities that begin in childhood and persist throughout the lifespan, represent unmet needs for care. These needs are illustrative of the coordination needed within the service system- processes that continue to fall squarely within the Department of Human Services. For people with intellectual disabilities (the condition formerly referred to as mental retardation), 50% have a dual diagnosis of a co-occurring mental health
condition. For people with Autism the numbers are higher: 50-70% (NADD, 2017). For families seeking care, often due to a psychiatric emergency, finding services from two divisions within the same department is often difficult. The reorganization would put an insurmountable burden on families to negotiate a pathway to care across two state agencies.

There continue to be adults with developmental disabilities in state psychiatric hospital, 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 mitigated by requiring providers to work with two separate state departments.

For the population of people with developmental disabilities and co-occurring mental health disorders, the service delivery challenges are provider education and training, coordination of care, and adequate reimbursement rates to address the complexity of this population. Changing the administrative location of services will not address or resolve these substantive challenges.

**The Centrality of Medicaid to the Delivery of Behavioral Health Services**

NJFamilyCare, the Medicaid program in New Jersey, provides health care coverage to 974,762 adults (6/2017). 16.9% of these adults are in the Aged/Blind/Disabled category. For all adults on Medicaid there is a high reported incidence of mental health needs (National Health Interview Survey, 2005/2006).
The Movement of Aging Services New Jersey having transferred Senior Services to the Department of Health, and then returning these services to the Department of Human Services, demonstrates the efficacious role of the Department of Human Services in delivering health care to vulnerable populations. In his state fiscal year 2013 budget address, Governor Christie cited “[T]he 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 this move (New Jersey State Strategic Plan on Aging, 10/1/2-13-9/30/2017). This shift created a single point of access for older adults, people with disabilities and their caregivers regardless of Medicaid eligibility. These analogous experiences support retaining the Division of Mental Health and Substance Abuse (DMHSA) within the Department of Human Services.

Managed Long Term Supports and Services The 36,420 Medicaid beneficiaries who are receiving their Long Term Care through Managed Long Term Services and Supports (MLTSS) represent individuals who are "dual eligibles", i.e. receiving both Medicare and Medicaid, and who have high and complex needs. For them, behavioral health services are “carved” into the MLTSS benefit and are provided through the Managed Care Organizations which contract with Medicaid. For these MCOS, similar to the DD providers previously referenced above, it would create additional burdens as well as increase the difficulty in integrating behavioral and physical health, for behavioral health services were moved to the Department of Health. The
contract between the Division of Medical Assistance and Health Services (DMAHS), (NJ Medicaid) and the Managed Care Organizations provides the mechanism for creating the benefit structure and the standards for providing care, as well as opportunities for improvement. To adjudicate these requirements across Departments would weaken their impact in defining service delivery.

The Experience of the Department of Human Services in Delivering Direct Services to Individual Patients and Clients

The experience of the Department of Human Services as the centralized Medicaid program in the state has continued primacy and importance for the delivery of behavioral health services.

The experience of the Department of Human Services in its administration of state mental health hospitals is also bolstered by the Department’s 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 would be eroded if the transfer would be effectuated. The role of the DHS Office of Program Integrity and Accountability would need to be replicated- creating inefficiency, duplication, and the loss of interoperability.

The Problems are Regulatory

The obstacles to the integration of primary care and behavioral health are regulatory and financial, not the administrative location of service delivery within state government. In the eight recommendation of the Seton Hall Report
on the Integration of Behavioral and Physical Health Care, four of the eight recommendations are about Licensing and Regulation; three are about Payment; and one recommendation on innovations, including Behavioral Health Homes- an initiative already begun within the Department of Human Services through DMHSSA and DMAHS. The identification within the Reorganization Plan, of conflicting and duplicative licensing statutes and requirements, can be reconciled and resolved through collaborative, interagency planning, exemplified by the successful development of the “Shared Space Waiver”, which eased the path for Federally Qualified Health Centers and other physical health providers to deliver behavioral health services. These changes can be effected without disrupting service direct service delivery.

**Change and Tumult in Health Care Nationally**

In the continued efforts to change the provision of health care coverage, dramatic changes for the Medicaid program and the structure of reimbursement, including for the Medicaid expansion are being proposed nationally. Making major state level changes to the delivery of behavioral health services now, rests on an unpredictable future-compounding uncertainty with dislocation and disruption.

Any major organizational shift in the administrative location of services has a minimum of two to five years of disruption and disequilibrium. New Jersey's citizens in need of behavioral services would be best served by maintaining the present administrative location of state services and working toward the
integration of behavioral and physical health through engaging stakeholders and interagency planning to eliminate barriers and obstacles and create coherence and access.

References


http://www.cshp.rutgers.edu/Downloads/10890.pdf


Thank you for the opportunity to testify on the governor’s proposed reorganization plan to transfer mental health and addiction functions from the Department of Human Services to the Department of Health. This is not a minor administrative issue; rather it represents one of the most radical changes ever in the organization of state departments in a century and deserves much more study than the allotted 60 days allow. While we appreciate the governor’s admission that there is a stunning lack of coordination and integration of services within his administration, this plan does not sufficiently support the conclusion that the solution is to put all of these services in one department.

We are 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 would 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 or death consequences for New Jersey residents—would make it even more so.

To some extent, this issue is déjà vu all over again. It was only six years ago that the state formally transferred addiction services from the DOH to the DHS to “provide increased efficiency, coordination and integration of the State’s addiction prevention and treatment functions.” Rather than continue to bounce state services back and forth between departments, we need to recognize that there may be other factors that are much more important in improving the efficiency and effectiveness of these services.

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 services 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 consumer’s mental health, including death.

We are also concerned that the state could lose federal Medicaid funding if these services are transferred to the DOH, since Medicaid is administered by DHS. The state has been particularly successful in funding more of these services thanks to the Medicaid expansion, which increased the number of New Jerseyans enrolled in Medicaid by about a half million residents. Also, the department is in the middle of a major transition to fee-for-service funding for mental health and drug addiction services to also maximize Medicaid funds. There have been major problems in administering this transition, which need to be remedied before other major structural changes are implemented.

The governor says there needs to be more integration between mental health and physical health. We strongly agree, but the DHS is the largest provider of physical health in the state through Medicaid so why transfer behavioral health services to the DOH? It would appear that problem could more easily
rectified by only relocating all licensing to the DOH rather than transferring all services to the department.

We are also extremely concerned that adding such a major new function to the DOH 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, such as consolidation of hospitals, the increase in for-profit hospitals, the growth in tiered network and value-based health services and the need for more accountability throughout the health care system to improve care and reduce costs. We are concerned that these critical functions will be reduced, rather than strengthened, as a result of adding an entirely new function to the DOH. Also, how can the department fairly evaluate the extent to which the state is meeting its health goals if the department itself becomes a major provider of health services?

We also disagree with the governor’s suggestion that since the DHS has a lot of staff and the Department of Health does not, there should be more of a balance. It should be pointed out that while the department does have about 11,000 staff now, that’s about half what it used to have when the department also included children services and corrections. In addition, most research in organizational theory shows that the size of an organization has very little to do with it its efficiency and effectiveness.

Lastly, such a major change in state government should not be made in the face of such uncertainty at the federal level. As we all know, there is a major effort to greatly reduce the amount of federal support the states receive to fund health care. The focus currently is on repealing the Affordable Care Act, but it’s also clear that Congress is very interested in many other health care cutbacks, including about $2 trillion in cuts to health funding over 10 years in the House’s proposed budget. Until we know what those changes are going to be, it would be premature to make major organizational changes in state government. For example, it appears quite likely that there’ll be a major reduction in federal funds to hospitals, in which case the DOH will have more than its hands full.

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 transferring these services that we have not identified.

We therefore urge that you vote to oppose the governor’s plan and direct him to provide a thorough study, with public hearings and stakeholder input, of the advantages and disadvantages of transferring these services to the DOH from the DHS, taking into account what the mission of the departments should be in the future given the many changes that will likely be made in Washington and the health field in general, and recommending any organizational and statutory changes that may be needed.

We also recommend that the report evaluate the extent to which the governor’s office has the authority to better coordinate these services in lieu of transferring them from one department to another in anticipation that the next governor will decide to take more of a leadership role in managing state services, promoting transparency and encouraging public input.

Thank you.
Members of the Senate Health, Human Services and Senior Citizens Committee and the Assembly Human Services Committee thank you for the opportunity to testify today. My Name is Phillip Lubitz. I am the Associate Director of NAMI NEW JERSEY, the National Alliance on Mental Illness. NAMI NEW JERSEY is a statewide organization founded by the families of persons with a serious mental illness. We are the state’s largest grassroots organization dedicated to improving the quality of life of individuals who have a serious mental illness and their families.

As the State Family Support Coordinator under the Family Support for the Families of Persons with a Serious Mental Illness Act, PL 1995, C.314, I have had the opportunity to conduct needs surveys of families for the past 21 years, so that the physical health needs of persons with a mental illness have risen to prominence comes as no surprise to me. The need for enhanced coordination between mental and somatic health care is something that we have been calling for in the State Family Support Plan since 1996.

During this time we have noted a growing awareness and response on the part of the Division of Mental Health and Addictions Services (DMHAS) to these concerns most notably in our state psychiatric hospitals where measuring indicators of metabolic disorders, a major contributor to the increased mortality of individuals with a serious mental illness has become a regular feature of the standard of care in these hospitals.

New Jersey DMHAS has also partnered with the Division of Medical Assistance (DMHAS) to develop Behavioral Health Homes (BHH). These health homes were launched in select counties in July of 2014. They provide a continuing standard of care that allows individuals to have all of their health care needs identified, addressed, and treated in a coordinated way. The same team of clinicians and practitioners either deliver, or coordinate the delivery of, all the necessary medical, behavioral, and social supports required for the individual, acknowledging the impact each area has on the others. Currently, Bergen, Mercer, Atlantic, Cape May, and Monmouth counties have been approved for the Behavioral Health Home Service.

Most recently through the Department of Human Services and the Division of Mental Health and Addictions Services New Jersey was one of only eight states that were selected to participate in the new Federal demonstration program to improve access to integrated high-quality behavioral and physical health services. During the two-year demonstration program Certified Community Behavioral Health Clinics (CCBHC) would receive an enhanced Medicaid prospective payment rate based on projected costs. States must certify that each CCBHC offers the following services either directly or through a formal contract with a designated collaborating organization (DCO) with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.
Behavioral health stakeholders around the country have identified this as a parallel construct to Federally Qualified Health Centers (FQHCs), allowing behavioral health providers to access similar levels of reimbursement for community-based care to high-need underserved populations and communities.

The recently adopted state budget also includes a $5 million increase for expansion of the primary care pilot program whereby physicians screen, manage and make referrals to mental health and substance use (SUD) treatment for children and youth.

These initiatives coming out of the Department of Human Services are genuine reasons to be optimistic about the coordination of behavioral and physical healthcare, but remain only part of the picture of improving health outcomes for individuals with a mental illness.

In general, the barriers that family members have found in attempting to find coordinated care for their ill family members have less to do with the administrative silos into which physical and mental health care tend to fall and more to do with the general shortage of available practitioners in the various fields. On the mental health side, families complain about the shortage of psychiatrists who accept Medicaid, the major insurance source for individuals with a mental illness. The same tends to hold true for other specialties such as dental care. Of course, reimbursement rates under the State's Medicaid program are a major contributing factor, but families also believe that in many cases the stigma associated with mental illness makes their ill family member unwelcomed at many primary care practices or in hospital emergency rooms. Families and their ill relatives frequently report that their complaints of physical ailments are often not taken seriously or interpreted as symptoms of their mental illness in these settings.

The delivery of high quality, integrated behavioral and somatic healthcare to individuals with mental illness and/or substance use disorders has rightly been elevated in the public discourse. We have learned that the "usual" system of healthcare has proven inadequate to meet the needs of these individuals and has contributed to a shorter life expectancy for individuals with a serious mental illness. A multitude of factors have been identified as contributing to this including: modifiable lifestyle factors, psychiatric medication side effects, lower access to and quality of received health care, psychiatric instability and treatment adherence. From psychiatric rehabilitation we have also learned that such factors as stable housing, supportive social networks and adequate financial support/income are major determinants of recovery. A "whole person" approach is multi-dimensional and crosses a number of our traditional systems. As such we must take care not to move our behavioral health services from one silo to another especially as it pertains to decoupling behavioral health services from Medicaid in DHS; our major funding source for behavioral health services coverage and expansion.

This also holds true for additional relationships that have been developed both internally and externally by the Department of Human Services (DHS). Clearly there is congruity among the physical health needs of other populations served by DHS such as the elderly, individuals with a developmental disability and the blind and hard of hearing. It is difficult to reconcile the advantage of separating their healthcare needs from those of individuals with behavioral health conditions. Additionally shifting DMHAS from DHS would inhibit the coordination that currently exists among the various populations served by DHS for housing services with the
Home Mortgage Finance Authority (HMFA) and the Department of Community Affairs (DCA),
employment programs with the Department of Labor as well as jail diversion programs with the
AOC and the Office of the Attorney General to name a few. To the extent that these
collaborations are managed at the department level shifting DMHAS to Health would essentially
"orphan" people with behavioral health conditions from these partnerships.

Above all, at a time when our public behavioral health system is undergoing the transition to a
fee for service reimbursement system, the largest structural change that the behavioral health
system has undergone in decades, it is only prudent that we approach a restructuring of this
system in a thoughtful manner that includes the recognition that the state will be new state
leadership in January. NAMI New Jersey shares the hope with DMHAS that the move to fee for
Service will be a positive change for our behavioral health system, but we are also cognizant of
the concerns of many experience, behavioral health providers that the proposed reimbursement
rates will be inadequate to support our current level of behavioral health services and will result
in the closing of a number of agencies and the resulting loss of services for thousands of
consumers. The risk of creating added chaos to our behavioral health system by precipitously
shifting DMHAS to the Department of Health before proper study and planning is too great. We
encourage the legislature to vote to delay the reorganization plan until it can be fully vetted.

Thank you for the opportunity to share our thoughts on the move of DMHAS to DOH. We
remain available to participate in ongoing discussions on improving the coordination of
healthcare for people with behavioral health conditions.
New Jersey Senate Health Committee Hearing – July 25, 2017

Testimony of Cory Storch, CEO, Bridgeway Rehabilitation Services

Thank you Senators for the opportunity to share my concerns about the transfer of the Division of Mental Health and Addiction Services (DMHAS) from the Dept of Human Services (DHS) to the Dept of Health (DOH). My name is Cory Storch. I have 40 years of New Jersey community mental health service experience, starting as a rehabilitation counselor and now serving as CEO at Bridgeway Rehabilitation Services. Bridgeway is a specialty service organization that assists adults who have serious and persistent mental health conditions. Many of them have co-occurring chronic medical conditions and/or substance abuse problems. Bridgeway serves 2000 people across 11 counties in northern and central New Jersey. We have been an integral part of the Olmsted Initiative, helping hundreds of people transition successfully from state hospitals into the community.

I will limit my comments to two areas of concern: timing and the integration of medical and behavioral health services.

This is a proposal lacking input from community stakeholders – consumers, their families and their helping service providers. And the ambitious decision making timetable will hinder any meaningful dialogue. There will be significant unintended consequences.

It saddens me to say that the safety net we have worked so hard to put in place, with the support of state government and DMHAS in particular, is going to be torn into pieces because of the way the fee for service arrangement is being implemented. Services won’t just be disrupted. They will be significantly cut back for those most in need of support. As we all struggle to come to grips with this new payment system – and we are committed to find a way forward – this departmental transfer would come at the worst possible time.

Integration of all branches of healthcare is one of the benefits claimed by the authors of the DMHAS transfer. It looks good on paper. The Jacobi Report is quoted. And while this report has a laudable recommendation streamlining regulations of health clinics to facilitate the integration of medical and behavioral health care for people with mild to moderate conditions, the underlying problem of inadequate
reimbursements for integrated care is not mentioned in the Jacobi report. To be fair to Jacobi et al, it is not even included in their scope of work.

Perhaps the transfer proposal will lead to a better solution for integration. But as it stands now, from this observer—and Bridgeway is not just an observer but a participant in the federal primary care–behavioral health integration pilot program—the people in state government working on integrated care solutions are employees of the Department of Human Services. They have led the way, through the Olmsted Initiative and Behavioral Health Homes, to steer funding to the Medicaid recipients who are dying 25 years early, who are filling up our emergency rooms and hospital beds, and who are, with the exception of state hospital patients, whose care is the most costly to the state.

I have a bone to pick with the state decision makers at DMHAS but it’s about the fee for service implementation details. They are still the state officials who best understand that positive consumer outcomes come from a Supportive Housing approach—that is, pairing services with good housing and career development opportunities. They are directionally correct in where they want our service system to go. Unfortunately the “medically enhanced supportive housing (MESH) that New Jersey has built through innovative, DHS led initiatives, will wither away under the new fee for service reimbursement rates and rules. I am speaking as an expert on this as Bridgeway has more MESH services than any other service provider in New Jersey. Bridgeway and four other major MESH service providers met with senior DMHAS officials to show our projected budget deficits under the new system. The deficits will be in the millions. It will result in more people served in emergency rooms and hospitals. We asked for a solution and we believe the way forward is together—community stakeholders hand in hand with DHS and DMHAS.

A departmental transfer will exacerbate the fee for service disruptions facing service providers. It will not eliminate the real barriers to integrated care. Regulatory barriers are the lesser challenge. The lack of adequate reimbursement rates for integrated care that addresses the social determinants of poor health are the main problem. Decision makers need to include housing, education and jobs in the mix for effective solutions. These are complex issues and will need time to sort through. New Jerseyans with the most complex mental health conditions deserve a well thought out solution to sustainable service delivery. So do New Jersey tax payers. The proposed departmental transfer is not well thought out and needs more time for us to consider the options.
July 25, 2017

Good Morning, my name is Heather Simms. I would like to thank you all for taking the time to listen to my perspective on the proposed transfer of DMHAS from the Department of Human Services to the Department of Health. I have both lived experience and professional experience on the topic of addressing both mental and physical health care needs and the stigma associated,

I want to express my concerns with a move at such a critical time of change when both individuals receiving behavioral health services and providers are currently learning how to navigate the new fee for service billing specifically for community support services (CSS). 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 how to implement the services under the new requirements, at the same time we also have had to educate the recipients of the services about what this means and how to utilize the services. We have helped them learn the skills, gain knowledge and become linked to services that empower them to reach their valued life roles.

I feel to add more change now at the department level would be detrimental to the strides that have been taken to reach the successes I have seen in the lives of the people we provide services to.

I was diagnosed with Bi-polar Disorder shortly after the birth of my second child and received supportive housing services before returning to work. I have provided supportive housing services at Collaborative Support Programs of NJ (CSPNJ) for almost 15 years using the wellness and recovery focused approach. During this time, I experienced and worked with individuals who have faced the challenges of addressing both mental and physical health. I have also seen the impact that not addressing both can have on a person’s quality of life and ability to become a fully involved community member.

I personally was isolated, cycling from being overweight to underweight, experiencing horrific side effects of medication, alone and scared before receiving 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 been able to become a healthier, happier and more productive community member. I am now a peer provider, mother, wife and have been very involved in community youth sports. I am currently more active and mentally healthier than ever. This was achieved by learning both skills in how to advocate and effectively communicate my needs and concerns to both my mental and physical health providers. I have 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 change when I started my recovery. This provided an environment for success.
There have been many benefits of 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 DMHAS, service recipients and community based agencies in assuring we do not lose the voice of the individuals receiving services especially regarding the management of both their mental and physical health care needs during this time of transition. An organizational change into a new Department threatens continuity of services and would put peer inclusion and recovery at risk.
TESTIMONY ON BEHALF OF DISABILITY RIGHTS NEW JERSEY

On the Proposed Reorganization of the Division of Mental Health and Addiction Services
Before the Senate Health, Human Services and Senior Citizens Committee
and the Assembly Human Services Committee

July 25, 2017

Chairwoman Valinieri Huttle, Chairman Vitale, and Members of the Committees:

I appreciate the opportunity to express the concerns of Disability Rights New Jersey about the proposed transfer of the Division of Mental Health and Addiction Services from the Department of Human Services to the Department of Health.

DRNJ is the designated protection and advocacy system for people with disabilities in New Jersey. As the protection and advocacy system, DRNJ is concerned about access to programs and services for all of New Jersey’s residents, regardless of the disability.

DRNJ shares the goal of the effective integration of programs and services, and we are equally frustrated by the instances of lack of collaboration, coordination, and communication. It is important to note, however, that suboptimal relationships occur throughout government and the private sector, and that these systems are complicated and complex.

The Seton Hall report, which apparently provided some impetus for the proposed reorganization, looked at only one, albeit an important one, issue involving improving the delivery of treatment and services to the residents of New Jersey. The proposed reorganization addresses only a portion of the report’s recommendations, and probably not the most important recommendations.

The Seton Hall report cites an earlier study that concluded that “[t]he main barrier to sustain[ing integrated behavioral and physical healthcare] was financial.” These financial barriers include start-up costs, low reimbursement rates, and complicated reimbursement rules, such as the refusal to reimburse activities that are fundamental to integrated care but are not considered traditional medical care or therapy, the refusal to reimburse for two services (behavioral health and physical health) provided on the same day, or the refusal to reimburse for case management or peer support services. The proposed reorganization does nothing to address greatest barrier to integrated care – adequate financing.

Advocating and advancing the human, civil and legal rights of persons with disabilities

New Jersey’s designated protection and advocacy system for individuals with disabilities | Member, National Disability Rights Network
In fact, the Seton Hall report cautions against seeing reorganization as the simple solution, observing "[w]here there is overlapping jurisdiction, it is always possible to argue for consolidation." However, "separate agencies exist in state government in order to allow the aggregation of technical expertise at a scale appropriate to the effective protection of the health and welfare of the public;" therefore, "the urge to simplify the regulatory burden in one aspect of regulations must be counterbalanced with the importance of maintaining the centers of expertise represented by existing systems." Reorganization "should take place carefully and with some degree of planning, in order to ensure continued vigilance over the safety."5

The absence, until today, of any discussion, much less planning, about this proposal is particularly troubling. While moving the Division of Mental Health and Addiction Services into the Department of Health will unite it with some minor functions of that department, it will separate the Division from two of its major partners - the Division of Medical Assistance and Health Services and the Division of Developmental Disabilities. There has been no discussion of the impact of the proposed reorganization upon the coordination of services for, among others, individuals with developmental disabilities and autism and mental illness, or for individuals with traumatic brain injury and illness. Supportive Housing Connections, the Department of Human Services' Office of Program Integrity and Accountability (which monitors state institutions and community service providers), and the Human Services Police are examples of collaborative programs within the Department of Human Services that will be affected by a reorganization. There has been no discussion of the impact of the proposed reorganization on these programs.

Of even greater concern is the timing of this proposal. Both the Division of Mental Health and Addiction Services and the Division of Developmental Disabilities are in the beginning stages of the most significant system's change probably since the advent of Medicaid in the 1960s. Both Divisions are transitioning from contracts and relative financial predictability to fee-for-service and financial uncertainty. There is concern in both communities that the reimbursement rates and the way reimbursement for services is structured may have a serious negative impact on the access to needed services and supports for individuals with mental illness, developmental disabilities and autism, and substance abuse disorders. This is a time when the community and the state agencies need to be laser focused on the continued viability of the community service system and not distracted by a major reorganization that to date lacks any pre-planning.

The proposed reorganization requires more discussion and planning because, without more reassurance, the appropriateness of the Department of Health as a home for the Division of Mental Health and Addiction Services is suspect.

When the Division of Addiction Services was transferred to the Department of Human Services in 2004, the governor noted the unique role of the Department:
The Department of Human Services (DHS) is the principal State department for administering programs designed to meet the social and human needs for citizens. It has substantial experience in administering programs to provide medical, mental health and specialty services to our people, and in particular to the fragile and special needs segment of society.6

In 2007, the Division published its Wellness and Recovery Action Plan7 with its emphasis on rehabilitation, recovery, and community integration. The Department of Health is more comfortable with regulations, disease, and symptom reduction. The Department of Human Services funds services, while the Department of Health is more likely to administer grants.

The historic trend has been to move services out of the Department of Health: the Catastrophic Illness In Children Relief Fund in 1994,8 the Division of Addiction Services in 2004,9 and the Division of Aging Services in 2012.10

It has been the Department of Health that has required separate entrances, waiting rooms, and bathrooms for individuals seeking physical and behavioral health services. And while it has waived these requirements for ambulatory care facilities seeking to provide behavioral health services, it has not issued a similar waiver for mental health programs seeking to provide physical health care.11

The Commissioner of Health has also failed since 2005 to promulgate regulations implementing the New Jersey Advance Directive for Mental Health Care Act in psychiatric facilities it licenses.12

"Nothing about us without us" has been a consistent mantra of disability advocates. This proposed reorganization plan clearly violates that admonition. There should be no transfer until the full implications of the transfer of the Division of Mental Health and Addiction Services has been explained to and understood by the community. During that process, I would expect that alternatives can be identified that will achieve comparable results with a less drastic disruption existing institutions.

Your consideration and assistive in this effort would be greatly appreciated.

Joe Young
Executive Director
Testimony on Transfer of Division of Mental Health and Addiction Services to DOH
Valerie Sellers
Senate Health and Human Services and Assembly Human Services Committees
July 25, 2017

Good Afternoon, I am Valerie Sellers, Chief Executive Officer of the New Jersey Association of Community Providers
(NJACP). On behalf of the 54 agencies NJACP represents and the thousands of people our members serve with
intellectual and developmental disabilities, thank you for the opportunity to testify. NJACP has several concerns with
recently announced transfer of the Division of Mental Health and Addiction Services (DMHAS) from the Department

While people with intellectual and developmental disabilities access their services primarily from the Division of
Developmental Disabilities (DDD) in the DHS, many individuals with IDD also have a co-occurring mental health
diagnosis and must access mental health services from DMHAS. This population is referred to as having a "dual
diagnosis."

Those with a dual diagnosis receive mental health as well as IDD services. NJACP is concerned about individuals with
dual diagnosis “falling through the cracks” of a move at this time since no plan has been distributed to stakeholders
that identifies how services and supports will be maintained for this population during and after such a significant
move.

Importantly, NJACP is also concerned with the lack of transparency surrounding the determination to move mental
health services out of DHS. As mentioned above, NJACP is not aware of stakeholder involvement or discussion in
order to carry out the move in a planned, thoughtful manner.

Of substantial concern is that DDD and DMHAS are both currently undergoing considerable transitions to FFS, and
not all components of the transition have moved forward smoothly on either side. In a recent public meeting, DHS
Leadership described the DDD transition as complete systems change, not just simply a transition to FFS. The changes
include a new reimbursement model with new technology, agencies becoming Medicaid providers, which requires
new documentation and audit risks, changes in care management and a new system on the residential side, the
Supportive Housing Connection, will be utilized by both DDD and mental health providers. A similar transition is
occurring in mental health. Therefore, the timing of the decision is concerning in the context of the ability to conduct
systems change and deliver timely, quality services.
Also, DHS community services are key to quality, engaged lives for people, in both DDD and DMHAS. NJACP is unaware of discussion about how managing a community service delivery system "fits" in the DOH, which is not experienced in this area. Despite the transition of staff, new procedures and policies would be difficult to incorporate at this time of transition.

NJACP would appreciate the opportunity for stakeholder input into the move, which is essential in a complicated community services system. Those with Dual Diagnosis and their families should be aware of the plan for a seamless continuation of services to this vulnerable population and a move of this magnitude should be fully transparent with opportunities for meaningful stakeholder input. We hope you and Governor Christie will consider slowing down the process to allow for adequate planning and input to ensure uninterrupted services for vulnerable populations.

I would be happy to answer any questions from the committee and please do not hesitate to contact me with any follow up questions or information you may need at 609-406-1400.

Thank you for your consideration.
COMMUNICATIONS
WORKERS OF AMERICA
AFL/CIO
LOCAL 1040

CAROLYN C. WADE
President

230 PARKWAY AVENUE • TRENTON, NJ 08618-2914
(609) 538-6899
FAX: (609) 538-8868

MICHELE LONG-VICKERS
Executive Vice President

TESTIMONY TO THE ASSEMBLY HUMAN SERVICES AND THE SENATE HEALTH,
HUMAN SERVICES AND SENIOR CITIZENS JOINT COMMITTEE

Good morning members of the Assembly Human Services and the Senate Health, Human
Services and Senior Citizens Joint Committee. Thank you for this opportunity to communicate with you

My name is Carolyn C. Wade and I am President of CWA Local 1040. We represent
Administrative Clerical, Supervisory and Professional workers in the Division of Mental Health and
Addiction Services (DMH&AS) in the Department of Human Services. I address you today out of
concern for the Governor’s reorganization plan to move Mental Health and Addiction Services from the
Department of Human Services to the Department of Health. Let me preference my remarks
recognizing that opiate use is in Crisis; however, a well thought out plan must be promulgated to address
this crisis responsibly. The plan should be treatment driven by those who are committed and
experienced in the field.

The Governor’s proposal stressed integration as his rationale to move this Division to the
Department of Health (DOH). This Division (DMH&AS) is already integrated under the Department of
Human Services and the mission of this Division is being executed. It seems that the Governor’s
interest is solely on opiate use, however this Division’s mission encompass so much more. The DHS
are experts in meeting all Federal Criteria to insure a continuous flow of Federal funds to these hospitals.
The DHS has expertise in operating a twenty-four (24) hours, seven (7) day a week operation, of which
the DOH is unfamiliar.
What needs to be emphasized is that under the DHS, the DMH&AS address so much more than addiction. The vast majority of clients under this Division suffer from Mental illness. When they enter the door, however the addiction is generally the tertiary diagnosis. It is often difficult to tell if the mental health problems were caused by the addiction or the addiction was a way to self-treat the underling mental disease. This describes a fragment of the population; still there are others whose diagnosis maybe developmentally delayed with an underlying mental disease. The DHS has been and is equipped to deal with all of the varied diagnoses efficiently and effectively.

There is still another area that need to be emphasized in DMH&AS called the Special Treatment Unit (STU). This population is a very unique group of sex offenders who have served their time in prison but cannot integrate to the community because of a need for intensive mental health treatment and rehabilitative care. These clients are Megan Law implemented and require specialized treatment at STU. In addition, many of the DMH&AS clients are legally or Civilly committed and DHS is experienced in dealing with this clientele.

We can go on and on with the specialties provided by DMH&AS that have nothing to do with the use of opiate substance. However, it seems that the Governor is interested solely in addressing the opiate crisis. What will happen to those who are not opiate users?

The transfer of DMH&AS to the DOH will not effectively improve mental health or addiction services, but will redirect resources to the Governor's project. DHS is and had been equipped to coordinate the full spectrum of care for the New Jersey's most vulnerable population. They (DHS) not only treat the mind and body but also teaches the clients to reintegrate to the Community, providing and coordinating support and care after discharge to the Community.

To reorganize as proposed in Executive Order No. 001-2017 is irresponsible having only six months left in this term of office. This plan offers no emergent reason for such a transfer.

I urge you to pass concurrent resolution to stop this reorganization.
Testimony before the Senate Health, Human Services and Senior Citizens Committee and Assembly Human Services Committee

Response to Reorganization Plan No. 001-2017 Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health.

July 25th, 2017

Good Morning Chairman Vitale, Chairwoman Vainieri Huttle, and members of the Committees. My name is Susan Loughery and I am Director of Operations for Catholic Charities, Diocese of Trenton. Thank you for the opportunity to testify on behalf of Catholic Charities, Diocese of Trenton, on the Reorganization Plan to transfer mental health and addiction functions from the Department of Human Services to the Department of Health.

A brief overview of Catholic Charities, Diocese of Trenton: we serve 4 counties (Monmouth, Ocean, Mercer and Burlington) and provide a variety of services including specialized abuse and trauma counseling, mental health and addiction treatment, domestic violence services for victims and families, and concrete services such as housing, food and clothing to all in central New Jersey, regardless of religious affiliation.

Catholic Charities, Diocese of Trenton, employs 532 staff, of whom 57% work in behavioral health services. Each year we serve approximately 100,000 individuals. Of these, more than 4,000 individuals receive professional behavioral health services through our programs. Our programs include Outpatient, Substance Abuse Treatment, Psychosocial Rehabilitation, Crisis Intervention, Programs of Assertive Community Treatment, Employment, Residential and Supportive Housing Services. We provide Behavioral Health Home services and participate in the Certified Community Behavioral Health Clinic demonstration project.

There is significant empirical evidence to support the integration of behavioral health, addictions treatment and physical health. Specifically, early integration studies such as the PCARE Study (A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation [PCARE] study, Druss BG, von Esenwein SA, Compton MT, Rask KJ, Zhao L, Parker RM) demonstrate effective, holistic approaches for management of behavioral health and physical health conditions in community mental health centers. Data such that of the PCARE study shows that this integrated approach results in the reduction of symptomology for certain behavioral health conditions and improvement of certain chronic conditions such as metabolic syndrome. This approach results in reduced costs of care over the lifetime of the most vulnerable healthcare consumers.
and reduces the frequency of episodes of care in acute care settings. Therefore, the integration of services is critical.

Integration however must be carefully considered, as it does not simply reflect mergers of systems, departments and services. Considerations must also be given to (1) fiscal sustainability for services provided by safety net providers and (2) ancillary systems that address social determinants and mitigate disparities that impact health outcomes.

Fiscal sustainability for services provided by 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 significantly impede progress for the new system, by disrupting the synergy between claims, outcomes and measures data. Payment, service and reporting infrastructure must move in tandem in order to reduce data silos and achieve population health objectives.

Consideration must also be given to ancillary 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 limitedly through 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 of models such as the PACT teams. Since this type of work is done primarily in the community, it needs to be flexibly woven into the new system in order to achieve success.

The question is not why this should be done, it is how and when. The reorganization should be addressed in a carefully planned way in order to achieve maximum benefits of this effort. Comprehensive stakeholder engagement should be considered. Communication should be bi-directional and at regular intervals between governmental entities and the providers.

Thank you once more for the opportunity to participate in this critical discussion. I would be happy to answer any questions you may have.
I am Walter Kalman, Executive Director of the National Association of Social Workers for New Jersey, one of the largest chapters of NASW, which is the largest association of professional Social Workers in the world. I am here today speaking on behalf of over 20,000 Social Workers in New Jersey and the many, many thousands of clients we serve each day.

I am here to comment on the proposal by the Governor to transfer the Division of Mental Health and Addiction Services from the Department of Human Services to the Department of Health.

This proposal is the kind of 'punch in the gut' approach, for which this governor has become infamous, to a problem which requires a sustained, thoughtful, methodical solution in a systemic way which will achieve long term success for the citizens of New Jersey and their families who are equally the victims of the disease of addiction.

The end of an administration is not the time to rearrange the deck chairs to solve a problem, now suddenly deemed a crisis with lots of fanfare, which we in the helping professions, have recognized as a developing problem for many years. We do not question that the Governor has been profoundly affected by this problem touching close to home, but the recent recognition of a problem of which we have long been aware does not warrant a quick fix answer in the waning days of this administration.

Let us take the Governor's call to arms as a signal that the severity of the problem has now reached the highest office in the state and use that to inform and motivate the general public and begin a serious dialogue and planning effort to address this problem in a comprehensive manner.

As Social Workers, we learn to look at the person in their environment, examine the communities in which the person lives, works and recreates, seek out the resources and supports available to them, motivate and mobilize their strengths to address the problem. So too must government look at those aspects of the problem and organize and focus its resources in a meaningful process in search of a successful outcome for its citizens.

It's taken years, largely during this administration, to transfer the Division of Addictions from the Department of Health, a department largely known for its regulatory role over services, to the Department of Human Services, more engaged in the process of delivering services, and now it is proposed to reverse that entire process. Instead of all the bureaucratic energies required to facilitate such a change, we should be spending our efforts in analyzing, evaluating, refining and creating the services needed to confront this problem, and its many tentacles that reach throughout our communities.

I ask that your committees recommend that both houses of the Legislature pass a resolution to reject this reorganization proposal and instead propose a task force on addiction, such as was done in the administration of Governor Codey to develop a comprehensive plan to address the issues of mental health of which he has long been a champion. Such an effort would yield far better outcomes than would this short sighted effort which is more a temporary treatment than a careful prescription for a cure.
Testimony to the Assembly Human Services & Senate Health, Human Services and Senior Citizens Committee
Tuesday, July 25, 2017; 11:00 AM
Committee Room 4, 1st Floor, State House Annex, Trenton, NJ

Testimony 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."

Wayne E. Wirta
President and CEO
NCADD-NJ
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 (NCADD-NJ).

I wish to thank Senator Vitale, and Assemblywoman Huttle for holding this hearing on the proposed reorganization plan.

NCADD-NJ does not represent addiction treatment providers or treatment professionals. Our constituency is made up of individuals affected by addictive illness. As such, we can whole heartedly support Gov. Christie's desire to foster the integration of primary health care and behavioral health treatment. There's no question that a better integration of the two would result in better services for our population in many ways. It would also benefit the state through the reduction of health care costs that increased integration of services brings.

NCADD-NJ also strongly supports the notion that addiction is a health problem and not a criminal justice issue or simply a social problem. Admittedly, addiction impacts on both of those realms, but it is primarily a health issue. One of our agency's mottos is "Addiction Is a Disease, Let's Treat It That Way."

However, we are not convinced that simply moving the Division of Mental Health and Addiction Services out of the Department of Human Services and into the Department of Health will promote the integration of primary and behavioral health care. The fact is, the Division of Addiction Services was located in the Health Department for many years and no such integration took place.

Others today will be giving testimony regarding the potential administrative problems with the movement of the Division. Given these potential issues, it is our belief that further study needs to be made so that a comprehensive plan to better integrate primary and behavioral health care can be developed. Some sort of a mechanism, such as an inter-departmental task force, could be developed to study the issue. Certainly, if one of the recommendations from such a study suggested the movement of the Division of Mental Health and Addiction Services into Department Health would be an integral part of such a plan and would benefit those affected by addictive illness, we would certainly support that recommendation.

Thank you for your time and the opportunity to provide this testimony.
I strongly urge the Committees to elicit more input from stakeholders from NJ affected by this change. I would also suggest other states be contacted where similar reorganizations have occurred to determine if these changes had any improvements in client outcomes. Connecticut would be a good start as not too long ago they implemented a massive organizational change to deliver services for these individuals.

Thank You
The Partnership For A Drug-Free New Jersey

Statement supporting the reorganization plan transferring the Division of Mental Health and Addiction Services

Governor Christie's executive order to transfer the Division of Mental Health and Addiction Services from the Department of Human Services to the Department of Health is good public policy, particularly in addressing the issues of substance use disorders and the opioid and heroin epidemic.

Focusing on public health in addressing the opioid epidemic is critical to reversing this epidemic and bringing additional focus on the fact that addiction is a disease.

The reorganization will help eliminate stigma, expand emphasis on prevention efforts and allow for a more comprehensive cross-disciplined approach to what is clearly a multi-faceted public health crisis.

The Partnership for a Drug-Free New Jersey is particularly pleased that as we focus on the issue of substance use disorders from a disease perspective, like with all diseases, we will have an opportunity to assist New Jerseyans in taking steps to prevent the onset of disease of addiction.
New Jersey Psychiatric Association

July 19, 2017

Honorable Joseph Vitale
569 Rahway Avenue
Woodbridge, NJ. 07095

Honorable Valerie Vainieri Huttle
1 Engle St., Suite 108
Englewood, NJ 07631

Re: REORGANIZATION PLAN NO. 001-2017- "Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health"

Dear Chairman Vitale and Chairwoman Vainieri Huttle:

On behalf of the physicians of the New Jersey Psychiatric Association, we thank you for the opportunity to provide the following comments regarding Reorganization Plan 001-2017 as proposed by the Governor.

The New Jersey Psychiatric Association supports the "Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health" as it is in keeping with the principles of parity and integrated collaborative care. That said, we do urge both the Administration and Legislature to:

1. Remain attentive to limiting the negative impact on patient care while implementing the transfer process;
2. Solicit input from stakeholders including psychiatrists and patient advocates to define the potential impact on patient care; and
3. Advise stakeholders of each step in the process in a timeframe that allows them to participate in the transfer process with the intent of ensuring minimal impact on the delivery of care.

We thank you in advance of these comments, and as always NJPA looks forward to our continued partnership in working to improve patient care for all of New Jersey's patients.

Sincerely,

Randall B. Gurak, MD
NJPA President

Cc: Senate Health, Human Services & Senior Citizens Committee
Assembly Human Services Committee
July 24, 2017

Senator Joseph F. Vitale, Chair
SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS
Assemblywoman Valnieri Huttle, Chair
ASSEMBLY HUMAN SERVICES

Ms. Diane Riley
Executive Director

Senator Vitale, Assemblywoman Huttle and members of the committees. My name is Diane Riley and the agency I direct, the Supportive Housing Association of NJ (SHA), is an 18 year old membership organization of over 100 agencies all dedicated to creating permanent, affordable housing with supportive services for people with special needs. Thank you for giving me the opportunity to submit testimony today. I wish to specifically address the Governor’s Reorganization Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health. SHA does not support the proposed plan at this time and urges the legislature to disapprove this proposal. Moving forward, the integration of behavioral and physical health services will be critical to providing the best support for those suffering from mental health or addiction illnesses. How best to integrate these services is a question that needs careful consideration. In this case careful consideration has not been given. Of great concern is the ultimate goal of delivering services to those who need it. Should this order take effect at this time, these services could be at risk.

While this hearing is not the place to discuss the pros or cons of such a move. I will name three areas of concern. First, is in the area of housing. Over the last year a great shift in the management of housing services for people with special needs has taken place. The Supportive Housing Connection, a partnership between the New Jersey Housing and Mortgage Finance Agency (HMFCA) and the New Jersey Department of Human Services (DHS), was formed to administer DHS rental subsidies to individuals served by DHS. The individuals include both individuals served under the Division of Developmental Disabilities (DDD) and the Division of Mental Health and Addiction Services (DMHAS). Moving DMHAS to the Department of Health will certainly make this a more complicated arrangement. The management of housing subsidies to the Supportive Housing Connection is still in its implementation phase. The next year or two will be an important time of stabilization and not the time for more changes. Secondly, NJ Medicaid’s functioning is a consideration. NJ Medicaid is under the purview of the Division of Medical Assistance and Health Services under the Department of Human Services. There are many outstanding questions and concerns to be considered regarding how the proposed move will affect those receiving services through NJ Medicaid under these two different Departments. Of additional consequence are individuals diagnosed dually as those who have developmental disabilities and those having mental health needs. Service delivery to these individuals will have specific challenges and a very thorough examination is needed so that these individuals will not fall through the cracks.

185 Valley Street, South Orange NJ 07079  Diane Riley  908.931.1131
diane.riley@shanj.org
Finally, and most significantly, the community-based behavioral health system is in the midst of an already disruptive shift away from contract billing to the Medicaid billing reimbursement system known as “fee for service”. Both committees have heard testimony to the effects of this transition and its anticipated strains to community based providers. State agencies monitoring and supporting such systems have expended and will need to expend an inordinate amount of time and attention to this transition in order to continue to provide services. It is essential that this attention on the part of providers and state agencies be focused and not sidetracked by any other planned move or transition.

These are but a few of the concerns that SHA has in the proposed move at this time. As a member of the New Jersey Mental Health Coalition, we affirm that the impact of the proposed reorganization needs to be thoroughly examined to determine whether the move will result in better integration of behavioral health and physical health services or whether integrated services can be achieved in other ways without other detrimental consequences. All affected stakeholders should be given an opportunity to comment on the proposal so as to achieve the best outcomes for individuals with mental health and addiction as well as other service needs.

Thank you for your consideration.
Sincerely,

Diane Riley
Executive Director

185 Valley Street, South Orange NJ 07079 Diane Riley 908.931.1131
diane.riley@shanj.org
New Jersey Mental Health Coalition

Statement on Reorganization of the Division of Mental Health and Addiction Services

July 2017

The New Jersey Mental Health Coalition is a collaboration of eleven statewide mental health consumer, provider, and advocacy organizations concerned with New Jersey’s public mental health system and the mental health needs of New Jersey citizens.

The Mental Health Coalition encourages the Legislature to disapprove at this time Governor Christie’s proposal to remove the Division of Mental Health and Addiction Services from the Department of Human Services and reassign it to the Department of Health.

While the Coalition supports improved integration of behavioral and physical health services, such a major reorganization should not be attempted while the community-based behavioral health system is in the midst of an already disruptive transition to fee-for-service. During this transition, it is critical that both the community-based behavioral health providers and the state agencies monitoring and supporting the transition be focused solely on ensuring that community providers maintain their viability and individuals in need of services continue to receive those services.

The Coalition also believes that the impact of proposed reorganization needs to be thoroughly examined, and all the affected stakeholders be given an opportunity to comment on the proposal, including ways to achieve integrated services while a review of the plan is undertaken.
# New Jersey Mental Health Coalition

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coalition of Mental Health Consumer Organizations</td>
<td>Wayne Vivian</td>
<td><a href="mailto:COMHCO@aol.com">COMHCO@aol.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:mhcaw@aim.com">mhcaw@aim.com</a></td>
</tr>
<tr>
<td>Collaborative Support Programs of New Jersey</td>
<td>Jody Silver</td>
<td><a href="mailto:jsilver@cspnj.org">jsilver@cspnj.org</a></td>
</tr>
<tr>
<td>Community Health Law Project</td>
<td>Erika Kerber</td>
<td><a href="mailto:EKerber@chlp.org">EKerber@chlp.org</a></td>
</tr>
<tr>
<td>Disability Rights New Jersey</td>
<td>Joe Young</td>
<td><a href="mailto:jyoung@DRNJ.org">jyoung@DRNJ.org</a></td>
</tr>
<tr>
<td>Mental Health Association in New Jersey</td>
<td>Carolyn Beauchamp</td>
<td><a href="mailto:cbeauchamp@mhanj.org">cbeauchamp@mhanj.org</a></td>
</tr>
<tr>
<td></td>
<td>Barbara Johnston*</td>
<td><a href="mailto:bjohnston@mhanj.org">bjohnston@mhanj.org</a></td>
</tr>
<tr>
<td>National Alliance on Mental Illness New Jersey</td>
<td>Sylvia Axelrod</td>
<td><a href="mailto:saxelrod@optonline.net">saxelrod@optonline.net</a></td>
</tr>
<tr>
<td></td>
<td>Phil Lubitz</td>
<td>plubitz@namnj</td>
</tr>
<tr>
<td>National Association Of Social Workers – New Jersey</td>
<td>Walter Kalman</td>
<td><a href="mailto:wkalman@naswnj.org">wkalman@naswnj.org</a></td>
</tr>
<tr>
<td>NJ Association of County Mental Health Administrators</td>
<td>Robin James</td>
<td><a href="mailto:rjames@hcnj.us">rjames@hcnj.us</a></td>
</tr>
<tr>
<td>NJ Association of Mental Health and Addiction Agencies</td>
<td>Debra Wentz</td>
<td><a href="mailto:Dwentz@njamhaa.org">Dwentz@njamhaa.org</a></td>
</tr>
<tr>
<td></td>
<td>Shauna Moses</td>
<td><a href="mailto:Smoses@njamhaa.org">Smoses@njamhaa.org</a></td>
</tr>
<tr>
<td></td>
<td>Mary Abrams</td>
<td><a href="mailto:Mabrams@njamhaa.org">Mabrams@njamhaa.org</a></td>
</tr>
<tr>
<td>NJ Psychiatric Rehabilitation Association</td>
<td>Kim Higgs</td>
<td><a href="mailto:khiggs@njpra.org">khiggs@njpra.org</a></td>
</tr>
<tr>
<td>Supportive Housing Association of New Jersey</td>
<td>Diane Riley</td>
<td><a href="mailto:Diane.riley@chanj.org">Diane.riley@chanj.org</a></td>
</tr>
<tr>
<td>Children's System of Care</td>
<td>Richard Hlavacak</td>
<td><a href="mailto:richardh@factnj.org">richardh@factnj.org</a></td>
</tr>
</tbody>
</table>

*Chair, NJ Mental Health Coalition*
The New Jersey Prevention Network (NJPN) is a public health agency working to create healthier communities by reducing the burden of substance abuse, addiction and other chronic disease.

Our vision is a healthy New Jersey supporting wellness one person and one community at a time. Over the 20 years since our inception, NJPN's mission has evolved from a primary substance abuse prevention focus to a comprehensive public health focus. This transition was strongly supported by the National Prevention Strategy, developed in 2011 to move the Nation from a focus on illness to a focus on wellness.

The recommendation to move the Division of Mental Health and Addiction Services under the Department of Health supports the National movement to integrate physical health and behavioral health to coordinate and improve the systems of care. From the prevention perspective, it follows best practice as well. The National Prevention Strategy, noted above, documents the importance of going up stream to identify the root causes of chronic disease which often mirror root causes of community health. It defines and reinforces the importance of addressing these issues with a comprehensive plan that supports the whole person's movement toward wellness while providing a roadmap to improving population level health. It outlines best practices to address chronic disease by supporting: wellness, active living, social & emotional development, prevention of drug and alcohol misuse and tobacco-free living. The primary lesson generated from the National Prevention Strategy is to focus on a comprehensive community health approach to more effectively encompass both system and community changes that will drive significant health outcomes.

NJPN has experienced the benefits of working with systems supported by both the Department of Human Services and the Department of Health. Both Departments have aided our efforts to integrate individual-focused substance abuse prevention with community-level health policies, practices and programs. NJPN understands and agrees with bringing the Division of Mental Health and Addiction Services under the Department of Health. This move from service to health will make a big step toward true integration that allows NJ providers, like NJPN, to continue to find new synergistic opportunities to promote health and wellness by utilizing population health strategies to improve the community conditions that support the health of the whole person.

Additionally, the transition of addiction-focused services under the umbrella of the Department of Health is a significant statement to the healthcare field that issues of addiction are issues of overall health. Thus, creating opportunity for health care professionals to become further educated and more knowledgeable about addiction. Though the transition timing may be challenging, the true integration of mental health and addiction services into the physical health system is essential to create a “no wrong door” healthcare system that will allow those in need of mental health and addiction prevention, intervention, treatment or recovery services the same access to care as any other patient.
Regarding a Plan for the Transfer of Mental Health and Addiction Functions from the Department of Human Services to the Department of Health

Joint Meeting of the Assembly Human Services and Senate Health, Human Services and Senior Services Committees

July 25, 2017

The New Jersey Hospital Association (NJHA) is a not-for-profit trade association committed to helping its members deliver quality, affordable and accessible healthcare to their communities. On behalf of NJHA and our nearly 400 hospital and post-acute members, thank you for the opportunity to provide comments on Reorganization Plan 001-2017 (Plan), the transition of the Division of Mental Health and Addiction Services from the Department of Human Services (DHS) to the Department of Health (DOH).

More than one third of medical patients have a co-occurring mental health or substance use disorder diagnosis in the inpatient setting. This epidemic is growing and we need to continue to provide more help to the patients seeking these vital services. NJHA has been engaged in bipartisan legislative and administrative solutions to achieve this end, but much more needs to be done.

The proposal outlined above and discussed today has elicited many reactions from stakeholders across the continuum of care, including our members. We are currently reviewing the details of the proposal and are very grateful for this hearing to help provide some more details of the proposal. While our Board of Trustees has yet to meet to discuss our position on the proposal, several members have offered the following questions and concerns that we wanted to share with the committee.

Programmatic Integration — Longstanding has been DHS’ ability to collectively address issues where clinical need, practice, wraparound supports and payment intersect. With certain services remaining in DHS while others make the shift to DOH, concern exists that policy will not be integrated across departments and their divisions. For example, efforts to shift payment models (fee-for-service, partial hospital programs, transport) have only progressed when department staff from the Division of Medical Assistance and Health Services (Medicaid), DMHAS and stakeholders work collaboratively. Spreading the responsibility across two departments raises concern about the ability to efficiently implement these changes. Among the provider community there is mixed concern on how the separation of policy and payment oversight would be affected.

Equally concerning is the further separation of services intended for those at highest risk of need. In 2006, the Department of Children and Families was created, dedicated to safeguarding the most vulnerable children and families in New Jersey. Responsible for the system of children’s mental health care, services remain separate and distinct from their counterparts in the
adult system. With this reorganization keeping services for the developmentally disabled in the DHS, there will be now three cabinet-level departments responsible for the care of the state's most vulnerable individuals.

**Timing** – The system of care is currently undergoing a shift in fee-for-service funding and other community programming. There have been mixed reports on those transitions, the way in which changes are occurring, and system issues that providers and state agencies may be facing. The timing of such a large undertaking could risk successful implementation while disrupting other transitions already underway.

**Specificity** – Without exposition of the details surrounding the programmatic transition, specific goals and budget implications, it is difficult to understand fully any impact that the transition may have on service provision and continuity of care for individuals in need. Certainly any resulting reduction to the programmatic scope or budget of these vital functions would be of serious concern.

We appreciate the ability to offer these questions and concerns on behalf of our membership and we look forward to a continued dialogue with policymakers on this issue.
July 25, 2017

Dear Senator Vitale & Assemblywoman Huttle,

Thank you for hosting today’s hearing about 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 (DOH).” As you know, individuals with intellectual and developmental disabilities (I/DD) who also have mental health issues, receive their services via the Division of Developmental Disabilities, and their health and some mental health services via Medicaid managed care plans, within the Department of Human Services. Should the transfer of the Division of Mental Health and Addiction Services (DMHAS) to the Department of Health move forward as proposed, we want to ensure that those we represent continue to receive the critically-important services they rely on in order to live in the community. People with both I/DD and mental health issues, or as they are often referred the dually diagnosed, require a delicate balance of services, especially for behavioral challenges.

As you vet the proposal put forth by the Governor, The Arc of New Jersey urges you to consider all the populations that receive services through DMHAS, especially those with I/DD. We want to ensure that coordination between the two Departments is seamless and that those served do not experience a gap in service or an increase in bureaucratic regulation that will make it harder for them to access needed mental health supports in a timely manner. We are grateful to you for hosting today’s meeting and we ask that you continue to examine and investigate the real life impacts this proposal will have on vulnerable populations, specifically those with intellectual and developmental disabilities.

Thank you for making this issue a priority for the Senate Health, Human Services and Senior Citizens Committee and the Assembly Human Services Committee. We look forward to a robust conversation and your continued work on this matter.

Sincerely,

[Signature]

Tom Baffuto
Executive Director

For people with intellectual and developmental disabilities
Senator Vitale, Assemblywoman Huttle, Committee Members, Former Colleagues:

Thank you for the invitation to submit testimony for your consideration at this important hearing to discuss the Governor's recent Executive Order. I testify as someone who has served in several capacities throughout my entire career in the mental health and addiction field. As a Certified Prevention Specialist since 1996, I am intrigued by the Division of Mental Health and Addiction Services moving to the NJ Department of Health. Addiction and mental illness are public health issues and this move would recognize that on a more universal level. Behavioral health integration into the general health world is a necessity if we are ever going to make substantial and sustaining in-roads into healthy communities. Historically Department of Health has had a much greater focus on prevention of many diseases and for that, I would be excited about DMHAS moving to DOH. I expressed this to Commissioner Bennett recently.

But, as a practical matter, and as a CEO of Preferred Behavioral Health Group, I must state my concern and urge caution in making such a wide sweeping change at this particular time of DMHAS changing its funding structure to a fee for service environment which began for the majority of community agencies on July 1, 2017.

Most of the people we serve are Medicaid recipients. Besides mental illness and addiction, many of these individuals and families have several other issues that need addressing such as housing, employment, and medical needs. My concern is that the clients will experience a fragmented system of care as some services will be through DOH and some through DHS, since only DMHAS and licensing is moving to DOH and Medicaid remains in DHS. These individuals are in our system due to their complexities. Having them maneuver a disjointed system will present obstacles for many. As a former Legislator, I know well the speed or lack thereof when bureaucracies are challenged or changed. My fear is that taking this step will not be welcomed by mid-level DOH employees and this may very well delay and challenge the move.

Although full integration of behavioral and general health has been discussed for years, but slow to become practice, it is my understanding that a goal of NJ's Medicaid Waiver is to promote and advance physical health care integration by expanding behavioral health homes.

Overall I am not 100% 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 NJ substantially more due to visits to the hospital emergency rooms. That being said, if the plan moves forward, I will commit to assisting in any way necessary for successful implementation.

Thank you for this opportunity to testify.

Mary Pat Angelini, M.P.A., C.P.S.
I believe, based upon my own experiences as Commissioner of the Department of Human Services for three different Governors, and during that time overseeing the transfer of Divisions from one Department to another, and currently serving as the Chairman of the Boards of the Mental Health Association in New Jersey and the National Council on Alcohol and Drug Dependence, - NJ, that the current Governor's proposal to move the Division of Mental Health and Addiction Services to the Department of Health above is both ill-conceived and problematic at this time.

I do respect the Governor's commitment to effectively address the epidemic of opioid abuse and his apparent desire to frame this issue as one of public health. I also respect the apparent effort to better coordinate behavioral and primary health care which, if effective, would undoubtedly reduce the disparities of mortality and morbidity of individuals suffering from these problems. Yet, moving the boxes in the bureaucracy at this late date through the mechanism of the Executive Reorganization Act without a very full and deliberate examination of all the necessary issues and data is a disservice to those it intends to help. I have stated some concerns I have based on my own experience below.

Historically and currently, the Department of Health performs predominately a regulatory and oversight function for health policies and programs. They do it well and this is their strength. Human Services, on the other hand has the strength and history to conduct wide scale operations serving tens of thousands of residents in institutional and community settings. It took literally years of leadership experience and building strategic and management capacity to do this well. The learning curve for the Health Department to do this will be long and dangerous to clients.

In addition, I have found the actual process of transfer is fraught with interagency conflict (who gets or keeps specific appropriations, staff, computers, buildings, etc.) and extensive bureaucratic detail. Both departments have shrunk in staff over the years due to hiring freezes, early retirements, loss of institutional memory etc. and may lack the depth, strength and capacity to conduct an orderly transfer and perform their currently mandated responsibilities. I know the DMAHS is currently transforming their contracting system to move to a unit cost framework and ultimately a managed care approach. This is truly a "heavy lift".

From a study recently conducted at Rutgers, it turns out that the population using the greatest amount of Medicaid funds are persons with behavioral health issues that are often homeless, unemployed and heavy users of hospital emergency room care. In order to both serve these individuals effectively and control costs, the social determinants of care for these individuals must be addressed. The latter services are clearly under the purview of the Department of Human Services which presents far greater opportunity for the integration that is needed.

Finally, the DMAHS uses extensive amount of Medicaid funds to finance its operations and services. Controlling Medicaid costs while preserving quality and access is both a national and state priority. Truncating Medicaid policy, oversight and funding priorities will make it even more difficult to achieve this end and will be a recipe for conflict and even failure.

Perhaps a number of the concerns above may be addressed but I am convinced we will not achieve the outcome we all want absent an inclusive, comprehensive data-driven and bi-partisan approach. I believe the residents of our State deserve no less.
Any consideration given to my thoughts on this issue as expressed above will be greatly appreciated. Please note I am submitting these as my own views which do not necessarily reflect those of the two organizations whose governing bodies I chair as noted above.

Sincerely,

William Waldman, MSW, CSWM  
Professor of Professional Practice  
Rutgers University School of Social Work
The Honorable Joseph F. Vitale  
Chair, Senate Health, Human Services and  
Senior Citizens Committee  
569 Rahway Avenue  
Woodbridge, NJ 07095

The Honorable Valerie Vainieri Huttle  
Chair, Assembly Human Services Committee  
1 Engle Street, Suite 108  
Englewood, NJ 07631

Dear Chairman Vitale, Chairwoman Vainieri Huttle and members of the committees:

Thank you for your invitation to appear before the Senate Health, Human Services and  
Senior Citizens Committee and the Assembly Human Services Committee meeting on Tuesday,  
for the Transfer of Mental Health and Addiction Functions from the Department of Human  
Services to the Department of Health.”

Transferring mental health and addiction services to the Department of Health is  
necessary to improve health care by allowing the Department to treat mental health and  
addictions no different than infectious and chronic diseases, like Zika, asthma, heart disease or  
diabetes. This plan to transfer the responsibility for mental health and addiction-related functions  
to the Department will give it both the power and resources to focus on integrating physical and  
mental health care, improving access to both types of care, and confronting opioid addictions as  
a public health crisis. Unfortunately, I will be unable to attend this hearing due to a long-  
standing commitment out-of-state on that date but have prepared my written testimony.

I thank you for the invitation and if you have any questions about my testimony, please  
do not hesitate to ask.

Sincerely,

Cathleen D. Bennett  
Commissioner
NJ Health Commissioner Cathleen D. Bennett Testimony
Joint Hearing Senate Health, Human Services and Senior Citizens Committee
and Assembly Human Services Committee
July 25, 2017

Chairman Vitale, Chairwoman Vainieri Huttle and members of the Senate Health, Human Services and Senior Citizens Committee and Assembly Human Services Committees, I am unable to testify before you today due to a previous commitment to attend a Health Policy Advisors Institute out of state. However, I want to provide you and those invited here today with some information about the importance of the Governor’s Reorganization Plan.

Helping healthy New Jerseyans stay well, preventing those individuals at risk from getting sick, and keeping those individuals with chronic health conditions from becoming sicker—what we call Population Health—is a key focus not only for the New Jersey Department of Health, but also for our health care and community partners around the State.

Our focus on Population Health goes hand in hand with the philosophy at the heart of the Governor’s Reorganization Plan—integrating physical, mental and substance use disorder health care. As our Region 2 Substance Abuse and Mental Health Services Administrator noted, integration is critical if we are going to make progress in Population Health, and this reorganization highlights the importance of treating health across the spectrum.

Considering one of the main missions of the department is Population Health, it is impossible to meet the needs of all New Jerseyans by focusing only on their physical health. Mental illness and addictions can influence the onset, progression, and outcome of other illnesses and often correlates with health risk behaviors. The CDC estimates that half of American adults will develop a mental illness during their lifetime, that in any given year, 25% of American adults experience a mental disorder, and that 1 in 17 American adults lives with a serious mental illness. A CDC report found that chronic diseases, including diabetes, obesity, and cardiac disease, are associated with mental illness.

Similarly, people who suffer from addiction tend to also have one or more co-occurring health issues—chronic diseases, such as cardiovascular disease and cancer; infectious diseases; or mental disorders. A public health crisis in Indiana serves as a recent example of how addiction can lead to further illness. An increase in injection of opioids caused HIV and hepatitis outbreaks in rural Indiana in 2015—leading their Governor to declare a public health emergency in the state. Health experts predict the lifetime cost of treatment for those individuals impacted could reach $58 million. Likewise, ensuring that pregnant women who use substances find the help they need to deliver a healthy baby is another critical area where physical and behavioral health care intersect.

Many frequent users of Emergency Departments have behavioral health conditions. Appropriate community-based care of their total health needs can reduce reliance on expensive hospital-based care, according to a 2016 study by Seton Hall Law School.
The study also found that people with serious behavioral health conditions suffer due to lack of access to primary care, while people with mild to moderate behavioral health conditions—too often unconnected to behavioral health care—could benefit from care delivered in primary care settings. Mental and substance use disorder health care should not be treated any differently than chronic diseases like diabetes or heart disease although, at times, the health care providers may be different.

Research demonstrates that integrating mental, substance use disorder and physical health care is the most effective way to treat the “whole person.” It results in improved health outcomes for patients, while reducing the cost of care. As Greg Paulson, Executive Director of the Trenton Health Team, said “with the reorganization, the integration that we have been talking about will be advanced.”

In addition, Kennedy Health President & CEO Joseph W. Devine, believes “there is no longer a practical reason for the separation of two individual agencies to oversee health services, and mental/addiction services. The needs and services provided in these areas must be interconnected to ensure the best delivery of care to New Jersey residents. Achieving this proposed combination will provide an oversight authority, which, in turn, will enable healthcare providers to collaborate more effectively and make an impactful change for the people of New Jersey.”

The transition to designate the Department of Health as the single state agency to perform the administrative and operational functions of mental health and addiction services will expedite the important integration of physical, mental and addictions health management. As the state’s public health agency, the Department of Health can identify risk factors, increase awareness about behavioral health and the effectiveness of treatment, reduce health disparities, and, ultimately, remove the stigma that prevents people from seeking and receiving the care they need.

Existing regional collaboratives such as the South Jersey Behavioral Health Collaborative, Trenton Health Team, the Greater Newark Health Care Coalition, the Camden Coalition and, most recently, the Passaic County Health Coalition, have demonstrated that a proactive and coordinated approach within regions can significantly impact health care delivery and outcomes.

In rural Tennessee, Cherokee Health Systems has become a national model for integrating primary care and behavioral health services at 22 Federally Qualified Health Care Center sites. A behavioral health care team is embedded in its primary care practice, and its success has been recognized by the U.S. Agency for Healthcare Research and Quality. A study of Cherokee's interdisciplinary team approach by Blue Cross and Blue Shield of Tennessee found a 68% decrease in emergency room visits, a 32% decrease in referrals to specialists, and an overall 22% reduction in cost.

Recognizing the need for better integration, the Department of Health has already granted a waiver allowing community health centers licensed by the Department to add behavioral health in shared clinical space. This reorganization will allow the department to take the next steps to ensure the on-going integration of care.
There is no question that the task ahead is challenging, and we understand the concerns that have been articulated by some stakeholders. But this reorganization is the first step in advancing a new system of integrated care. As part of this transition, the Department will gain the expertise of the management team and staff who currently work in and supervise the psychiatric hospitals and oversee hundreds of mental health and substance use disorder contracts. This expertise will add to the Department’s long history of distributing hundreds of millions of dollars in grant funding each year to early interventions services providers, cancer education and early detection providers, community health centers, health care facilities, local health departments and faith- and community-based partners. In each of the last two years, the Department distributed $1.5 billion in grant funding annually.

Creating a more efficient and coordinated system of care that treats the whole person is the right move for New Jersey and especially for patients who will benefit from having their behavioral and physical needs met in the same hospital clinic or community health center.

Many county mental health and substance use disorder directors and community health centers have expressed support for integration and have offered their assistance during our calls with them over the past couple of weeks. They recognize that we need to foster integration in the physical and behavioral health care community and the best way to do that is to lead by example.

In collaboration and coordination with our partners, we need to create a patient-centered system that meets the needs of all patients and does not cordon off behavioral health from the rest of health care.

We look forward to working with you and all of our stakeholders as we move forward.

Thank you for the opportunity to provide testimony on this important Reorganization Plan.