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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Agency Unification

418 Main Capitol Building – Harrisburg, PA

June 5, 2017

AGENDA

11:00 a.m. Welcome and Opening Remarks

11:10 a.m. Panel of State Officials:

- Teresa Miller
  Secretary Designee
  Pennsylvania Department of Health and Human Services

- Eric Hagarty
  Deputy Chief of Staff
  Office of Pennsylvania Governor Tom Wolf

- Meg Snead
  Deputy Secretary of Policy
  Office of Pennsylvania Governor Tom Wolf

- Jen Swails
  Special Advisor to the Secretary
  Pennsylvania Office of the Budget

12:20 p.m. Closing Remarks

www.governor.pa.gov/health-and-human-services

THE FOLLOWING STATEMENTS WERE SUBMITTED TO BE ENTERED INTO THIS HEARING'S OFFICIAL RECORD

COUNTY COMMISSIONERS
Association of Pennsylvania

TO: Members of the House Democratic Policy Committee

FROM: Brinda Penyak, Deputy Director

DATE: June 5, 2017

RE: **CCAP Comments on Proposed Human Services Agency Consolidation**

On behalf of the County Commissioners Association of Pennsylvania (CCAP), we write today to share our comments regarding the Governor's proposal to consolidate the Departments of Aging, Drug and Alcohol Programs, Health, and Human Services into a single Department of Health and Human Services.

Counties are uniquely positioned as key partners with the state in the delivery of a broad set of human services to all of the commonwealth's citizens, including mental health, intellectual disabilities, children and youth services, drug and alcohol programs, nursing homes and long-term care, housing and juvenile justice services. While CCAP has not taken a position on the Governor's proposal, the Association is committed to exploring opportunities to incorporate strong state-local relationships and innovative approaches toward meeting county service goals.

To that end, working together with our six human services affiliate organizations, CCAP has developed what we believe are the basic and necessary components that must be in place and adopted system-wide prior to implementation of a unified model. First and foremost, counties believe that the goals of any change made to the structure of government must be service-recipient centered and not driven by advocacy groups, as the goal must be to assure ongoing service provision of the many programs impacted. In addition, counties must remain in the forefront of delivery models that may result from this transition and must be at the table as those plans are developed because counties are closest to the people who rely on critical services.

Below you will find additional detail regarding those elements the Association believes must be incorporated into any unification effort. Following that, you will find a number of ways we have identified opportunities for enhanced partnership and cooperation to assure improved services and access for service recipients of the various human services systems.

Basic, Necessary Components of a Unified Model – The following are key components that must be in place and adopted system wide prior to implementation of a unified model, noting that first and foremost CCAP believes that the goals of any change made to the structure of government must be service-recipient centered and not driven by advocacy groups. The goal must be to assure ongoing service provision of the many programs impacted and not be a means of shifting costs to counties.

- Counties must remain in the forefront of delivery models that may result from this transition, and CCAP and their human services affiliates must be at the table as those plans are developed because counties are closest to the people who rely on critical services.
- Counties must retain the option of selecting the form and structure of local human services delivery. A "one-size-fits-all" approach mandated upon counties would be opposed.
- The implementation plans for the new agency must include a clear, concise and consistent methodology for assuring that county government remains a key stakeholder whenever decisions are made about our joint constituencies and the provision of services.
- CCAP believes that the commonwealth should work with counties to develop partnerships to assure that all care recipients are advised of services options and the means to access those services.
- CCAP strongly urges an understanding and agreement that involvement of counties in decisions for addressing concerns or requests of federal regulating and funding entities must include counties at the earliest possible time. For instance, if CMS is suggesting a program disallowance, the new DHHS must consult with county leaders to assure that counties have the ability and capacity to comply with procedural changes before a commitment is made to CMS. Further, counties may be able to offer alternatives that retain local connections for constituents while still meeting the federal demands. Examples include recent decisions to contract for services formerly provided by county entities to assure CMS that no conflicts exist.
- CCAP believes that the provision of substance abuse services and other prevention, policy and licensure functions would be enhanced through adoption of legislation that provides statutory authority to the Single County Authorities and renames them as the Offices of Prevention and Addiction Services. The Offices of Prevention and Addiction Services would continue to be the local entity responsible for the planning and implementation of a full continuum of services based on locally identified need. Legislation would be patterned after the statutes governing other human services programs and provide stability and a more clearly defined duty that is a vital component of a unified service delivery system.
- CCAP believes that the commonwealth must designate a specific person/position to serve as a liaison between departments to address overlapping concerns, to ensure regular meetings while plans for implementing the unification are developed, and to continue this role throughout the implementation phase.
- CCAP believes that the commonwealth must develop and present a plan for how coordination between departments with similar interests will be maximized under the unification.
- CCAP believes that the organizational structure of a unified agency must include a clearly defined pathway for a designated representative to communicate state and federal policy

concerns and needs directly to the Governor. Specifically, a clearly defined role for an individual representing the concerns of older adults with access to the Governor must be included to assure that funding and regulatory goals do not outweigh the advocacy role of the current Department of Aging. CCAP believes a similar focus on advocacy for addictions services should be included so that policy issues can be brought directly to the Governor.

- CCAP believes there must be a strong commitment to develop policy from an integrated mindset and work with legislators to help shape expectations.
- CCAP believes that there must be regular and open communication between the new department and County agencies and that discussion must take place before decisions are made that commit counties to mandates or budgetary cuts. Under no circumstances should state administrative agencies or departments be considered to be speaking on behalf of the counties.
- CCAP believes that communication must be enhanced between DOH and DHS with regard to nursing facilities. There are funding and programmatic concerns (DHS) that affect licensing (DOH), but there is no demonstrated practice that suggests the two entities coordinate or discuss policy regularly. Unification plans should including ongoing coordination between DOH/DHS to discuss the programmatic and funding impediments affecting quality in nursing homes.
- CCAP believes that the integrity of the State Lottery fund must be maintained and assured so that older adults can rely on continued programs and support consistent with the enabling acts.

Opportunities – The following are areas where the state and counties could enhance partnership and cooperation to assure improved services and access for service recipients of the various human services systems. Additionally, opportunities to streamline and improve the ability of counties to provide services on behalf of the commonwealth are included.

Successful service delivery

- CCAP believes the unification presents an opportunity for a larger management role for counties in assuring services are contracted for or provided. Counties have a great track record serving as gatekeepers and share with the commonwealth the requirement to assure the best use of public funds. Legislation should be included with the unification package that develops this authority for counties with an option to decline. For example, many counties use a cross systems integrated framework to enable service blending.
- CCAP believes that the delivery of human services in rural parts of the commonwealth presents unique challenges, and urges the commonwealth to make a commitment and demonstrate adequate support for the needs of rural communities in human services delivery.
- CCAP believes that the unification should include the encouragement for counties to develop and implement innovations that enhance service. The unification should encourage the development of prevention models and define opportunities to direct services to high utilizers and service recipients with complex problems. Further, if prevention strategies or enhancements result in cost savings, counties must be given the option to reinvest in services, processes and structures that will enable ongoing support.

Improved coordination

- CCAP believes that opportunities to improve and enhance access may be gained through close collaboration between the state and counties where we have a joint role in service provision, and CCAP believes that services can be enhanced through extending the partnership to other areas including eligibility and determination, for instance. Counties have the ability to begin the process on enrollment and qualification on behalf of service recipients that we serve.
- CCAP believes that opportunities to use county service structures and sites to deliver state services is another area we encourage the state to consider. For instance, county human services offices could serve as locations for state public health locations for inoculation clinics, Hepatitis C Testing Centers, for example. County nursing facilities could serve this function as well – these facilities have their own on-site pharmacies in many cases, allowing the state to fulfill public health duties without a full physical presence.
- CCAP believes that there should be improved coordination of services for public safety/ health mandates at the state level and improved partnership between counties and the state. For example, substance-exposed infants who are reported to children and youth would benefit from greater coordination with public health services for notifications and evaluation by nurses, as well as coordination with early intervention, child welfare (for social/safety issues), and drug and alcohol services (for any needed drug treatment). Having mental health, drug and alcohol, public benefits, intellectual disabilities and education built into a human services system that provides seamless delivery through child welfare may greatly improve outcomes for service recipients.
- CCAP believes that counties should be given the option to arrange for all protective service, from birth to death, which facilitates the important relationship with court and local law enforcement.
- CCAP urges the commonwealth to implement policies that protect against the loss of safety net nursing facilities that serve the most vulnerable citizens. Currently, county nursing homes serve a disproportionately higher percentage of Medicaid (MA) eligible individuals than private facilities, comprising a true safety net for long-term care. CCAP urges the Department to look at innovative program and policies that would ensure the sustainability of these facilities and to stop their privatization. For example, the commonwealth has previously supported a Medicaid Day One Incentive payment for non-public facilities with high MA occupancy. Public homes could have a similar incentive program to prevent privatization that continues to occur and to ensure safety-net services continue to exist.
- CCAP believes that interested county nursing facilities, at their option, could partner with the Department of Military and Veterans Affairs as the location for the delivery of nursing home services to veterans. While that department is not considered for the unification, we mention this as an example of considering that county buildings and services exist throughout the state and capacity may exist to meet local need.
- CCAP believes that counties should retain responsibility for all planning and quality assurance. Counties should be responsible for complex care management to assure communication and collaboration among disciplines for the most vulnerable citizens. Counties and the state should partner, rather than duplicate efforts for licensing and quality

oversight sharing in the process as opposed to duplicating thereby saving costs and undue burden on providers.

Compliance and regulation

- CCAP believes that the commonwealth must adopt a cooperative compliance approach to regulation, especially with licensed entities. Safety could be maintained while saving dollars with on-site inspections every three years, instead of annually, especially for entities with consistent compliant track records. Compliance inspections still occur, assuring that state licensure staff would be present in buildings on a cycle more frequent that every third year.
- CCAP believes that licensed entities should have the option to request a technical assistance inspection to assist with policy, training, and staff compliance efforts. This can be best accomplished by separating licensing from technical assistance. Currently, if counties ask for technical assistance, they run a very high likelihood of being cited for any deficiencies, probably even for the very reasons they reached out for assistance in the first place. This provides an incentive to not seek assistance when needed.
- Current regulations require civil monetary penalty money collected from nursing homes to be utilized to enhance nursing home quality. The CMP Grant Program should be restored immediately to insure funds are being utilized as required.
- CCAP believes that licensure and regulatory compliance structures must allow for mediation and appeal, especially permitting the option of correction of low-level violations during the time of the inspection. The goal is to get licensees into compliance as opposed to make findings and collect penalties except for instances of serious ongoing violations.

Streamlining and efficiencies

- CCAP believes that services can be enhanced through elimination of redundant monitoring, contracting and reporting processes as well as alignment of monitoring tools. Time spent on these duties could be better utilized in the direct provision of service.
- CCAP believes there should be a comprehensive examination of confidentiality laws to allow human service categorical programs to share information on behalf of service recipients and families. This will reduce redundant services and provide better care for service recipients.
- CCAP believes that the unified agency must develop more efficient methods to share information and eliminate silos by creating processes to share information between programs. In addition, consideration of development of individual consumer level master service recipient information system that permits viewing of all programs with appropriate privacy protections would enhance service delivery and outcomes.

Staff Recruitment and Retention Goals – The following are opportunities to enhance human services careers as a means of improving service provision to clients.

- CCAP urges the commonwealth to develop and implement human services career incentives that improve the ability of the state and counties to recruit and retain staff who are dedicated to the delivery of service to our residents.

- CCAP believes that jointly training licensure and regulatory staff beside facility and/or licensed entity staff will improve understanding of regulatory intent and expectations for compliance and improve overall service quality.
- CCAP believes that reform of the civil service system is needed to make it easier to hire and to make testing processes more realistic for the position. CCAP urges the commonwealth to work with counties to develop mechanisms for approvals where counties have adopted a merit hire structure to ensure timeliness of audits, approval of plans, etc.
- CCAP urges the commonwealth to consider payment/reimbursement schedules that promote adoption of best practices at the county level. For instance, in the child welfare system, a graduated reimbursement schedule that reimburses counties at a higher level when they pay their caseworkers a more livable wage could be a carrot and stick approach to gain compliance, improve services, and outcomes. Additionally, we believe reimbursement rates associated with evidence-informed practice will promote improved outcomes.
- CCAP suggests that the commonwealth consider the development of emergency units comprised of trained child welfare caseworkers at the state level who could fill in when there is large turnover in a county to prevent negative consequences related to staff shortages. If not needed, they could cycle through the counties for a few days each to relieve pressure and allow those counties to get caught up.
- Further, with turnover being so devastating to the system, consider modifying regulations and statute to permit counties to bring in caseworkers on a substitute basis or to allow independent providers to maintain a cadre of caseworkers that are trained and able to fill in when there is turnover. Many counties lose staff who become overwhelmed by the demands of their positions. While they may be unwilling to work full-time in the field, they may be willing to fill in or cover for a couple days a week to help offset some of the workload until new staff can be hired and trained.
- CCAP believes that quality of care in nursing homes can be improved through an upfront commitment to worker wages. The commonwealth should consider a program that will set aside new money for nursing facilities specifically to raise their Certified Nurse Assistant (CAN) hourly rates. Connecticut did this a few years ago, allocating money in the budget specifically for that purpose.
- Further, consider allowing nursing facilities to include non-certified nursing assistants in staffing numbers. In order to reduce the issues facing facilities due to the CNA shortage, we support including hours of work done by Resident Care Assistants (RCAs) in the required hours per patient per day for facilities. Many facilities currently utilize RCAs, or similar type staff (Patient Care Assistants (PCAs), Valets, etc.) in their buildings. Essentially, individuals in this role many times work with the CNAs as extra caretakers for the residents, under the supervision of the RN or LPN, as they are training to become a CNA. Allowing facilities to include these assistants in their hours per resident per day number would alleviate the impact of the CNA shortage.

PACA MH/DS
Pennsylvania Association of County Administrators of Mental Health and Developmental Services

To: Members of the House Democratic Policy Committee

From: Lucy Kitner, Executive Director

Date: June 2, 2017

RE: Comments on Proposed Human Services Unification

On behalf of the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS) I write regarding the Governor's proposal to unify the Departments of Aging, Drug and Alcohol Programs, Health, and Human Services into a single Department of Health and Human Services. While PACA MH/DS has no formal position on the Governor's proposal we believe that the ultimate goal of any unification effort must be to assure ongoing service provision of the many programs that will be impacted and not be a means of shifting costs to counties.

Some observations regarding potential opportunities for improved service and efficiency under the proposed unification model:

- The implementation plans for the new agency must include a clear, concise and consistent methodology for assuring that county government remains a key stakeholder in making decisions about our joint constituencies and the provision of services.

- Counties are uniquely positioned and should retain responsibility for all planning and quality assurance regarding human service delivery. Counties should be responsible for complex care management to assure coordinated communication and collaboration across all disciplines with the goal of maintaining the highest standard of care for the most vulnerable citizens.

- The commonwealth must adopt a cooperative compliance approach to regulation, especially with licensed entities. Safety could be maintained while saving dollars with on-site inspections every three years, instead of annually, especially for entities with consistent compliant track records. Compliance inspections still occur, assuring that state licensure staff would be present in buildings on a cycle more frequent that every third year.

From an operational perspective it is difficult to map existing structures and functions for OMHSAS and DDAP to the proposed new table of organization. It would be helpful if the department would create a crosswalk of existing structures and staffing to the proposed new structure.

Some areas for operational clarification follow:

- HealthChoices Behavioral Health oversight is currently managed by a combination of OMHSAS Bureaus, management staff, and Field office staff. Can the Department articulate how the current HealthChoices Behavioral Health management structures will be performed and incorporated into the new structure? We ask the Department to consider further refining the proposed Bureau of Program Support. Given the complexity and scope of Fiscal Operations for HealthChoices (which are highly specialized and interface with CMS and counties and BH-MCOs). Block grant and non-block grant programs may also benefit from a dedicated Fiscal Bureau rather than being subsumed with Administrative Support and Special Projects.

- It is unclear how the current OMHSAS structure that includes Eastern and Western Operations and Field offices will be captured under the Bureau of Community Operations. Currently in OMHSAS, licensing functions are divided between Field Office staff, who conduct licensing for some MH programs. Field Office staff also have other OMHSAS roles and functions beyond licensing. BHSL staff, who have now been incorporated back into DHS departments, licensed other MH programs but those staff have been dedicated solely to licensing. Can the Department further articulate how changes may impact current Field Office staff with whom County MH/ID Programs have most of their contact?

- The current Children's Bureau will be housed in the Division of Special Populations. Can the Department clarify how existing Children's Bureau roles and functions will continue?

- How will the Division of Special Populations work with the other divisions to support the ongoing development of community services?

General Observations:

- Further incorporating Substance Use Disorder oversight into OMHSAS could provide a significant benefit to the consumers, especially the co-occurring population. Substance Use providers who participate in HealthChoices have oversight from BH-MCOs, which are overseen by OMHSAS staff, so further aligning oversight within OMHSAS may also improve efficiency and quality. What division will have oversight of the SCAs?

- Many Counties have a planning council model for MH, ID and D&A services. Efforts on the departmental level in the proposed HHS to align service delivery, treatment

philosophies, and licensing functions could further enhance local efforts to increase collaboration and effective treatment approaches for persons who need services among those systems. Where would the planning function be housed in OMHSAS, ODP or OCDEL? How will HHS mange cross systems planning efforts?

Additional comments gathered from a survey of the PACA MH/DS membership:

1. We would encourage DHHS to explore the fact that there may need to be regulatory relief for providers and counties related to oversight, compliance and licensure.

2. Information Systems and Data – We encourage DHHS to consider that there will need to be forethought and planning around the ability to share information and data. There are already multiple systems within each of the categorical programs. We are not suggesting that there be one system but that there be provisions related to usage of data in and out of the various systems (import and export functions). We at the county levels already do this to some extent, but having a statewide model would be easier and more efficient to manage.

3. Consideration of DHHS being a single HIPPA covered entity would simplify compliance efforts.

4. Some counties have a unified Release of Information agreement between categorical programs for information sharing. It will be essential to better customer service that our consumers do not have to re-share the information with each program that they enter for service.

5. Clarification is necessary regarding the impact of county operations as it relates to the local replication of the state's DHHS model. Obviously, each county does not have the same structure as the state or each other.

6. If as the draft proposal assumes, OMHSAS and DDAP are combined. How does the Commissioner of Substance Abuse and Addiction Policy relate to OMHSAS? Also, how does the positon interface with the local MH/ID/D&A programs?

REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

Testimony of Richard Edley, President and CEO,
Rehabilitation and Community Providers Association (RCPA)

Before the Pennsylvania House Democratic Policy Committee on Unification of the Department of Human Services, Department of Health, Department of Aging and Department of Drug and Alcohol Programs

House Democratic Caucus Room, Rm 418 Main Capitol, Harrisburg, PA
Monday, June 5, 2017

Good morning Chairman Sturla and members of the committee. My name is Richard Edley and I am here representing the Rehabilitation and Community Providers Association (RCPA), a statewide association representing over 330 providers of health and human services across the Commonwealth, and our member organizations serve well over 1 million Pennsylvanians annually. RCPA is among the largest and most diverse state health and human services trade associations in the nation. RCPA members offer mental health, drug and alcohol, intellectual and developmental disabilities, brain injury, medical rehabilitation, physical disabilities and aging services through all settings and levels of care for individuals of all ages.

I want to express my appreciation to the committee for holding this joint hearing. My testimony today deals with the proposed unification of the Departments of Human Services, Health, Aging, and Drug and Alcohol into one Department of Health and Human Services (DHHS).

RCPA is supportive of a new and unified Department of Health and Human Services. Our association views the proposed unification as an opportunity to modernize and streamline an outdated system, and to find efficiencies – all of which should lead to better service and potentially freeing up dollars for better use in the community. RCPA was founded under similar circumstances. Approximately four years ago, RCPA was established as a result of a merger between two associations – the Pennsylvania Community Providers Association (PCPA) and the Pennsylvania Association of Rehabilitation Facilities (PARF). The Boards of Directors for PCPA and PARF decided that both associations were providing duplicative services to members and could better serve their constituents by merging the associations into a new, unified organization — RCPA. As a provider community we, too, believe that bringing all these groups under one unified structure and vision brings about better information sharing and collaboration. After over four years of this new structure, RCPA has been able to create a new vision and meet these goals.

So we are supportive of the unification proposal based upon what we have heard from the administration and from RCPA's own history. Of course, as with any stakeholder group, and as we have heard the past few weeks of discussion and testimony, we share some concerns. One concern is whether this merger will be fully vetted and ready to go in such a short time frame, if this proposal will be a part of the final budget. While RCPA appreciates that the Administration has stated that this unification is not just about cost savings, RCPA too has questions regarding the ability to truly gain these savings, especially in year one.

In a new merger, RCPA is concerned that drug and alcohol services continue to be a focal point for a new, unified DHHS. RCPA staff have been in meetings with administration officials and we have been told that the Governor will appoint a cabinet-level position to oversee drug and alcohol issues. That is certainly a good step, and it is assumed that we will see a more formal proposal and detail from the Administration regarding this new cabinet-level position. Our members are naturally focused on this particular issue in light of the opioid epidemic that is permeating the Commonwealth.

In terms of addressing these issues and gaining stakeholder input and involvement, Secretary Dallas made a presentation to RCPA's Board of Directors about the unification proposal and had a good, open discussion with us. I, along with representatives from other state associations, have also met with the Governor's staff about the unification, and have been assured that these will be ongoing discussions. Another meeting has already been set for later this month.

We are pleased with this outreach and effort and encourage the Administration to continue to create stakeholder work groups and/or task forces as needed to collaborate and create the best unified agency possible. By creating work groups and task forces, and collaborating with health and human service providers, counties, managed care organizations, consumers, and other interested parties, these work groups and task forces will be able to provide necessary feedback regarding: best management practices, streamlining reporting requirements, revamping/repealing burdensome and costly regulations, and recommending other efficiencies for additional system-wide cost savings.

The Administration has asked RCPA and its members to provide comments and suggestions about efficiencies; however, the presentations at these meetings have thus far been more about organizational structure and not yet about specific recommendations. RCPA strongly recommends that a more formal and structured collaboration with the aforementioned groups be convened to help create a unified Health and Human Services organization that transforms and organizes service delivery to those we all serve and truly creates the efficiencies we are all referring to.

As stated previously, RCPA contends that merging the agencies is a positive move; however, our association has been asked by numerous legislators whether we can gain efficiencies and cost savings under the current agency structure. Of course the answer to that inquiry is – yes. Under the current agency structure, efficiencies and cost savings can be realized by analyzing current regulations and reporting guidelines that health and human service providers must abide by. Intellectual and developmental disabilities, mental health, drug and alcohol, and rehabilitation providers are among the most heavily regulated businesses in the country. Health and human service providers must undergo duplicative audits and in some cases are licensed by multiple state agencies. While unifying might be the best option, there are things that the Commonwealth can do now under the current structure to help maximize efficiencies such as streamlining the licensing process or reducing the number of audits, for example, if a provider is nationally accredited.

Under the current agency structure, however, while the Commonwealth could achieve efficiencies and cost savings by making a number of small but effective changes, this would require an overhaul of the current bureau structure in the agencies and a revamp of a multitude of regulations currently in place. So our contention is that the question should really be: What is the *best* way to achieve these efficiencies? We believe that answer is through the unification of the departments.

In conclusion, RCPA is supportive of a new and unified Department of Health and Human Services, and encourages the Administration and members of the General Assembly to continue to seek feedback from health and human service providers, consumers of those services, and other stakeholders. If a unification occurs, then let's take a serious and hard look at how we can streamline services, and reduce over-burdensome regulations and unfunded mandates. While I have also outlined some basic concerns in this testimony, we do not believe any are insurmountable with good planning and stakeholder discussion and input. We stand ready to work with the Administration and the General Assembly to do what is in the best interest of everyone involved.

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DISABILITY RIGHTS
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June 5, 2017

TO: Members of the House Democratic Policy Committee

RE: Proposed Merger of Aging, Health, Human Services, and DDAP

Thank you for the opportunity to provide testimony on the proposed consolidation of the Department of Human Services, Department of Aging, Department of Health, and Department of Drug and Alcohol Programs.

Disability Rights Pennsylvania (DRP) is the organization designated by the Commonwealth under federal law to protect the rights of and advocate for Pennsylvanians with disabilities. DRP works to ensure that individuals with disabilities are able to live the lives they choose, free from abuse, neglect, discrimination, and segregation. Since 1977, DRP has helped tens of thousands of children and adults with disabilities access special education services, obtain needed health and mental health care, gain access to employment and housing, and intervened to stop the abuse, neglect and rights violations of Pennsylvanians with disabilities.

Today we write to express concerns about the proposed consolidation of the Department of Human Services, Department of Health, Department of Aging, and Department of Drug and Alcohol Programs. DRP is not opposed to the merger outright, but we do note these concerns. If these concerns can be addressed by the Departments, then we could be

supportive. To date, these many of these concerns have not been addressed.

First, we are concerned about potential impact on services to individuals with disabilities. A stated goal of the consolidation is a cost-savings to the State. The Secretaries have stated that there will not be service cuts, but without much forthcoming information about how the various program offices will be merged, it is nearly impossible to determine impact on services. We are also concerned about any impacts on eligibility determinations. In the past two years there have been some changes to various eligibility processes within the Department of Human Services. These changes were not well planned for and resulted in individuals waiting months for the determination of eligibility. If any modifications to eligibility processes are possible under the merger, then it must be carefully considered to ensure that determinations are made in a timely way. There cannot be delays to individuals who are waiting on the necessary services and supports to remain at home.

In addition, we have heard the concerns of many providers regarding licensing and concerns regarding the time spent preparing and the volume of reviews that providers must prepare for. We respectfully would like to highlight the importance of licensing of providers and settings. The intent of licensing is to ensure that services are being provided in accordance with regulations and in a high quality. The regulations have been developed based on past experience where individuals were in unsafe situations and people were harmed. If you need examples, please speak with advocacy groups about why and how the current regulations regarding homes and settings for people with disabilities were developed. We still deal with cases regularly where staff fail to follow a service plans for an individual. For instance, staff do not keep harmful substances locked and the individual ingests them. This could lead to death of the individual. Annual licensing inspections ensure that the regulations are being followed to ensure participant safety. Preparing for the inspections, regular training for staff to ensure compliance with regulations is crucial to providing services in a way that comports with necessary safety regulations and keeps the needs of participants in focus. The needs of individuals

receiving services must be a foremost consideration going forward. We must learn from history to remember why stringent licensing is so important to ensure the safety of participants. Any changes to the licensing process must be considered through robust stakeholder engagement, including stakeholders who represent people receiving services, and advocacy groups.

We would also suggest that service participants are surveyed before the merger or the Departments on their experiences related to services and then be surveyed twice after the merger. This would allow for a way to measure the impact on individuals and identify any potential issues relating to the merger from the view of service recipients.

Consolidation has been considered before, and while the sharing of information is important, we are concerned that the various data systems are not able to communicate with each other. Any modifications to the systems to allow for sharing of information could take a year or more of planning. How will information be shared across the combined Departments in the meantime? If the silos are still remaining and systems are unable to share the information in a way that is helpful to the individuals receiving services, then the consolidation should wait until these barriers are broken down.

Next, in various meetings we have heard the Secretaries discuss the stakeholder engagement process relating to consolidation. To date, the Departments and program offices have not reached out to DRP for stakeholder meetings relating to consolidation. DRP is also not aware of any other disability groups being invited to stakeholder meetings related to consolidation. The Departments must undertake a meaningful stakeholder engagement process to ensure that the concerns of the disability community are understood and addressed in any potential merger. As the Departments take longer to engage stakeholders it will only take longer to address concerns in a meaningful way.

We have grave concerns regarding the proposed elimination of the OMHSAS Children's Bureau, as depicted in the organization chart posted

on the HHS Unification webpage. Within OMHSAS, children's services account for a significant proportion of state mental health expenditures, yet access to and quality of care issues remain constant. Each month, DRP receives many calls from family members who are encountering numerous obstacles to accessing the care their children need in a timely manner, whether it be Applied Behavior Analysis, Behavioral Health Rehabilitation Services, psychological and psychiatric evaluations, therapeutic foster care, crisis stabilization, or psychiatric inpatient. This is especially true for children with co-occurring developmental disabilities and those in the child welfare system. Many are suffering disastrous outcomes due to this crisis in children's service delivery, among them: prolonged hospitalizations with seclusion, placement in state hospitals or centers for individuals with developmental disabilities, and out-of-state placement.

Now is not the time to eliminate a Bureau dedicated to children's services. It is, however, an opportune time to ensure that the Children's Bureau works with efficiency and effectiveness, and in cooperation with OCYF and ODP, to ensure that the necessary array of services and supports are made widely available to children and youth as required under EPSDT. In fact, this is also a perfect opportunity to establish a Children's Bureau in ODP to ensure effective state-level cross-systems coordination necessitated by the complex needs of Pennsylvania's most vulnerable children.

Finally, the proposal does not have a program office that would provide services and supports to children with developmental disabilities that do not have a Mental Health or Intellectual Disability diagnosis. Children with disabilities such as Cerebral Palsy, Reactive Airway disease, Muscular Dystrophy, to name just a few, have difficulties in accessing necessary services to allow them to receive supports and services, such as respite care and home adaptations, in the community, sometimes resulting in unnecessary, developmentally harmful, and expensive institutional care apart from a loving home. As the merger is considered, these children should be included explicitly in one of the program offices, such as the Office of Developmental Programs, to ensure availability of services.

We look forward to continuing to receive information on the merger, and hope to have our concerns addressed as this process moves forward. Please contact Jennifer Garman, Director of Government Affairs at jgarman@disabilityrightspa.org with questions.

Senator Roy C. Afflerbach, Ret.
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Testimony To the House Democratic Policy Committee

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Presented by Sen. Roy C. Afflerbach, Ret.

Chairman Sturla, Members of the Committees, and staff, thank you for inviting me to present testimony today.

My name is Roy Afflerbach. In the spirit of full disclosure, I must say that I represent the Pennsylvania Adult Day Services Association (PADSA), the Pennsylvania Association of Senior Centers (PASC), the Meals on Wheels Association of Pennsylvania (MOWAPA), and am a volunteer for the Southwestern Pennsylvania Partnership for Aging (SWPPA). I am not, however, writing on behalf of any of these organizations.

As the saying goes, those who do not know their history are doomed to repeat the errors of the past. With that in mind, as we review the Governor's proposal to consolidate four departments, including the Department of Aging, permit me to provide you with a historical perspective of the events that led to the formation of the Department of Aging as a separate cabinet level department.

My first-hand knowledge of how and why the Department of Aging and several other senior programs were created began when I joined the Senate staff in December 1970. One of my first assignments was to assist in drafting the Lottery Act and the concurrent implementing legislation for property tax relief for the elderly. Two years later I served as Chief of Staff to the Senate Majority Whip and continued to help with amendments to the Lottery Act. In 1977 as Chief of Staff to the Senate Majority Leader I was tasked with helping to guide to passage Act 1978-70 to create the Department of Aging.

The story of the Department of Aging (PDA) begins with the passage of the Older Americans Act of 1965 (OAA), after which the Department of Public Welfare (DPW) was designated as the single state agency to receive OAA funds and to do two principle things: (1) Establish a focus upon services to the elderly; and (2) Establish a network of Planning and Service Areas (PSA) within which an Area Agency on Aging would

administer OAA funds to provide the services OAA required, notably the provision of socialization and nutritional meals through congregate settings.

Eight years later in January 1974 DPW established the first 40 PSAs and the AAAs to administer them. It was never clear to us why DPW was unable to more quickly or efficiently implement the requirements of the OAA. Many in the Legislature opined it was because these new duties had been thrust upon a department ill-prepared to receive them, in part because it was wrestling with the overwhelming issues of general welfare, individuals with disabilities, and the Medicare/Medicaid Act which was passed at the same time as the OAA.

By 1978, four years after DPW created 40 PSAs and twelve years after it received responsibility for implementing OAA requirements, it was clear to the Legislature and the Governor that allowing DPW to continue to implement the OAA, and potentially future Lottery funded programs, was simply not working.

Simultaneously, individual seniors and organizations such as the Grey Panthers and the Pennsylvania Association of Older People increasingly called upon Legislators and the Governor to take the Office of Aging out of DPW and establish it as a separate Department. They argued that there were significant differences between the needs, desires, and aspirations of younger individuals with disabilities and the needs, desires, and aspirations of older, aging individuals

(Several years later DPW also agreed with this argument when it sought and received approval from the Centers for Medicare and Medicaid Services (CMS) to utilize Medicaid funds to provide home and community based services for seniors. Not surprisingly, this program is called the Aging Waiver and was administered by PDA under an interagency agreement with DPW until approximately 2012.)

By 1977 the Legislature and the Governor agreed with the concerns expressed by seniors that the needs of the elderly were completely overshadowed in DPW by the needs of individuals with disabilities and general welfare/Medicaid recipients. Therefore, after the long-debated 1977-78 budget was resolved in December 1977, the Legislature moved to approve Act 1978-70 by votes of 194-3 in the House and 49-0 in the Senate, creating the Department of Aging effective January 1, 1979. As Pittsburgh newspapers reported, when the final vote was taken in Senate a gallery filled with seniors began singing God Bless America and were joined in song by every senator on the floor at that moment. We should not mistake the relative quiet of our seniors today as opposed to the activism we experienced in the 1970's. They have been caught by surprise both by the proposal and the speed with which the Administration wants to have it approved.

Upon taking office in 1979, Governor Dick Thornburgh appointed Gorham L. Black, Jr. to serve as Secretary of the new department and the Senate unanimously confirmed him soon thereafter.

Act 70 of 1978 included language directing that all the programs for the elderly, the staff, and the funding for those programs, be transferred from the Departments of Public Welfare and Transportation to align them within the Department of Aging.

For a variety of reasons, not the least of which was uncertain budgetary times, the new Department was given a sunset date of January 1, 1985, unless renewed by statute. Through the application of subsequent Sunset Act procedures, the deadline was extended to 1988. By 1988 the Legislature had determined PDA was performing as intended in an efficient and cost effective manner and therefore, with the passage of Act 1988-153 PDA was reestablished with additional powers and responsibilities, including administration of the Pharmaceutical Assistance Contract for the Elderly (PACE), and later PACE-Net. (As a Member of the House I had voted to establish the PACE program and in 1988, as a member of the Senate, I voted to reestablish the Department of Aging with its increased powers.)

Now, under the banner of breaking down silos and creating a more efficient delivery of services, the Administration is asking us to return to the pre-1979 days with the hopeful presumption that what did not work before would somehow work today.

Although the language the Administration recently presented to the Legislature in the form of an amendment to the Administrative Code demonstrates it has been listening to concerns expressed about the repeal of the Department of Aging, the fact remains that the programs presently aligned within PDA are to be transferred into different levels of an expanded bureaucracy within a Department of Health and Human Services (DHHS).

The Administration purports that its proposed relocation of programs will “create a structure to reduce bureaucratic hurdles”, “create the ability to coordinate programs”, and “create the ability to reduce duplication and overhead expenses”.

The organizational flow chart published by the Administration indicates that the programs presently within the Department of Aging would be dispersed among several Offices, Bureaus and Divisions within an expanded DHS. The experiences I have recited, raises serious concerns about whether a department the size of the proposed DHHS can absorb and effectively administer the programs it will inherit from PDA.

For example, the public hearing jointly convened by Senator Brooks and Representative Hennessey in October 2016 revealed that DHS either did not understand or did not adequately prepare for the complexity, necessary components, or personal assistance required of the administrative service enrollment function for the elderly when DHS transferred that function from the AAAs and awarded it to a private bidder.

Rather than rushing to repeal the Department of Aging, wouldn't it make more sense to have the Administration and DHS focus upon fully resolving the enrollment issue; Focus upon Implementing its massive and complex Community Health Choices managed care program, which is scheduled to begin in Southwestern Pennsylvania in January; Focus upon resolving non-uniform IT issues; And focus upon addressing other Harrisburg back office issues, such as human resources and licensing, that are not unique, and need not be unique, to any one department? None of these outstanding issues requires the repeal of the Department of Aging to resolve and focusing upon addressing what can be done with far less controversy and disruption can begin to reduce duplication and overhead costs more quickly. And none of these issues requires a risky return to a failed structure of the past with a hope that it would somehow work better today.

Recent discussions with the Administration and changes to the Governor's website indicate that the Governor is now willing to create a Commissioner for Aging as a cabinet level post, structured in a manner similar to that of the Physician General. In my view, this is an improvement from the original proposal, but only if the proposed Commissioner reports directly to the Governor and is given actual authority to intervene across all departments, offices, divisions, bureaus, and agencies as necessary to assure that programs and services for seniors are administered and delivered as appropriate and as intended by the Legislature.

The authority to intervene and to participate in decision-making processes is what makes the office of a Commissioner meaningful. Without this authority, it is merely an advisory post that cannot assure seniors of the voice they need in lieu of a Department of Aging, as their numbers continue to grow to above twenty-five percent of our population.

Thank you for your consideration of my testimony and for your hard work and dedication in evaluating and deciding upon this proposal.