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Final Report of the

HEALTH & SOCIAL SERVICES TRANSITION TEAM

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

A. Origin; Purpose

The Health and Social Services Transition Team was created by Resolves 1993, c. 36 to develop all of the legislation necessary to abolish the Department of Human Services and the Department of Mental Health and Mental Retardation and create two new departments: the Department of Children and Families and the Department of Health. The Resolve provides a basic framework for the new departments and leaves it to the Team to make more detailed recommendations. The Resolve also directs the Team to make policy recommendations in a number of specific areas, including homelessness, juvenile corrections, regional planning, and advisory boards.

B. Recommendations

With a few exceptions, the Team reached consensus on the functions that should go into each of the new departments. The Team also agreed on an organizational scheme for the Department of Children and Families. In an almost evenly divided vote, however, the Team split regarding the organizational scheme for the Department of Health.

The Team recommends an implementation date of July 1, 1995, giving the existing departments a 15 month transition period from the expected date of enactment. Although the Resolve calls for an implementation date of July 1, 1994, the Team felt that such an early date could seriously disrupt service delivery and would very likely result in the loss of federal funds.

C. Scope of Report

Chapter I describes the Team's recommendations for the Department of Children and Families. It includes an organizational chart and mission statement.

Chapter II describes the Team's recommendations for the Department of Health and Developmental Services. It includes a mission statement and two organizational charts, representing the majority and minority recommendations.

Chapter III focuses on Team recommendations to make services more customer-friendly. Included in this chapter is the recommendation to establish a single point of access for services.

Chapter IV outlines the recommendations of the Team in the area of administrative functions.

Chapter V describes the Team's recommendations in the following additional areas: juvenile corrections, regional planning and delivery, homelessness, advisory boards, food safety, substance abuse, administrative hearings and advocacy.

INTRODUCTION

The Health and Social Services Transition Team was created by Resolves 1993, c. 36 to develop all of the legislation necessary to abolish the Department of Human Services and the Department of Mental Health and Mental Retardation and create two new departments: the Department of Children and Families and the Department of Health. The Resolve provides a basic framework for the new departments and leaves it to the Team to make more detailed recommendations. The Resolve also directs the Team to make policy recommendations in a number of specific areas, including homelessness, juvenile corrections, regional planning, and advisory boards.

The Team reached consensus on a remarkable number of issues, given the size and complexity of the task, the shortness of time, and the understandable resistance to change. With a few exceptions, the Team reached consensus on the functions that should go into each of the departments. The Team agreed, after much debate and compromise, on an organizational scheme for the Department of Children and Families. In an almost evenly divided vote, however, the Team split regarding the organizational scheme for the Department of Health. Though more time might have led to agreement on this issue, the Team's primary concern was providing a timely report to the Legislature. The legislation provided embodies the majority view on this one outstanding issue.

The Team recommends an implementation date of July 1, 1995, giving the existing departments a 15 month transition period from the expected date of enactment. Although the Resolve calls for an implementation date of July 1, 1994, the Team felt that such an early date could seriously disrupt service delivery and would very likely result in the loss of federal funds.

The Team has estimated immediate transitional costs of $75,000 in State funds. The funds would be used to prepare a new federal cost allocation plan to ensure that the State continues to receive its full share of federal match for administrative expenses. The State currently receives over $16 million annually from the federal government for this purpose. The Team has also recommended future costs in the range of $100,000 to fund an existing but unfunded position in the Interdepartmental Council, and to provide contract funds for the Child Welfare Services Ombudsman, which is currently an unfunded State line. Although an amount can not be estimated with any accuracy at this point, the Team anticipates that the reorganization will result in some permanent savings, particularly through the consolidation of certain administrative functions, such as auditing.

The Team's primary charge was to prepare legislation, and the Team has met that charge with a bill of nearly 1000 pages. The bill repeals Titles 22 (Human Services) and 34-B (Mental Health and Mental Retardation) of the Maine Revised Statutes and enacts in their place Titles 22-A (Children and Families) and 22-B (Health and Developmental Services). This report is intended to be an outline to the legislation; it does not contain all of the Team's deliberations in detail. For those who are interested in obtaining more background information, a complete set of minutes and other materials are on file at the Law and Legislative Reference Library in the State House.

Ironically, as the work of the Team progressed, many Members found themselves increasingly attracted to the consolidation of all health and social services into a single agency. It became clear that, whatever the shortcomings of such a model, interdepartmental coordination and administrative efficiency would be enhanced. However, the Team's charge was clearly to organize services into two departments, and the implications of a single agency were not fully explored.

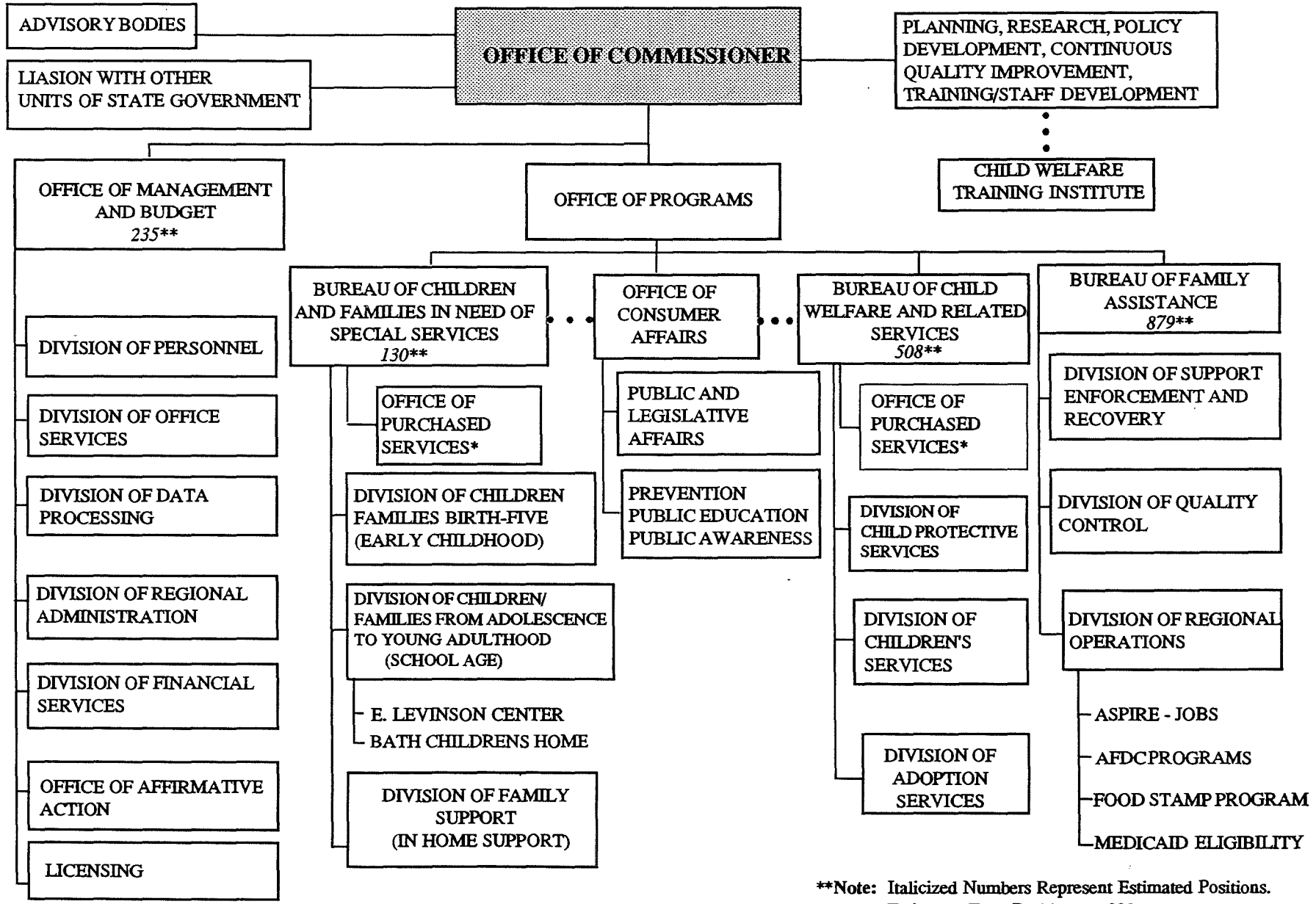
The Legislature had intended for the Team to begin meeting in July but the Members were not appointed until September. Beginning September 14, the full Team met 12 times and various ad hoc subcommittees met to address particular issues. The public was invited to comment at every meeting of the full Team. A public hearing was to be held in Presque Isle, Bangor, Augusta and Portland through the University's ITV system on January 8th, but it had to be canceled because of the storm on that day.

The experience was fast-paced and intense, and the Team stands ready to assist the Legislature as this very important issue moves to that forum for continued debate and closure.

I. DEPARTMENT OF CHILDREN AND FAMILIES

Chart I-A

DEPARTMENT OF CHILDREN & FAMILIES



* Designation Should Be Made for Contracted Service Based on Lead Bureau Identification: Policy and Program Decisions Rest with Bureaus. Offices of Purchased Services Executes Contract Administration Functions. Office of Purchased Services Coordinate Single Contracts on Service Functions.

**Note: Italicized Numbers Represent Estimated Positions.
Estimated Total Positions: 1800.
Estimated State and Federal Funds: $485 Million.

Health and Social Services Transition Team, 12/93

DEPARTMENT OF CHILDREN AND FAMILIES

MISSION STATEMENT

The State of Maine declares that every child has the right to a consistent, nurturing environment in order to achieve optimal growth and development. Families have the primary responsibility of meeting the needs of their children and the State has an obligation to help them fulfill this responsibility when families are unable to do so. The state has the responsibility to ensure the availability of an integrated continuum of services that is responsive to the physical, emotional, social, and educational needs of children and their families and which helps children develop as healthy, productive, and caring persons. The role of the State is to complement what families and public, private, and nonprofit agencies provide in order to enhance the strengths and talents of each child and family.

GOALS

- To support consistent, nurturing environments that promote optimal growth and development for children and families;
- To promote physical and emotional well-being, educational opportunities, financial stability, and healthy interdependence of family members, their communities, and the State;
- To ensure that children are protected when their families are unable or unwilling to do so;
- To support those who provide the care, education, treatment, supervision, and protection of children; and
- To ensure that families are Maine's most valuable resource as providers of care, nurturing, and parenting to our children.

GUIDING PRINCIPLES

- Priority should be placed on the development of a community-based, culturally- and linguistically-sensitive, and multidisciplinary system of care and outreach;
- Services should follow the child and be child-centered, family-focused, and provided in the least restrictive and most appropriate and integrated setting;
- Services should strengthen family involvement so that families are empowered to better care for their children;
- The ideal system should ensure a unified system of entry and provision of services according to an individualized treatment plan that is respectful of the child's and family's strengths and needs;
- The service delivery system should represent a decentralized approach to the resolution of problems faced by children and families; and
- The ideal system should unite the public, private, and nonprofit sectors in a new effort to plan and create new service resources at the local level.

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A. Functions

The Team agreed that the following functions should be in the new Department of Children and Families:

- Child mental health, mental retardation, autism and other special services. This includes all of what is currently provided by the Bureau of Children with Special Needs, the children's portion of the Division of Mental Retardation, the Bath Children's Home and the Elizabeth Levinson Center;

- Child welfare services, including child protection, child custody, foster care, adoption and other related services. These are currently provided by the Bureau of Child and Family Services;

- All income assistance functions, including AFDC, Food Stamps, ASPIRE, SSI and child support enforcement. These functions are currently provided by the Bureau of Income Maintenance;

- Medicaid eligibility. Because Medicaid eligibility is tied to AFDC and SSI, this function would be provided by the Department of Children and Families while all other aspects of the Medicaid program would be administered by the Department of Health and Developmental Services. The Department of Children and Families would be responsible for ensuring access to Medicaid for people who receive services from the Department of Health and Developmental Services;

- Child care services, including Head Start. These are currently administered by the Division of Purchased and Support Services; and

- Purchased social services that are currently administered by the Division of Purchased and Support Services.

The Team spent a considerable amount of time debating whether maternal and child health services should be in this department or in the Health department. These are preventive health services for children and mothers that are provided through the Bureau of Health and funded primarily by the federal government through the Maternal and Child Health Block Grant (Title V of the Social Security Act). The Team examined both legal and policy issues.

The legal issue is whether federal law would permit the Block Grant to be administered by the Department of Children and Families. Title V, Section 509(b) requires that the "State Health Agency...shall be responsible for the administration (or supervision of administration) of programs carried out with allotments made to the State under this title..." The Team asked the federal Maternal and Child Health Bureau whether some kind of contractual relationship could be fashioned that would allow the Department of Health and Developmental Services to receive and be responsible for the Block Grant while the Department of Children and Families actually administered it. The response was ambiguous, suggesting that the questions would need to be pursued further when the new departments were actually in place.

The main policy issue debated by the Team was whether children's health should be with other health services or with other children's services. Proponents for placing the services with other children's services argued that, in order to treat children holistically, the State must find ways to break down categorical service barriers, bringing professionals from all disciplines together to provide real "one-stop shopping" to children. While acknowledging the attractiveness of fully integrated children's services, most Team Members concluded that the benefit of doing so in this instance would not outweigh the consequence: fragmentation of health services to families. Many families never come into contact with the social service system, but all families receive health services on some level, and it is critical that the families' health needs be treated holistically.

Another difficult issue for the Team was whether to move Child Development Services (CDS) from the Department of Education to the Department of Children and Families. The central CDS office works with local CDS sites to identify children from birth to 5 who have disabilities, and to provide "free appropriate public education" to eligible children from 3 to 5 years of age. This issue also had legal and policy components. Although the State does have discretion in locating the services for children from birth to age 2 (Part H), it is more constrained in the location of services for 3 to 5 year olds (Section 619). Federal law requires that the Section 619 program be supervised by the "State educational agency," which is the Department of Education in Maine. (See federal Individuals with Disabilities in Education Act, 20 USC §1400 et seq., Part B) Although this does not make it impossible to move CDS to the Department of Children and Families, it raises an issue of practicality, since CDS would be in one State agency (Children and Families) but supervised by another (Education). This arrangement exists in Wyoming, where CDS-type services are located in the health department.

The major policy question debated by the Team was whether CDS services are primarily social services or educational services. Proponents for moving CDS to Children and Families argued that CDS is an integral part of the service system for children with special needs, and that educational services can not be divorced from other services commonly needed, such as physical and speech therapy. They also suggested that the educational system has more than it can do to meet its obligations to school-aged children with disabilities, and should not be expected to do an adequate job with preschool-aged children. They also argued that the Department of Children and Families will focus on the needs of the entire family, rather than only on the needs of the child. As with maternal and child health, proponents for moving CDS argued for a fully integrated, multidisciplinary agency for children.

Most Members decided, however, that maintaining CDS in the Department of Education brings that multidisciplinary perspective into the schools, where it needs to be encouraged. They argued that a central goal of CDS is preparing children for public schools, and that schools must be fully involved in pursuing that goal. Collaborative agreements with Head Start, Public Health Nursing and the Bureau of Children with Special Needs have encouraged a multidisciplinary approach.

B. Organization of Department

The Team is very pleased to offer unanimously an organizational chart for the Department of Children and Families. (See Chart I-A) The chart is the result of vigorous debate and compromise. Although the Resolve called for 4 Bureaus, the Team could not recommend that large a bureaucracy in what will be a relatively small agency. Furthermore, Members felt that fewer bureaus would result in fewer organizational barriers for consumers. In fact, many Team Members were attracted by an early proposal to have only two bureaus, but decided in the end that services to children with special needs are significantly different from services to children in need of protection, and are appropriately located in different bureaus.

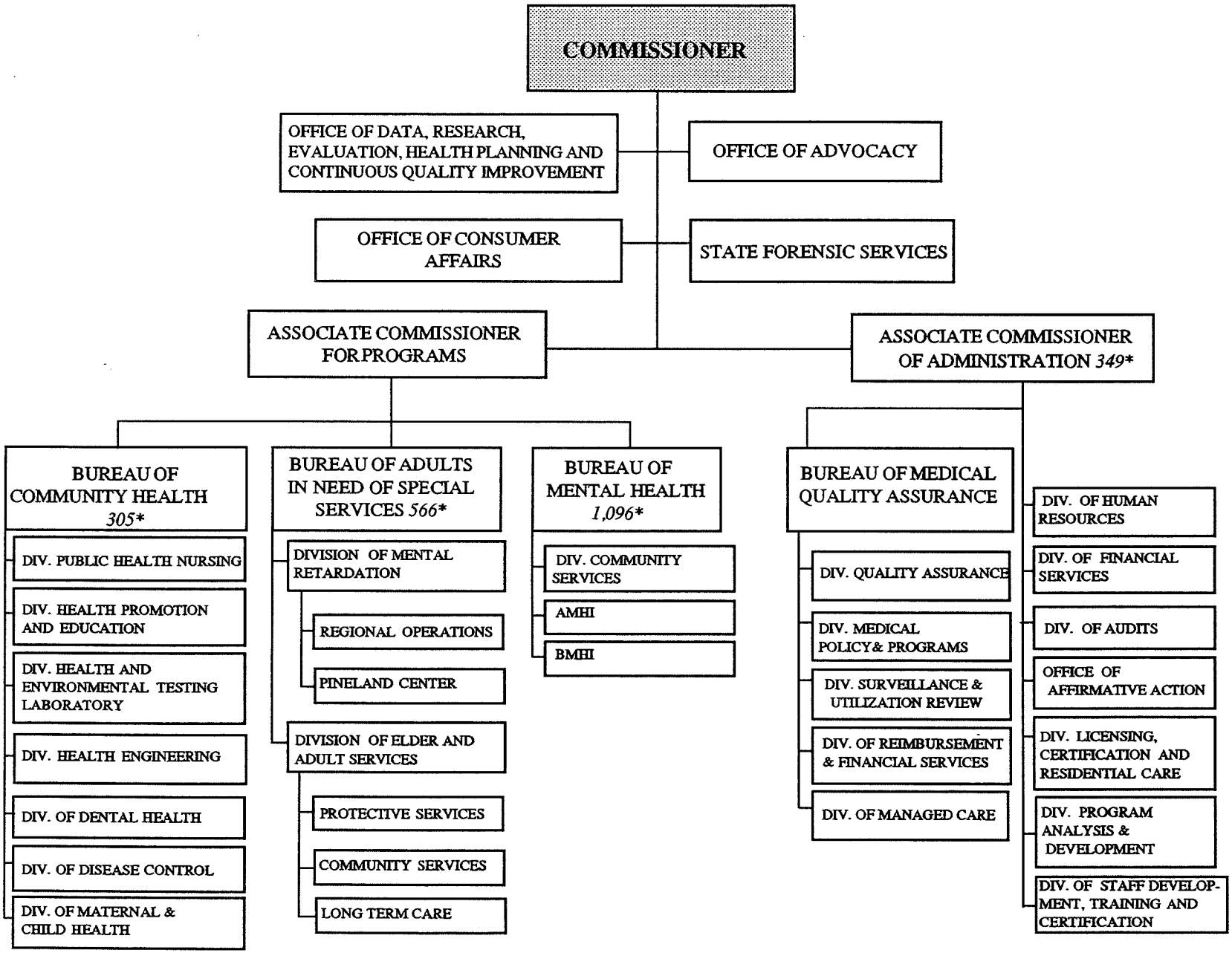
Each bureau would administer its contracts through an Office of Purchased Services. The Office of Consumer Affairs would perform public and legislative relations functions for the entire Department.

Other aspects of the chart are discussed in Part III (Customer Focus and Coordination) and Part IV (Administration).

II. DEPARTMENT OF HEALTH AND DEVELOPMENTAL SERVICES

Chart II-A

MAJORITY REPORT: DEPARTMENT OF HEALTH & DEVELOPMENTAL SERVICES

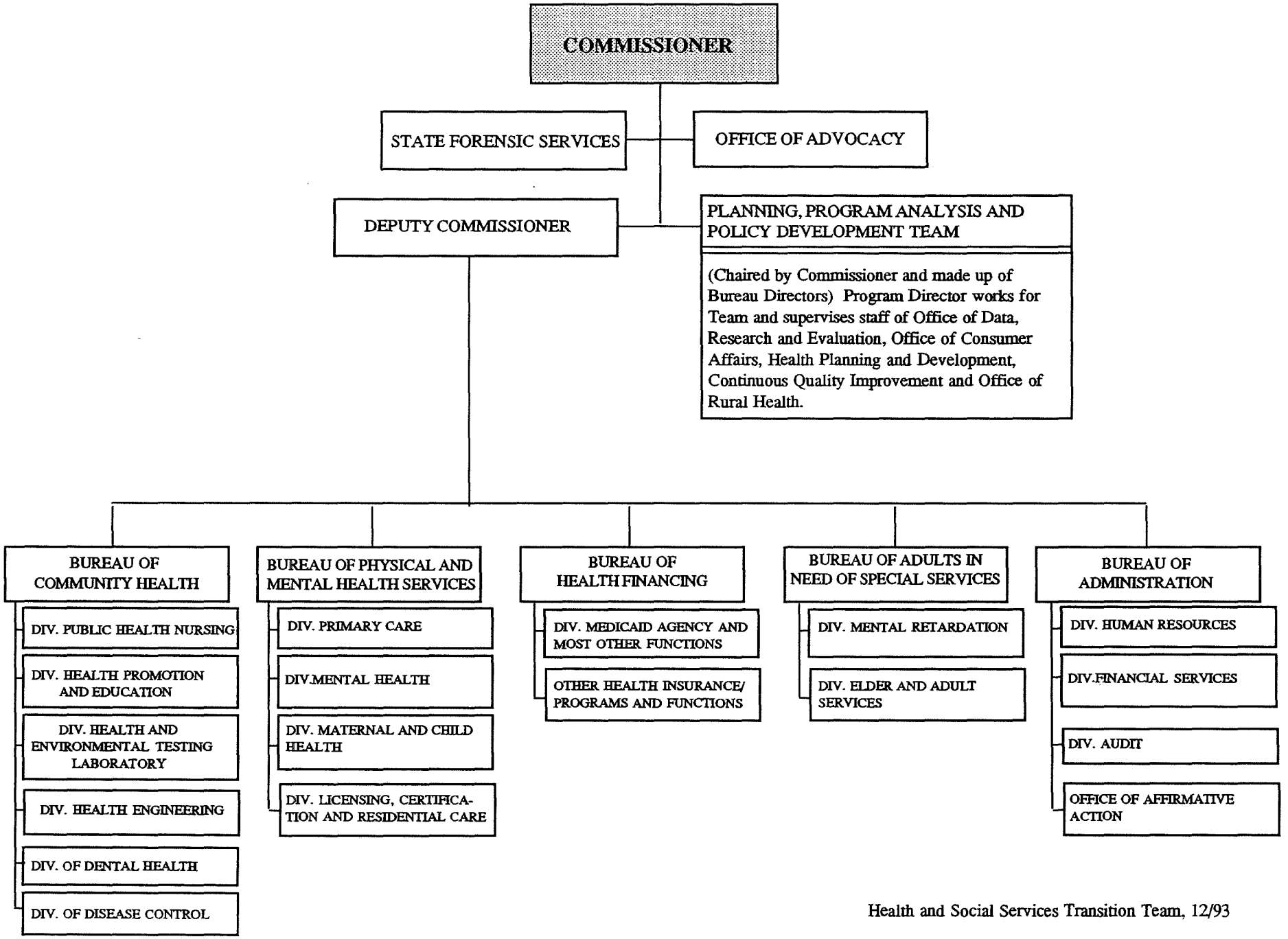


*NOTE: Italicized Numbers Represent Estimated Position Count
Estimated State and Federal Funds: $940 Million.
Estimated Total Positions: 2,418.

Health and Social Services Transition Team, 12/93

Chart II-B

MINORITY REPORT: DEPARTMENT OF HEALTH & DEVELOPMENTAL SERVICES



Health and Social Services Transition Team, 12/93

DEPARTMENT OF HEALTH AND DEVELOPMENTAL SERVICES

MISSION STATEMENT

The State of Maine declares that all citizens must have the opportunity to live in healthy surroundings and must have adequate access to health care and social services. The State must provide leadership to promote health, prevent disease and to reduce or eliminate the health, social, geographic and economic barriers to optimal independence for all Maine citizens by:

- Generating organized community effort to pursue public health by applying the latest scientific and technical knowledge;
- Ensuring that the health care system is rational and well integrated, and that it meets the needs of all citizens; and
- Ensuring that a comprehensive system of care exists that enables citizens with chronic physical or mental conditions to fully participate in their communities.

The State's role is to ensure that vital elements are in place to pursue the mission and to facilitate a partnership with citizens and public, private and nonprofit agencies to achieve common goals.

GOALS

- To ensure that health and social services necessary to achieve agreed upon objectives are provided efficiently and effectively and are continuously improved through an appropriate balance of public and private efforts;
- To assess health needs in the State based on State-wide data collection and to establish State-wide health outcomes, collaborating with regional and local health entities where they exist;
- To promote State and federal legislation that provides an adequate statutory base for health activities in the State;
- To ensure appropriate organized State-wide, regional and local efforts to develop and maintain essential personal, vocational, educational, and environmental health services; to provide full access to necessary services; and to solve problems inimical to health; and
- To ensure that services are accessible to all Maine citizens and to advocate for empowerment, choice, personal responsibility and participation by consumers and families.

GUIDING PRINCIPLES

- Priority should be placed on the development of a comprehensive, coordinated, community-based system of services that is driven by customer needs and desired outcomes;
- Maximum feasible involvement of all Maine people should be promoted in the establishment of State health policy;
- The health services delivery system should be decentralized and services should be accessible to all Maine citizens;
- The ideal health services delivery system should ensure the provision of services that are respectful of the complete health needs, both physical and mental, of each individual; and
- The ideal system should unite the public, private, and nonprofit sectors in a new effort to plan and create new service resources at the local level.

A. Functions

The Team agreed that the following functions should be in the new Department of Health and Developmental Services:

- Adult mental retardation and autism services. This includes the adult portion of the Division of Mental Retardation, the Aroostook Residential Center and Pineland Center;

- Adult mental health services. This includes all services currently provided by the Division of Mental Health, plus consent decree coordination, the Augusta Mental Health Institute and the Bangor Mental Health Institute;

- All public health functions. For the most part, these are currently provided by the Bureau of Health;

- Medicaid policy and program administration. This includes everything except eligibility, which would be performed by the Department of Children and Families pursuant to a Memorandum of Understanding. The Department of Health and Developmental Services would be the designated Medicaid agency;

- Aging and adult protection functions. These are currently provided by the Bureau of Elder and Adult Services;

- Licensing of health, mental health and adult residential facilities. These functions are currently split between the two agencies. Because it is considered a health facility, the Department of Health and Developmental Services would also license the Elizabeth Levinson Center;

- Vital statistics, health planning, rural health and certificate-of-need. These are currently provided by various organizational units of the Department of Human Services; and

- Disability determination. This function, performed under contract with the federal government, is limited to Social Security-related disability determinations, and is currently performed by a free-standing unit within the Department of Human Services.

The recommended name, the Department of Health and Developmental Services, is different from the name in the Resolve (Department of Health). We recommend it as an important symbolic step after hearing from members of the disability community who fear that their inclusion in the new department will result in a medical model being forced onto services that are, in reality, social service-oriented or are both medical and social. For instance, a person with mental retardation who lives in a supervised group living situation may need assistance with medication and other health issues, but also receives residential supports, vocational and life skills training as part of a plan developed by the individual and an interdisciplinary team.

B. Organization of Department

How the Department of Health and Developmental Services should be organized was the one major issue that the Team could not resolve by consensus. In an almost evenly divided vote, the majority favored the organization in Chart II-A; that is the organization embodied in the legislation. The minority favored Chart II-B.

The minority argued that the new department should be organized along the lines recommended by the Institute of Medicine's report on the future of public health, giving Maine a strong, progressive Health department that is well positioned to implement national health care reform. That would create an agency with truly integrated health functions. For instance, mental health would become part of the Bureau of Mental and Physical Health Services, allowing treatment of mind and body to be integrated. The minority also argued that Health Care Financing (Medicaid and other public health care programs) should be treated as a program rather than merely a financing mechanism, since policy decisions in Medicaid and elsewhere have a great impact on overall health policy. Finally, the minority would establish a management team, comprised of bureau directors and chaired by the Commissioner, to establish policy and planning direction for the Department. This would ensure that bureau directors would pursue interrelated and consistent goals within their respective bureaus and that planning would occur in a coordinated, integrated manner.

The majority argued that the minority recommendation, while philosophically compelling in the abstract, does not acknowledge the very real problems that exist in our mental health system today. The mental health system is in a state of flux; to diminish its visibility now would be a major mistake. The majority argued that, in the future, when the mental health system has stabilized, integration of physical and mental health should be reevaluated. The majority conceded that national health care reform will require some response, perhaps organizational, but argued that no one will know what the appropriate organization is until federal legislation passes. Given the magnitude of this change, it is prudent to concentrate on getting the related functions in the same department, and to let further functional integration evolve over time. The majority favors placing Medicaid and other health financing mechanisms under the Associate Commissioner of Administration, since Medicaid would comprise the single largest piece of the Department's budget, and would be used by all of the other bureaus. With each program bureau attempting to maximize its use of Medicaid, an effective budget control mechanism is needed to ensure affordability. The majority also favors a high-level, centralized policy and planning function, but would give the Commissioner more discretion in managing the process. The Office of Data, Research, Evaluation, Health Planning and Continuous Quality Improvement would serve as a staff office, under the direct supervision of the Commissioner, but accessible to each bureau.

Although the Resolve calls for preservation of the Bureaus of Mental Retardation and Elder and Adult Services, both the majority and minority recommend consolidation of the two bureaus into one. Provision of least restrictive services is an important philosophy that guides both fields, and long-term care and guardianship services are provided by both existing bureaus.

Certainly, more time might have led to a compromise on the organization of the Department of Health and Developmental Services. However, it was clear to the Team that, in order for the Legislature to act this year, the Team needed to end its deliberations and submit its report. Members on both sides of this particular debate look forward to working with the Legislature to resolve the issue and move ahead with the reorganization.

III. CUSTOMER ORIENTATION AND COORDINATION

The degree to which the new departments will respond to customer needs was a key question before the Team. More specifically, the Team wanted to establish processes and structures that would make the current maze of services less mysterious and more accessible to those who use the services. The most important of these proposals are the recommended development of a single point of access for all health and social services and unified case coordination for customers whose needs cross organizational boundaries. These proposed systems are discussed further below.

Certainly, the new configuration of services takes a major step in making services more rational, but it does not eliminate the ongoing need for close cooperation between the departments. The systems we set into place must not only be suited to respond to current needs, but must be flexible and self-correcting, with an ability to continuously improve themselves. To that end, the Team makes the following recommendations.

A. Single Point of Entry; Unified Case Coordination. Establish a single point of entry to the system for customers of all health and social services, and a unified case coordination system for customers whose needs cross organizational boundaries.

This will not be an easy task, but it is among the most important ones recommended by the Team. A single point of entry system is one in which a customer can enter the system from a designated point, regardless of the specific nature of the person's needs. The designated point will not necessarily deliver all of the services, but will serve as an information and referral source. Customers who need services from more than one department will benefit from unified case coordination, through which the customer's needs will be identified and service delivery will be coordinated, providing ease of access, a holistic approach to the customer, and central accountability. Customers who previously "fell through the cracks" will be caught by the case coordination net.

Because it will affect customers and workers at all levels of the service system, the Team recommends creating these systems over a two-year time period. The Commissioner of Human Services is directed to take the lead by establishing a planning process that incorporates the principals of total quality management. Two process action teams are to be created, one for single point of entry and the other for unified case coordination. Progress reports, along with implementing legislation if needed, are to be submitted to the Legislature on January 1, 1995 and October 1, 1995 regarding single point of access. Unified case coordination reports are due by November 1, 1995 and March 1, 1996.

B. Continuous Quality Improvement. Establish a highly visible structure for continuous quality improvement in each department.

In the Department of Children and Families (Chart I-A), this is embodied in the box to the right of the Commissioner's Office, labeled "Planning, Research, Policy Development, Continuous Quality Improvement, Training/Staff Development" In the Department of Health and Developmental Services majority report (Chart II-A), this function can be found to the left of the Commissioner, labeled "Office of Data, Research, Evaluation, Health Planning and Continuous Quality Improvement." In the minority report (Chart II-B), this would be performed by the "Planning, Program Analysis and Policy Development Team."

C. Co-location. Co-locate services to the greatest extent practicable.

As leases expire, the departments should work with the Bureau of General Services to continue the trend of co-locating in multi-service government centers. In some instances where offices currently occupy rent-free space, the benefits of this approach will have to be weighed against the costs.

D. Interdepartmental Coordination. Strengthen the Interdepartmental Council (IDC) by moving it to the Governor's Office and have the Governor designate the Chair from among the Governor's staff. Move existing IDC staff lines to the Governor's Office and fund an existing position that is currently without funding.

The IDC has much potential for serving as an ad hoc coordination device among the new departments, the Department of Corrections, the Department of Education and the Office of Substance Abuse. It suffers, however, from being perceived as being located in one department or another. Currently, it is physically housed in the Department of Human Services. The chair rotates from one commissioner to another, giving the perception that the role is not important and that coordination is a second priority. Currently, 1 and 4/5 positions exist, but only the 4/5 position is funded. The Team recommends funding both positions.

IV. ADMINISTRATIVE ITEMS

The Resolve calls for streamlined organization and administration of services, and the Team spent a great deal of time trying to meet that charge. In passing the Resolve, the Legislature specifically rejected consolidation of all health and social services into a single department, yet that alternative looked attractive to many Members when administrative issues were discussed. On many occasions, the Team found itself trying to force the new departments to share certain functions, only to find the idea impractical. For example, the idea of a single licensing unit that would perform that function for both departments is intuitively appealing. Yet, when the Team discussed the idea with program people, it became clear that licensing is an important tool used by program operators in carrying out their duties, and strong, convincing arguments were made that if a commissioner is responsible for a program, that commissioner must also be responsible for licensing.

Many Members were supportive of a plan offered to create a centralized Service Bureau that would sit between the two new departments. Some Members felt that the lack of clear lines of authority in such a model would present significant problems, but others felt that potential conflicts between the two departments could be avoided with careful planning. When a lengthy list of administrative functions was reviewed, however, the Team could only agree that three would be appropriately placed in a central bureau. It appeared to most Members that trying to force the efficiencies of a single department onto two departments would not work. A majority of the Team decided, therefore, to recommend consolidation in one department or the other where that makes sense, and to continue capacity in each department where consolidation does not make sense. Specific recommendations follow.

A. Accounting. Retain accounting capacity in each department, with the greater capacity located in the Department of Health and Developmental Services, reflecting the larger size of that agency.

B. Affirmative Action. Retain existing affirmative action capacity in each department.

C. Auditing. Centralize auditing in the Department of Health and Developmental Services; provide those services to the Department of Children and Families through an interagency agreement. This is consistent with the expected recommendation of the Advisory Committee for the Maine Uniform Accounting and Practices Act, which supports consolidation of the so-called "MAP" audits in one agency.

D. Contracting. Each department executes its own contracts. The Team is convinced that contracting is not merely an administrative process, but is an integral part of program delivery.

E. Licensing. The Department of Children and Families will license all children's homes and programs, including day care, except for the Elizabeth Levinson Center, which will be licensed by the Department of Health and Developmental Services. The function will be centrally located in the Office of Management and Budget. The Department of Health and Developmental Services will perform all licensing related to public health, health facilities, adult residential facilities, and adult programs. This will consolidate mental health licensing with other adult licensing.

F. Training & Development. Each department will have training capacity. The existing training contract between the Department of Human Services and the University of Maine System will be split between the two departments.

G. Personnel, Payroll & Employee Relations. Each department have its own capacity in this area, commensurate with size.

H. Plant & Office Services. Locate in the Department of Children and Families; provide to the Department of Health and Developmental Services through interagency agreement. These are inter-office services currently located in the Department of Human Services that are used to move mail and supplies among the department's many sites in the Augusta area.

I. Regional Administration. Locate in the Department of Children and Families; provide to the Department of Health and Developmental Services through interagency agreement as departments co-locate, except that each department performs its own regional bill payment and payroll.

J. Third-party Reimbursement. Centralize in the Department of Health and Developmental Services; provide to the Department of Children and Families by interagency agreement.

K. Data Processing. Place the existing Department of Human Services unit in the Department of Children and Families and contract Medicaid data processing to the Department of Health and Developmental Services until Medicaid's new free-standing co-processer system is certified by the federal Health Care Finance Administration. An appropriate number of positions will be transferred to the Department of Health and Developmental Services at that time. Given that the Medicaid program has already begun this transition, the recommendation may be outdated by the time the new departments are organized.

L. Cost Allocation. Immediately authorize six project positions of six months each ($49,037 State dollars) to the Department of Human Services to construct new plans for both new departments, plus a six month project position ($25,404) to complete a plan for the Department of Education. Ongoing cost allocation will be a centralized function in the Department of Children and Families.

V. OTHER ITEMS

The Team offers recommendations in the following additional areas.

A. Juvenile Corrections. Adopt the recommendations of the Juvenile Corrections Task Force.

The Resolve charges the Team with making "any changes in the juvenile correctional services that the team recommends after considering the report of the task force on juvenile corrections..." The Task Force was to decide whether juvenile correctional services should stay in the Department of Corrections or move to the Department of Children and Families. A majority of the Task Force recommended reassessing this question within the first year of operation of the new department. Accordingly, the Team recommends that such a review be completed and presented to the Legislature by January 1, 1996. For more discussion of this topic, see Determination and Recommendations to the Health and Social Services Transition Team Regarding Juvenile Correctional Services, Juvenile Corrections Task Force, November 4, 1993.

B. Regional Planning and Delivery. Support the mental health regional authority pilot project and evaluate further decentralization when the results from that project are in.

The Team heard very persuasive testimony regarding the benefits of decentralized planning and delivery of services. Although many social services are delivered locally in Maine, they are, for the most part, planned and directed through the central bureaucracy in Augusta. A key concern of many Members, however, is the potential cost of establishing regional-level organizations. The cost and effectiveness of the recently created mental health authority pilot project will be evaluated. This will provide important data and experience to the Legislature that should be considered before large-scale decentralization occurs.

C. Homeless Services. Direct the new departments, the Maine State Housing Authority and the Office of Substance Abuse to work with interested parties to determine where services for people who are homeless should be located and recommend a consolidation plan to the Legislature by 11/96.

The Resolve directs the Team to consult the Interagency Task Force on Homelessness and determine whether services for people who are homeless or at risk of becoming homeless should be consolidated in one agency and, if so, which agency. The Team's task was complicated by the fact that the Interagency Task Force on Homelessness was not functioning during the Team's deliberations. Although the Team found merit in the idea of consolidating services for people who are homeless or at risk of becoming homeless, it could not determine the best location. The Maine State Housing Authority, while very strong on the housing end of this issue, is not a social service agency. Once the new departments are operating, they should join the other interested parties in taking an in depth look at this issue.

D. Advisory Boards. Direct the Commissioner of each new department to: convene periodically the chairs of the departments' advisory committees to get a global policy view; review membership of committees to ensure all important constituencies are represented and the composition reflects the new departments' charges; and review, once the new departments have operated for a year, whether advisory boards should be consolidated into a single board for each department.

E. Food Safety. Ask the Presiding Officers of the Legislature to establish a process whereby the committees of jurisdiction (Human Resources, Agriculture, and Marine Resources) can study this issue further and make policy changes.

This is an issue that the Team did not intend to examine, but it became clear that a considerable amount of confusion exists regarding the roles of the various State agencies involved in food safety (the Department of Human Services, the Department of Agriculture, Food and Rural Resources, and the Department of Marine Resources). Although the departments understand their respective responsibilities, it does not appear rational to vendors and consumers. For example, a donut shop that serves breakfast and lunch is licensed as a bakery by the Department of Agriculture, while diners are licensed as restaurants by the Department of Human Services.

F. Office of Substance Abuse. Transfer funds from the Office of Substance Abuse to the Department of Health and Developmental Services to create two auditor positions who would be responsible for conducting OSA audits.

This will further consolidate audits in one agency. When this issue was first discussed, many Members favored moving the Office of Substance Abuse into the Department of Health and Developmental Services, but, given clear Legislative intent to leave OSA in the Governor's Office, the Team recommends this arrangement which allows OSA to receive auditing services. The location of OSA should be reviewed when the new departments have been in place for a period of time.

G. Administrative Hearings. Locate in the Department of Children and Families; provide to the Department of Health and Developmental Services by contract; direct the Department of Children and Families and the Attorney General to study the feasibility of transferring the function to the Attorney General and report to the Legislature by January, 1995.

H. Advocacy. Locate current Office of Advocacy in the Department of Health and Developmental Services, except for 1 position, which is to be located in the Department of Children and Families to focus on children with special needs; have the Department of Children and Families contract with a private vendor for the child welfare services ombudsman.

MINORITY STATEMENTS

Minority Statement
Maternal and Child Health

We are increasingly learning that categorized, segmented services do not work for the recipients of those services. Our state government is historically and traditionally tied to categorical funding streams that inhibit and prevent interdisciplinary, wholistic approaches to helping people. These funding streams inhibit and prevent providers from various professional backgrounds (such as nursing, medicine, social work, psychology, education, counseling, speech, occupational and physical therapies) from coming together easily to share their expertise and provide interdisciplinary training for one another.

Maine's restructuring effort should be making every attempt to move toward less categorical, segmented ways of seeing its people and doing its business. One important way to do this is to place all, or significant parts of the Maternal and Child Health program into the new Department for Children and Families. If the psychosocial, education and therapies for children with special needs are going to be coming from the Department for Children and Families, then the public health nursing and other medical services should as well. This will come much closer to the kind of "one-stop-shopping" that both administration, legislators and families have indicated they want.

Maine's Bureau of Health says that it is not possible for Title V (federal MCH funds) to be administered by anything other than a state's health department. A federal MCH official gave a very unclear and ambiguous written response when this requirement was questioned. Her indication is that once Maine's two new departments are actually in place, this is a question that can be pursued.

Spokespersons from MCH state that because MCH personnel are health related professionals, they must be administratively placed with other health professionals in the new Department of Health. In fact, going back to the earlier point, we need to be taking the lead in bringing professionals from many backgrounds together so that Maine's clients will benefit from an interdisciplinary, teamwork approach.

Jane Weil

#258STUDY

Minority Statement
Child Development Services

At least one bureau in the new Department of Children and Families is being conceptualized as serving children from a developmental or age-appropriate perspective. The Bureau of Children with Special Needs plans for a division for young children from birth to school entrance and a division for school-aged children.

Child Development Services serves a large number of Maine's three to five year old children with special needs and their families. CDS, until it came quite recently under Education's administration, took *services to families* very seriously. This wholistic attention to the child *in the family context* is now seriously eroded. The new Department is for children *and* families. CDS would be more appropriately placed in a department whose purpose is to serve both, and in a department where *all* of a child and family's needs -- not just "educational" needs -- are taken into consideration.

Maine's Department of Education indicates that because CDS funds come to the state through federal education mandate, that they must be administered through the Department of Education. This is not true. There are instances where this program is administered by the state health agency through an interagency agreement and instances where the program is administered through a contract with another part of state government. These options are certainly possible in Maine and should be pursued.

Historically, education as an institution has very, very rarely taken any kind of lead in creating or administering services for children below kindergarten at either the Departmental or local level. We have an educational system in Maine that is struggling just to do its job at the K-12 levels. We do not need to, and should not, give it further responsibilities for our very young children.

Further, the Department of Education is trying to make a case that it should take over, from the Bureau of Children with Special Needs, the services to birth-through-two year olds with special needs. These services are supported with federal funds (referred to as Part H) which come from the federal DOE. Again, the facts are that in only 18 states (out of 57 states and jurisdictions) are the Part H birth-through-two funds administered by a state Department of Education.

The entire birth-to-five system of services to young children with special needs and their families should be placed in the new Department along with Head Start, child care, respite, child welfare and other services with which it can coordinate in an interdisciplinary manner.

Jane Weil
Bonnie Post

Addendum to Minority Statement
Child Development Services

At the final meeting of the Transition Team, our minority report regarding Child Development Services received considerable written support. The letters received by the Team are available for review. They are unanimous in their support for services for birth to five year old children and their families being placed in the Department of Children and Families. No comments were received favoring placement of these services in the Department of Education. Comments were received from the Maine Child Care Directors' Association, the Maine Speech and Hearing Association, the Maine Association of Infant Mental Health, Speech-Language Pathologist Ellen H. DeCotiis, Speech-Language Pathologist Jane Hodges, and Cynthia Donaldson, L.M.S.W.

Jane Weil
Bonnie Post

#257STUDY

APPENDIX 1

RESOLVES, 1993, C. 36, CREATING THE HEALTH AND SOCIAL SERVICES TRANSITION TEAM

APPROVED
JUN 24'93
BY GOVERNOR

CHAPTER
36
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-THREE

H.P. 1112 - L.D. 1508

Resolve, to Abolish the Department of Human Services and the Department of Mental Health and Retardation and Create a New Department of Health and a New Department of Children and Families

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the Legislature finds that health, social and developmental services must be reorganized for maximum efficiency and effectiveness; and

Whereas, Maine State Government must reflect the changes and restructuring that are occurring in the business community by centralizing administrative functions and combining fragmented services in a way that does not adversely affect the provision of services; and

Whereas, the transition process for reorganization must begin immediately; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Reorganization of health, social and developmental services. Resolved: That, on July 1, 1994, the Department of Human Services and the Department of Mental Health and Mental Retardation are abolished and the functions of those agencies are reorganized functionally into a newly created Department of Children and Families and a

newly created Department of Health, and are delegated to other existing State agencies as specified in this resolve. On July 1, 1994, the Commissioner of Mental Health and Mental Retardation becomes the Commissioner of Health and the Commissioner of Human Services becomes the Commissioner of Children and Families; and be it further

Sec. 2. Health and Social Services Transition Team; creation. Resolved: That the Health and Social Services Transition Team, referred to in this resolve as "the team," is established. The team shall develop all legislation needed to implement the reorganization of services in accordance with this resolve, including, but not limited to, amendments to the statutes, reallocation of funds and transitional language. The legislation must be presented to the Legislature by January 1, 1994 for consideration during the Second Regular Session of the 116th Legislature; and be it further

Sec. 3. Content of legislation. Resolved: That the legislation prepared by the team must provide for at least the following:

1. Abolition of the Department of Human Services and the Department of Mental Health and Mental Retardation;

2. Creation of the Department of Children and Families with the following bureaus: the Bureau of Child Welfare, the Bureau of Child and Family Services, the Bureau of Children with Special Needs and the Bureau of Income Assistance;

3. Creation of the Department of Health with the following bureaus: the Bureau of Mental Health, the Bureau of Mental Retardation, the Bureau of Community Health, the Bureau of Medical Quality Assurance and the Bureau of Elder and Adult Services;

4. Streamlined organization and administration of services, including, but not limited to, the elimination of service duplication, the consolidation of regulatory and other administrative functions, and the coordinated development of management and information systems;

5. Creation of a universal information and referral system for all health, social and educational services, including a single point of entry for families in need of services;

6. A single case management system within each of the new departments;

7. A single contracting, evaluation and licensing system within each of the new departments;

8. Emphasis on regional and community-based planning and delivery of services;

9. Authorization for the Department of Children and Families and the Department of Health to share resources such as, but not limited to, regional office space, data management services and payroll services; and

10. Any changes in juvenile correctional services that the team recommends after considering the report of the task force on juvenile corrections created pursuant to section 6; and be it further

Sec. 4. Additional recommendations. Resolved: That the team shall make recommendations regarding the following:

1. Whether services for people who are homeless or at risk of becoming homeless should be consolidated within one agency and, if so, which agency. In developing these recommendations, the team shall consult with the Interagency Task Force on Homelessness;

2. Where the Division of Disability Determination Services should be located;

3. Which of the new agencies should be responsible for determining Medicaid eligibility; and

4. Whether, given the new configuration of the departments, any change is needed in the existing advisory board structure; and be it further

Sec. 5. Team process. Resolved: That the team shall conduct its work in an open and accessible manner. The team shall consult the business community, private industry councils, consumers and consumer advocates, health care and social service providers, mental health and mental retardation treatment providers and advisory councils on health and social service issues. As time and resources permit, the team shall hold regional meetings and hearings to gather technical information and consider public policy issues; and be it further

Sec. 6. Juvenile corrections task force. Resolved: That, by July 1, 1993, the chair of the team shall appoint and convene a task force to determine whether juvenile correctional services should remain part of the Department of Corrections or should be moved to the Department of Children and Families, recommend strategies to improve services for consumers of juvenile correctional services

and increase the eligibility of juvenile correctional clients for 3rd-party payment of services. The task force must include parents of children receiving correctional services; representatives from community advocacy organizations involved in juvenile corrections issues; a representative from the Juvenile Justice Advisory Group; at least one representative from the educational policy advisory committee for the Arthur R. Gould School; representatives from the Department of Corrections, the Department of Human Services and other appropriate executive agencies; 2 members of the Joint Select Committee on Corrections, one member of the Joint Standing Committee on Human Resources and one member of the Joint Standing Committee on Judiciary.

The chair of the team shall call the first meeting, at which the members of the task force shall select a task force chair by majority vote. The task force must report its findings to the team by September 1, 1993. Copies of the task force report must be submitted to the Joint Select Committee on Corrections and the Joint Standing Committee on Human Resources.

For the purposes of this resolve, "juvenile correctional services" include juvenile detention, probation and parole, the Maine Youth Center and community-based juvenile programs; and be it further

Sec. 7. Composition of the Health and Social Services Transition Team; chair. Resolved: That the team must be created before July 1, 1993 and consists of the following members:

1. Five Legislators, appointed jointly by the President of the Senate and the Speaker of the House of Representatives:

A. Two of whom must serve on the Joint Standing Committee on Human Resources;

B. Two of whom must serve on the Joint Standing Committee on Education; and

C. One of whom must serve on the Joint Select Committee on Corrections;

2. Two representatives from the Department of Mental Health and Mental Retardation, appointed by the Commissioner of Mental Health and Mental Retardation;

3. Two representatives from the Department of Human Services, appointed by the Commissioner of Human Services;

4. Three members from constituency or advocacy groups concerned with health, mental health, social services and homelessness issues, one appointed by the Governor and 2

appointed jointly by the President of the Senate and the Speaker of the House of Representatives;

5. Two representatives of providers of health, mental health and social services, one appointed by the Governor and one appointed jointly by the President of the Senate and the Speaker of the House of Representatives;

6. One representative from the Executive Department, appointed by the Governor; and

7. One member representing the public, appointed by the Governor, to serve as the chair of the team.

No expenses or reimbursement are authorized for members of the team. The Department of Human Services and the Department of Mental Health and Mental Retardation shall absorb the costs of preparing and distributing the team's report; and be it further

Sec. 8. Assistance from agencies. Resolved: That the following officials shall provide information, advice and assistance to the team upon request: the Commissioner of Human Services; the Commissioner of Corrections; the Commissioner of Education; the Commissioner of Mental Health and Mental Retardation; the Commissioner of Labor; the Commissioner of Economic and Community Development; the Director of the Office of Substance Abuse; the Director of the State Planning Office; the Director of the Maine State Housing Authority; and the chair of the Interagency Task Force on Homelessness. The team may request assistance from the Legislative Council to prepare the legislation required by this resolve.

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

APPENDIX 2

MEMBERSHIP, HEALTH AND SOCIAL SERVICES TRANSITION TEAM

#5343LHS

Health and Social Services Transition Team
(Resolves 1993, c. 36)

Governor's Appointments	**Category**
Rosalyne S. Bernstein, Chair 112 Craigie St. Portland, ME 04102 Home: 774-0416 FAX: 774-1127	The Public
John Robinson 202 U.S. Rt. 1, Box 184 Falmouth, ME 04105 Home: 833-6354 FAX:	Constituency or Advocacy Group
Edward J. McGeachey, Pres. & CEO Southern Maine Medical Center 1 Medical Center Drive P.O. Box 626 Biddeford, ME 04005-626 Work: 283-7220 FAX: 283-7020	Provider
Andrew McLean Office of the Governor SHS #1 Augusta, ME 04333 Work: 287-3531 FAX: 287-1034	Executive Department
Commissioners' Appointments	
Jane Sheehan, Commissioner Department of Human Services SHS #11 Augusta, ME 04333 Work: 287-2736 FAX: 287-3005	Department of Human Services
Douglas Porter, Deputy Commissioner Department of Human Services SHS #11 Augusta, ME 04333 Work: 287-2546 FAX: 287-3005	Department of Human Services
Roger Deshaies, Acting Commissioner Dept. of Mental Health & Mental Retardation SHS #40 Augusta, ME 04333 Work: 287-4223 FAX: 287-4268	Department of Mental Health & Mental Retardation
Robert Durgan, Director Bur. of Children with Special Needs SHS #40 Augusta, ME 04333 Work: 287-4250 FAX: 287-4268	Department of Mental Health & Mental Retardation

President's and Speaker's Joint Appointments

Bonnie Post Maine Ambulatory Care Coalition P.O. Box 390 Manchester, ME 04351 Work: 621-0677 FAX: 621-0577	Constituency or Advocacy Group
Jane Weil P.O. Box 22 Steuben, ME 04680 Home: 546-2269 FAX: 422-3889	Constituency or Advocacy Group
Ronald G. Thurston Maine Health Care Association 303 State Street Augusta, ME 04330 Work: 623-1146 FAX: 623-4080	Provider
Sen. Jane A. Amero 444 Old Ocean House Road Cape Elizabeth, ME 04107 Home: 799-0798	Education Committee
Sen. John E. Baldacci 79 Palm Street Bangor, ME 04401 Home: 947-6088 Work: 945-5813	Human Resources Committee
Rep. Birger T. Johnson 27 Rhode Island Avenue So. Portland, ME 04106 Home: 772-9593	Human Resources Committee
Rep. Hugh A. Morrison 18 Plaisted Street Bangor, ME 04401-4417 Home:942-4137	Corrections Cmte.
Rep. Elizabeth H. Mitchell RFD #1, Box 520 Augusta, ME 04330 Home: 622-2629	Education Committee

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