



Advocating for Older Adults of Today and Tomorrow

Testimony of

The Connecticut Commission on Aging

Select Committee on Aging: State Department on Aging bills

March 3, 2009

Thank you for this opportunity to comment today regarding the potential creation of a new State Department on Aging.

As you know, the Connecticut Commission on Aging is the independent, nonpartisan state agency that is part of the legislative branch of government. We are devoted to preparing our state for a burgeoning aging population while promoting policies that enhance the lives of the present and future generations of older adults. For fifteen years, the Commission has served as an effective leader in statewide efforts to promote choice, independence and dignity for Connecticut's older adults and persons with disabilities.

In these difficult budget times, research-based initiatives, statewide planning efforts, vision and creative thinking are all needed and provided by the Connecticut Commission on Aging. We pledge to continue to assist our state in finding solutions to our fiscal problems, while keeping its commitments to critical programs and services.

Statement on Senate Bill 841 and Senate Bill 993

The Connecticut Commission on Aging is grateful for this Committee's and the Governor's acknowledgement that aging and long-term care issues warrant greater attention and bold action by the executive branch. Improvements can and must be made to our current system.

Specifically, the Connecticut Commission on Aging supports a state structure that provides easy access for residents and that integrates and coordinates the delivery of social services. To that end, we recommend to this Committee that it ask the newly created Commission on Enhancing Agency Outcomes (HB 6602, as amended by House A and B—the February deficit mitigation bill) to examine the Department of Social Services and its organizational structure.

Connecticut's Department of Social Services is a large agency with responsibility for a wide range of programs for older adults, persons with disabilities, children, parents, low-income adults and others. A reorganization effort could better streamline services, reduce duplication of efforts, better coordinate funding streams, and create efficiencies. The Commission on Aging believes that the newly created Commission on Enhancing Agency Outcomes is the appropriate venue for exploring these ideas.

The Commission on Aging has specific concerns about the following:

- Both bills separate out certain programs that serve older adults, while leaving others at the Department of Social Services (DSS). For example, Senate Bill 841 recommends moving the CHOICES information and referral service to a new Department on Aging, but leaving

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ConnPACE at DSS. Similarly, Senate Bill 993 recommends moving the state-funded portion of the Connecticut Home Care Program for Elders to a new State Department on Aging, while leaving the Medicaid-funded portion of the CT Home Care Program for Elders at DSS. This type of fragmentation can be confusing for state residents and is administratively burdensome.

- Senate Bill 993, section 2(d) appears to unnecessarily and hopefully unintentionally place the Commission on Aging under the auspices of the Department on Aging. It is a proven fact that the Commission's role as an independent, nonpartisan agency would be lost altogether by that move.
- Senate Bill 993, section 7 adds the Commissioner of the new Department onto the Long-Term Care Advisory Council. The Advisory Council does not include any other executive branch officials in its membership, and the Commission believes that this addition is inappropriate for the mission of the Advisory Council.

We can, and should, look to national research about the effectiveness of state structure in other states, and then model our own structure on those that have been most effective and efficient.

We offer three attachments for your consideration:

- *Attachment 1:* The state's Long-Term Care Needs Assessment, based on national research conducted by experts in aging, recommends an all-ages, all-disabilities approach to the delivery of services and supports for those in need;
- *Attachment 2:* AARP's 2008 National Public Policy Book also recommends a consolidated, across-ages approach to state structure as it has proven to provide more choice and independence in how and where one receives long-term care services and supports; and,
- *Attachment 3:* In Commissioner Starkowski's March, 2008 memo regarding a study of a new Department on Aging, Commissioner Starkowski states "Advocating the transplantation of several extremely complicated yet successful direct-service programs from DSS into a new agency could be a prescription for confusion and disorganization over the coming years."

The Connecticut Commission on Aging stands ready to assist this Committee and/or any policymaker in designing a state structure that best coordinates the delivery of services to older adults. We have objective research regarding demographic trends, what's working in other states, and the needs of our state into the future. Again, we believe that the new Commission on Enhancing Agency Outcomes is a most appropriate venue for consideration of any ideas to create, eliminate or consolidate state agencies at this time.

Thank you for your consideration of this important issue.

Long-Term Care Needs Assessment

*see recommendation #7

XI. Recommendations for Connecticut

The following recommendations are offered for consideration by Connecticut lawmakers and policymakers. They are based on:

- Analysis of the results of the long-term care needs assessment surveys of Connecticut residents and service providers;
- A comprehensive review of the current system of organization, financing and delivery of long-term care in Connecticut; and
- A comparison of Connecticut's long-term care services, organization and financing with those of other states, several of whom are leaders in this field.

The recommendations are also based on two guiding principles, which should be considered in connection with any policy or program changes developed to implement the recommendations:

- Create parity among age groups, across disabilities, and among programs through allocating funds equitably among people based on their level of need rather than on their age or type of disability.
- Break down silos that exist within and among state agencies and programs. Use the model of systems change grants such as the Money Follows the Person Grant and the Medicaid Infrastructure Grant to foster integration of services and supports.

I. Create a statewide Single-Point of Entry (SPE) or No Wrong Door (NWD) Long-term Care Information and Referral program across all ages and disabilities. Survey respondents, providers and state agency staff all reported that it is difficult for Connecticut residents who need long-term care to find basic information about the types of care that are available to them and who will provide this care. An expert team comprised, for example, of State Unit on Aging staff, members of the Long-Term Care Planning Committee and Advisory Council, consumers and providers should develop a plan to implement a centralized SPE/NWD in Connecticut. The SPE/NWD should encourage equity in allocation of services and supports across ages and across disabilities. Many of the 43 jurisdictions throughout the U.S. with existing Aging and Disability Resource Centers (ADRCs) present models for doing so. The SPE/NWD should also inform the hospital discharge planning process to avoid unnecessary institutionalization, and should consider the creation of common applications for program eligibility to avoid the necessity of giving the same information multiple times.

Another promising avenue would be to consider modeling a Connecticut SPE/NWD on certain features of the existing CHOICES program, which currently provides referral services through each of the five AAAs. If CHOICES is used as the most appropriate model for Connecticut, it would require centralization of at least the initial point of contact, an increase in the capacity to include Centers for Independent Living or other community-based organizations, additional staff training on all long-term care options across ages, disabilities and income, across all entry point agencies, and increased visibility of its services. Whatever method is chosen, provide a wide range of access (e.g. face-to-face, telephone, and web) that will help individuals and their families: first, identify the most appropriate type of long-term care services and supports and second, select specific providers that will meet their needs. Utilize standard assessments and programmatic coordination to increase equity in access, enhance residents' knowledge of options, enable better decision-making, and encourage better discharge planning.

2. Provide a broader range of community-based choices for long-term care supports. Major policy and financing efforts should be undertaken to develop a broadly integrated infrastructure for community-based services including home health, homemaker and adult day services. Reduce restrictions on who can provide this care. States such as Oregon and Washington can serve as useful models. Both diversion and transition strategies must be improved in order to maximize opportunities for individual choice. Comprehensive, coordinated pre-admission screening for need and eligibility is necessary in order for these strategies to work. In addition, systematic attention must be directed toward expanding available slots in pilot programs for assisted living and other supportive community-

based residence settings, and making these programs permanent. Combine HUD and other housing programs to cover housing costs for those whose assisted living services are covered by Medicaid.

3. **Foster flexibility in home care delivery.** Develop increased flexibility in Connecticut's rigid, highly professionalized model of home care delivery. In the current model, both agencies and individual providers are subject to extensive and sometimes inflexible licensing requirements and regulations. Increase in-home delivery with more cost-effective models. Study, and implement where appropriate, initiatives such as nurse delegation of specific tasks in specific settings, and using lower cost alternatives (e.g. homemaker vs. home health care) while not compromising the quality of care. Review the current scope of practice definitions for the nursing professions, and develop options for refinement in order to promote flexibility. Consider allowing an independent provider model in which providers are not required to work for an agency, a model that is more cost-effective and flexible.

4. **Address scope and quality of institutional care.** Explore and establish effective incentives to encourage the downsizing of public and private institutions while at the same time improving quality in remaining institutions. Examples include single rooms, report cards, and creation of a reimbursement system for all institutional settings based on quality improvement indicators. Other alternatives should be sought when additional institutions are proposed. Facilitating national efforts to change the culture and quality of life in nursing homes, the Department of Public Health, in collaboration with Centers for Medicare and Medicaid Services, should assess and amend existing regulations to allow for continued development of individualized care and culture change models within this care setting. The long-term care Ombudsman Program and coalitions such as the long-standing Breaking the Bonds Coalition should be engaged in this process.

5. **Provide true consumer choice and self-direction to all long-term care users.** Develop policies and programs to: a) allow consumers/family members to choose their own care providers, including from within their own informal care network, particularly family members, b) allow consumers to control their own budgets, c) make case management optional for individuals who are able to manage their own care, d) use the DMR waivers as a model for self-directed care, and e) make these options available across all ages and disabilities. Programs should operate with as much flexibility as possible, including the ability to arrange for as many care provider hours as necessary, in whatever configuration across providers is appropriate and preferred by the consumer. Since many consumers/family members come into a long-term care situation without prior knowledge or experience, it is important that they have assistance in making choices and self-direction, and that the assistance be comprehensive and unbiased.

6. **Simplify Connecticut's Medicaid structure.** Strive for simplification in Connecticut's Medicaid structure, which is based heavily on waivers and pilot programs. Add essential community-based services such as personal care assistance options to the state Medicaid plan. Strive for a universal waiver with consistent requirements across ages and disabilities, or include HCBS services in the state plan, as was recently done in Iowa. Include programs for adults with developmental disabilities who are not mentally retarded. If it is determined that one waiver is not feasible, every effort should be made to ensure that consistent eligibility and level of need reporting forms are consistent across waivers. In addition, pilot programs that have proven successful should be made a permanent feature of the Medicaid program.

7. **Create greater integration of functions at the state level, and consider alternative configurations of state government structure in order to best meet Connecticut residents' long-term care needs.** Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid dollars and Older Americans Act funds rather than dividing them. Reconsider the establishment of a separate cabinet-level State Department on Aging. Address the needs of persons with autism without the creation of a separate Board of Education and Services for Citizens with Autism Spectrum disorders. Study recent trends in states with successful long-term care and other programs that serve all age and disability groups. As appropriate, individual departments could function with some level of autonomy under one umbrella agency in order to maximize expertise about specific conditions.

8. **Address education and information needs of the Connecticut public.** In addition to establishing a highly visible SPE/NWD for people needing long-term care (as described in Recommendation #1), targeted information campaigns concerning long-term care services and supports should be developed in collaboration with high-visibility, convenient community partners, such as hospital discharge planning offices, community and senior centers, AAAs, and public libraries. These campaigns should integrate existing internet resources such as the long-term care website. Additional training and resources should be provided to those who are the most frequent sources of long-term care information and advice, such as social workers and health care providers, as well as Probate Court officials and conservators.

More broadly, the state should consider investing in a public information and education campaign directed at educating the public about long-term care. All educational efforts should emphasize a broad public understanding of long-term care that combats misperceptions created by the traditional definition that relates solely to medical facilities. Connecticut should investigate the joint federal-state "Own Your Future" long-term care Awareness Campaign designed to increase consumer awareness about, and planning ahead for, long-term care needs. Another model for a public education campaign is the "Able Lives" series produced by Connecticut Public Television.

9. **Increase availability of readily accessible, affordable transportation.** In order to facilitate true choice in care and support alternatives, improve transportation options at the state and local level for persons who require additional assistance due to disability or other decline in physical or mental functioning. Encourage municipalities to work together to form regional plans that meet local and regional needs. Consider the formation of a broadly representative task force, led by a state-wide liaison from the Department of Transportation, to fully investigate alternative approaches and resource needs to accomplish this goal. Coordinate with the Medicaid Infrastructure Grant (Connect-Ability) team which has identified transportation as a priority area.

10. **Address long-term care needs of persons with mental health disabilities.** It is noteworthy that approximately 25 percent of the Needs Assessment survey respondents reported symptoms of depression, and that persons with psychiatric disabilities stressed the difficulty in accessing mental health services. Therefore, it is imperative that, under the Mental Health Transformation Grant, and in the development of the Medicaid Home and Community-based Services Program for Adults with Severe and Persistent Psychiatric Disabilities, state agencies work together to increase the financing and availability of comprehensive mental health services, including community-based care options, to meet the needs of Connecticut residents.

11. **Address access and reimbursement for key Medicaid services.** Psychiatric, dental, and podiatric services were identified in the Long-Term Care Needs Assessment survey as a particular problem for those receiving services through the Medicaid program. Difficulties involving access and financing persist. The Department of Social Services should assess the feasibility of increasing reimbursement rates to attract providers willing to serve this population. Several states, including Washington and Oregon, have already accomplished this critical component.

12. **Expand and improve vocational rehabilitation for persons with disabilities.** Connecticut has begun to address this identified need through its Medicaid Infrastructure Grant (Connect-Ability). The Connect-Ability project coordinators should review the findings from the Long-Term Care Needs Assessment. To the extent feasible, targeted analyses of relevant data should be conducted, based on needs identified by project coordinators.

13. **Address the long-term care workforce shortage.** Workforce Investment Boards should be engaged to develop approaches to increase the size of the formal long-term care workforce, including training, education and incentives. The wage gaps, including benefits, between public and private frontline

workers and across those workers who care for different populations should be addressed. Increased flexibility in Connecticut's self-direction model, allowing consumers to choose their own care providers, will also help to address the workforce shortage.

14. Provide support to informal caregivers. Provide assistance with training, financing (including incentives) and information for informal caregivers, including family members. Respite and adult day programs should be available statewide without age and specified disability restrictions. Caregivers should be a target group for education about long-term care services availability and financing.

15. Continue and expand efforts to build data capacity and systems integration in the service of better management and client service. Build upon the web technology and systems integration efforts of DMR and the Medicaid Infrastructure Grant to enhance access to data for providers and policymakers.

This Long-Term Care Needs Assessment was charged with providing a broad overview of the existing long-term care system in Connecticut and projecting long-term care needs in the coming decades. These recommendations focus on the major areas where Connecticut's long-term care system must be improved in order to meet these needs.

In implementing these recommendations, systematic review of successful models being used in other states is essential. As a result of federal developments such as the Olmstead Supreme Court decision, the New Freedom Initiative and the Deficit Reduction Act, a number of states have implemented innovative programs designed to achieve rebalancing goals. Whenever feasible, the successes, accomplishments and lessons learned from these states should be used to inform policy and planning efforts in Connecticut. Connecticut's lawmakers and policy-makers are well-positioned, with the assistance of expert advisors and the examples of leading states, to bring these recommendations to fruition.

A planned series of in-depth issue briefs from the long-term care needs assessment survey data, which will address specific long-term care topics, will assist in this continuing endeavor.

Commission on Aging: Attachment 2

AARP National Public Policy Book

person can call himself or herself a GCM and offer services to the public. There is little information on whether there is fraud and abuse in this unregulated field and whether clients are getting informed advice.

FEDERAL & STATE POLICY

COORDINATION AND INTEGRATION OF LONG-TERM SERVICES AND SUPPORTS

Steps to Improve Coordination

All federal and state agencies with a key role in financing or delivering long-term services and supports (LTSS) should coordinate their efforts and when appropriate and feasible help coordinate activities among LTSS agencies and agencies serving people who use LTSS (e.g., agencies dealing with income support and housing). For example the federal government and the states should ensure that LTSS agencies and mental health authorities address the mental health needs of older people in need of LTSS and the LTSS needs of people with mental illness. At the local level, area agencies on aging should have cooperative working agreements with community mental health centers to meet older people's mental health needs.

Care management should be an essential part of any LTSS system because it can address the fragmentation of present delivery systems and help ensure that clients' needs are met cost effectively.

STATE POLICY

COORDINATION AND INTEGRATION OF LONG-TERM SERVICES AND SUPPORTS

Steps to Improve Coordination

AARP supports consolidated long-term services and supports (LTSS) agencies. A consolidated agency has responsibility for administration, policy and funding for all long-term services and settings. This includes Medicaid-funded institutional care and community-based programs such as personal care, home- and community-based services waiver programs, home health care, hospice care, Programs for All-Inclusive Care for the Elderly, and state-funded LTSS programs. The model structure includes the state agency on aging with its Older Americans Act (OAA) programs. A consolidated agency has responsibility for Medicaid financial eligibility determinations and for quality management for the LTSS system. The agency can cover all populations of people with disabilities—older people, other adults with physical disabilities, and people with mental retardation/developmental disabilities. (People with mental illness are rarely included.)

Ideally, a state should have one administrative organization with the following attributes:

- an independent single entry point for people seeking publicly or privately funded LTSS—The entry point should provide comprehensive,

consumer-friendly counseling at critical decision points, conveniently located offices in neutral settings, an 800 number to assist in finding the nearest office, comprehensive information on care options and funding sources, neutral assessment and care plan development based on consumer needs and preferences, and prompt determination of functional and financial eligibility for all publicly funded services;

- global budgeting with flexibility and authority to fund an array of LTSS, whether institutional or HCBS—Global budgeting allocates a set level of funds within which providers must operate (whether the funds are applied at the federal, state or institutional level). However, global budgets must be based on the projected needs of the population and the anticipated changes in LTSS delivery and be adjusted for expected inflation;
- administrative simplification—Elimination of unnecessary paperwork and other inefficiencies through administrative and systems reform would help contain costs. For example providers could use standard, simple terms and billing forms, including electronic billing. Current data on nursing home charges and all other LTSS providers should be available to the public;
- case management capacity to provide assistance and oversight for consumers;
- a process for resource development that meets consumer demand for services and supports;
- a guarantee that consumers have a choice of care managers and the ability to change care managers;
- fair rate setting and contracting processes for service providers;
- a structure and process for ensuring quality oversight throughout the system;
- integration of programs supported by OAA funds;
- a comprehensive assessment to determine beneficiaries' LTSS needs—States should have uniform assessment instruments to reduce paperwork for people covered by more than one program. Assessments should take into account the different needs of people with different conditions and should focus on both the person's current care needs and his or her potential ability to live in the community with appropriate LTSS; and
- a system to ensure that services to address a person's health and LTSS needs are appropriately and cost effectively coordinated.

In overseeing care management systems, states should:

- ensure that care management is available through a community organization (such as an area agency on aging) that does not directly provide LTSS (this would not apply to people in managed care programs);
- require training, annual continuing education and supervision for care managers—States should require care managers to practice according to professional standards and norms, which include attention to recommended safe caseload limits;

- require training for care managers so they can develop high-quality service plans that meet client needs and program cost constraints;
- require care managers to use a client-centered approach that emphasizes the autonomy of the individual, incorporates the client's goals in the development of the LTSS plan, and develops the service plan in partnership with the client and relevant family members based on the client's needs and choice of LTSS—Care managers should inform consumers about the costs of service options, and consumers should sign off on their care plans as equal partners;
- require care management agencies to have strong consumer representation on their boards, particularly consumers who use LTSS;
- require that public and private geriatric care managers are registered nurses or clinical social workers with documented geriatric training; and
- ensure that individual care plans are based on clients' LTSS needs.

COORDINATION AND INTEGRATION OF LONG-TERM SERVICES AND SUPPORTS

Background

Integrating Health Care and Long-Term Services and Supports

In the 1980s Congress authorized two demonstration projects to examine the financing and coordination of health care and long-term services and supports (LTSS) systems. The first project, On Lok Senior Health Services, is a nonprofit community-based organization providing a full range of coordinated health care, LTSS and social services to frail elderly residents of San Francisco. On Lok combines funds from many sources, including Medicare and Medicaid, to provide these services for a capitated payment. The On Lok model was expanded and tested as the Program of All-Inclusive Care for the Elderly (PACE) at sites around the country. The Balanced Budget Act of 1997 changed PACE from a demonstration project to a permanent component of the Medicaid and Medicare programs.

Social health maintenance organizations (SHMOs) represent another type of organized delivery system that integrates acute care and some LTSS—primarily community-based and in-home services—for Medicare beneficiaries who are enrolled in a Medicare Advantage (MA) plan (see Chapter 6, *Health: Health Care Coverage—Publicly Administered Health Insurance—The Medicare Program—Private Health Plans in the Medicare Program: Medicare Advantage*). However, the SHMO plans are paid 5.3 percent more than the MA county rates to cover the expanded benefits Medicare does not provide.

Congress authorized the first demonstration of SHMOs in 1984 and has since extended it six times. A revised, “second-generation” model was authorized in 1990 (and begun in 1996) and designed to reflect greater



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MEMORANDUM

To: The Hon. M. Jodi Rell, Governor
The Hon. Donald E. Williams, Jr., Senate President Pro Tempore
The Hon. James A. Amann, Speaker of the House
The Hon. Martin M. Looney, Senate Majority Leader
The Hon. John McKinney, Senate Minority Leader
The Hon. Christopher G. Donovan, House Majority Leader
The Hon. Lawrence F. Cafero, Jr., House Minority Leader
The Hon. Toni Nathaniel Harp, Senate Chair, Appropriations Committee
The Hon. Denise W. Merrill, House Chair, Appropriations
The Hon. David J. Cappiello, Senate Ranking Member, Appropriations
The Hon. Kevin M. DelGobbo, House Ranking Member, Appropriations
The Hon. Jonathan A. Harris, Senate Chair, Human Services
The Hon. Peter F. Villano, House Chair, Human Services
The Hon. John A. Kissell, Senate Ranking Member, Human Services
The Hon. Lile R. Gibbons, House Ranking Member, Human Services
The Hon. Paul R. Doyle, Senate Chair, Select Committee on Aging
The Hon. Joseph C. Serra, House Chair, Select Committee on Aging
The Hon. Sam S.F. Caligiuri, Senate Ranking Member, Select Cmte on Aging
The Hon. Al Adinolfi, House Ranking Member, Select Committee on Aging
The Hon. Robert L. Genuario, Secretary, Office of Policy and Management

From: Michael P. Starkowski, Commissioner

Date: March 18, 2008

Subj: **Transmittal of Southern Connecticut State University study regarding re-establishment of a Department on Aging, in accordance with PA 05-280**

Attached please find the report by Southern Connecticut State University's Louis and Joan M. Sirico Center for Elders and Families, funded by the General Assembly in Public Act 07-01 to obtain "a recommendation as to the functions and responsibilities of the new Department on Aging, its organizational structure, the recommended number of staff, the type of staff, the programs that should be included, and the projected costs associated with such a department." (MOA #93SCS-ELD-01)

The report's executive summary describes preference for phased-in 'gatekeeper' approach, which would "centralize control of all programs dealing with seniors, even if this means dividing Medicaid and Medicare according to age criteria." The other agency

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approaches under consideration are defined as 'coordinator,' 'local networker' and 'expert advocate.' [Summaries of these models on pages 2-3 of attached report and in addendum at end of this transmittal memo.]

In direct contrast to 2007 conclusions by the University of Connecticut Health Center's Center on Aging, the new report's preference for a 'gatekeeper' approach presents significant program and cost implications for policymakers. [More on conclusions by the UConn Center on Aging on page 4 of this transmittal memo.]

According to the consultant, the first step of a phased-in 'gatekeeper' approach would be creation of an independent Department on Aging with a cabinet-level position of Commissioner, reporting to the Governor. The programs recommended to be included in the first phase include the Long-Term Care Ombudsman Program, all Older Americans Act programs and the Connecticut Home Care Program for Elders. In the second phase, the Protective Services for the Elderly Program would be added, as well as increased communication and strategic planning with the Commission on Aging. The third phase would expand responsibilities to include the potential transfer of other major programs affecting elders, ConnPACE. These phases are summarized on page 3 of the report.

Total funding for a new department envisioned in the SCSU Sirico Center for Elders and Families report appears to be about \$239.5 million, the bulk being programs and the following for new (non-transferred-in) positions: \$128,000 for Commissioner, \$57,000 for Administrative Assistant, \$70,000 for Legislative Liaison PR Comm Mgr, \$64,000 for IT Infrastructure Specialist, \$64,000 for Human Services/Payroll Specialist, \$56,000 for Accountant, \$64,000 for Grants and Contracts Manager; and \$681,000 for fringe benefits, \$57,000+ for Commissioner Search Costs, \$150,000 for Staff Relocation Costs and \$200,000 for IT. Total additional cost is put at \$2,251,298, of an agency total of \$239,482,624.

* * *

***From Department of Social Services:
Initial implications for consideration***

1. **The 'gatekeeper' model is the most elaborate and extensive** of the models under consideration.
2. **The 'gatekeeper' model would reverse much of the comprehensive Human Services Integration** for program and budget efficiencies adopted by the General Assembly after the report by the Commission to Effect Government Reorganization (Hull-Harper Commission), effective July 1993. At that time, the former Departments of Income Maintenance, Aging and Human Resources merged into the Department of Social Services.
3. **To effect a 'gatekeeper' departmental model,** the report recommends uprooting several complex multi-client direct-service programs from the Department of

Social Services and sending them to a new Department on Aging. Examples: Connecticut Home Care Program for Elders (a Medicaid-affiliated program); programs for elders funded under the Older Americans Act; Protective Services for the Elderly (social workers investigating abuse/neglect/exploitation); and, potentially, ConnPACE and long-term care services (presumably, Medicaid). In addition, the independent State Long-Term Care Ombudsman Program (attached to DSS for administrative purposes only) would move to the new department.

4. **Advocating the transplantation** of several extremely complicated yet successful direct-service programs from DSS into a new agency could be a prescription for confusion and disorganization over the coming years. Whether this is in the best interests of Connecticut's elders and their families/advocates is an open question.
 - o The Connecticut Home Care Program for Elders, with its Medicaid eligibility processes, is enough to give pause in itself. Federal law requires eligibility determination be made by staff in the Medicaid agency. DSS cannot delegate Medicaid eligibility responsibilities to any other entity. With regard to the state-funded portion of the Home Care program, eligibility determination is made by the same DSS eligibility staff using the same eligibility system. DSS also has an intricate information system for purposes of obtaining federal revenue for Medicaid programs through an approved federal claiming process.
 - o With regard to the clients receiving services, it begs the question whether elders and their families would now have to deal with two agencies – Aging and DSS (the Medicaid agency). The notion of pulling Medicaid programs or state-funded programs such as the Connecticut Home Care Program for Elders away from the agency that is required to establish the financial eligibility process jeopardizes the goal of enhanced customer service.
5. **To carve out ConnPACE** services for the elderly would require information systems change and administrative changes to a program that is intertwined with other medical assistance systems, a task that would be costly and wasteful. In addition, DSS has complex information systems in place for the coordination of benefits with Medicare Part D, obtaining pharmaceutical manufacturer rebates and supplemental rebates, and information systems that assist in determination of Medicaid spenddown for ConnPACE clients.
6. **The consultant report has a vision for a Department on Aging that is far more than the strong advocacy**, information/referral, think tank, planning and troubleshooting roles that some may have wanted for a new agency. The consultant's vision is about transplanting administering complex direct-service programs. The report seems to ignore the sheer challenges involved in moving federal/state medical assistance programs and state social work programs and underestimates the value of a unified eligibility system and federal claiming system.

* * *

In summary, the task of considering a new Department of Aging presents a variety of significant implications for policymakers to weigh. It should be acknowledged that SCSU's Sirico Center was given a difficult assignment about a controversial subject. However, there are profound concerns about and drawbacks to the consultant's far-reaching recommendation for a 'gatekeeper' approach to create a major operational agency. If the recommendation for a 'gatekeeper' approach is supported, additional and more in-depth review will be required because of the model's direction to uproot direct-service Medicaid and social work programs from an environment where they work for people, tap economies of scale, and offer community presence through 12 DSS field offices, and coordinate with similar programs.

In its 2007 Long-Term Care Needs Assessment, developed for the Connecticut Commission on Aging, the UConn Health Center's Center on Aging states the following in support of improved access to long-term care information and services, and increased coordination among state agencies:

- **"The proposal to establish a cabinet-level Department on Aging has generated concerns regarding further splitting of responsibilities and lack of coordination between Medicaid waivers and Older Americans Act (OAA) programs. Separating OAA money from other Medicaid programs in a cabinet-level Department on Aging is likely to make the system more complex and confusing and thus be counter-productive for older people. Generally, the interests of older people are not served well when they are isolated from other groups and from the primary funding source, Medicaid." (page 30, Executive Summary, Long-Term Care Needs Assessment, June 2007; www.cga.ct.gov/coa/needsassessment.asp).**

The UConn Center on Aging also stated the following in support of greater integration of functions at the state level, and consideration of alternative configurations of state government structure in order to best meet Connecticut residents' long-term care needs:

- **Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid dollars and Older Americans Act funds rather than dividing them. Reconsider the establishment of a separate cabinet-level State Department on Aging... Study recent trends in states with successful long-term care and other programs that serve all age and disability groups. As appropriate, individual departments could function with some level of autonomy under one umbrella agency in order to maximize expertise about specific conditions." (page 33, Executive Summary, Long-Term Care Needs Assessment, June 2007; www.cga.ct.gov/coa/needsassessment.asp).**

If anything, a new Department of Aging may be most beneficial to clients and most feasible administratively in the 'expert advocate' model. The SCSU consultant notes, for example, that the 'expert advocate' model "minimizes the duplication of services with other programs providing similar services to younger individuals and families" (page 3 of

attached report and addendum portion at end this memo). In other words, there *would* be duplication of services with other programs if the gatekeeper approach is given traction. In this vein, the Department of Social Services would favor re-establishment of a sole-purpose Division of Aging Services as an operational entity within DSS in close coordination with the Commission on Aging and, if implemented, a new Department on Aging that assumes the administrative roles as explained in the expert advocate model.

If you would like further information at this point, please feel free to contact me at 860-424-5053 or Michael.starkowski@ct.gov. If necessary, we can arrange a meeting with interested legislators and the consultants who prepared the report. Thank you and best regards.

c: Julia Evans Starr, Executive Director, Commission on Aging
Nancy B. Shaffer, State Long-Term Care Ombudsman
Claudette J. Beaulieu, DSS Deputy Commissioner, Programs
Amalia Vasquez Bzdyra, DSS Deputy Commissioner, Administration
Pamela Giannini, DSS Director, Aging, Community & Social Work Services
David Parrella, DSS Director, Medical Care Administration
Lee Voghel, DSS Director, Financial Management & Analysis

Addendum: the four approaches cited by the Southern Connecticut State University's Louis and Joan M. Sirico Center for Elders and Families in considering a new Department on Aging

From the SCSU Sirico Center report (pages 2-3 of electronic report version):

"In an examination of Departments on Aging across the United States, the team identified four different paradigms that had been successfully implemented, and championed by various stakeholders within Connecticut.

"1. **Coordinator** – The Coordinator paradigm is currently used to provide elder care in Connecticut and enjoys considerable support within the state departments (Social Services, Health, etc.). These respondents favor strengthening the current Bureau of Aging, but maintaining an environment of decentralized governance. Elder services shares authority with larger units, such as the Department of Health or the DSS, and with a number of agencies, bureaus and programs. This coordination structure incorporates Connecticut's Bureau of Aging, a number of DSS programs, as well as an independent Commission on Aging (COA) in charge of legislative advocacy.

"2. **Local Networker** – The Local Networker paradigm transfers many administrative powers and responsibilities to area agencies and authorities. Connecticut's local Area Agencies on Aging consistently request this type of decentralization. From this community services perspective, those closest to the delivery of services are most informed concerning current needs and administrative requirements.

"3. **Gatekeeper** -- Gatekeeper departments, in their pure form, centralize control of all programs dealing with seniors, even if this means dividing Medicaid and Medicare according to age criteria. Embraced by many states and championed by many Connecticut legislators, gatekeepers are designed to be independent power holders typically directing programs with large budgets, certification, and approval and enforcement powers. Such powers give these departments 'bureaucratic teeth' that command respect and direct action from local agencies and providers. Thus gatekeeper departments can champion the needs of seniors in resource allocation battles with other state programs.

"4. **Expert Advocate** – Expert advocate departments preserve their independence and centralization, but are limited in significant administrative responsibilities. Many respondents in Connecticut's DSS and DPH favor a stronger CDA, as long as the new department does not affect certain critical programs. These departments for the elderly are independent and report directly to the governor, but do not shoulder many resource allocation, enforcement or certification responsibilities. This minimizes the duplication of services with other programs providing similar services to younger individuals and families."