

Eastern Regional Mental Health Board, Inc.

The citizen's voice in mental health policy.

The DSS Discount Sale: reduced prices on everything of value

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The DSS budget is one of the densest, most complex documents I regularly read. There are so many programs that affect so many people directly, that anyone with a large family is likely to know something about a lot of sections—perhaps more than the generalists who devised this stuff. Unfortunately, many of those programs are cut this year in the misguided belief that less *care* means less *cost*. I will mention just a few.

The Independent Living Centers. Cutting \$274,000 from the Independent Living Centers is a perfect example of penny wise/ pound foolishness. That cuts at least one job from each of the five centers, but it will mean more than five people who are newly unemployed. It means that they will not be able to help as many people go back to work or stay out of nursing homes as before. Like so many other small non-profits, their few underpaid, overworked staff get paid partly in money and partly in satisfaction, but the same can't be said for their creditors. Unless you can cut the cost of living, you shouldn't cut people who are already sacrificing so much. The one percent COLA recently added to the budget is a welcome token of the Governor's esteem, but it will go mostly to health insurance companies.

Medicaid LIA and related subdivisions of the poor. DSS proposes several changes to state programs *in anticipation* of federal healthcare reforms coming in two years. The purpose of these changes *should be* to promote continuity of care and set as few barriers to care as possible. So, the programs for people on Medicaid, Medicaid LIA, and the "Basic Health Program" for people between 133% and 200% of the official poverty line should be the same, and one should not have to reregister every time one's income crosses those invisible and meaningless lines. Re-creating *asset limits* is another hurdle that DSS will divert resources to create, only to tear it down again in 2014. Even DSS admits it does not have the staff to process all those changes.

Different programs, different benefits, and re-registration *deny care* to people who are put into limbo every time their income goes up or down with the weather. People at this level often do not work steadily for steady wages. They get and lose temporary jobs all the time. Their health care costs go *up* in the long run because they cannot see the same provider twice, they get sicker between visits, and often wind up in Emergency Rooms.

Good care is always cheaper than bad care. That is why we promote health homes, information technology, and care management. Needless distinctions among the poor defeat this goal. Imposing **limits on the quantity** of care is similarly self-defeating. Does DSS think that poor people heal *faster*, so they won't need to stay as long in nursing homes or see doctors as often? I'd look closely at that data if I were you.

Finally, I want to make a general point about **merging agencies**, especially the Office of Protection and Advocacy (**P & A**) and the Commission on Human Rights and Opportunities (CHRO). I support the *goal* of eliminating the obsolete and mismanaged. *But* these agencies do different things and do them differently. Superficial logic may obscure practical realities. Merging troubled agencies only merges the troubles unless you have a new strong administrator with the credibility and charisma to make reforms, and that is rarely required by such proposals.

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