
LEGISLATORS: STATE OF CONNECTICUT

Senator Harris, Representative Villano, and Members of the Human Services Committee I appreciate the opportunity to provide testimony regarding this important legislative initiative. My name is Ronald Fleming [Ph.D., LCSW]. I am the President and CEO of Alcohol and Drug Recovery Centers, Inc. [ADRC, Inc.], in Hartford, Connecticut. Today I am here speaking as a member of the Connecticut Association of Substance Abuse Agencies (CASAA) and on behalf of ADRC, Inc.

ADRC, Inc. serves approximately 3,000 different persons each year in over 5,000 episodes of care provided through the operation of 150 residential beds and two outpatient counseling centers. We employ a diverse workforce of 135 fulltime persons and an additional 65 part-time persons in one of the poorest communities in the state.

My Agency operates services from six [6] different buildings located in the greater Hartford area. Providing services to drug and alcohol addicted persons requires safe, secure, and supportive settings which can meet the requirements of health departments, fire departments, accrediting bodies, and funding agencies [such as DMHAS].

Passage of the Community Provider Rescue legislation would work to resolve some long-standing issues within the non-profit provider community. Without this legislation the quality and scope of services will suffer – if not the very viability of some agencies.

Salary & Benefits: My colleagues and I have come to the legislature year after year trying to impress upon you the tremendous disparity that exists between private non-profit provider salary rates and that of their peers working for State agencies. The COLA provided last year was welcome support but does not address the fundamental disparities that continue to exist. In addition, due to the inconsistent availability of COLA support most agencies have not been able to keep up with the escalation in their payroll costs. At my Agency our most recent health insurance cost increases were the equivalent of 62% of last years COLA . While our Agency did provide a 3% COLA to our employees this pay increase was covered only in small part by last year's COLA.

Physical plant – Maintenance & Repair: A related and comparably serious problem for most agencies is the cost of maintaining and repairing the infrastructure of their service structure. Buildings, computer systems, and vehicles constitute critical aspects of most agencies and yet are not adequately supported by existing funding arrangements with the State of Connecticut. Grants typically do not allow agencies to make “capital expenditures” [costs of \$5,000 or more]. Even in cases where agencies attempt – through budget controls – to save \$5,000 to \$10,000 for a major infrastructure expense these expenditures are typically not allowed under existing funding rules.

Substance abuse providers deliver services on a fee-for-service basis. They also receive grant funds from DMHAS in order to provide uncompensated care or specialty care that is critical but not reimbursable by SAGA, Medicaid, Medicare, or

other third party entities. These grant dollars come from both the federal budget and the state general fund.

When the legislature grants a cost of living adjustment to DMHAS providers, it is based on only the state grant portion of our budgets [there are occasions that DMHAS will provide COLA funds based on some portion of federal funds received by the Agency]. At ADRC, our total DMHAS grant dollars represent 40% of our budget. We deliver hundreds of thousands of dollars of uncompensated care each year persons lacking eligibility for health care service support [while DMHAS provides some support for such services our Agency provides thousands of dollars worth of care beyond that which DMHAS supports - \$755,000 FY08 YTD, calculated at posted costs of services]. What does all of this mean? If the Legislature grants a 3% COLA the Agency realizes an approximately 1 ¼ % COLA based upon Agency revenues and expenses [FY 2008].

Rate relief, along with additional COLA funds in Fiscal Year 2009, is fundamentally critical to our sustaining the ability to care for our neediest citizens and to provide a living wage to the persons who provide their care – our staff.

Rate relief is a critical aspect of the funding and viability cycle of issues for private non-profit agencies. Our Detoxification Center has received 19.2% in rate increases **since 1997** – an annual rate of approximately 1.6%. Inflation alone rose nearly 33% in the same time period [a 14% disparity]. Many rates do not reflect the actual cost of providing the service. For example, rates for outpatient visits with a doctor [to evaluate and monitor medication] run \$5 to \$40 less than the actual cost

of paying the doctor to provide the care [other related costs not included] – yet these services are critical to many clients.

-One final point, in the last several years Agencies such as ADRC, Inc. and others in CASAA have also struggled with spiraling costs of health insurance, utility bills, and trying to maintaining an aging infrastructure of facilities.

Infrastructure issues are particularly difficult in that these expenses, while critical to program operation, can rarely, if ever, be directly supported by grant funds [61% of our grant funds can not be used for capital expenditures]. Connecticut citizens are well served by the efforts of hundreds of non-profit agencies, such as ADRC, Inc. and those in CASAA. I believe that the Legislature and your constituents would find every dollar invested in the non-profit agencies that serve Connecticut would be a dollar well spent.

S.B. 413, if passed, will help agencies throughout the state remain viable and to provide a more consistent level and quality of care. The bill will rectify some short term funding disparities but, more importantly in my view, will work towards a more stable solution to the funding the role played by non-profit providers in the system of human services in the State of Connecticut.

See attached Tables:

- 1. Reimbursement Rate Changes 2003-2008**
- 2. Medication Management Costs & Reimbursement Rates.**

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1. Reimbursement Rate Changes 2003-2008

	Reimbursement Rate		Total Rate Change ² %	Annual Rate Change %
	2003	2008		
Intensive Outpatient Service [group care]	\$83.00	\$89.76	8.1	1.35
Medication Management¹ [up to 20 minutes]	\$25.93	\$29.38	13.3	2.5
Medication Management¹ [up to 45 minutes]	\$50.62	\$57.35	13.3	2.5
Detoxification Rate [daily rate]	\$248.00	\$268.21	8.1	1.6
Outpatient Group Treatment [90 minute session]	\$16.87	\$19.12	13.3	2.5
Clayton [daily rate]	\$65.00	\$80.34	23.6	4.3
Intensive [daily rate]	\$150.00	\$152.48	1.65	0.35
Intermediate [daily rate]	\$105.00	\$108.15	3.0	0.6
Coventry [daily rate]	\$85.00	\$80.34	-5.4	-1.0

¹ See Medication Management Information in Table 2 – below.

² Rate of Inflation for 2003 to 2008 = **16.17%**;

- the average rate change was approximately one half the rate of inflation.

2. Medication Management Costs & Reimbursement Rates.

Medication Management Service	Reimbursement Rate		Actual Physician Cost – 2008 ³	Financial Loss per visit ³
	2003	2008		
Medication Evaluation [up to 45 minutes]	\$50.62	\$57.35	\$97.00	\$39.65
Medication Evaluation [up to 20 minutes]	\$34.09	\$38.63	\$43.00	\$4.64
Medication Management [up to 20 minutes]	\$25.93	\$29.38	\$43.00	\$4.64

³ Physician cost and loss figures per visit do not include any related costs.

****END OF TESTIMONY****