



February 15, 2013

Testimony - Appropriations Committee

Re: DMHAS Budget

Good evening Senator Gerratana, Representative Dillon, and members of the Health & Hospitals Committee. My name is Ron Fleming and I am President / CEO of Alcohol and Drug Recovery Centers (ADRC), a member of the Executive Committee of the Connecticut Association of Substance Abuse Agencies, and a Member of the Connecticut Community Providers Association Board of Directors. I am here today to advocate for the reinstatement of the DMHAS grants to substance abuse agencies – which are scheduled for substantial reductions in the budget proposed by Governor Malloy and OPM.

ADRC has been serving the citizens of central Connecticut since 1973; providing a comprehensive array of services to persons with substance abuse disorders – many of whom also experience co-existing problems with their mental or physical health. Our agency employs approximately 200 persons; 140 full time employees and 50-60 part-time employees. Our staff provides services to 3,000 persons in more than 5,000 episodes of care each year.

I would like to first express sincere appreciation to the legislature and Governor Malloy for past support of the safety net for human services in our state that serves our most vulnerable citizens. We are specifically grateful that our agencies were offered a reprieve from the most recent round of recessions and budget mitigation cuts.

The proposed cuts in the Department of Mental Health & Addiction Services Substance Abuse grants are approximately fifty [50] percent over the budget cycle and are apparently intended to target outpatient services in particular. For substance abuse agencies such as ADRC cuts of this magnitude could result in significant, and

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presumably unintended, consequences. We are still lacking the detailed description of these cuts, so providing an exact accounting of the impact is difficult.

Over the last many years of essentially flat funding and no adjustments to service rates, ADRC has all ready been forced to reduce staff levels in each of the last three years. A further reduction in support, as a consequence of lost grant support, will necessitate further cuts in staff levels and, in all likelihood, service capacity.

As best I can determine the grant reductions are built upon the assumption that, beginning in January 2014, the increasing number of persons with available Medicaid coverage will eliminate, or significantly reduce, the need for grant support. This assumption is flawed for several reasons. First, at ADRC most clients all ready have Medicaid coverage, so changes in the frequency of coverage will have minimal impact. Second, the extent of uncompensated care [not compensated by an entitlement] is more often a result of factors such as co-pays, DSS spend downs, and lack of appropriate paperwork [such as lost or stolen identification papers such as a birth certificate]. Third, Medicaid services are inherently more costly to the Agency due to the nature of service regulations. Fourth, many Medicaid rates do not cover the cost of the provided service; this is especially true of services involving medical practitioners [e.g., psychiatrists]. Fifth many needed services are not covered by Medicaid at all.

Among the outpatient services which are not covered by Medicaid, but which are needed by clients: 1) assistance with Basic Needs applications, 2) a wide variety of case management services [such as those related to securing stable housing], 3) assistance with legal issues such as probation follow-ups, or court related proceedings, 4) assistance with Department of Children and Family proceedings, including consultations with DCF workers and court related proceedings, and 5) toxicology related activities such as breathalyzers and drug screening.

Reductions in substance abuse grant support would threaten the viability of my outpatient services and potentially other service centers within my agency. Most

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agencies and ADRC specifically, operate their various levels of service as linked one to another. Grant support has been essential to the creation and maintenance of these integrated systems of care. Grant support, especially in the recent environment of flat funding and service rates, has been critical to keeping ADRC fully operational – in the sense of maintaining service capacity.

Based upon the information available to me as I write this testimony, ADRC has as much as 4.5% of our **total agency budget** at risk in these SA grant cuts. Using the assumptions of increased Medicaid coverage making up for lost grant revenue ADRC would have to experience a net increase of nearly 4,000 intensive outpatient [IOP, the outpatient service with the highest level of Medicaid reimbursement] visits each year. Our outpatient center provided approximately 13,000 visits, of all kinds, last year [without regard to whether or not they were covered by an entitlement]. To make up for the lost grant revenue one would have to assume that more than thirty [30] percent of our visits involved persons lacking an active entitlement – which is simply not our experience.

Thank you for this opportunity to be heard. I am happy to answer any questions you might have.

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