Act Number:	09-149	
Bill Number:	6320	
Senate Pages:	5389, 5400-5401	**3**
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that item might be added to the consent calendar?

THE CHAIR:

Motion on the floor to add item 542, Calendar Number 542 to consent. Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Yes, thank you, Mr. President. Also calendar page 12, Calendar 643, House Bill 6320. I would move to place that item on the consent calendar.

THE CHAIR:

Motion is to place Calendar Number 643 on the consent calendar. Without objection, so ordered, sir.

SENATOR LOONEY:

Yes, thank you, Mr. President. And also Mr. President, calendar page 28, Calendar 303, Senate Bill 902. Move to place that item on the consent calendar.

THE CHAIR:

Motion is to place Calendar Number 303 on the consent calendar. Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Yes, thank you, Mr. President. Mr. President if the Clerk might call, as the next item, calendar page 32, Calendar 427, Senate Bill 826.

Senate on the consent calendar. Will all Senators please return to the chamber. Immediate roll call has been ordered in the Senate on the consent calendar. Will all Senators please return to the chamber.

Mr. President the items placed on the first consent calendar begin on calendar page 4, Calendar Number 412, Senate Bill 931; calendar page 12, Calendar Number 643, Substitute for House Bill 6320; calendar page 32, Calendar Number 427, Senate Bill 826; calendar page 37 -- correction, calendar page 34, Calendar Number 502, Substitute for Senate Bill 1127;

Calendar page 37, Calendar Number 358, Senate Bill 1078; and calendar page 38, Calendar 472, Substitute for Senate Bill 1157.

Mr. President, that completes the items placed on the first consent calendar.

THE CHAIR:

We'll call for the consent calendar, the machine will be open.

THE CLERK:

The Senate is now voting by roll call on the consent calendar. Will all Senators please return to the chamber. The Senate is now voting by roll call on the consent calendar. Will all Senators please return

to the chamber.

THE CHAIR:

Have all Senators voted? If all Senators have voted, please check your vote. The machine will be closed. The Clerk will call a tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1.

Total Number Voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

Consent Calendar Number 1 passes. Senator Looney.

SENATOR LOONEY:

Yes, thank you, Mr. President. Would move for immediate transmittal to the House of Representatives of items acted upon today here in the Senate requiring additional action by the House.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President. Mr. President, if we

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DEPUTY SPEAKER MCCLUSKEY:

The bill, as amended, is passed.

Will the Clerk please call Calendar 392?

THE CLERK:

On page 12, Calendar 392, Substitute for House Bill Number 6320, an Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning Substance Abuse Treatment for Adults, favorable report of the Committee on Public Health.

DEPUTY SPEAKER MCCLUSKEY:

The distinguished chair of the Program Review and the Investigations Committee, Representative Mushinsky, you have the floor, madam.

REP. MUSHINSKY (85th):

Thank you, Mr. Speaker. I move acceptance of the Joint Committee's favorable report and passage of the bill.

DEPUTY SPEAKER MCCLUSKEY:

Question before the chamber is acceptance of the Joint Committee's favorable report and passage of the bill.

Will you remark?

REP. MUSHINSKY (85th):

Thank you, Mr. Speaker. This bill includes the

recommendation -- most of the recommendations of PRI Committee following extensive study of how the State handles substance abuse treatment for adults. And if you are interested, the results are also summarized in a results based accountability format that is only a few pages long. And you should know that Connecticut's rate of substance abuse has been rising from 8.6 percent to 10.1 percent over the last five years and is higher than the national rate of 9.2 percent so you should be aware of this in our chamber.

This bill establishes benchmarks for state-run programs that the State Department of Mental Health and Addiction Services substance abuse plan must address, requires the Department consult with a list of stakeholders when developing the plan; requires the Department to report on progress made toward achieving the benchmarks; and requires the implementation of a dual license. This is a streamlining measure -- a dual license for providers who provide both mental health and substance abuse services at the same facility.

Beginning January 1, 2011, the Public Health Committee did recommend that we delete some of our recommendations due to physical constraints on the agency, and we concurred with their recommendation.

But I hope you will support the remainder of the bill and thanks to the Public Health Committee for giving us assistance.

DEPUTY SPEAKER MCCLUSKEY:

Thank you, madam, for your remarks.

Will you remark further on the bill?

The distinguish ranking member the Program Review Investigations Committee, Representative Carson, you have the floor, madam.

REP. CARSON (108th):

Thank you, Mr. Speaker. I also rise in support of this, first of all, most worthwhile study and the recommendations that the Committee put forward. We were somewhat disappointed that we could not move forward with all of the recommendations, but, as Representative Mushinsky said, we're very appreciative of the support of both Senator Harris, Representative Ritter and Representative Giegler for guiding us, not only with some of the physical concerns, but also some of the provider concerns that we hope we'll be able to work through perhaps over the next couple of years.

So, thank you again, Mr. Speaker, and, again, I urge my colleagues support this bill.

DEPUTY SPEAKER MCCLUSKEY:

Thank you, madam, for your remarks.

Will you mark further on the bill? Will your mark further on the bill? If not, will staff and guests please come to the well of House. Will the members please take their seats? The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call, members to the chamber. The House is voting by roll call, members to the chamber, please.

DEPUTY SPEAKER MCCLUSKEY:

Have all the members voted? Have all the members voted? Will the members please check the board to determine that your vote has been properly cast? If all the members have voted, the machine will be locked.

Will the Clerk please take a tally? Will the Clerk please announce that tally?

THE CLERK:

House Bill Number 6320

Total number voting	144
Necessary for passage	73
Those voting yea	144
Those voting nay	0
Those absent and not voting	7

DEPUTY SPEAKER MCCLUSKEY:

Bill passes.

Will the Clerk please call Calendar 371?

THE CLERK:

On page 11, Calendar 371, House Bill Number 6391, an Act Concerning Revision to the HIV Testing Consent Law, favorable report of the Committee on Public Health.

DEPUTY SPEAKER MCCLUSKEY:

The distinguished vice chair of the Public Health Committee, Representative Gentile, you have the floor, madam.

REP. GENTILE (104th):

Thank you, Mr. Speaker, good afternoon. Good to see you up there. Mr. Speaker, I move for acceptance of the Joint Committee's favorable report and passage of the bill.

DEPUTY SPEAKER MCCLUSKEY:

The question before the chamber is acceptance of the Joint Committee's favorable report and passage of the bill.

Will you remark?

REP. GENTILE (104th):

Yes, Mr. Speaker, thank you. This bill eliminates the requirement for separate, written or oral consent for HIV testing and instead allows

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CHAIRMEN: Senator Kissel
Representative Mushinsky

MEMBERS PRESENT:
SENATORS: DeFronzo, Frantz, Guglielmo

REPRESENTATIVES: Candelora, Carson, Giuliano, Sharkey, Urban

REP. MUSHINSKY: The public hearing will now start. And our first witness is Commissioner Thomas Kirk. He'll be followed by Commissioner Peter O'Meara.

THOMAS A. KIRK JR.: Good afternoon, Senator Kissel, Representative Mushinsky, and distinguished members of the Program Review and Investigations Committee. I'm Dr. Tom Kirk, the Commissioner of the health care agency known as the Department of Mental Health and Addiction Services. I'm here to speak today regarding two bills coming out of Program Review and Investigations: House Bill 6319 and House Bill 6320.

Allow me to begin my remarks by thanking the committee for giving us the opportunity to speak on these two important bills. Also I'd like to recognize the work performed by committee staff in their review of Connecticut's substance abuse treatment system for adults.

The study undertaken by the committee covers a broad range of department direct -- department functions and the report's recommendations are far-reaching in their scope. While DMHAS generally agrees with the intent of the committee's recommendations now reflected in

these two bills, it should be noted that their implementation will have budgetary as well as operational implications both for DMHAS and our providers -- and I'll come back to that as we move along.

Relative to House Bill 6319, the breadth and scope of the changes proposed in House Bill 6319 would have significant fiscal impact. The wording of the bill provides a limited direction as to the proposed scope of the ten year-assessment, making it difficult to estimate the resources that would be required. At a minimum it would require either additional staff resources beyond the agency's current position or funds to hire an outside consultant to conduct a study of this apparent magnitude. In addition, DMHAS already employs several methods to determine the financial viability within our provider system of care providers, including an eight month internal fiscal report, an annual financial report, and an annual state single audit report done on each provider. At each point of reporting DMHAS has the opportunity to assess that provider's financial viability; thus, we do not support the expense of creating another process which will duplicate the existing efforts.

I'd like to make a couple side comments on this. So your intent there is to assess the financial viability of these providers to meet what it is we're hoping to -- accomplish, but over a ten year period of time. The DMHAS -- the substance abuse service system is multiply funded; so DMHAS is one of the players, but you have DOC, CSSD, and others. Further, a significant percentage of providers receive third-party billing from private health care plans. I would also hazard a guess -- or I

know for a fact, that an individual provider from the service point of view -- they may well have collateral organizations, collateral separate organizations -- let's say a real estate holding company that they're -- that they use to -- to oversee their -- their properties. If we're going to do this -- you want us to do this to the full extent. We have to touch all those bases to get the complete read of the financial viability of the service network multiply funded system, based upon state agencies -- other components to the -- to the revenues of these agencies coming from private funds; and the fact that they are in some cases multiple organizations within -- within themselves.

At this point in time -- I mean, I would never tell you that the degree of the financial reporting and the accountability is at the absolute highest level that I would like to see, but the measures that we have in place already clearly give us a good start. And I would hazard a guess that our provider community would say that we track their financial viability very, very closely. I think the concern I raise is the scope of your effort, particularly predicting something ten years away, but at the same time -- I mean, I agree with the spirit, I agree with the intent, and all I say is that if you want something that's going to make operational sense as well as strategic sense, we'd better do some modification of the language. I would be glad to offer some suggestions if you so please.

Relative to House Bill 6320, DMHAS supports the intent of the proposed revisions to section 17a-451. Some of the expansive modifications recommended therein would

require additional resources which the department may be able to address by reallocating existing resources. And I'll give you one example of that, as -- in one section below. I'll come back to this at the conclusion of my testimony.

Several requirements contained in the bill are already under way or in development. Some areas we wish to highlight are the following: Establishing a waiting list system -- makes sense, figure that someone's trying to get into a program they should know are they fourth on the list, fifth on the list; measuring treatment demand is complex and depends upon a number of factors. Currently there's no uniformity in the collection of information on persons waiting to enter treatment among providers, and an individual could be on more than one waiting list. In my early tenure at -- as then I think a deputy commissioner overseeing addictions, I looked at this particular piece. And coming from a provider background out of Stamford, I was well aware the waiting list that we had in many ways was meaningless, because we would find that the same person is on the waiting list for a program in Norwalk and so the cross-checks and so on were questionable. Furthermore, a person could enter treatment with one provider while still appearing on the wait list for other providers, skewing the actual numbers of those needing treatment.

I will say from this perspective, and I think your emphasis on planning is very much on the mark, that back in the late nineties well I think early into 2000, we were able to secure federal funds from the Substance Abuse and Mental Health Service Administration to do needs assessment types of studies. And the

University of Connecticut Health Care, UCHA -- UCHC, Dr. Tom Babor was one of the players, as well as a Yale group went ahead and helped to conduct needs assessments. So there we go -- based upon a couple different things, it might be a telephone survey, it might be a diagnostic piece, it might get data from CSSD, probation, DOC, and others, and they would come up with a composite. The beauty of their approach, which was federally funded, was that you not only had needs assessment data, but then what we could do was look at -- Well, tell us the resources that we have in the eastern part of the state, tell us the resources we have in the capital -- north -- north central region, and see if the mix seems to be right. That degree of sophistication -- the feds, they decided they were not going to fund that anymore. So if we're going to do something like this, playing off a waiting list, again, it's got to be more sophisticated than just using that. That is one indicator, and frankly, it is just a very soft indicator. I think there's different ways to do it better.

The other piece is that if you live in the eastern part of the state -- we went ahead and funded a call line so that someone calls this particular line and that -- that gives an area of -- a sense of where a slot for services is. We also have it in the Hartford area -- here's an example, where if we were going to establish some type of common call line, what I'd probably be -- end up doing is I'll pull the data -- I'll pull the dollars back for the eastern area, I'll pull the dollars back from the capital region area, go to a single system so that the statewide system would have a single call line. It would require some reallocation of dollars, but we think it's

doable if that's where we want to go. I will also tell you that every day, every residential program that we fund in this capacity, every program that we fund has got what's called "respite beds". We get a listing so -- and the detox services, the provider's required to call in the morning and tell how many beds are available today at program X, and so we have a complete list of actual beds available on a daily basis. We saw that as a smarter way to go about it rather than working off a wait list.

Tracking the availability of some of these treatment services. DMHAS currently manages service utilization access, informs the public of these services via a service directory on our web site, there's a consumer line operated as part of our general system (inaudible) health program, and a daily census of residential service -- I mentioned this. One of the complications here that is not a -- if you will, make it impossible -- is that the DMHAS system is a multiply funded system. The Department of Correction funds some residential treatment beds, the Community Service Support Division under Probation funds some beds; and so when we talk about the available beds -- and the way CSSD does it in particular, they say we are funding you for ten beds, and whether all ten of those beds have a person in it, those are our beds -- other people cannot be admitted to the bed. So these -- these idiosyncrasies, if you will, are the way that the operational -- the operation works, and you have to pay attention to that.

Performance monitoring. This was a great piece, and frankly I'm glad you -- you tweaked us on this particular one. The department has

implemented national outcome measures. We're in the process of developing a provider report card. Some aspects of the latter included in the bill would require the collection of new information. Let me spend a little bit of time with this. And when your two staff folks came over, at least when I had spoken with them, we went over a variety of things relative to our General Assistance Behavioral Program. This is an $80 million program that is based upon claims or fees for services. Compared to grants, what's the benefit of that? If Tom Kirk was admitted to program X, it's a detox program, a residential program today, a claim is paid to the provider that gave me that service. Then you can track to where Tom Kirk went after that service, and over a period of years we have put into place -- we've tracked three critical measures.

If you truly have an effective substance abuse service system, you don't look at an individual service, you look at how the services link together. And one of the things we found was that if I was in the detox program and I stayed there for five days or whatever the number was, a critical, critical piece is how long it was before I was connected to the next level of care. So if I get out of detox today, when do I get connected with a residential program to continue? Because detox is just one little piece; and what we found was that if the person was not linked up with follow-up care other than detox, within somewhere of the range of ten days or so, the likelihood of them having to be readmitted gets spiked up -- and that's $300 a day for us. So we looked at ways to emphasize that -- so we put into place what we call "connect-to-care". So we have

data that looks at every detox program "connect-to-care" throughout the entire system -- pay attention to that. We also know what we're paying for each one of those days.

The second piece that we added in for that kind of program, as well as older residential programs, is what we call a "readmission rate." If someone goes into a program for 30 days, or detox program for X number of days -- more expensive types of programs, I'm interested in knowing whether the person gets readmitted to that program within 30 days, 45 days, 90 days. Because if they have a high readmission rate, that says something's being missed in the care. And so one of the major measures that we added into GA is that we can compare X number of providers with the same level care, what their readmission rate is, what -- and also the "connect-to-care" rate.

The other piece that's very important to us also, is how much we're paying for each day. And what may turn out is that provider recs may have a relatively low rate, but the readmission rate within 30 days, 60 days, is pretty high. So it's actually costing us more per person because of the high readmission rate. And I will tell you, based upon the report card, we've worked on this for moons, and I'm perfectly comfortable as of July 1, 2009, to put up on our web site and publish the data for these particular measures. We've looked at these measures. We're comfortable with these measures, and so sometimes when we get into these discussions of different rates -- rates should be higher or lower, I will tell you sometimes the highest rate providers we pay to -- the highest providers to whom we pay a rate to, are not necessarily always the best outcomes. We wanted to look

at outcomes that are driven by dollars as well as by the quality of care.

So we're going to take the opportunity -- frankly, based upon your -- your initiatives -- said fine, It'll be published, transparent. You'll know what the quality is, what we're paying for it. And when a provider comes in to me and says, I want to increase my rate, I'm going to look at those measures to see whether we're going to negotiate whether rates should be increased or not based upon the quality.

Relative to that also, you asked about -- you wanted to make sure that we pay attention to licensed staff, bilingual, people who are deaf and blind, and so on, and we don't have any issue with that because obviously that's very, very important. But one of the things that we're paying attention to, and I would ask that the committee and -- and you consider this as we continue to go along -- sometimes these different processes do not necessarily give you better outcomes. So we said, well more staff, more licensed staff, more this -- that doesn't always give you -- those are process outcomes. They're not -- they're not -- those are process measures, they're not performance outcomes.

And one of the things that you should be aware of and I'll alert you to as we speak here, as we look at measures -- I was looking for measures that would be viewed by the general field as clearly credible, credible because they would meet some sort of decent goal or standard. And probably the most accepted measures for health care, whether it -- talking about behavioral health or general health, are those measures out of the

Institute of Medicine -- the Institute of Medicine -- prestigious group, and they've come up with a variety of measures. And so what we've done is that this -- we did this in version one and in version two, Practice Guidelines for Recovery-Oriented Health Care for Mental Health and Substance Abuse Conditions; what this does -- it ties the IOM measures with the kinds of programs we have, and those will be the next stage of measures that we put into our contracts as we move along from here on out. So we're -- we're in concert with you relative to performance monitoring, report cards, and I will tell you that we're going to raise the edge up a different level. We'll see where that goes.

Access to treatment. DMHAS has been exploring the addition of a "time-to-treatment" measure that would assess timely access to treatment. However, while important, implementation would require providers to modify the information systems to accommodate the collection of new data. I'll give you an example of two providers that really stepped up. Regional Network of Programs in Norwalk, the APT Foundation in New Haven, the feel as whole is one is that if you wanted to come into a methadone maintenance program because of your opiate problems, sometimes it will take a fairly extensive period of time to have that occur. Both of those programs set very, very close limits so the person gets in in a day, two days. Those kinds of changes are internal, and I think that the impetus that you're giving us for this will reinforce that.

Full involvement of key stakeholders in the planning process. DMHAS has a strong history of collaboration with other state agencies, advocacy organizations, providers, advisory

groups, and others. I think we do very, very well in that regard. I will mention one thing that I should have mentioned before, that is that as part of our contract -- and this goes back to the report card -- we have a uniform survey that's given out, it's required to be completed by every mental health and addiction program in the state of Connecticut that we fund. It's a standardized survey. Our contract requires that every agency has a reading level of at least 75 percent with to be compliant the contract, and we go arrange that -- this is on our web site. The kinds of questions that are asked are the kinds of questions that you and I would ask if we were to secure -- if we were going to try to find care through one of our providers. I'm not going to go through it. It's about 33 questions, but I'll pick out two. "If you had your choice, would you still receive your service at this agency? Would you recommend this agency to other -- to your family members and others?" Required by contract, we run a web site -- this document here is given to Commissioner Lantz, it's given to Mr. Carbone in Probations, so they know that any agencies they're funding, this is what people say about the quality of the care that's provided. So I urge you to interpret the report card -- that will be added into it.

Evidence-based programs. DMHAS is forerunner in adopting proven practices and programs within its system of care. It should be noted that the introduction of evidence-based programs can incur significant costs including training and technical consultation for service providers, measurement of program fidelity, and continued to support of the practice over time. Two concerns that we have about these. One of them is that some -- some

practices that are viewed as evidence-based do not necessarily include as wide a representation of people as we have in our service system. I'll give you an example, it is not surprising to find supposedly evidence-based practices that did not have a very diverse population of people on whom they tested. So we have a very diverse population in Connecticut among the Latino community, African American community, as well as the Caucasian/white community. We get concerned when we see supposedly evidence-based practices that do not have that diversity and we would question that.

I would also tell you that, related to this, is that we have been very successful over the last nine years or so securing federal dollars to test out practices. And so in the substance abuse area, for example, since 1999 we have competitively won $83 million worth of federal grants which have served to test out the efficacy of these different practices: Screening and brief intervention, criminal justice system -- $3 million there; gender, culture, $11 million; a variety of other practices. I say this because while -- when your staff went and looked at these different areas, they may not understand these specific aspects of that as these programs -- as these federally funded programs ended, we converted these -- we tried to make sure they were converted into practice.

So we've been -- I'll use one -- motivational enhancement therapy, we took training resources after finding it was clearly an evidenced-based practice, provided training resources so providers could go ahead and get the training. We're doing the same thing with these other pieces, so part of my message

that -- please understand we're not sitting on our hands relative to evidence-based practice research demonstrations. What we tried to do is get other funding, namely, the feds, to put the dollars on the table. Let us test out the mechanism and then we'll convert it through the system as a whole, and this is reflected in the document that we had. There was another significant pool of money on the mental health side for the same thing.

Licensed or certified staff to perform treatment services. We understand the importance of this as reflected in our current policies and compliance with DPH licensing requirements. However, it's been the department's practice that services delivered by peer or recovery specialists are also important in promoting a sustained recovery. I'll give you a very short scenario here. We went and tracked those people who are high, frequent readmissions into detox or expensive services, identified them -- and then what happens is Tom Kirk showed up for detox three times within X number of months. I was flagged. Before I get out of that detox program, I was linked with a care manager who tied me with other appropriate level of care.

We have spent millions of dollars for those types of services, and I will show you clear data that says we've actually decreased that repetitive -- rate of readmission. More people being treated with better outcomes and we still save money. So as you go about this, yes, licensed or certified staff are important, and often the most important person that a person with substance abuse issues talks to is someone who's been through it as -- in the same way, it's helped greatly.

Development and review of performance and outcome information on methadone maintenance and other opioid replacement programs. No issue with this. DMHAS already distributes monthly performance and outcome reports for methadone maintenance providers. As persons in opioid replacement programs may remain in treatment for an extended period of time, data currently is collected only at the time of admission and discharge. At present, DMHAS does not require periodic updates which would result in performance measures being collected at more frequent intervals.

We are exploring the possibility of requiring providers to collect and report status updates at specific intervals. Why is your hit of this particular area very important? The largest number of people treated in the DMHAS health care system for substance abuse everyday are persons of the methadone maintenance program -- it's in excess of 5,000 people. So if you're going to try to pay attention to the outcome, this is a group based upon the numbers -- it's an important piece to look at, and we'll do that with you.

Dual licensing for behavioral health care providers. As an agency we support section nine of the amended statutes regarding implementation of dual licensure program for behavioral health care providers. DMHAS, the Department of Public Health, and service provider representatives have met and completed a thorough review of the current licensing statutes. New licensure language is being drafted for consideration within DPH, and my understanding is that it's close to some degree of closure.

DMHAS continues to actively pursue ways to

enhance the delivery of efficient, effective, and quality care. This involves strengthening internal structures, procedures and policy, as well as promoting even greater collaboration among our partners. In the coming year we are committed to enhancing treatment access, service quality, and overall accountability of the DMHAS substance abuse treatment system even further. This can be seen in the agency's focus on evidence-based practices and treatment therapies with proven results. These efforts will continue with renewed energy and commitment.

The Department is in the process of drafting a substantial response to the committee's recommendations and the issuance of the final report by the committee.

If there was a time that this particular issue could be paid -- paid to by your committee, by this -- by the legislative committee as a whole -- fiscal constraints, the reality of persons with substance abuse needs, we want to make sure that we can continue to provide the services in a proper and effective way and at the best cost. And so the kinds of things that you're focused upon, and we will focus in concert with you, are clearly in the right directions.

I thank you for the opportunity to address the committee on these bills. I'd be happy to answer questions you may have at this time.

REP. MUSHINSKY: I have two questions and then ask the committee. If -- thank you very much, first of all, I -- I am extremely impressed with your department and how you handle casework. And I've had many dealings with your department and always been happy with the

department's care and with the concern for the folks suffering from substance abuse. So good job.

THOMAS A. KIRK JR.: We have great staff. They're the ones that deserve the credit.

REP. MUSHINSKY: Yeah, and the man at the top deserves the credit too because he sets the tone, so congratulations for that.

If you decide through your research that unlicensed peers, say former addicts, are more effective even than some of your licensed clinical staff at getting -- at reducing recidivism, would the department increase their number of -- in other words are measuring who is most effective with these substance abusers, so you know to increase that type of staff?

THOMAS A. KIRK JR.: It's a good question. It's interesting you raise that because what we have found is that those people are treated by teams, not by individuals, and so that the addition of a peer specialist -- a certified peer specialist, to a team informs the way the group goes about carrying forward. So in any of these programs there's typically nurses, social workers, licensed counselors, and so on; the peer specialist, recovery specialist that we're talking about, they're part of a team. So I would not be suggesting in any way that somebody's going to be moved out or not providing care. It's more how those -- those types of persons enhance the quality of care.

I would also emphasize to you that it's actually part of our Mental Health Transformation Grant. We've been able -- we've released a RFP to get a group to go

ahead and put in place certified peer specialist training. And so this will meet Medicaid requirements, as well as other requirements for reimbursement. So it's not a matter of just taking someone who says, well -- I'm a recovering alcoholic or drug addict and bringing them into the loop with no proper -- without the training. We would make sure that proper training -- and it's not a matter of replacing it, but how they would meld as part of a team, that's -- that's the difference -- it's going to make a difference.

REP. MUSHINSKY: Okay. Now, if you have a substance abuser -- you said there's 5,000 methadone -- and what is your total substance abuser population that you're dealing with?

THOMAS A. KIRK JR.: About 50,000.

REP. MUSHINSKY: Okay. If -- that's a big number, but if they're coming in at -- in different directions, say one day they come in through Norwich, another day they happen to be in New Haven and they have a seizure and they get picked up in New Haven -- because some of these folks also have very unstable home situations and they're drifting from here and there, but do you have these folks in a statewide --

THOMAS A. KIRK JR.: Database?

REP. MUSHINSKY: -- treatment list? Yeah, so that if they -- so that no matter where they might pop up in the system, you know it's the same case?

THOMAS A. KIRK JR.: As it's set up now, Representative Mushinsky, it's that particularly with General Assistance the

provider has to call in to a central number, identify the person -- and we have at this point in time, we have ten years worth of data. So we know when so and so has been off and on during the course of all those years. The same is true -- I'm quite sure the same is true for all the methadone maintenance clients. And other clients even though they may not be GA, our data systems now include the -- sort of the grant data system roster is now able to be mixed with the GA data system, so we can see the clearest -- the clearest and most effective approach that we have is directly related to General Assistance. That's where we actually track the person. It's part of the -- it's part of the scenario here is to make sure that person X is not getting methadone in Hartford, then going down to Norwalk and getting it down there too, so that's built into -- the rules.

REP. MUSHINSKY: My last question -- and then I'll turn it over to the committee questions -- you said that sometimes your -- to do some of the recommendations, you might require the collection of new information. Now that should not be a problem if you have a contract with them, correct? You just build it into the contract and when their contract comes up for renewal, you just make them do it as part of their renewal? I mean, if they want the business with the state I assume they have to produce --

THOMAS A. KIRK JR.: I'm sure you'll hear -- because sometimes these are described as "unfunded mandates" by our service provider system. But then just -- this is justification for that, because providers for substance abuse service are multiply funded. Does any number of them have -- kind of

invested in really good information systems for all their different payers so to speak? They're not uniquely set to the DMHAS system. They are set for a larger piece. So therefore, if we go in and say, We want these particular items collected, and they're not currently being collected, some adjustment has to be made to the information system at provider X. When that occurs, they usually have to pay their techie consultant to come in and make those changes. So yes, we might say that, well, the reality is that they're a provider, and that's what we want them to do; that's what they need to do.

Sometimes it's a tweak, but sometimes it's a more significant piece in terms of funding. And to this day we've been fairly good in terms of putting dollars on the table to make some of those changes, but I would -- we try to do it in a measured way. And that's why I'm saying, if you start talking about information we want brought in, you need to measure what the operational and financial implications would be for that.

REP. MUSHINSKY: I appreciate that. And hopefully all these folks asking for data will eventually be using the same data, make everybody's life easy. I'm glad you're using the Institute of Medicine measures because the feds probably would use that too.

Other questions for the Commissioner?

Representative Carson.

REP. CARSON: Thank you, Madam Chairman.

Good afternoon, Commissioner. Good to see you. I have two questions. One, it seems

that you have concerns certainly about fiscal impact on House Bill 6319, but you said you might have some suggestions for us. And the second question, as you're wrapping up your testimony you said that the department is in the process of drafting a substantial response to our recommendations before the issuance of a final report, and I think we're at -- we've done the final report, and now we're going ahead to propose legislation. I'm just not sure if there is additional testimony that is indeed being prepared?

THOMAS A. KIRK JR.: It was my understanding that the final report from the committee with whatever edits -- whatever -- that there's still some pieces that were being -- that might be modified. And we were looking to get the formal final draft, if what you have on the table now is what you consider the final report, we can give you a response within two days --

REP. CARSON: Yeah.

THOMAS A. KIRK JR.: -- because we've already drafted one. But we were waiting to see whether --

REP. CARSON: Okay. Maybe we can get a clarification from staff that even if there is to be another final report, right now today is the day for gathering information, and we're going to be proposing legislation is my understanding.

Ask, Madam Chair?

REP. MUSHINSKY: Does the staff have an answer for how much time the Commissioner would have to send in the information?

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Oh, Jill is here?

JILL JENSEN: What the Commissioner is referring to is it's the Committee's policy to request a formal agency response to include in the published document, and that is still pending. We're still compiling the final report to send to them as a final document that will include that published statement. But the recommendations that require legislative action, nothing will change. It's all the recommendations that were adopted by the committee in December, and so the response that he provides today would be incorporated into that.

REP. CARSON: And again for clarification, we've proposed some recommendations that I would assume that the hearing, the information that we gather we could go back and change some of those recommendations, is that not correct, based on the testimony submitted?

Through you, Madam Chair.

REP. MUSHINSKY: I don't see why not.

But Carrie, you want to comment on that?

That's what the hearing is for.

CARRIE VIBERT: The recommendations of the committee approved in December, which are going to be memorialized in this final printed report, will I think -- those existed, you know, those will stay the same. But obviously what you can change is the bill. Depending on, you know, what you want to do when it gets time to (inaudible) up.

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REP. CARSON: Thank you for all the clarification, and I guess I would just suggest if there is more of a response from the agency before we actually pass the bill out of committee, that might be a good idea.

But your suggestions for House Bill 6319, you said you might have some --

THOMAS A. KIRK JR.: That's the --

REP. CARSON: -- ideas for us?

THOMAS A. KIRK JR.: -- the fiscal one?

REP. CARSON: Yes.

THOMAS A. KIRK JR.: What I would request is that let us take a shot at putting something in writing to you, that we think might work more effectively, get to where you want to go but in a more realistic, manageable fashion. And I will tell you that the ten-year piece is the one that's problematic. How would you presume financial viability of an agency relative to its purpose over a ten year period of time? So I guess what I would suggest, and this is what, Tuesday? I'd like to see if we can get it back to you no later than Friday, give you some ideas about considerations we might have relative to modifications of language. Relative to the committee's report, I have -- my staff has given me a draft response. I can give you that draft response if that could help to inform your process, or we'll wait and -- and do something, either way you want to go.

REP. CARSON: Thank you, Commissioner.

I would -- I guess I would just ask how much

CINDA CASH: Good afternoon, Senator Kissel, Representative Mushinsky, and members of the committee. My name is Cinda Cash, and I'm the Executive Director of Connecticut Women's Consortium, which is a statewide policy, training, and advocacy organization specializing in women's behavioral health needs. I'm also Chair of the Connecticut Association of Substance Abuse Agencies, and a member of Connecticut Association of Nonprofits.

I'm here today to testify on House Bills 6319 and 6320. CASAA has concerns that those bills will result in increased administrative and reporting burdens for nonprofit providers. Those bills call for the Department of Mental Health and Addiction Services to collect and report additional data on top of the extensive data collection the department already does. This will only result in additional nonprofit provider dollars being directed to filling out forms instead of providing services to clients. We recognize that during the current fiscal crisis the state will be unable to offer private providers any cost of living adjustments for increased funding and therefore feel it is irresponsible to require providers of DMHAS for that matter, to redirect dollars and time to data collection rather than the provision of services.

Another major concern we have is that -- is with section six of House Bill 6320. This section calls for DMHAS to "encourage the use of staff licensed or certified by the Department of Public Health" -- encourage the use of staff licensed or certified by DPH when providing a clinical service in any state-funded or state-operated substance abuse

treatment program. Requiring that all clinical staff be licensed or certified would be cost prohibitive for private providers and would ultimately result in fewer nonprofits able to provide clinical substance abuse services. Currently the common practice among many providers is to hire licensed or certified individuals as program directors or managers who supervise other clinical staff members. One Hartford area substance abuse provider pays a minimum two to three dollars per hour more for a licensed or certified staff member. This provider has 35 counselors; ten are licensed or certified and this is in addition to his licensed program directors, and 25 are not licensed. If this were instituted, this policy would cost the provider, at a minimum, an additional $140,000 per year in salary expenses for the 25 newly licensed staff. It would also be -- it should also be noted that increased educational and licensing requirements would hit minority staff the hardest, further jeopardizing diversity in substance abuse programs.

We do support section nine of House Bill 6320, which calls for DMHAS and the DPH to implement a dual licensure program for behavioral health care providers who provide both mental health and substance abuse services. This is a welcome change as several nonprofits -- several nonprofits provide both services, yet their facilities have to be licensed separately, resulting in additional time and costs. At some levels of care, lack of a dual license often results in providers being unable to provide both services at one site. This causes clients sometimes -- that have to be transported between various sites at great costs to all involved.

We appreciate the time that Program Review Committee staff took to come out and talk with the private providers about substance abuse treatment. And we appreciate the efforts they put into their findings and recommendations. However, as I stated before, CASAA and the Connecticut Nonprofits must have cautioned about unintended consequences that portions of these bills will have on the private provider system. DMHAS already requires extensive data collection from providers about those -- about those clients and services.

Commissioner Kirk is well aware of the financial constraints that providers are facing at this time, and he and DMHAS staff have come to the table for discussions with providers about our concerns over the existing amount of required reporting. Additional data collection and licensing requirements would be mandates that would accrue to providers without any additional funding to support them. Private nonprofit providers are a partner with the state in the delivery of health and human services, and while we fully support the state developing the most efficient and effective substance abuse delivery system possible, we hope that it will not be done placing additional stress on the private provider system.

Thank you.

REP. MUSHINSKY: Well the Commissioner did warn us that some nonprofits would have problems with the data collection --

CINDA CASH: Yes.

REP. MUSHINSKY: -- so we were warned. But where the committee is going is we're trying to

analyze effectiveness and reward really effective programs and then take money away -- I mean we wouldn't take the money away. We would just talk to the Appropriations Committee, and they would take the money away. But we're trying to do this in a more scientific way and medically responsible way. So that's why we're looking for the data.

Now, maybe there's a way we can have staff help us try to hone in on the essential data, and maybe there's a way we can use some of the department's data they're collecting already to get some of our information. But we're not making you fill out forms just for the merry sake of filling out forms, because we're actually trying to shift money in the budget to reward programs that are very effective and to cut off funding for programs that are not as effective. That's really what we're trying to do so --

CINDA CASH: Yeah, I have a question.

REP. MUSHINSKY: -- that's what the data collection is for.

Go ahead.

CINDA CASH: Does this have -- does this have to do with results-based accountability?

REP. MUSHINSKY: Yes, it does. And you're doing some of the data question for "Approps" as well, right?

CINDA CASH: I believe so, yes. I believe so.

REP. MUSHINSKY: Okay. So we should be able to -- if we sit down with the forms, we should be able to get the nuggets of information that we

both need and maybe reduce the additional data you're collecting. But that's what it's for so...

CINDA CASH: Well, you know, you're right. Commissioner Kirk has heard many, many times about our concern about unfunded mandates. And so I don't need to say any more, you made yourself --

REP. MUSHINSKY: But you know the situation we're in is that we have this enormous --

CINDA CASH: I know.

REP. MUSHINSKY: -- deficit, and even before we had it, we were working on RBA anyway --

CINDA CASH: Right.

REP. MUSHINSKY: -- just because we need to make the wisest use of the public money so --

CINDA CASH: I know.

REP. MUSHINSKY: -- and also we want to get results, so whatever produces the good results we want to replicate it. Because that's part of our job too --

CINDA CASH: I know.

REP. MUSHINSKY: -- so we're not doing this to be mean and nasty, but strictly to get better results for less cost, and that's how we're doing it. So hope -- maybe we could take another look with staff -- the data you do for the department anyway, the data we need, see if we can compress it a little more.

CINDA CASH: It would be very helpful if the -- the

members of the not-for-profit sector who provide the services were part of that dialogue.

REP. MUSHINSKY: Sure.

CINDA CASH: I mean --

REP. MUSHINSKY: Sure. That makes perfect sense.

CINDA CASH: -- Commissioner Kirk is very, very open, and you know he comes to our meetings constantly. We have an open dialogue with him, and so as long as the people on the ground floor who are really doing the work are part of that dialogue --

REP. MUSHINSKY: No, that makes --

CINDA CASH: -- I think that can result in some good work.

REP. MUSHINSKY: No, that's good. You know for example, you're talking about increased licensing hits minority staff the hardest, and you know -- if you're able to show us that the unlicensed staff are better at the peer counseling than the licensed staff because they've been there, you know, and they get better results, that tells us we shouldn't be pushing the licensing so much. We should be --

CINDA CASH: Uh-huh.

REP. MUSHINSKY: -- you know hiring more unlicensed people if they have experience with reaching sobriety and getting rid of substance abuse. So that's the kind of information we need to make good budget decisions.

CINDA CASH: Sure.

REP. MUSHINSKY: And it will help you because it will show -- we'll all be looking at the same numbers, and then you'll say, these unlicensed people actually do a better job, and then we'll agree with you and then we'll let you have unlicensed people.

CINDA CASH: Okay.

REP. MUSHINSKY: So these numbers actually come back and help us make some good decisions that we both can agree on.

CINDA CASH: Yeah, we understand.

REP. MUSHINSKY: Are there other questions? Back row, no?

CINDA CASH: Thank you very much.

REP. MUSHINSKY: Thank you, Cinda.

And the final -- nope, two more. Final two witnesses that are signed up here are Leslie Simoes and Terry Edelstein. And then if there's anyone else that wishes to sign up, let us know.

SB752
SB753

LESLIE SIMOES: Hello. Good afternoon, Senator Kissel, Representative Mushinsky. My name is Leslie Simoes. I'm the assistant executive director of the ARC of Connecticut. We're a 57-year old statewide advocacy organization for people with intellectual disabilities and their families. We have 23 local chapters that provide supports and services and advocacy for individuals with intellectual disabilities throughout Connecticut.

disabilities, and we're not bringing people with disabilities to the table. And so I would just strongly urge the committee to accept this recommendation on behalf of the people who live at Southbury and -- and all the people in the state that would be benefiting from services.

That's all.

REP. MUSHINSKY: Thank you.

LESLIE SIMOES: Thank you.

REP. MUSHINSKY: Good reminder.

Are there any questions?

Okay. Thank you.

LESLIE SIMOES: Thank you.

REP. MUSHINSKY: Terry Edelstein.

ALYSSA GODUTI: Good afternoon, Senator Kissel, Representative Mushinsky, and members of the committee. I'm Alyssa Goduti. I'm the vice president for Public Policy for Connecticut Community Providers Association, and I'll be providing the testimony today.

REP. MUSHINSKY: So you're Alyssa?

ALYSSA GODUTI: Alyssa, yeah. Goduti.

REP. MUSHINSKY: Okay. You're speaking for Terry?

ALYSSA GODUTI: Yes -- well, for CCPA.

I'm pleased to provide testimony this morning regarding H.B. 6319 and H.B. 6320, regarding

substance abuse treatment for adults. We appreciated the opportunity to work with the committee's staff as they did research on this very important topic.

We strongly support H.B. 6319 regarding the financial viability of providers of substance abuse treatment for adults. This legislation seeks to assure that client needs are met in a way that improves their quality of life. The mission of community providers is to provide services that support individuals with disabilities and significant challenges in the community. In order to do this, there needs to be an infrastructure in place that assures the ongoing viability of providers and of services.

A reimbursement structure that covers costs of services is the first step in assuring that client needs are met. Over a 20-year period, the private provider COLA has been increased by 33.16 percent, that's compared to a medical consumer price index of 197 percent. I've attached a chart to your testimony that will describe that. Reimbursement just doesn't match the cost of providing services.

As you're aware, there was no cost of living adjustment in FY09 and the Governor's current budget proposed includes flat funding for FY10 and FY11. A zero percent COLA over a three-year period means that private providers will be forced to reduce services, rather than expand to meet the growing treatment needs of Connecticut citizens.

Furthermore, the Governor's proposed budget cuts funding to some substance abuse levels of care through program and rate restructuring: Developing a tiered methadone maintenance

treatment system, eliminating "excess capacity" in medically managed detox systems, eliminating the funding for zero tolerance programs, and developing ambulatory detox. Such programmatic and funding shifts should be developed as part of a comprehensive plan for addiction treatment in DMHAS, the Behavioral Health Partnership, DOC, CSSD, and DSS, and that should be done through work from your committee through this study rather than as a budgetary fix.

There are related capacity issues in the private provider sector. Our turnover is approximately 26 percent for direct care staff. We have an average vacancy rate of about eight percent, which means that almost one in ten positions are vacant at any time. Staff turnovers and COLAs are intertwined. We need to be able to afford to pay our staff for their fine work, and consumers need to benefit from consistent staff to support their recovery.

And finally I'd like to comment on a provision in H.B. 6320. In section seven of the bill, the bill requires that provider profile -- Cinda Cash spoke very articulately to this point in her earlier testimony -- we're very concerned that while we support the development of uniform information that can be readily available to potential or current recipients of services, it's essential that providing that level of detail does not become an unfunded mandate. We're very concerned with reduced funding over the last few years -- that any additional requirements on the private sector would be a serious problem.

And thank you for your time and the ability to testify. I'll be glad to answer any

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questions.

REP. MUSHINSKY: Are there any questions from the committee?

Okay. I won't repeat what I said to the previous witness, because you already heard it.

ALYSSA GODUTI: She answered it well.

REP. MUSHINSKY: But that's why -- you see why -- you know why we are looking for information.

All right. Is there anybody else that wishes to testify?

If not, we can close the hearing.

Has anyone not voted yet, Madam Clerk?

CLERK: (Inaudible).

REP. MUSHINSKY: Okay. Are they in the building?

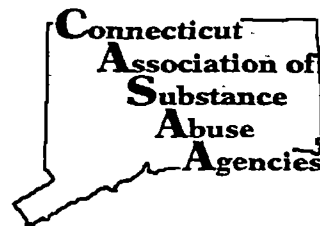
CLERK: (Inaudible).

REP. MUSHINSKY: Okay. All right. So the meeting is still in recess -- the meeting itself is in recess till five. People can still vote.

CLERK: (Inaudible).

REP. MUSHINSKY: Right, the meeting is open until five, but the hearing is closed.

See you on the twentieth.



Testimony before the Program Review & Investigations Committee
2/10/09

HB 6319, AA Implementing the Recommendations of the Program Review & Investigations Committee Concerning the Financial Viability of Providers of Substance Abuse Treatment for Adults

HB 6320, AA Implementing the Recommendations of the Program Review & Investigations Committee Concerning Substance Abuse Treatment for Adults

Good afternoon Senator Kissel, Representative Mushinsky and members of the committee. My name is Cinda Cash and I am the Executive Director of CT Women's Consortium, a statewide policy, training and advocacy organization specializing in women's behavioral health. I am also Chair of the CT Association of Substance Abuse Agencies (CASAA) and a member of CT Association of Nonprofits. I am here today to testify on House Bills 6319 and 6320.

CASAA has concerns that both bills will result in increased administrative and reporting burdens for nonprofit providers. Both bills call for the Department of Mental Health and Addiction Services (DMHAS) to collect and report additional data on top of the extensive data collection the department already does. This will only result in additional nonprofit provider dollars being directed to filling out forms instead of providing services to clients. We recognize that during the current fiscal crisis the state will be unable to offer private providers any cost-of-living adjustments or increased funding and therefore feel it is irresponsible to require providers, or DMHAS for that matter, to redirect dollars and time to data collection rather than to the provision of services.

Another major concern we have is with Section 6 of HB 6320. This section calls for DMHAS to "encourage the use of staff licensed or certified by the Department of Public Health when providing a clinical service in any state-funded or state-operated substance abuse treatment program." Requiring that all clinical staff be licensed or certified would be cost prohibitive for private providers and would ultimately result in fewer nonprofits able to provide clinical substance abuse services. Currently, the common practice among many providers is to hire licensed or certified individuals as program directors/managers who supervise other clinical staff members. One Hartford-area substance abuse provider pays a minimum $2-3 per hour more for a licensed or certified staff member. This provider has 35 counselors, 10 are licensed/certified (this in addition to his licensed program directors) and 25 are not licensed. If instituted, this policy would cost the provider, at a minimum, an additional $104,000 per year in salary expenses for the 25 newly licensed staff. It should also be noted that increased educational and licensing requirements will hit minority staff the hardest, further jeopardizing diversity in substance abuse programs.

We support Section 9 of HB 6320, which calls for DMHAS and the Department of Public Health to implement a dual licensure program for behavioral health care providers who provide both mental health and substance abuse services This is a welcome change as several nonprofits provide both services yet their facilities have to be licensed separately, resulting in additional time and costs. At some levels of care, lack of a dual license often results in providers being unable to provide both services at one site, causing clients to have to be transported between various sites at great costs to all involved.

We appreciate the time that PRI Committee staff took to come out and talk with private providers about substance abuse treatment and we appreciate the efforts they put into their findings and recommendations. However, as I stated before, CASAA and CT Nonprofits must caution about the unintended consequences that portions of these bills will have on the private provider system Again, DMHAS already requires extensive data collection from providers about both our clients and services. Commissioner Kirk is well aware of the financial constraints that providers are facing at this time and he and DMHAS staff have come to the table for discussions with providers about our concerns over the existing amount required reporting. Additional data collection and licensing requirements would be mandates that would accrue to providers without any additional funding to support them. Private nonprofit providers are a partner with the state in the delivery of health and human services, and while we fully support the state developing the most efficient and effective substance abuse delivery system possible, we hope that it will not be done by placing additional stress on the private provider system.

Thank you for the opportunity to testify.

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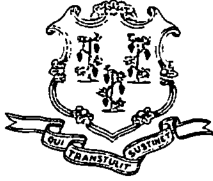

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A HEALTHCARE SERVICE AGENCY

M. JODI RELL
GOVERNOR

THOMAS A. KIRK, JR., Ph.D.
COMMISSIONER

Testimony of Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health and Addiction Services Before the Program Review and Investigations Committee February 10, 2009

Good afternoon, Senator Kissel, Representative Mushinsky, and distinguished members of the Program Review and Investigations Committee. I am Dr. Thomas A. Kirk, Jr., Commissioner of the health care agency known as the Department of Mental Health and Addiction Services. I am here today to speak regarding two bills — **H.B. 6319, An Act Implementing The Recommendations of the Legislative Program Review and Investigations Committee Concerning the Financial Viability of Providers of Substance Abuse Treatment for Adults** and **H.B. 6320, An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning Substance Abuse Treatment for Adults.**

Allow me to begin my remarks by thanking the Committee for giving us the opportunity to speak on these two important bills. Also, I would like to recognize the work performed by Committee staff in their review of Connecticut's substance abuse treatment system for adults.

The study undertaken by the Committee covers a broad range of departmental functions, and the report's recommendations are far reaching in their scope. While DMHAS generally agrees with the intent of the Committee's recommendations (now reflected in these two bills), it should be noted that their implementation will have budgetary implications, both for DMHAS and our providers.

The breadth and scope of the changes proposed in **H.B. 6319** would have significant fiscal impact. The wording of the bill provides limited direction as to the proposed scope of the 10-year assessment, making it difficult to estimate the resources that would be required. At minimum, it would require either additional staff resources beyond the agency's current positions or funds to hire an outside consultant to conduct a study of this apparent magnitude. In addition, DMHAS already employs several methods to determine financial viability within our provider network, including an 8-month Internal Fiscal Report, an Annual Financial Report and the annual State Single Audit Report done on each provider. At each point of reporting, DMHAS has an opportunity to assess that provider's financial viability; thus, we do not support the expense of creating another process which will duplicate existing efforts.

With regard to **H.B. 6320**, DMHAS supports the intent of the proposed revisions to CGS sec. 17a-451. However, some of the expansive modifications recommended therein would require

additional resources which the Department may be able to address by reallocating existing resources. I will come back to this at the conclusion of my testimony. Moreover, several requirements contained in the bill are already underway or in development. Some areas we wish to highlight include the following:

- Establishing a waiting list system: Measuring treatment demand is complex and depends upon a number of factors. Currently, there is no uniformity in the collection of information on persons waiting to enter treatment among providers, and an individual could be on more than one "wait list." Furthermore, a person could enter treatment with one provider, while still appearing on the wait lists of other providers, skewing the actual numbers of those needing treatment

- Tracking the availability of substance abuse treatment services: DMHAS currently manages service utilization and access — and informs the public of these services — via a "Service Directory," a "Consumer Line" operated as part of its General Assistance Behavioral Health Program, and a daily census of residential services.

- Performance monitoring: The department has implemented the National Outcome Measures, and we are in the process of developing a provider "report card." Some aspects of the latter included in the bill would require the collection of new information.

- Access to treatment: DMHAS has been exploring the addition of a "time-to-treatment" measure that would assess timely access to treatment. However, while important, implementation would require providers to modify their information systems to accommodate the collection of new data.

- Full involvement of key stakeholders in the planning process: DMHAS has a strong history of collaboration with other state agencies, advocacy organizations, providers, advisory groups and many others. These efforts will continue to be part of our comprehensive planning process.

- "Evidence-based programs": DMHAS is a forerunner in adopting proven practices and programs within its system of care. It should be noted that the introduction of evidence-based programs can incur significant costs, including training and technical consultation for service providers, measurement of program fidelity, and continued support of the practice over time. These must be taken into account in any planning and implementation effort.

- Licensed or certified staff to perform treatment services: We understand the importance of this, as reflected in our current policies and compliance with DPH licensing requirements. However it has been the Department's experience that services delivered by peer or recovery specialists are also important in promoting a sustain recovery.

- Development and review of performance and outcome information on methadone maintenance and other opioid replacement programs: DMHAS already distributes monthly performance and outcome reports to methadone maintenance providers. As persons in opioid replacement programs may remain in treatment for an extended time period, data

currently is collected only at the time of admission and discharge. At present, DMHAS does not require periodic updates which would result in performance measures being collected at more frequent intervals. In order to remedy this issue, we are exploring the possibility of requiring providers to collect and report status updates at specific intervals (i.e., 3 months, 6 months, one year).

- Dual Licensing for Behavioral Health Care Providers: As an agency, we support Section 9 of the amended statutes regarding implementation of a dual licensure program for behavioral health care providers. DMHAS, the Department of Public Health and service provider representatives have met and completed a thorough review of the current licensing statutes. New licensure language is being drafted for consideration.

DMHAS continues to actively pursue ways to enhance its delivery of efficient, effective, and quality care This involves strengthening internal structures, procedures and policies, as well as promoting even greater collaboration among our partners. In the coming year, we are committed to enhancing treatment access, service quality and overall accountability of the DMHAS substance abuse treatment system even further. This can be seen in the agency's focus on evidence-based practices and treatment therapies with proven results. These efforts will continue with renewed energy and commitment.

The Department is in the process of drafting a substantial response to the Committee's recommendations, pending issuance of the Final Report.

Thank you for the opportunity to address the Committee on these two bills. I would be happy to answer any questions you may have at this time.

February 10, 2009

To: Program Review and Investigations Committee

From: Terry Edelstein, President/CEO

Re: Public Hearing February 10, 2009 Testimony – Substance Abuse Treatment for Adults

I am pleased to provide testimony regarding H.B. 6319 and H.B. 6320 regarding substance abuse treatment for adults. We appreciated the opportunity of working with Committee staff as they did their research on this important topic.

H. B. No. 6319 (RAISED) AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING THE FINANCIAL VIABILITY OF PROVIDERS OF SUBSTANCE ABUSE TREATMENT FOR ADULTS.

We strongly support H.B. 6319 regarding the financial viability of providers of substance abuse treatment for adults. This legislation seeks to assure that client needs are met in a way that improves their quality of life. The mission of community providers is to provide services that support individuals with disabilities and significant challenges in the community. In order to do this, there needs to be an infrastructure in place that assures the ongoing viability of programs and services.

A reimbursement structure that covers the "Cost of Services" is the first step in assuring that client needs are met. Over a twenty year period, the private provider COLA increased by 33.16% compared to the Medical CPI increase of 197.2%. Reimbursement is not matching the costs to provide services.

As you are aware, there was no Cost of Living Adjustment (COLA) in the FY09 budget for community providers, and the Governor's FY10, FY11 budget proposal "level funds" most

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private provider accounts. A 0% COLA over a three year period means that private providers will be forced to reduce services, rather than expand to meet the growing treatment needs of Connecticut's residents.

Furthermore, the Governor's proposed budget cuts funding to some substance abuse levels of care through program and rate restructuring: developing tiered methadone maintenance treatment, eliminating "excess capacity" in medically managed detox system, eliminating funding for zero tolerance program, and developing ambulatory detox. Such proposed programmatic and funding shifts should be developed as part of a comprehensive plan for addiction treatment in the DMHAS, Behavioral Health Partnership (BHP), DOC, CSSD and DSS systems, and through the work of your Committee, rather than as a budgetary fix.

There are related capacity issues in the private sector. Our turnover is approximately 26% for direct care staff, with an average vacancy rate of 8%. Almost one in ten positions is vacant at any one time. Our employees are leaving our ranks to take direct care jobs with state agencies and at other private provider agencies that can afford to pay higher wages. Staff turnover and COLAs are intertwined. We need to be able to afford to pay our staff for their fine work and consumers seeking treatment benefit from consistent staff to support them in their recovery.

Another area that should be part of the assessment process in H.B. 6319 is to review the impact of government re-procurement on service provision. The executive branch is currently revamping re-procurement plans for the human services state agencies. Over a period of time, it is expected that almost all human services will be re-bid. Although state agency commissioners may seek to waive rebidding, commissioners are not required to seek waivers. In recent months all DOC contracts were rebid. DMHAS Employment Opportunities services were rebid.

While reprocurement offers opportunities for open competition, that some of our members welcome, there are a number of issues of concern including continuity of care and community presence. A bid process that tends toward seeking a lower price for the services will further undermine the ability of community providers to adequate meet consumer needs.

The assessment required under H.B. 6319 should go far in identifying obstacles to care and may reinforce the measures that need to be taken to assure private provider provision of services.

H. B. No. 6320 (RAISED) AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE CONCERNING SUBSTANCE ABUSE TREATMENT FOR ADULTS.

I'd like to comment on section 7 of H.B. 6320 that requires the development of a "provider profile." We welcome the potential to provide data in a uniform manner that would include DMHAS and DOC-funded programs. It is important that providing information for this provider profile can be done as efficiently as possible through the use of a report format that utilizes specific rather than general information. For example, items (1) and (2) such as client populations served and provider's accreditation status are quick to compile. Item (8) "the percentage of staff responsible for assessment, treatment plan development and delivery of treatment services..." asks a question that might be labor-intensive to complete. Several other categories overlap each other. Item (12) asking for "any other information deemed pertinent" by DMHAS creates a huge potential obligation on private providers. In short, while we support the development of uniform information that can be readily available to potential or current recipients of services, it is essential that providing this level of detailed information doesn't become an unfunded mandate that takes critical time away from service provision. We would like to work with the Committee to refine this list of items included in the provider profile.

Thank you for the ability to testify today.

Community Providers Association
Caring for Connecticut.