CAADPE

CALIFORNIA ASSOCIATION OF ALCOHOL AND DRUG PROGRAM EXECUTIVES, INC.

BOARD OF DIRECTORS

OFFICERS

President
Albert M. Senella
Tarzana Treatment Centers, Inc.
Kern, Los Angeles, Orange,
Ventura Counties

Vice President
Trisha Stanionis
Family Service Agency
Yolo County

Secretary
William Dombrowski, Ph.D.
Didi Hirsch CMHC
Los Angeles County

Treasurer
Norman Sprunck
Western Pacific Med Corp
Los Angeles, Orange, Ventura Counties

BOARD MEMBERS

Lynne Appel
Southern California Alcohol & Drug Programs, Inc.
Los Angeles, Orange Counties

Jack Bernstein
CRI-HELP, Inc.
Los Angeles County

Kimberly Bond
Mental Health Systems
San Diego, San Bernardino,
Imperial, Riverside, Santa Barbara,
San Luis Obispo, Kern,
Stanislaus, Fresno and Orange Counties

Vitka Eisen, MSW, Ed.D.
Walden House, Inc.
Kings, Los Angeles, Madera,
Riverside, San Francisco,
and Sutter Counties

Kimberly Hendrix
Volunteers of America
Los Angeles County

Shawn Jenkins
WestCare California
Fresno, El Dorado, Kern,
and Sacramento Counties

Stephen Maulhardt
Aegis Medical Systems
Butte, Fresno, Kern, Los Angeles
Merced, Placer, San Bernardino,
San Joaquin, San Luis Obispo,
Santa Barbara, Stanislaus, Sutter,
Ventura, Yuba Counties

Luis Montes
Narcotics Prevention Association Inc.
Los Angels County

Henry van Oudheusden
Behavioral Health Services, Inc.
Los Angeles, Orange Counties

Elvia Torres
SPIRITT Family Services
Los Angeles County

Elizabeth Stanley-Salazar
Phoenix Houses of California, Inc.
Kings, Los Angeles, Madera, Orange,
San Bernardino, San Diego,
Ventura Counties

Sushma Taylor, Ph.D.
Center Point, Inc.
Contra Costa, Marin, Riverside,
Sacramento, San Diego, San Joaquin,
Solano, Toulomne Counties

Brenda Wiewel
Los Angeles Centers for Alcohol & Drug Abuse
Los Angeles County

In memoriam
Dale Shimizu

DATE: May 20, 2011

TO: Senate Budget and Fiscal Review Committee
Subcommittee No.3 on Health and Human Services:
Hon. Mark DeSaulnier Chair
Hon. Elaine Alquist
Hon. Bill Emmerson

Assembly Budget Committee
Subcommittee No.1 on Health and Human Services
Hon. Holly Mitchell, Chair
Hon. Wesley Chesbro
Hon. Kevin Jeffries
Hon. Alan Mansoor
Hon. Bill Monning

FROM: California Association of Alcohol and Drug Program Executives (CAADPE)

RE: Item 4200 Department of Alcohol and Drug Programs –
MAY REVISE Proposals
Governor's Proposal: Eliminate the Department of Alcohol and Drug Programs **OPPOSE**
Governor's Proposal: Transfer Drug MediCal to the Department of Health Care Services - **SUPPORT**

The California Association of Alcohol and Drug Program Executives (CAADPE) **opposes** the Governor's proposal to eliminate the Department of Alcohol and Drug Programs (DADP) as a free-standing department and **supports** the Governor's proposal to transfer the Drug MediCal Program to the Department of Health Care Services (DHCS).

There are no efficiencies to be gained by eliminating the Department of Alcohol and Drug Programs. Elimination of the Department of Alcohol and Drug Programs is not a strategy that will produce efficiencies. On the contrary it will dismiss Substance Use Disorders (SUD) as insignificant and diminish the ability of the state agency to promote effective evidence-based substance use disorder services and policies, even though substance use related problems are a major cost driver of health care and other state expenditures . . . some $62 billion of state funds are spent annually to pay for health care conditions resulting from untreated substance use disorders.

1127 - 11th Street, Suite 208, Sacramento, CA 95814
(916) 329-7409 FAX (916) 442-4616 caadpe@pacbell.net

The proposal to eliminate the Department of Alcohol and Drug Programs is not a new idea; the state explored this issue in depth under the past administration. It was concluded then that this idea does not produce cost savings or efficiencies in state government.

As stated by then chairman, Michael Alpert, in the Little Hoover Commission's 2003 report, ***For Our Health & Safety:*** *Joining Forces to Defeat Addiction:*

"*If you are concerned about public safety, address addiction.*
If you are worried about the cost of government, address addiction.
If you are worried about abused children, homelessness, struggling families, address addiction.
If you are worried about economic productivity and prosperity, address addiction.
Drug and alcohol abuse is not the source of all problems, but it is a cancer in our communities that is sapping our resources and limiting our potential."

To date, neither the legislature nor the two Governors since the release of the report have heeded the Commission's advice nor have implemented their recommendations. The state is not strategically using prevention, treatment, and enforcement tools to reduce the consequences of addiction.

The costs of treatment for health problems attributed to substance use in California are significant – not $62 billion annually. Over two-thirds of substance use costs are HIV/AIDS related, and 10% of alcohol costs are for the care of fetal alcohol syndrome. Furthermore, nearly $1 of every $4 (a substantial 25%) Medicare/MediCal spends on inpatient hospital care is associated with substance use. Substance use disorder treatment significantly decreases criminal activity during and after treatment. And, substance use disorders treatment is more cost effective than incarceration or emergency medical care.

CAADPE's opposition, from the provider perspective, is based on the absolute necessity to protect a vastly under funded critical system of specialty care and to protect the state's investment in an existing system of treatment that is high quality and cost effective.

Elimination of the Department of Alcohol and Drug Programs is contrary to this goal and will not achieve the goals set out by the State. In order to implement substance use disorders policy and services that will actually achieve the objective of reducing direct and indirect costs of substance use to the State, effective collaboration as an equal agency between DADP and multiple other State and community agencies is absolutely essential.

The need for interagency collaboration is greater for the state agency addressing substance use disorders than for almost any other health or human services agency because virtually every public agency, especially the criminal justice system and primary healthcare, has clients with substance use disorders. These agencies and programs include: Education, Social Services (CalWORKs and TANF), California Youth Authority, Corrections (and Parole), and the Judicial Branch (Drug Courts). To achieve effective interagency collaboration, the agency/department addressing substance use disorders must be highly visible, relatively autonomous and not completely subsumed within any agency that does not fully share its priorities and mission.

California should not ignore the experience of other states in making a decision about the status of the Department of Alcohol and Drug Programs. Studies have shown that state agencies addressing substance use disorders having high visibility and related credibility in their state system, and a corresponding allocation of resources and leadership, report being much better at promoting effective substance use disorder policies and services through their agency's collaboration with other state administrative units. These agencies also report being better able to devote internal resources to the effort required to obtain discretionary Federal funds in addition to their formula-driven block grants. The system of providing substance use disorders services, which is currently collaboration among four stakeholders – federal, state, local governments and providers – has proven to be both cost and programmatically effective.

In order to address substance use related problems and to strategically utilize SUD services and create greater efficiencies in state government CAADPE recommends the following:

1. Streamline counselor certification process.

   - Repeal the delegation of counselor licensing and certification to non-governmental entities and return the function to the Department of Alcohol and Drug Programs. Returning certification functions will reduce the workload of DADP to keep track of 9 organizations by consolidating the licensing and certification functions within the already existing licensing unit in the Department of Alcohol and Drug Programs. From a provider perspective, it will allow providers to go to one central place to determine the validity of potential employees, if any complaints have been filed, or if there have been any disciplinary actions imposed on an applicant. Centralizing the licensing and certification function will allow providers to focus their attention and resources on direct services. Under the current process, employers must check with each of the nine non-governmental certifying programs to verify applicant's qualifications.

   - Health care reform will require an increase of 30% in the workforce. It will be inefficient for those seeking certification to sort through nine non-governmental organizations' requirements to determine which is the most appropriate certificate for their individual career objectives.

   - The disarray of the current certification system could be a major barrier to meeting the parity and access requirements under the Affordable Care Act (ACA)

2. Streamline the program certification and facility licensing process.

   - Large national certifying organization such as the Commission on Accreditation of Rehabilitation Facilities (CARF). Council on Accreditation (COA) and The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) conduct their facility renewals every 3 years with an intensive multiple day survey of the accredited organization. The Joint Commission accredits over 19,000 health care organizations and programs in the United States. The state DADP should accept these accreditations in lieu of its own certification for all accredited agencies. This would eliminate significant state expense and workload. Providers could, and are, willing to negotiate a state fee to use these accreditations in lieu of a separate and duplicative state licensing process.

   - Further streamlining of the facility licensing process can be accomplished by automatically renewing licenses in the same manner Health Services now does for acute care facilities, through the use of a one page form.

   - Other California departments use this efficient method of renewal and there is no reason why the same cannot be instituted for the Department of Alcohol and Drug Programs.

CAADPE supports the Governor's proposal to transfer Drug MediCal to the Department of Health Care Services. In addition, CAADPE supports a streamlining of the Drug MediCal program. The transfer offers an opportunity to both improve and streamline the program with little effort. One such opportunity is to conform the state law governing Narcotic Replace Treatment (or Medication Assisted Treatment) to the federal law. The federal law allows use of new, evidence-based treatments that have proven to be cost effective and provide medical personnel with a wider range of medication use that leads to more appropriate treatment for individuals, especially for youth. By conforming to federal standards, the state again will produce efficiencies and cost savings.

As the California Health and Human Services Agency and DADP prepare to transfer the Drug MediCal program to the Department of Health Care Services, CAADPE believes there are savings and program efficiencies that can be realized from this conformance and has held some preliminary discussion with the Department of Alcohol and Drug Programs.

By far the most efficient transfer would be to move all Drug MediCal SUD services into the 1115 waiver as a mandated benefit and to require all MediCal providers to conduct SBIRT (Screening, Brief Intervention and Treatment Referral). CAADPE recommends this alternative proposal, to place all Drug MediCal Substance Use Disorder services under the state's 1115 Medicaid waiver, in preparation for the implementation of the Affordable Care Act (ACA-health care reform) in 2014.

It should be noted, as much as 1/3 of the dollars identified as savings in the proposed Drug MediCal realignment are state general fund dollars not currently used for any federal match. The CDCR, SUD services program funds also fall into this category. This should be taken into account when considering the 1115 waiver options.

1. Substance Use Disorder services are mandated under the Federal Affordable Care Act (ACA). It is estimated that approximately 300,000 individuals (including some 100,000 currently in custody in the state prison system) who are currently in need of SUD services will become eligible for Medi-Cal in July 2013, the estimated date the state will begin Medi-Cal enrollment for the January 1, 2014 implementation date of ACA.

2. The recently approved federal Medicaid waiver "1115 Waiver" is intended to be the "Bridge to Health Care Reform". However, California omitted SUD services as a mandate and instead designated it as a county optional benefit.

The eligibility requirements under the waiver are broader than under the state's Medi-Cal program and the SUD benefit can be different from state Drug Medi-Cal.

Many individuals who are currently substance use disorder patients qualify under the new "1115 waiver" eligibility requirements.

3. The amount of funds estimated for savings through the realignment proposal could be applied as the state match under the "1115 Waiver," thereby bringing individuals into enrollment. They could receive needed services and the state would be able to draw down federal matching funds for the services.

And last, CAADPE recommends greater involvement of stakeholders and consideration of their perspectives at the planning stages of state initiatives and transfers of programs. Stakeholder participation is essential to effective implementation of any plan. However, all too often stakeholder input is solicited only after the plans have been decided, not while they are being formulated.

CAADPE recommends and supports the Governor's proposal for transfer of the Drug MediCal program to the Department of Health Care Services. CAADPE also recommends the Department of Alcohol and Drug Programs be retained as an independent department and that a number of efficiencies be instituted that will streamline the department and potentially yield state savings

CAADPE is a statewide association of community-based nonprofit substance use disorder agency executives who provide services at over 300 sites in California for approximately 250,000 clients each year. Collectively, CAADPE member agencies employ approximately 7,000 professionals. CAADPE is the only statewide association representing the full continuum of care. Its members comprise the major component of the state's delivery system for publicly funded substance use disorder treatment services.

CAADPE continues to make its expertise available as a resource for the Committee and the Governor.

cc: Hon. Mark Leno, Chair, Senate Budget Committee
Hon. Robert Huff, Vice-Chair, Senate Budget Committee
Hon. Bob Blumenfield, Chair Assembly Budget Committee
Hon. Jim Nielsen, Vice-Chair, Assembly Budget Committee
Hon. Jim Beall, Jr. Chair, Assembly Select Committee on Alcohol and Drug Problems
Diana Dooley, Secretary, Health and Human Services Agency
Diane Cummins, Special Advisor on Realignment, Department of Finance
Jennifer Troia, Consultant Senate Budget Committee
Nicole Vasquez, Consultant Assembly Budget Committee
Chantele Denny, Consultant, Senate Budget Republican Caucus
Allan Cooper, Consultant Assembly Republican Fiscal Consultants
David Panush, Consultant, Senate President Pro Tem Darrell Steinberg
Gail Gronert, Consultant, Assembly Speaker John Perez
Shawn Martin, Analyst, Legislative Analyst Office
Lisa Magnet, Program Manager, Department of Finance
Theresa Calvert, Program Budget Analyst Department of Finance
Wayne Sauseda, Deputy Secretary, Health and Human Services Agency

Substance Use Disorder Benefit for California

CAADPE recommends the following principles be used as guidance for determining benefits under the "1115 waiver"/ACA implementation and the services to be provided:

Principles

- *Least Restrictive Setting/Patient Choice (Provider)*
- *ASAM Driven, placement criteria and continued stay*
- *Utilization Review/Care Review*
- *Staff Credentialing*
- *Facility Accreditation/Certification*
- *All care will be managed*
- *All care will be confidential*
- *Care will be coordinated across Health Care System*
- *Embrace Healthcare Homes/Cross Integration and the 4 quadrant model*
- *Reimburse by or under the supervision of licensed practitioner of healing parts*

Recommended SUD Benefit:

- *Screening*
- *Assessment*
- *Brief Intervention*
- *Consultation*
- *Acute Stabilization*
- *Detoxification*
- *Residential/Rehabilitation*
- *Medication Assistant Treatments including Addiction & Psych Medication and Behavioral Therapy*
- *Outpatient Service - Full Range*
- *Traditional, Structured, Intensive, Partial Hospitalization/Day Rehabilitation Treatment*
- *Disease Management/Care Manager*
- *Telemedicine*