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In memoriam
Dale Shimizu

February 21, 2012

Honorable Senator Ed Hernandez, O.D., Chair
Senate Committee on Health

Honorable Senator Mark DeSaulnier, Chair
Senate Budget Subcommittee on Health and Human Services

Honorable Assemblymember Bill Monning, Chair
Assembly Committee on Health

Honorable Assemblymember Holly Mitchell, Chair
Assembly Budget Subcommittee on Health and Human Services

**RE: Restructuring of the Behavioral Health System in California
Joint Hearing Assembly and Senate Health Committees Assembly
Budget Subcommittee No. 1 on Health and Human Services and
Senate Budget and Fiscal Review Subcommittee No. 3 on Health and
Human Services**

The California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) is submitting its comments about the Governor's proposal to eliminate the Department of Alcohol and Drug Programs and to restructure the state's behavioral health (substance use and mental health disorders) systems and its response to specific questions contained in the committee's background document. CAADPE's overriding concern is that individuals with substance use disorders (SUD) will be able to access the appropriate health care they need to adequately treat their diagnosis.

In addition to responding to the specific questions raised in the committee's background paper, CAADPE is also submitting supplementary comments and recommendations for consideration as the Legislature deliberates the Governor's proposal. These include:

The recently released draft assessment of SUD and MH services conducted as part of the terms and conditions of the state's 1115 state Medicaid waiver must be considered. (CAADPE's letter to Director Toby Douglas, DHCS)

The importance of an adequate essential benefit for SUD and MH services and how such services integrate with the restructuring of broader healthcare reform "Adequate essential benefit" for SUD and MH services

means strong availability of services at the assessed and medically necessary levels of need. (CAADPE position paper on essential benefits)

SUD services must be at a level and with needed leadership in the state organizations to ensure the full and complete viability of the SUD treatment services. CAADPE is recommending two deputy directors; one for SUD and one for MH, both reporting directly to the Director. (CAADPE letter on restructuring.)

The following is CAADPE's response to the specific seven questions posed to providers in the Committee's background paper:

Question #26: *What are your primary concerns with the Administration's proposals to reorganize mental health and substance use disorder programs?*

Response to Question #26:

CAADPE supports the Administration's proposal to eliminate the Department of Alcohol and Drug Programs. CAADPE's support for the elimination is based on the belief that SUD services are a key component of the state's healthcare system and an important specialty service which should be fully integrated into healthcare. CAADPE believes healthcare reform offers the opportunity to fully address this integration.

However, CAADPE is concerned with the Governor's proposal to distribute SUD programs across three departments. Assigning DADP's key functions across multiple state departments is inefficient, dilutes the field in its importance, increases the burden on providers, provider groups, consumers and other stakeholder's and drains valuable resources from stakeholders' mission of providing adequate treatment services. They will instead spend valuable resources navigating various departments, many who are unfamiliar with SUD treatment laws and regulations. Eliminating DADP, losing the full representation of a state Director, and distribute DADP functions among multiple state departments is contrary to DCHS's state goal of seamless transition. Such changes, without appropriate planning will lead to chaos, not smooth transition.

Question #27: *What, if any, information about the proposed reorganization have you been waiting for from the Administration in order to evaluate its effects on the group(s) that you represent?*

Response to Question #27:

CAADPE participated in early discussions with Administration representatives in an effort to try to understand the rationale behind the proposed elimination of DADP and the proposed transfer of functions into multiple departments. CAADPE requested, but have not yet received the detailed rationale that supports the Administration's belief the most effective way to carry out the restructuring of the system is dividing the functions of DADP between three other state departments.

CAADPE has not been provided with any organizational details as to how these functions fit within the three departments. How and who will manage? What processes will be established for stakeholder involvement and ongoing input? And, how the placement of these functions in disparate departments will impact implementation of ACA

Question #28: *What have you learned from the ongoing efforts to transfer Medi-Cal related mental health and Drug Medi-Cal Treatment Program functions that can inform what the Administration is proposing to do to further change how mental health and substance use disorder services are administered?*

Response to Question #28:

The transfer process of Drug Medi-Cal services to DHCS was a process prescribed by the legislature to ensure a smooth transition. The requirements for DADP and DHCS to work together with stakeholders to develop a transition plan provided a vehicle to ensure good planning and consideration of important concerns. This was handled well by the two departments.

However, the legislature also requested that improvements to services also be included in the plan. Unfortunately, DHCS decided to focus solely on the process to transfer all elements of the Drug Medi-Cal program, including those areas that clearly need improvement. Essentially, most stakeholder concerns for improvement have been deferred to an unspecified date and no ongoing stakeholder venues have been established to address them. CAADPE would not like to see this repeated if the DADP is to be eliminated.

Question # 29: *What are your main questions or concerns for the July 1, 2012 transfer that the Legislature and Administration should be made aware of at this time?*

Response to Question #29:

CAADPE recognizes the current proposal to eliminate DADP and the move of its functions to three departments is a massive undertaking, but it also provides the opportunity for an examination of needed improvements. An opportunity that should not be overlooked. CAADPE strongly recommends that the 2012-2013 fiscal year be used as a planning and transition year for the elimination of DADP to address the elimination and explore important improvements which should be included in this effort. The planning process should also include more discussion on the Drug Medi-Cal program and how it will align with ACA implementation.

CAADPE recommends all the functions of DADP should move together to DHCS and not be divided between multiple state departments. However, should the Administration's proposal to distribute DADP functions to other departments be approved, CAADPE recommends that licensing and certification functions for residential programs and for narcotic treatment programs be kept together. Separating these two functions will result in chaos and disarray for anyone attempting to conduct business with the state. (e.g. obtain license, discuss audit findings, process reimbursement claims).

CAADPE also recommends program certification be a state requirement; not voluntary as it is currently.

CAADPE further recommends that accreditation by national accrediting organizations such as the Joint Commission or Commission on Accreditation of Rehabilitation Facilities be recognized and accepted in lieu of state certification. Such national standards far exceed state certification.

Question# 30: *Do you think the proposed reorganization will make it easier for you to work with the state?*

Response to Question #30:

No. The current proposed reorganization will at minimum, triple the work for providers, consumers and other stakeholders who must seek state approval to operate publicly funded treatment programs or interface with the state on related matters. CAADPE continues to support a plan that would keep all DADP functions under one authority.

Question #31: *What program regulations, practices and policies would you like to see changed if DMH and DADP are merged with DHCS?*

Response to Question #31:

There are a number of immediate areas that could benefit from this opportunity to collaborate and plan for healthcare reform and for better integration of SUD and MH services with the broader healthcare systems:

Streamlining processes and eliminating duplicative state regulations governing the DMC program are necessary and must be a part of the plan's development. There are many areas of changes needed that were conveyed to DHCS during the DMC program transition which still need to be addressed, including streamlining the DMC certification process.

CAADPE recommends that all five services under the DMC Program be reviewed with the goal of updating the program requirements to more comprehensively reflect current evidence based practice and to remove the overly burdensome state regulations. These added state regulations are unnecessary, add cost to providing services, are cumbersome, inefficient, and interfere with the delivery of appropriate treatment and health care delivery. These burdensome state regulations make the use of medically recognized best practices impossible.

Examples of such restrictions are:

- Restrictions on medications which can be used especially new evidence-based therapies or medication assisted treatments (MAT).

- Limitations the frequency and type of sessions;
- Requiring operating hours in excess of federal regulations which are costly; reimbursing only the five limited services instead of an appropriate continuum of services to meet the needs of the recipients according to assessments.

In summary, CAADPE believe that the state can improve access to healthcare, improve SUD outcomes and “bend the cost curve” on health care by:

- Combing program certification with licensing for residential and outpatient services.
- Recognizing national accreditation.
- Addressing the residential licensing prohibitions on providing basic medical care within residential facilities.
- Fully addressing medication assisted treatment (MAT) access and availability for SUD, in a manner equal to primary care and mental health access to medications.
- Addressing counselor certification and licensing under one single state authority
- Fully adopting an adequate essential benefit for those suffering from substance use and/or mental health disorders.

CAADPE offers its expertise in systems and service delivery for SUD treatment to the committee as it further deliberates these issues.

CAADPE appreciate the opportunity to submit is comments and looks forward to continuing dialogue.

Respectfully,



Albert M. Senella
President

CALIFORNIA ASSOCIATION OF ALCOHOL AND DRUG PROGRAM EXECUTIVES, INC.

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Los Angeles Centers for Alcohol & Drug Abuse
Los Angeles County

In memoriam
Dale Shimizu

January 30, 2012

Att: Steve Larsen

Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G

Washington, DC 20201

RE: Essential Health Benefits

The California Association of Alcohol and Drug Program Executive, Inc (CAADPE) is submitting comments on the Essential Health Benefits.

Contact the CAADPE office at if you have any concerns or questions regarding CAADPE's comment paper.

Respectfully,



Al Senella
President

CALIFORNIA ASSOCIATION OF ALCOHOL AND DRUG PROGRAM EXECUTIVES (CAADPE)

CAADPE, the California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) is a statewide association of community-based nonprofit substance use treatment agencies. Its members provide substance use disorder (SUD) treatment services at over 300 sites throughout the state and constitute the infrastructure of the state's publicly funded substance use disorder treatment network. It is the only statewide association representing all modalities of substance use disorder treatment services.

Untreated substance use disorders radically increase health care costs. Substance use disorder treatment provided at the assessed level of need and duration determined by health care providers will decrease health care costs. In California, treating substance use disorders reduces all other health and social services costs such as emergency room visits, jails and prisons, hospital days, and foster care, anywhere between \$4 and \$7 for every dollar spent on substance use treatment. And, Kaiser Permanente of Northern California, in a recently completed study found that treating the individual with substance use and treating the individual's family members for both substance use disorder as well as primary health care *reduced the overall health care cost for everyone*.

Any benchmark plan adopted by a state *must* include mental health and substance use disorder services in compliance with Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requirements. Current coverage models are based on historical efforts to control the treatment expense of substance use and mental health disorders, with little or no concern as to how the under-treated efforts impact other medical and social costs. **Current plans largely have not met the MHPAEA parity requirements.** Current small business plans tend to overlook other costs that are associated with providing limited or no substance use and mental health treatment services. For example, employers may not cover substance use disorder treatment or limit the Substance Use Disorder/Mental Health benefit in their company insurance plan. While a limited or no benefit saves a company/business money on health care premiums, the costs show up in the business' bottom line. While employers limit SUD benefits to save on the health insurance premium, their cost are doubled as the business pays for the employee's sick days and incurs the cost of lost productivity. Now that the Affordable Care Act has identified mental health and substance use disorder benefits as one of the 10 categories required to be included in the essential health benefits, CAADPE strongly urges HHS to ensure that states are following these guidelines.

Because treatment for substance use and mental health disorders have been historically underrepresented in health insurance packages, CAADPE feels that there need to be well established guidelines as to what constitutes substance use and mental health disorder treatment. To this end, CAADPE recommends that comprehensive coverage of mental health and substance use disorder services include the following:

Assessment, including a comprehensive medical and bio-psychosocial assessment of related mental health and substance use issues, ongoing mental health and substance use disorder assessments, specialized evaluations including psychological and neurological testing, and diagnostic assessments of MH/SUD in general medical settings, including education and counseling for mild MH/SUD;

Patient placement criteria, evidence-based patient placement criteria and guidelines can help to effectively place individuals into the optimal level of MH/SUD care for the amount of time that is deemed medically necessary;

Outpatient treatment, including individual, group, and family therapies; devices and technology interventions for mental health and addictive disorders; general and specialized outpatient medical services; consultation to caregivers and other involved collateral contacts, such

as school teachers, in accordance with confidentiality requirements; evidence-based complementary medicine services, comparable to complementary medicine services covered for other health conditions; and monitoring services, comparable to those provided to determine compliance with the treatment regimens for other health conditions;

Intensive outpatient services, including substance use intensive outpatient treatment, mental health intensive outpatient treatment, partial hospitalization, dual-diagnosis partial hospitalization and intensive outpatient services for persons with co-occurring MH and SUD conditions, and intensive case management for MH/SUD;

Residential and inpatient services, including crisis stabilization; detoxification in clinically-managed non-hospital residential treatment facilities for SUD care and hospital settings, including the use of medication-assisted withdrawal management services; mental health residential for adults and youth; substance use disorder residential, including the use of medication-assisted treatment, for adults and youth; dual-diagnosis services for adults and youth with co-occurring MH and SUD conditions; clinically managed 24-hour care; clinically managed medium intensity care; inpatient psychiatric hospital; inpatient mental health and substance use disorder care; and inpatient hospital dual-diagnosis care for youth and adults with co-occurring MH and SUD conditions.

Pharmacotherapy and medication-assisted treatment (MAT), Medication Assisted Treatment (MAT) should be as automatic in availability and use for substance use disorders as medications are for any other chronic disease. The MAT services should include medication management and monitoring; medication administration; pharmacotherapy (including medication-assisted treatment); home-based, mobile device or internet-based medication adherence services; assessment for medication side effects; and appropriate wellness regimens for consumers who are experiencing metabolic effects as a result of their medication.

Emergency services, including crisis services in both MH/SUD and medical settings, including 24 hour crisis stabilization and mobile crisis services, including those provided by peers; 24/7 crisis warm and hotline services; and hospital-based detoxification services;

Laboratory services, including drug testing;

Maternal and newborn services, including pre-natal and perinatal screening and brief interventions for maternal depression and substance use disorders and referral to treatment; health education; targeted case management; and maternal, infant, and early childhood home visiting programs;

Pediatric services, including screening for substance use, suicide, and mental health conditions using rapid identification tools; early intervention services; service planning; caretaker coaching on children's social/emotional development and support; therapeutic mentoring; skill building; intensive home-based treatment; and targeted case management;

Rehabilitative services, including psychiatric rehabilitation services; behavioral management; comprehensive case management in physical health or MH/SUD settings which should include individualized service planning with periodic review to address changing needs, treatment matching, navigation between all needed services, communication between all service providers, enrollment in Medicaid/insurance, and support to maintain continued eligibility; Assertive Community Treatment (ACT) Teams; peer-provided telephonic and internet based recovery support services, including those delivered by recovery community centers; recovery supports, including those delivered by peer run mental health organizations; and skills development including supported employment services;

Recovery supports, including peer-provided recovery support services for addiction and mental health conditions; recovery and wellness coaching; recovery community support center

services; support services for self-directed care; and Community Support Programs and other continuing care for mental health and substance use disorders;

Habilitative Services, including personal care services; respite care services for caregivers; transportation to health services; and education and counseling on the use of interactive communication technology devices;

Preventive and wellness services and chronic disease management, including screening (including screening for depression, alcohol, drugs, and tobacco), brief interventions (including motivational interviewing) and facilitated referrals to treatment; general health screenings, tests and immunizations; appropriate MH/SUD related educational programs for consumers, families and caretakers, including programs related to tobacco cessation, the impact of alcohol and drug problems, depression and anxiety symptoms and management, and stress management and reduction, and referral for counseling or support as needed; caretaker education and support services, including non-clinical peer-based services, that engage, educate and offer support to individuals, their family members, and caregivers to gain access to needed services and navigate the system; health coaching, including peer specialist services, provided in person or through telehealth, e-mail, telephonic, or other appropriate communication methods; health promotion, including substance use prevention and services that impact well-being and health-related quality of life; wellness programming for youth, including student assistance programming; services for children, including therapeutic foster care interventions aimed at facilitating compliance with treatment and improving management of physical health conditions; care coordination (including linkages to other systems, recovery check-ups, linkages to peer specialists, recovery coaches, or support services based on self-directed care); and relapse prevention, including non-clinical peer-based services, to prevent future symptoms of and promote recovery strategies for mental and substance use disorders.

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Los Angeles County

In memoriam
Dale Shimizu

February 13, 2012

Mr. Toby Douglas, Director
California Department of Health Care Services
Sacramento, CA
Sent Via E-mail

Dear Mr. Douglas:

This letter contains comments on the January 30, 2012 draft of the California Mental Health and Substance Use Needs Assessment from my perspective as President of the California Association of Alcohol and Drug Program Executives (CAADPE). CAADPE is a statewide association of community-based substance use treatment agencies. Its members provide substance use disorder (SUD) treatment services at over 300 sites throughout the state and constitute the infrastructure of the state's publicly funded SUD treatment network. CAADPE is the only statewide association representing all modalities of SUD treatment services.

First, I want to commend the Department, the Technical Assistance Collaborative, and the Human Services Research Institute on preparing a generally thorough and fair assessment of the condition of Mental Health and Substance Use services in California. The Assessment is a valuable resource that will be used by many organizations, including CAADPE, to plan the transition to 2014. This letter focuses primarily on the shortcomings in the Assessment and concentrates, with a few exceptions, on Chapter XII which lays out the priorities for development of the service plan that will be produced by the Department over the next several months. And, although many CAADPE members provide mental health and co-occurring services, the focus of this letter is on substance use disorders [SUD] and their treatment. It must be again noted, SUD services are not part of the 1115 waiver which required the Assessment and therefore not being addressed as part of the waiver's bridge to reform efforts in any direct way.

1. Proxy best-practice indicators – wait times for SUD treatment admissions

The Assessment discusses CalOMS data that indicates that close to 90% of SUD admissions occur within 1 – 7 days; an estimated 72% happening within one day (p. 107). This measure does reflect best practice but should not be misinterpreted. It reflects the promptness with which SUD treatment providers respond to need. It does not accurately describe the long wait lists for treatment that many programs maintain. If DATAR data were also reviewed it would show the reality that, given current funding landscape, most SUD providers today are struggling with wait times between weeks or months depending on level of care needed. Some programs waiting lists appear

shorter than they actually are because patients give up on hope of getting admitted. It must also be noted, the data used for the report was during a period when funding for SUD services in California was much greater. The field has lost hundreds of millions dollars with the total elimination of prop 36 funding as well as reductions in other funding categories.

2. Inpatient Detoxification

“The need for more inpatient detoxification was noted by several key informants who described that people in need of this service often cannot access it but rather have to accept what is available (e.g., outpatient care) rather than what they need to properly treat their addiction” (p. 215)

“The qualitative data presented here, such as long wait times for access to certain services such as inpatient detoxification and psychiatry along with the penetration rate data discussed in Chapter IV of this report do suggest a large unmet need for mental health and substance use services.” (p. 244)

Citing the findings of the Frequent Users of Health Services Initiative, the Assessment says:

“Overall, the project shed light on several important policy issues for the Medi-Cal program including: The lack of availability of substance use treatment in the state was identified as a contributing factor to the problem of emergency department overutilization. The dearth of beds available for medical detoxification, especially for the uninsured, was identified as a particular driver of ED utilization.” (p. 253)

“In order to most efficiently use the detox services there needs to be a continuum of care to other substance use services.” (p. 122)

This series of quotes from the report reinforce several key points about detoxification services:

- a) The Assessment correctly concludes that there are insufficient licensed detoxification beds relative to need. But an analysis based on licensed beds may understate the actual gap because many of these licensed beds sit empty because of lack of funding to compensate for care. A review of occupancy data would be helpful to get a more accurate picture.
- b) Detoxification services are a critical part of the continuum of care. Medical necessity criteria exist for each level of detoxification services: medically-managed inpatient, medically-monitored residential and medically-monitored outpatient.

- c) Detoxification services are overused when there is inadequate provision for services downstream in the continuum of care. Patients discharged from detox service must be able to get follow-up care in a residential or outpatient setting, depending again on medical necessity.

3. Long term residential

“Although California’s use of all types of residential services is consistent with national data, the use of short term residential is considerably lower than for long term residential. As noted above, only 1% of admissions are for short term residential services, while 16% of admissions are for long term residential services. This may indicate an over-reliance on long term residential care, which is typically one of the most expensive service components in most local systems. Longer term residential services are not typically reimbursed by Medi-Cal, and thus are likely to remain as state/county funded resources after 2014.” (p. 125)

The need for long-term residential treatment for SUD should be determined by medical criteria and state funding can be justified as cost-saving. For example, those chronically ill with co-occurring SMI and SUD and frequently homeless need long-term residential treatment. Without it, they will frequent hospital emergency departments (both medical and psychiatric) resulting in expensive inpatient hospital day stays. These patients, in many instances stay longer than necessary because hospitals are unable to secure a discharge to needed community mental health and/or SUD treatment services and because they are unwilling to simply discharge patients back to the streets. The rationale for state-level coverage of long-term residential can be based, in part, on avoiding these hospital ED and admission costs. Relegating funding of long-term treatment to Counties guarantees that variation in services will occur and the burden on hospitals will be unevenly distributed. Effective treatment requires effective use of a continuum of services which must include long term residential care as needed.

4. Workforce Training & Development

“70% of the overall expansion population is expected to be non-Caucasian, with 23% non-English speaking.” (pg.8)

We need to be concerned about the aging of our current SUD workforce and to what extent we are training the next wave of leadership. Our aging SUD leadership is generally comprised of males and White/Caucasians. Given expansion population demographics we need to train more women and racial/ethnic minority leaders. Mentorship programs should be promoted

statewide that allow for the paring of aging leaders with new emerging leaders from the SUD field, particularly women and racial/ethnic minority groups.

In addition, it will be important to position SUD services as a viable career option for individuals just entering the workforce. This will require that we continue to stress the value of current statewide certification efforts and the on-going development of a professional workforce. We will need resources to retrain our workforce to better work under insurance and managed care models and need to create financial incentives to attract more bi-lingual service providers, particularly Spanish speakers. SUD providers will need to implement on-going competency workforce Assessments and National Standards on Culturally and Linguistically Appropriate Services (CLAS).

5. Provider Capacity

There is value in the experience base and geographical and cultural diversity of the existing pool of SUD treatment providers that should be preserved. Business failures and mergers to prevent failure have increased in the past year. Because SUDs are chronic diseases many of the chronically afflicted consider these providers as a health home. There will be health and health care cost consequences if this provider base is severely damaged by system changes.

DHCS should foster development of regional networks similar to the HIT regional extension centers with the aim of strengthening and transforming the SUD provider base. Collaboration with NIATX and the Pacific Southwest Addiction Technology Transfer Center and similar entities would accelerate development of such networks.

6. Strengths Section of Chapter XII

“Enrollment of seniors and people with disabilities (SPDs) into managed care is likely to increase participation of these individuals in behavioral health as well as physical health primary care and preventive interventions. It is also likely to provide more powerful incentives at the county level to share information and coordinate care across the specialty health plans and the physical health plans.” (p. 288)

Physical medicine for SPDs is the responsibility of health plans and MH and SUD services are carved out to County Departments which the Assessment refers to as “Specialty Plans”. There has been little coordination between the physical health plans and agencies in most Counties and no communication to providers of primary care or MH/SUD services about how to affect an increase in participation of SPDs in MH/SUD services. The Assessment calls for better

integration among the plans at the County level but an equal or greater emphasis should be placed on the need for provider-level integration.

7. Strengths Section of Chapter XII (cont.)

“The enrollment of uninsured single adults in the Low Income Health Plans (LIHP) will increase access to mental health (not substance use in most cases) services. And, as with the SPD managed care initiatives, enrollment in LIHP is expected to increase both the potential and the incentives for LIHP counties to coordinate care across the physical health and specialty health plans. Anecdotal information from several LIHP counties indicates that this type of information sharing and care coordination is beginning to occur, albeit informally.” (p. 289)

There must be incentives for coordination of physical / MH / SUD care across at both the health plan and provider levels. In addition there must be financial incentives for the delivery of care integration services such as Case Management, Care Navigation, Care Coordination Teams, etc.

8. Specialty Plans Section of Chapter XII

“.....And, although California’s Drug-Medical program and covered services is limited and incomplete, it is on par with Medicaid coverage for substance use services in many other states.” (p. 17)

“This Assessment frequently refers to the very limited behavioral health (particularly substance use) benefit for Medi-Cal beneficiaries who do not qualify for or access services through the specialty health plans. This Assessment also emphasizes the bifurcation between the physical health plans and the specialty health plans. However, these issues should not mask the fact that California has a relatively complete benefit structure for substance use and mental health services in the specialty plans.” (p. 289)

The quote from page 17 is a sad commentary on the state of SUD treatment in California and in the rest of the nation.

Read from front to back, the Assessment drifts toward referring to Drug Medi-Cal (DMC) and County Mental Health Plans as “specialty health plans”. Drug Medi-Cal is not a “health plan” in any sense but is a very limited entitlement fee-for-service health benefit. It should not be likened to but should be contrasted with the frequently-capitated physical health plans and the tightly managed County Mental Health Plans.

The treatment services included in the DMC benefit are limited in scope, constrained in delivery, and in some cases obsolete. Thus the underlined sentence in the quote from page 289 is plain wrong. DMC needs to be

significantly restructured to include a broader set of benefits congruent with the needs outlined in the assessment. These benefits would need to be on par with physical health services, driven by medical necessity and not limited by visit or time constraints.

9. Benefit Design Section of Chapter XII

“The fact that California has relatively good covered services (benefit design) in the specialty plans does not mean that (a) it has all the covered services, best practice service definitions, etc. that are desirable; or (b) that these services are being widely or correctly implemented. For example, Drug Medi-Cal (DMC) includes Naltrexone, an evidence-based medication assisted therapy for substance use disorders, as a covered benefit. To date, this benefit is rarely if ever accessed by DMC providers on behalf of DMC participants.” (p. 290)

This paragraph optimistically cites oral naltrexone as an evidence-based medication without recognition of the structure and cost required to achieve success with the oral form of the medication. The Assessment should recognize the research on effectiveness of injectable naltrexone (Vivitrol) and other medications that currently exist and will continue to emerge for SUD. The Service Plan should call for changes in regulation, e.g., those that hinder use of medical staff in residential treatment programs, and to support the use of medications in SUD treatment programs. Medication support for SUD must be on par with that which is in place for primary and mental health needs.

10. Health Homes Section of chapter XII

“Section 2703 of the ACA, Health Homes for Individuals with Chronic Conditions, holds great promise for improving care for individuals with mental health and substance use disorders.” (p. 289)

The Needs Assessment focuses on changes needed in the MH/SUD arena but changes are needed in physical healthcare as well. Among them, SUD needs to be understood by primary care providers as a chronic medical condition that requires attention and treatment. The Service Plan should include workforce development to achieve that end. In addition, Medi-Cal-reimbursement for brief substance use assessments in the primary care setting are essential followed by ability to bill for a MH/SUD service on the same day that physical health is addressed. Ideally, primary care providers would be incentivized to refer and coordinate care with MH/SUD providers as part of a reimbursement plan aimed at lower total costs of healthcare.

11. Health Homes Section of Chapter XII

Missing from this Assessment and the other consultant-produced documents recently delivered to DHCS including the ACA 2703 Medical Home Pilot, and, to a lesser extent, the RFS for Dual Eligibles and the 617 Coordinated Care Initiative is a vision of what integrated care looks like at the point of care. These valuable contributions describe the potential architecture for care coordination at the health plan level but do not describe expectations for care integration at the provider level.

The Assessment cites the Frequent User Project (Tarzana Treatment Centers was the lead grantee in Los Angeles County), the Integrated Behavioral Health Project, SAMHSA PBHCI grants and other integration projects. The Service Plan should outline what care integration should look like on the ground perhaps in the form of the NCQA PCMH criteria extended to better integrate MH/SUD.

12. Prudent Purchasing Plan and Strengthened Local Oversight

“TAC/HSRI recommends conceiving of the task as the development of a comprehensive and uniform purchasing plan for DHCS, DMH and DADP. This purchasing plan would provide an overall framework for making management, financing and performance monitoring decisions across multiple health plans and multiple county-managed/operated systems.” (p. 298)

“The county role in managing the mental health and substance use systems in the context of the purchasing plan must be strengthened and clarified as well. Because of the great variation among counties, the state will have to assist counties to select and develop management strategies and tools tailored to their own local systems.” (p. 299)

We agree with the purchasing plan approach and the need for greater local oversight. What DHCS should purchase are the outcomes of integrated care including lower total costs of healthcare, improved quality of care and improved health measured broadly to include mental health and freedom from addiction.

13. Benefit Design Section of Chapter XII

“First, we recommend that the essential benefit behavioral health services benefit design and service definitions be consistent between the Medi-Cal benchmark plan and the benchmark benefit for the exchange ...

Second, we recommend that DHCS assure that there is not a substantive gap between the benefit design for the benchmark plans and that for the specialty plans.” (p. 301)

These are two very good points that essentially are saying the same thing. The point that is missing, is the one in regard to producing parity between physical health and MH/SUD benefit designs. Some of the plans, (frankly maybe none of the plans) recommended as models for the Medi-Cal benchmark benefit design do not meet MH/SUD parity requirements. The Assessment should point out the cost-effectiveness of robust MH/SUD benefits in holding down the cost of admissions/readmissions to hospitals and reduced medical and psychiatric ER use as a justification for parity in benefits that goes beyond equity. Additionally the state, different from a health plan, must also be concerned with the cost of untreated SUD on criminal justice, social services, welfare and business.

14. Target Areas for Planning Section of Chapter XII

"DHCS and its partners will be looking at a three to five year horizon for addressing some of the provider sufficiency, information technology, and evidence based practice redeployment and development strategies." (p. 298)

SUD treatment providers lag behind physical health and MH providers in the adoption of Health Information Technology to the extent that long-run viability of many small SUD providers is questionable if they must bill fee for service Medi-Cal or private insurance to survive.

Implementing modified meaningful use incentives for California MH and SUD providers would pull some of these providers in the direction of health information technology and could take advantage of the infrastructure of the regional extensions centers. This approach is preferable to the approach modeled on the MHSAs county-administered distribution of HIT resources.

Please do not hesitate to contact me via e-mail at asenella@tarzanatc.org or by phone at 818-654-3815 should you have any questions. Thank you.

Respectfully,

A handwritten signature in cursive script, appearing to read "Albert Senella".

Albert Senella
President

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In memoriam
Dale Shimizu

CAADPE Position – Support Elimination of the Department of Alcohol and Drug Programs and establish a Division of Substance Use Services in the Department of Health Care Services.

CAADPE has historically opposed any state efforts to merge, consolidate or eliminate the state's Department of Alcohol and Drug Programs. This position is based on the long held belief that the voice of the field needed a strong visible position in state government and that anything less than a recognizable and highly placed independent department would not fulfill this requirement.

Recent events at both the federal and state level have caused CAADPE Board of Director's to reexamine this position through the lens of how clients seeking Substance Use Disorder (SUD) treatment services will best be served and what kind of delivery system would allow for the easiest access, remove administrative and systems barriers, be flexible enough to adapt to both the changing needs of the clients and to yet adaptive to new evidence based treatments now and in the future.

At the federal level, CAADPE is working with other state associations to assure that the essential benefit, required by the Affordable Care Act (Health Care Reform) is adequate, and that states and private insurance markets implement the Wellstone/Domenici Substance Use and Mental Health Parity Act according to law. The Health Resources and Services Agency (HRSA) has established a new division called Specialty Care that includes SUD treatment and will soon be requiring all primary care clinics to establish reciprocal treatment protocols with the SUD field for treatment services. In addition CAADPE and its members have also been working at federal, state and local levels in support of integrated care.

At the state level, four initiatives are in various stages of implementation.

- Transfer of the Drug MediCal program to the Department of Health Care Services
- Elimination of the Department of Alcohol and Drug Programs, effective July 1, 2012
- Needs assessment to meet the conditions of the State's 1115 Medicaid waiver
- Planning for Health Care Reform, January, 2014

The federal efforts and these four state initiatives open up opportunities that have not historically existed for our field but now do. The Board believes now is the time to participate as a full partner in the state's health care delivery system and to provide expertise that can help inform the governance decisions about SUD treatment in California. SUD treatment is specialty healthcare for a chronic disease. It is time it is fully recognized as such.

Thus CAADPE has decided to reverse its long standing position and will now support Governor Brown's proposal to eliminate the Department of Alcohol and Drug Programs (DADP) and recommends placement of all substance use disorder prevention and treatment authority in the Department of Health Care Services (DHCS), since the Department of Health Care Services is the main authority for health care services in California.

However, our decision to support this move does not eliminate many of CAADPE's historical concerns for the SUD field, such as its visibility and voice, specialty care nature, barriers and access to care and the impact of untreated SUD on the broader healthcare systems. CAADPE is therefore further recommending that all substance use disorder related services be located in a yet to be created Division of Substance Use Prevention and Treatment Services at the Deputy Director level to the Director of the Department of Health Care Services. CAADPE does not support the proposal of a Behavioral Health Division, where SUD is under such a heading, nor do we support the merger with Mental Health programs and services.

At the same time CAADPE is also making a number of recommendations that, if integrated into the Governor's proposal, will position the field to be a fully recognized partner in the state's health care delivery system and gain better access to services for clients/consumers. CAADPE will be better able to inform the Health and Human Services Agency and Department of Health Care Services as they prepare the FY2012/13 budget proposal which we understand needs to be completed by October 1, 2011.

CAADPE believes now is the time to transfer of all Department of Alcohol and Drug Programs functions to the Department of Health Care Services. The Department of Health Care Services is the single state agency for health care services and, substance use disorder, as a specialty care, should now be under their jurisdiction as we prepare for implementation of healthcare reform. As the state implements ACA/Health Care Reform, most of people served in treatment programs will be eligible for health care through medical insurance or through the state's Health Benefit Exchange. All the health care benefits, primary care and specialty care will come through the Department of Health Care Services.

CAADPE also believes that in the future, the state will not want to continue SUD services as a "carve out" to DADP. A more likely scenario is the state will globally contract with counties and private health plans to manage all aspects of health care. It is our belief it will be the health plans that will determine if there is a "carve out" of SUD and mental health services to counties and/or providers for the delivery of care. This is consistent with the states actions under the 1115 Medicaid waiver and this year's realignment of SUD services to counties.

CAADPE also believe that it can more fully advance the field with other policy maker's goals of improving access, improving treatment, embracing recovery, improving outcomes and instituting more efficiency through participation in the Department of Health Care Services' broader discussion of health care delivery.

CAADPE also believes that its presence in the Department of Health Care Services will enhance overall health delivery systems since primary care practioners are not well versed in our specialty care. Well versed and experienced SUD treatment staff can provide the necessary technical assistance to the Department of Health Care Services.

CAADPE believes now is the time to embrace and take advantage of doing "business" in a different way under a different governance structure.