ASSOCIATION OF SUBSTANCE ABUSE PROGRAMS
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WRITTEN TESTIMONY

Sunset Commission Hearing
HHSC Staff Report
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The Association of Substance Abuse Programs is a membership organization representing Substance Use Disorder prevention and treatment providers across the state of Texas. The majority of our members are not-for-profit private entities who contract with DSHS to provide safety net services for Texans and their families. We appreciate the opportunity to provide comment on the HHSC Staff Report and appreciate the hard work, research and thoughtful analysis staff put into preparing its recommendations and report. We respectfully submit the following comments which primarily address Issues I & 2.

GENERAL COMMENT: Issues I & II

Issue I: The Vision for Achieving Better, More Efficiently Run Services Through Consolidation of Health and Human Services Agencies Is Not Yet Complete.

- Consolidate the 5 HHS system agencies into one agency called the Health and Human Services Commission with divisions established along functional lines and with a 12-year Sunset date.

Issue II: Incomplete Centralization of Support Services Deprives the State of Benefits Envisioned in Consolidating the Health and Human Services System.

The Association of Substance Abuse Programs believes a well-supported, coordinated and better integrated health and human services system will lead to improved outcomes, enhanced client experiences and efficient use of the taxpayer dollars. As the Report points out, the HHSC service delivery system is complex. It consists of a myriad of individual programs/services which often have to comply with different grant requirements, reporting mechanisms, service delivery and contracting patterns, funding levels, target populations and specialized programing needs. Achieving meaningful integration given these various differences is a challenging but worthy goal and we appreciate the thinking and rationale behind the reorganization proposal to combine current state agencies into a single Health and Human Services Commission. However, our members have long histories and extensive experience with providing government contracted services and have expressed concerns

similar to the ones noted on page 21 regarding the practical difficulties involved in governing an "*organizational behemoth*". They are uneasy about the sheer size and scope of a combined HHS agency that will be responsible for managing 56,000 employees, coordinating its extensive portfolio of services and administrative supports and balancing the needs and policy attention of both large and small constituencies.

One of the observations our members were quick to note is that the new structure actually decentralizes services for providers and spreads various components of service delivery and contracting across multiple divisions. This could result in decreased efficiencies for providers because there is greater risk for communication errors and information omissions to happen across divisions, divergent guidance from multiple sources and the development of more cumbersome and time consuming bureaucratic processes because policy, contract and programmatic changes have to travel through multiple approval levels within the medical and social services division and then over to functional support areas before being implement.

The report did identify and address some of these concerns by recommending the creation of organizational homes that focus on system performance, change management, evaluation and process improvement and cross system coordination as well as the development of an executive level office for policy and performance. We support creating these components in whatever organizational structure moves forward and encourage the state to provide ample FTE allocations to fully staff these functions. We suspect these new organizational components will drive a great deal of the successful integration efforts.

We would also like to highlight several other recommendations we feel should be included in whatever structure moves forward:

- Combined rate analysis and forecasting: Substance abuse services do not have a process for setting rates. We do not know when and how the base rate was set and for over 2 decades the small rate increases that have been received are simply added to a an outdated base rate that has not keep pace increased licensure requirements, contract requirements, clinical advances and business costs. The inadequate base rate for DSHS was then adopted by Medicaid without a rate or cost analysis. The demands to supplement the steadily increasing gap between cost and reimbursement levels has produced a fragile infrastructure and loss of qualified providers. A regular review and rate analysis process is desperately needed to assess and cover the cost the providing treatment services.
- Simplified Performance Measures: DSHS collects a great deal of information for substance abuse services. The DSHS Sunset Review calculated that a total of 261 measures were collected. These are collected, but provide very little useful information, are often not even looked at and add an unnecessary burden on providers. A concerted effort to develop simplified measures that can be used across the HHS system is a difficult task but needed endeavor.

A primary concern we have regarding the proposed reorganization is the elimination of the advisory councils created by HB 2292. Even though these did not have decision making authority, the Association

advocated for these entities to be created for public accountability purposes and giving stakeholders the opportunity to provide comment, recommendations or opinions to a body that has no sway over business relationships with the state or pre-conceived outcomes. Developing a system that relies on staff to consider public input on proposals that staff created without some form of outside public involvement to help monitor the people's business is simply not good governance. While we agree that the number of advisory boards is not needed, there must be some sort of council, commission, board built into any new structure.

As we noted earlier, we are concerned about the depth and breadth of this proposed system and its potential to *"marginalize certain aspects of the system and harm the delivery of services"*. We are concerned substance abuse services could be in that mix despite the fact Substance Use Disorders are a significant cost driver for the state and increase service utilization and expenditures for health and human services as well as a range of other state-funded services including criminal justice, education, workforce, public safety and even the attorney general's office through its child support division.

A notable study from Columbia University, "Shoveling Up II: The Impact Of Substance Abuse On Federal, State And Local Budgets" found that of every dollar that federal and state governments spent on substance use and addiction 95.6 cents went to paying for the wreckage it causes; only 1.9 cents went to prevention and treatment despite a compendium of research that demonstrates the value and cost effectiveness of providing services. The burden to public programs in Texas was estimated at 96 cents with only 2 cents going for services (see appendix I).

Yet, despite the significant human and financial impact caused by substance use disorders and a 1:7 rate of return for prevention and treatment, these services remain a relatively small component of HHS the HHS System. It is also a significantly smaller component of behavioral health services which are weighted toward mental health. DSHS has estimated that current funding levels are only able to meet 3% of the need for substance abuse services. We are concerned that the new structure will make SUD even less visible than it is in the current system and attention will be given to the policy and administrative needs of larger, less stigmatized and better funded service systems with more powerful constituencies.

Within the emerging healthcare category of Behavioral Health, substance abuse services are struggling to achieve "parity" with mental health even though the impact of addiction on individuals, society and government is no less and may be even more damaging and costly. The following illustrates the disparity between these important and vital services: 1) the approximate $330M increase for MH services DSHS received last biennium is actually larger than the total DSHS substance use disorder services budget ($315M); and, 2) it is often reported that mental health and substance abuse or behavioral health services received an unprecedented $330 million budget increase during the 83rd Legislative Session. While substance abuse did receive an unprecedented increase and our members appreciate the additional dollars that were appropriated, the increase was comparatively small totaled $26M.

This disparity also affects the ability of mental health and substance abuse to achieve meaningful integration so that individuals with co-occurring MH & SUD conditions can be better served. There are also other differences that account for the difficulty in coordinating and combining services that ultimately must be taken into consideration, but a significant problem is simply the lack of substance abuse services as well as specialty providers that will accept the state rate.

Thank you for your time and consideration. Please feel free to contact us if we can answer questions or help in anyway. We want to a productive partner in designing and implementing an effective and efficient health and human services systems.