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National Association of State Alcohol and Drug Abuse Directors, Inc.

Comments presented at the  
SAMHSA Public Hearing on Narcotic Drugs in Maintenance and  
Detoxification Treatment of Narcotic Dependence  
November 1, 1999

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98N-0617

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My name is Jack Gustafson and I am the Executive Director of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). NASADAD represents State Alcohol and Drug Abuse Agencies that have responsibility for the prevention and treatment of alcohol and other drug abuse.

NASADAD's members have extensive experience in the treatment of opiate dependent persons as well as other forms of addictive disease. State Alcohol and Drug Abuse Agencies are responsible for all aspects of administering a \$4 billion public alcohol and drug abuse prevention and treatment system including certifying professionals, accrediting treatment programs, contracting with community based providers, analyzing data, and monitoring performance. In FY'97, State Alcohol and

Drug Abuse Agencies reported treatment admissions of over 1.8 million including 232,755 individuals with opioid addiction.

NASADAD's members have the front line responsibility for assuring the quality and effectiveness of prevention and treatment services. States also play an important role in financing services. Of the \$4 billion public alcohol and other drug treatment system they administer, Federal resources account for only one third of the dollars, with States contributing or leveraging the balance. In addition, States are also responsible for paying for the bulk of medications used to treat opiate dependent persons.

Before I move on to my comments, I'd like to take just a minute to express NASADAD's appreciation for the way

that CSAT has kept us apprised of the development of these proposed regulations every step of the way. Bob Lubran has met repeatedly with NASADAD staff, presented regular status reports to our Board of Directors, and provided updates to our full membership at our Annual Meetings. NASADAD is also appreciative of the opportunities provided that allowed us to participate in the NIH Consensus Development Conference on Effective Treatment of Heroin Addiction and the Expert Panel on Office Based Opioid Treatment.

NASADAD is in agreement with the authors of the proposed regulations when they suggest that the current methadone regulations are overly restrictive and could tend to limit accessibility. We also agree that the existing regulations focus on processes at the expense of improved

quality of treatment that would lead to better outcomes for individual clients. The proposed regulations represent a thoughtful attempt to address those issues.

Despite that level of thoughtfulness, NASADAD believes the proposed regulations have provisions or omissions of legitimate concern to the States and to the OTPs. During the brief time available to me in this forum, I'll limit my remarks to the areas of most immediate concern to our members. Before the end of the comment period NASADAD will provide written comments that will be more comprehensive.

Just to provide context for my comments I would note that as a group NASADAD's members license, accredit, or otherwise approve more substance abuse treatment

facilities than any other body. In 1997 that meant they performed that function for in excess of 7,000 facilities.

Each State that offers methadone detoxification or maintenance services has its own regulations that are as stringent or in many instances more stringent, than the corresponding Federal regulations.

Because of this wealth of experience a number of our members wonder if accreditation should be not remain an option within States rather than a mandatory condition that must be met to obtain Federal approval. States are well equipped to determine and monitor compliance with treatment standards. I would point out that in most other healthcare arenas accreditation by a national accrediting body is an option and not a mandate. Many healthcare facilities opt for such accreditation to meet conditions set

by payors and not as a condition that must be met simply to operate.

If accreditation were to remain an option, we believe that the States would be amenable to implementing new standards of oversight and monitoring activities. Such enhancements could include continuous quality improvement provisions consistent with the intent of the proposed regulations.

It must be understood, however, that if accreditation becomes a requirement, some States will still be required to conduct their own surveys for State licensing purposes, with significant duplication of costs.

States have expressed significant concerns regarding provisions that would make State AOD Agencies ineligible to serve as an accrediting body unless a State is able to accredit at least 50 OTPs a year. We believe that the minimum figure of 50 is arbitrary and would eliminate all but the largest States. NASADAD opposes the provision. We know of no support that can be drawn from practical experience or science that suggests that the volume of accreditation activities can be a legitimate predictor for the quality of accreditation activities.

We would also ask that the authors examine the criteria established for approval as an Accreditation Body. Several States have indicated that criteria now proposed are more appropriate for a private business providing accreditation services than for a unit that must operate within the context

of State government. This is especially true in the area of conflict of interest since States operate in the role of both payors and regulators. Concerns have also been expressed regarding the oversight role proposed for SAMHSA for those States that might be granted approval to serve as accrediting bodies. There is a very real possibility that conflicts will continually arise between existing State policies and practices and SAMHSA's expectations for accrediting bodies. The necessary flexibility to accommodate the realities of a governmental entity acting as an accrediting body should be incorporated into the final regulations.

States have also learned, through long and sometimes painful experience that a crisis or patient complaint within an OTP seldom results in a call to a national accrediting

body. Those calls are almost invariably made to the State AOD Agency. The proposed regulations do not spell out the role and authority of the States in those circumstances. From the public's perspective it will be the SSAs that will be held accountable.

There are also State concerns around the level of technical assistance which the OTPs will require both pre and post accreditation. We are unclear as to the degree to which CSAT is prepared to meet that need and to what extent that burden might fall on the States. We feel that the level and cost of these hidden accreditation expenses have been underestimated in the fiscal impact statement which accompanied the proposed regulations.

Currently each State that offers methadone services has an individual designated as the State Methadone Authority (SMA). Under the existing regulations, the role of the SMA is fairly well defined as is the partnership relationship between the SMA and the relevant Federal agencies. In the proposed regulations we find no mention of the SMAs. We feel that that omission should be addressed in consultation with the States.

Many of the State AOD Authorities feel that the proposed regulations lack specificity that can only be added when the CSAT supported accreditation study of 180 OTPs and the associated evaluation study are completed. NASADAD considers the careful assessment of those study findings to be a critical activity in shaping the specific content of any future Final Regulations. We were pleased to find the

Notification of Proposed Rule Making contained an explicit provision for including State Officials in that discussion.

NASADAD looks forward to continuing its active participation in the process.

Thank you