Joint Informational Hearing: "Implementing and Funding the Control, Regulate, and Tax Adult Use of Marijuana Act's (AUMA) Youth Education, Prevention, Early Intervention and Treatment Account (YEPEITA)"
Wednesday, February 13, 2019
1:30 p.m. John L. Burton Hearing Room (4203)

The Senate Committee on Health and the Senate Committee on Education will hold a joint informational hearing to explore the progress made by affected state agencies and stakeholders on the implementation and funding of the YEPEITA, which will fund specific programs for youth with, or at risk of developing, substance use disorders (SUDs). The creation of the YEPEITA presents an opportunity for a continuously appropriated funding stream, derived from a tax on recreational cannabis, for programs that educate about, prevent, and treat youth with SUDs. AUMA tasks the Department of Health Care Services (DHCS) with administering the YEPEITA, and requires DHCS to enter into interagency agreements with the Department of Public Health (DPH) and the Department of Education (CDE). During this hearing, DHCS, DPH, and CDE will discuss implementation plans and collaborative efforts to date, as well as plans for ensuring effective monitoring of programs funded by the YEPEITA. Stakeholders that represent the treatment, prevention/early intervention, and education sectors will discuss current efforts aimed at targeting youth with, or at risk of developing, SUDs, as well as their vision for how to best maximize the funds. The Department of Finance and the Legislative Analyst's Office will provide an overview of AUMA and highlight the process for determining the allocation of funds to the YEPEITA.

Background

On November 8, 2016, California voters passed Proposition 64, or AUMA, making California the sixth state in the nation to legalize the distribution, sale, and possession of cannabis for recreational use. AUMA allocates 60% of an excise tax that is levied on the cultivation and retail sale of recreational and medicinal cannabis by July 15 of each fiscal year beginning in 2018-19 to the YEPEITA to be administered by DHCS for programs for youth that are designed to

educate about and to prevent SUDs, and to prevent harm from substance abuse. The Governor's 2019-20 Budget Act forecasts that the excise tax will generate $355 million in fiscal year 2018-19 and $514 million in 2019-20. AUMA requires DHCS to enter into interagency agreements with DPH and CDE to implement and administer programs that emphasize accurate education, effective prevention, early intervention, school retention, and timely treatment services for youth and their families and caregivers. Programs are permitted to include components such as:

- Prevention and early intervention services to recognize and reduce risk factors related to substance use and the early signs of problematic use and of SUDs;
- Grants to schools to develop and support student assistance programs to prevent and reduce substance use, improve school retention and performance, support students who are at risk of dropping out of school, and promote alternatives to suspension and expulsion, with prioritization for schools that have higher than average dropout rates;
- Grants to programs for outreach, education, and treatment for homeless youth and out-of-school youth with SUDs;
- Access and linkage to care provided by county behavioral health programs for youth, and their families and caregivers, who have SUDs or are at risk of developing an SUD; and,
- Youth-focused SUD programs that are culturally and gender competent, trauma-informed, evidence-based, and provide a continuum of care that includes screening and assessment (for SUDs and mental health), early intervention, active treatment, family involvement, case management, overdose prevention, prevention of communicable diseases related to SUDs, relapse management for SUDs and other co-occurring behavioral health disorders, vocational services, medication-assisted treatments, psychiatric medication, and psychotherapy.

AUMA contains a provision that prohibits the Legislature, prior to July 1, 2028, from amending the allocation of YEPEITA funds for specified programs and for their stated purposes.

Youth behavioral health incidence

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), half of adult mental illness begins before the age of 14, and three-fourths before age 24. More than 40% of youth ages 13 to 17 have experienced a behavioral health problem by the time they reach seventh grade. In addition, suicide is the third leading cause of death among youth ages 15 to 24 after accidents and homicide. Compared with their peers, people within this age group with mental disorders are more likely to experience homelessness, be arrested, drop out of school, and be underemployed. Youth transitioning into adulthood have some of the highest rates of alcohol and substance abuse. SAMHSA states that rates of binge drinking (drinking five or more drinks on a single occasion) in 2014 were 28.5% for people ages 18 to 20 and 43.3% for people ages 21 to 25. SAMHSA states that an estimated 1.3 million U.S. adolescents ages 12 to 17 had an SUD in 2014 (5% of all adolescents). The 2014 rate of past-month illicit drug use was 3.4% among youth ages 12 to 13, 7.9% among youth ages 14 to 15, and 16.5% among youth ages 16 to 17. SAMHSA states that the highest rate of current illicit

drug use was among youth ages 18 to 20 (22.7%), with the next highest rate occurring among people ages 21 to 25 (21.5%). Adolescents and young adults also face challenges with mental health issues:

- In 2014, about one in ten youth ages 12 to 17 (11.4%) had a major depressive episode (MDE) in the past year. Among adolescents with MDE, 41.2% received treatment or counseling for depression in the past year;
- Combined 2010–2012 data from SAMHSA's National Survey on Drug Use and Health indicate that one in five youth ages 18 to 25 (18.7%) reported a mental illness in the past year and 3.9% were diagnosed with a serious mental illness; and,
- In 2014, 1.4% of adolescents had a co-occurring MDE and a SUD.

A federal government Web site dedicated to youth facts, youth.gov, states that substance abuse and problematic patterns of substance use among youth can lead to problems at school, cause or aggravate physical and mental health-related issues, promote poor peer relationships, cause motor-vehicle accidents, and place stress on the family. They can also develop into lifelong issues such as SUDs, chronic health problems, and social and financial consequences.

State spending on prevention and treatment

According to DHCS, in Fiscal Year 2014-15 counties spent a total of approximately $890 million on prevention, treatment, and administrative services from both Drug Medi-Cal and federal Substance Abuse Block Grant (SABG) funds (see Attachment A).

Drug Medi-Cal (DMC)
DMC is a benefit available to all Medi-Cal-eligible individuals who have an SUD diagnosis. Available services include: narcotic treatment program services; outpatient drug-free treatment services; individual and group counseling; day care habilitative services, perinatal residential SUD services, and naltrexone treatment services. Per state regulations, room and board are prohibited from being reimbursable through DMC.

DMC Organized Delivery System (DMC-ODS) Waiver
According to DHCS, the DMC-ODS is a five-year pilot program approved by the Centers for Medicare and Medicaid Services (CMS) in 2015, under the Section 1115 Bridge to Reform Demonstration, to test a new method for the organized delivery of health care services for Medi-Cal-eligible individuals with an SUD. Elements of the DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD treatment services; increased control and accountability; greater administrative oversight; utilization controls to improve care and efficient use of resources; evidence-based practices in SUD treatment; and increased coordination with other systems of care.

ASAM has established five main levels in a continuum of care for SUD treatment:
- Level 0.5: Early intervention services;
- Level 1: Outpatient services;

- Level 2: Intensive outpatient/partial hospitalization services (Level 2 is subdivided into levels 2.1 and 2.5);
- Level 3: Residential/Inpatient services (Level 3 is subdivided into levels 3.1, 3.3, 3.5, and 3.7); and,
- Level 4: Medically managed intensive inpatient services.

"Continuum of care" refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment, or down to less intense treatment, as needed. These levels should be thought of not as discrete levels of care but rather as points in a continuum of treatment services. In addition to the levels of care described by ASAM, outpatient treatment can be broken down into four sequential stages that clients work through, regardless of the level of care at which they enter treatment: 1) treatment engagement; 2) early recovery; 3) maintenance; and 4) community support.

After the initial approval of the five-year pilot program, which expires in 2020, counties could opt in to the DMC-ODS by submitting an implementation plan to DHCS for approval by DHCS and CMS. After approval of a plan, a county contracts with DMC-certified providers or offers county-operated services to provide all services available through the DMC-ODS. Counties are also permitted to contract with managed care plans to offer services to beneficiaries. In addition to standard DMC benefits, opt-in counties are required to provide, among other requirements: recovery services to support an individual's recovery efforts, including counseling, education and job skills, and linkages to housing, transportation, and case management services; comprehensive assessment and periodic reassessment, referral services, and patient advocacy, such as linkages to physical and mental health care; and physician consultation services, which are provided to DMC-certified physicians who seek expert advice on designing treatment plans for complex cases involving DMC-ODS beneficiaries.

According to the California Health Care Foundation (CHCF), as of December 2018, 40 of California's 58 counties had submitted implementation plans to participate in the DMC-ODS. The following 22 counties are now providing services: Alameda, Contra Costa, Imperial, Los Angeles, Marin, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Ventura, and Yolo. CHCF states that currently participating counties represent 75% of the state's Medi-Cal population, and that once all 40 counties begin providing services nearly 97% of Medi-Cal beneficiaries will have access to DMC-ODS services.

Federal Substance Abuse Block Grant (SABG)
DHCS submits a biennial SABG Application to SAMHSA outlining the state's plan to monitor grant-funded SUD prevention and treatment programs throughout California. According to SAMHSA's Web site, the SABG program's objective is to help plan, implement, and evaluate activities that prevent and treat substance abuse. SABG grantees are required to have the flexibility to distribute the SABG funds to local government entities, such as municipal, county, or intermediaries, including administrative service organizations and have SABG sub-recipients, such as community- and faith-based organizations (non-governmental organizations), as well as deliver substance abuse prevention activities to individuals and communities impacted by

substance abuse and SUD treatment and recovery support services to individuals and families impacted by SUDs.

The SABG program targets the following populations and service areas:

- Pregnant women and women with dependent children;
- Intravenous drug users;
- Tuberculosis services;
- Early intervention services for HIV/AIDS; and,
- Primary prevention services.

SAMHSA requires that grantees spend no less than 20% of their SABG allotment on substance abuse primary prevention strategies directed at individuals not identified to be in need of treatment. Grantees are required to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. According to SAMHSA, the program must include, but is not limited to, the following strategies:

- Information Dissemination: provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two;
- Education: builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination;
- Alternatives: provides opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities;
- Problem Identification and Referral: aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment;
- Community-based Process: provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning; and,
- Environmental: establishes or changes written and unwritten community standards, codes, and attitudes. Its intent is to influence the general population's use of alcohol and other drugs.

Treatment services include:

- Nonresidential, such as intensive outpatient treatment, outpatient drug free, and aftercare;
- Narcotic Treatment, such as outpatient and inpatient methadone detox, naltrexone, and narcotic replacement therapy services;
- Residential, such as free-standing residential detoxification, short and long-term residential/recovery, hospital inpatient detoxification and residential, and chemical dependency recovery hospital; and,
- Ancillary services, such as vocational rehabilitation, case management, tuberculosis services, and HIV counseling, education, referral services, and outreach.

Prevention services include:

- Primary prevention, such as information dissemination, education, alternatives, problem identification and referral, and community-based process; and,
- Secondary prevention, such as early intervention; outreach/intervention; and referral, screening, and intake.

Administrative services include:

- Support services, such as county support; quality assurance; training; program development; research and evaluation; planning, coordination, and need assessment; and start-up costs.

Related legislation

2019-20 Legislative Session

AB 258 (Jones-Sawyer) requires DHCS to establish an interagency agreement with the CDE to award YEPEITA funds to local educational agencies (LEAs) in which 55% or more of the pupils enrolled are unduplicated pupils for programs that provide support services that will include programs designed to educate pupils and prevent SUDs from affecting pupils and their families at or near the school. *AB 258 is pending in the Assembly Education Committee.*

AB 307 (Reyes) requires the Homeless Coordinating and Financing Council to develop and administer a grant program to support young people experiencing homelessness and prevent and end homelessness among California's youth, including addressing SUDs or the risk of substance abuse and ensuring that participating youth receive services that provide education, prevention, early intervention, and timely treatment services. AB 307 provides that the grant program is to be funded in part from available funds from the YEPEITA. *AB 307 is pending in the Assembly Human Services Committee.*

2017-18 Legislative Session

SB 191 (Beall) would have authorized a LEA to enter into a contract with a county or qualified mental health service provider to create a partnership for providing mental health services to students. SB 191 would have required the Mental Health Services Oversight and Accountability

Commission, in consultation with CDE and DHCS, to develop guidelines for the use of funds from the Mental Health Services Fund, including provisions for integration with funds and services supplemented with funds from YEPEITA. *SB 191 was held on the Senate Appropriations Committee suspense file.*

AB 1744 (McCarty) would have required DHCS to enter into an interagency agreement with CDE to implement and administer after school programs with an educational enrichment element that is designed to educate about and prevent SUDs and to prevent harm from substance abuse, and to allocate to schools funding from the YEPEITA. *AB 1744 was held on the Senate Appropriations Committee suspense file.*

AB 2328 (Nazarian) would have required the development of regulations for treatment and recovery programs for youth under 21 years of age, and the development of criteria for participation, including consideration of indicators of drug and alcohol use among youth, programmatic requirements, treatment standards, and terms and conditions for funding. AB 2328 stated intent that DHCS seek funding through Medi-Cal, federal financial participation, and funds allocated to the YEPEITA. *AB 2328 was held on the Assembly Appropriations Committee suspense file.*

AB 2471 (Thurmond) would have required DHCS to establish an interagency agreement with CDE to award YEPEITA funds to LEAs with high concentrations of disadvantaged students to increase in-school support services designed to prevent SUDs. *AB 2471 was held on the Assembly Appropriations Committee suspense file.*

Conclusion

This joint informational hearing presents an opportunity for the legislature to hear about the progress made to date by affected entities in planning, developing, and implementing programs that will educate about, prevent, and treat youth with SUDs. The hearing will also present affected state agencies with the opportunity to highlight any barriers that have prevented efforts in collaborating to implement the programs funded by the YEPEITA. The ultimate goal for the hearing is to provide the legislature and the public with information about when funding may be available to support and enhance programs; the larger vision from those in the education, prevention/early intervention, and treatment sectors about how YEPEITA funds can be maximized to ensure effective programs are funded; and how the various state agencies tasked with implementing the programs will collaborate to ensure that all services throughout the continuum are available to youth and their families when needed.

Substance Use Disorder Cost Reports: Total Expenditures by Service
Fiscal Year 2014-2015

County	Services				Services/Total Expenditures: %		
	Treatment	Prevention	Admin.	Total Spending	Treatment	Prevention	Admin.
Alameda	$ 31,102,230	$ 3,003,029	$ 3,313,061	$ 37,418,320	83%	8%	9%
Alpine	$ 53,036	$ 189,834	$ 88,206	$ 331,076	16%	57%	27%
Amador	$ 166,465	$ 89,764	$ 275,271	$ 531,500	31%	17%	52%
Butte	$ 5,720,016	$ 585,248	$ 192,652	$ 6,497,916	88%	9%	3%
Calaveras	$ 298,139	$ 109,317	$ 486,077	$ 893,533	33%	12%	54%
Colusa	$ 232,748	$ 184,221	$ 175,272	$ 592,241	39%	31%	30%
Contra Costa	$ 16,616,579	$ 1,560,079	$ 1,531,847	$ 19,708,505	84%	8%	8%
Del Norte	$ 399,142	$ 166,159	$ 300,270	$ 865,571	46%	19%	35%
El Dorado	$ 2,792,790	$ 367,158	$ 466,976	$ 3,626,924	77%	10%	13%
Fresno	$ 25,660,338	$ 2,100,690	$ 511,640	$ 28,272,668	91%	7%	2%
Glenn	$ 306,048	$ 134,438	$ 417,192	$ 857,678	36%	16%	49%
Humboldt	$ 1,932,108	$ 221,129	$ 387,652	$ 2,540,889	76%	9%	15%
Imperial	$ 873,204	$ 241,964	$ 1,025,374	$ 2,140,542	41%	11%	48%
Inyo	$ 281,163	$ 88,467	$ 159,447	$ 529,077	53%	17%	30%
Kern	$ 14,148,664	$ 899,717	$ 1,034,488	$ 16,082,869	88%	6%	6%
Kings	$ 1,018,382	$ 217,535	$ 213,606	$ 1,449,524	70%	15%	15%
Lake	$ 1,330,343	$ 115,753		$ 1,446,096	92%	8%	0%
Lassen	$ 542,942	$ 62,595	$ 185,129	$ 790,666	69%	8%	23%
Los Angeles	$ 183,437,281	$ 24,443,993	$ 26,707,482	$ 234,588,756	78%	10%	11%
Madera	$ 1,436,739	$ 226,269	$ 85,027	$ 1,748,035	82%	13%	5%
Marin	$ 7,334,863	$ 1,311,446	$ 1,639,438	$ 10,285,748	71%	13%	16%
Mariposa	$ 316,022	$ 80,263	$ 310,261	$ 706,546	45%	11%	44%
Mendocino	$ 1,311,840	$ 496,070	$ 122,555	$ 1,930,465	68%	26%	6%
Merced	$ 4,334,521	$ 406,118	$ 184,152	$ 4,924,790	88%	8%	4%
Modoc	$ 561,124	$ 151,477	$ 167,153	$ 879,754	64%	17%	19%
Mono	$ 353,295	$ 73,185	$ 107,100	$ 533,580	66%	14%	20%
Monterey	$ 4,437,408	$ 603,290	$ 399,717	$ 5,440,414	82%	11%	7%
Napa	$ 3,846,746	$ 392,442	$ 482,223	$ 4,721,411	81%	8%	10%
Nevada	$ 884,448	$ 216,948	$ 429,321	$ 1,530,716	58%	14%	28%
Orange	$ 32,651,732	$ 4,011,998	$ 1,830,909	$ 38,494,639	85%	10%	5%
Placer	$ 5,745,570	$ 390,255	$ 859,164	$ 6,994,989	82%	6%	12%
Plumas	$ 48,807	$ 146,609	$ 502,201	$ 697,618	7%	21%	72%
Riverside	$ 18,574,555	$ 4,335,146	$ 2,652,099	$ 25,561,800	73%	17%	10%
Sacramento	$ 27,437,526	$ 1,679,863	$ 7,253,030	$ 36,370,419	75%	5%	20%

Attachment A

County	Services				Services/Total Expenditures: %		
	Treatment	Prevention	Admin.	Total Spending	Treatment	Prevention	Admin.
San Benito	$ 739,796	$ 371,644	$ 75,524	$ 1,186,964	62%	31%	6%
San Bernardino	$ 25,144,878	$ 3,824,629	$ 2,350,137	$ 31,319,644	80%	12%	8%
San Diego	$ 63,785,981	$ 8,996,981	$ 3,307,471	$ 76,090,434	84%	12%	4%
San Francisco	$ 49,796,713	$ 12,495,817	$ 11,604,528	$ 73,897,058	67%	17%	16%
San Joaquin	$ 15,579,606	$ 889,863		$ 16,469,469	95%	5%	0%
San Luis Obispo	$ 7,517,159	$ 917,130	$ 969,362	$ 9,403,650	80%	10%	10%
San Mateo	$ 15,356,360	$ 1,420,353	$ 4,019,877	$ 20,796,590	74%	7%	19%
Santa Barbara	$ 11,907,540	$ 2,614,572	$ 2,136,339	$ 16,658,451	71%	16%	13%
Santa Clara	$ 39,351,713	$ 5,205,188	$ 2,654,331	$ 47,211,233	83%	11%	6%
Santa Cruz	$ 6,127,967	$ 887,257	$ 999,257	$ 8,014,481	76%	11%	12%
Shasta	$ 3,132,104	$ 406,905	$ 978,333	$ 4,517,341	69%	9%	22%
Sierra	$ 58,172	$ 99,113	$ 392,069	$ 549,354	11%	18%	71%
Siskiyou	$ 469,290	$ 267,166	$ 226,212	$ 962,668	49%	28%	23%
Solano	$ 6,689,386	$ 470,040	$ 958,719	$ 8,118,146	82%	6%	12%
Sonoma	$ 12,865,615	$ 1,342,902	$ 892,604	$ 15,101,121	85%	9%	6%
Stanislaus	$ 10,653,632	$ 735,938	$ 1,710,897	$ 13,100,466	81%	6%	13%
Sutter/Yuba	$ 1,621,587	$ 393,411	$ 81,005	$ 2,096,003	77%	19%	4%
Tehama	$ 901,677	$ 267,274	$ 1,054,929	$ 2,223,880	41%	12%	47%
Trinity	$ 286,370	$ 125,068	$ 220,848	$ 632,285	45%	20%	35%
Tulare	$ 6,742,375	$ 795,071	$ 1,465,841	$ 9,003,288	75%	9%	16%
Tuolumne	$ 536,950	$ 142,761	$ 431,013	$ 1,110,724	48%	13%	39%
Ventura	$ 15,069,342	$ 2,454,934	$ 2,747,346	$ 20,271,623	74%	12%	14%
Yolo	$ 1,882,939	$ 293,650	$ 419,899	$ 2,596,488	73%	11%	16%
Total	**$ 692,403,965**	**$ 94,720,135**	**$ 94,192,535**	**$ 881,316,635**	**79%**	**11%**	**11%**

Data Source: Substance Use Disorder Cost Reports for Fiscal Year 2014-15, submitted to and reviewed by the Fiscal Management and Accountability Section, Substance Use Disorder Program, Policy and Fiscal Division, Department of Health Care Services