California Legislature

SENATE COMMITTEE ON HEALTH

ED HERNANDEZ, O.D.
CHAIR

STATE CAPITOL, ROOM 2191
SACRAMENTO, CA 95814
TEL (916) 651-4111
FAX (916) 266-9438

Informational Hearing: Substance Use Disorder Treatment in California

Wednesday, January 31, 2018 - 1:30 p.m.
State Capitol, John L. Burton Hearing Room (4203)

The Senate Health Committee will hold an informational hearing to examine the substance use disorder (SUD) treatment system with a focus on treatment and services provided in residential facilities; insurance coverage; patient referrals; and the state's regulation and oversight of the system. With the rise in opiate use and abuse, treatment services are at a high demand. Beginning with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and in 2010 with the passage of the Affordable Care Act, health insurance coverage for mental health and SUD treatment expanded. The shift from mainly private pay to commercial insurance coverage has created significant growth in the residential treatment industry, including among multi-state, for-profit companies. SUD treatment can be provided in a variety of settings, including licensed hospitals, licensed residential treatment, or outpatient settings paired with supportive group homes in residential neighborhoods. Some elected officials and neighborhood associations have voiced opposition to locating such facilities in residential settings and concentrating facilities in certain neighborhoods. State and national media reports have also highlighted how some unscrupulous individuals have exploited the opioid epidemic and the expansion of coverage, mostly in the private insurance market, to lure unsuspecting people seeking SUD treatment services across state lines, fraudulently signing clients up for insurance benefits and billing for excessive services that are not actually delivered or are unnecessary, and then dumping clients when their insurance benefits are exhausted. There was a recent case reported in which medical treatment was promised to a client when the facility was not equipped to treat the client's other medical issues, resulting in the client's death. This hearing will provide an overview of the SUD system in California as it currently operates, and will provide testimony from those who receive and provide services. The hearing will also provide an overview of recent issues that have affected the state, and give an opportunity for state regulators to highlight efforts they have undertaken to combat the exploitation of the SUD system.

Drug Medi-Cal

Drug Medi-Cal (DMC) is a benefit available to all Medi-Cal-eligible individuals who have an SUD diagnosis. Available services include: narcotic treatment program (NTP) 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 is prohibited from being reimbursable through DMC.

DMC Organized Delivery System (DMC-ODS) Waiver. According to the Department of Health Care Services (DHCS), the DMC-ODS is a pilot program, 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 (Mee-Lee and Shulman 2003). 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.

Counties could opt in to the DMC-ODS by submitting an implementation plan to DHCS for approval by DHCS and the Centers for Medicare and Medicaid Services. After approval of a plan, a county contracts with DMC-certified providers or offer 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 DHCS, the following counties received final approval between February and July 2017 to begin providing DMC-ODS services: Contra Costa, Los Angeles, Marin, Riverside, San Francisco, San Mateo, and Santa Clara, with another three counties expected to begin services by March 2018. San Luis Obispo, Santa Cruz, and Napa counties recently had their implementation plans approved. DHCS anticipates that up to 40 counties will eventually be opt-in counties, meaning that approximately 90% of the Medi-Cal population would be receiving these enhanced services.

Licensed and certified facilities

DHCS is the sole authority in the state responsible for licensing and certifying all SUD treatment facilities, regardless of their funding source, that provide 24-hour residential and outpatient SUD treatment, detoxification, or recovery services to adults. DHCS licenses and certifies a total of 2,317 SUD facilities, which include 994 licensed residential alcoholism or drug abuse recovery or treatment facilities (RTFs), 262 licensed Driving Under the Influence programs, 162 licensed NTPs, and 899 certified outpatient facilities. According to DHCS, 110 staff within DHCS are dedicated to overseeing and regulating SUD facilities.

Social model residential facilities. RTFs licensed by DHCS, based on what is commonly referred to as the "social model," are currently allowed to provide recovery, treatment, and detoxification services. [The Department of Public Health (DPH) licenses medical model facilities known as chemical dependency recovery hospitals.] The services provided by DHCS-licensed RTFs include group and individual counseling, educational sessions, and alcoholism or drug abuse recovery and treatment planning. As part of their licensing function, DHCS conducts reviews of RTF operations every two years during the period of licensure, or as necessary. DHCS's SUD Compliance Division checks for compliance with statute and regulations to ensure the health and safety of RTF residents and investigates all complaints related to RTFs, including deaths, complaints against staff, and allegations of operating without a license. DHCS has the authority to suspend or revoke a license for conduct in the operation of an RTF that is harmful to the health, morals, welfare, or safety of either an individual in, or receiving services from, the facility.

Incidental medical services. Social model RTFs are allowed to provide clients first aid and emergency care, and since the passage of AB 848 (Stone, Chapter 744, Statutes of 2015), RTFs can apply to DHCS for an additional license to provide incidental medical services (IMS) by a licensed physician and surgeon or other health care practitioner. According to DHCS, IMS are services provided at a licensed RTF by a health care practitioner that address medical issues associated with either detoxification or the provision of alcoholism or drug abuse recovery or treatment services to assist in the enhancement of treatment services. IMS does not include the provision of general primary medical care. IMS must be related to the

resident's process of moving into long-term recovery. The following six categories of IMS services may be provided after receiving an additional IMS license from DHCS: obtaining medical histories; monitoring health status to determine whether the health status warrants transfer of the patient in order to receive urgent or emergent care; testing associated with detoxification from alcohol or drugs; providing alcoholism or drug abuse recovery or treatment services; overseeing patient self-administered medications; and treating SUDs, including detoxification.

Residential services in DMC-ODS opt-in counties. Counties that opt-in to the DMC-ODS will be required to provide at least one level of ASAM clinically managed residential services upon approval of the implementation plan and all three levels of services eligible to be provided at DHCS-licensed RTFs that have received ASAM designation from DHCS (ASAM levels 3.1, 3.3, and 3.5) within three years after approval of implementation plans. Counties will also be required to coordinate services offered at ASAM level 3.7 and 4.0 facilities (which will be provided at chemical dependency recovery hospitals or free-standing psychiatric hospitals that are licensed by DPH). According to DHCS, residential treatment is a non-institutional, 24-hour, nonmedical, short-term residential program providing rehabilitation services to beneficiaries with a SUD diagnosis. Under the DMC-ODS, a medical director or licensed practitioner of the healing arts (LPHA) must determine that the residential treatment is medically necessary and in accordance with the beneficiary's individualized treatment plan. LPHA includes a physician, nurse practitioner, physician assistant, registered nurse, registered pharmacist, licensed clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, and licensed-eligible practitioner working under the supervision of a licensed clinician.

Unlicensed group/sober living homes

A 2010 report found on the National Institutes of Health (NIH) Web site, *Sober Living Houses for Alcohol and Drug Dependence: 18-month Outcomes*, states that sober living homes (SLHs) are not formal treatment programs and are not obligated to comply with state or local regulations applicable to treatment. However, NIH nor any other entity provides a formal definition of an SLH, although the federal Department of Justice (DOJ) and Department of Housing and Urban Development (HUD) include them in the general term "group home." While SLHs do not provide formal treatment, they can serve as part of the continuum of treatment, providing a drug-free and alcohol-free environment for individuals recently discharged from an RTF who often do not have a home or who are not ready to return to the environment they were in before they entered treatment. The report also states that it is difficult to determine how many SLHs there are in California because they are outside of the purview of state licensing authorities. The NIH report cites the protection of SLHs under the Fair Housing Act (FHA) to be located in residentially zoned areas, and the right of people with disabilities to live together for a shared purpose, such as mutually assisted recovery and maintenance of an abstinent lifestyle, as reasoning for why SLHs do not need state licensure. While state law also does not provide a definition for an SLH, according to DHCS, facilities that do not provide SUD services and do not require licensure by DHCS include cooperative living arrangements with a commitment or requirement to be free from alcohol and other drugs, sometimes referred to as SLHs, transitional housing, or

alcohol- and drug-free housing. If an SLH is providing even one licensable service to adults, then it must obtain a valid RTF license from DHCS. Licensable services may include intake assessments; recovery, treatment, or detoxification planning; referral; documentation of the provision of recovery, treatment, or detoxification services; keeping records of clients; and discharge and continuing care planning.

Location of housing for the disabled. According to HUD, the FHA prohibits discrimination in the sale, rental, and financing of dwellings based on race, color, religion, sex or national origin. The FHA was amended in 1988 (effective March 12, 1989), which, among other things, expanded coverage to prohibit discrimination based on disability. In a joint statement issued in November 2016 by the federal DOJ and HUD, which together are responsible for enforcing the FHA, a person with a disability is defined to include an individual with a physical or mental impairment that substantially limits one or more major life activity, is regarded as having such an impairment, and has a record of such an impairment. The term "physical or mental impairment" includes having a drug addiction (other than addiction caused by current illegal use of a controlled substance) and alcoholism.

The DOJ and HUD statement declares that the term "group home" does not have a specific legal meaning, though land use, zoning officials, and the courts have referred to some residences for persons with disabilities as group homes. DOJ and HUD contend that persons with disabilities have the same FHA protections whether or not their housing is considered a group home, and that a household where two or more persons with disabilities choose to live together, as a matter of association, may not be subject to requirements or conditions that are not imposed on households consisting of persons without disabilities. DOJ and HUD further state that the provision of services is not required for a group home to be protected under the FHA. Group homes can also be opened by individuals or organizations, both for-profit and not-for-profit. DOJ and HUD also state that in communities where a certain number of unrelated persons are permitted by local ordinance to reside in a home, it would violate the FHA for the local ordinance to impose a spacing requirement on group homes that do not exceed that permitted number of residents because the spacing requirement would be a condition imposed on those with disabilities that is not imposed on those without disabilities. In California, the Fair Employment and Housing Act (FEHA) provides substantially similar protections as the FHA for those with disabilities.

A document published by the U.S. Department of Health and Human Services (DHHS), "Siting Drug and Alcohol Treatment Programs: Legal Challenges to the NIMBY Syndrome," recognizes that community opposition, "not in my backyard" (NIMBY), often prevents or delays the siting of treatment programs, even when an already existing program tries to relocate. NIMBY is often targeted toward other types of health and social service facilities, like shelters for the homeless, group homes for the mentally ill, halfway houses for ex-offenders, SLHs, and other health-related facilities. According to DHHS, many discriminatory zoning ordinances and practices may be unlawful under the FHA, the Rehabilitation Act, and the Americans with Disabilities Act.

Court rulings protecting housing for the disabled. In 2008, the Newport Beach City Council adopted an ordinance that changed how the city regulates group residential uses, defined as a "non-traditional single housekeeping unit," including a boarding house, dorm, reunion rental, state-licensed RTFs, SLHs, and elder care homes. The ordinance required many home operators at the time to obtain a use permit to stay in place. The ordinance requires city approval for new unlicensed homes for recovering addicts in certain neighborhoods. A September 2013 *Los Angeles Times* article, "Appeals court backs sober-living homes in suit against Newport Beach," states that the U.S. 9th Circuit Court of Appeals unanimously ruled that the Newport Beach ordinance may have illegally discriminated against those with a disability. The ordinance forced many group homes to close and prevented new ones from opening. In March 2014, the Newport Beach City Council petitioned the U.S. Supreme Court about the ruling by the 9th Circuit Court of Appeals, which the U.S. Supreme Court ultimately declined to review. By July 2015, Newport Beach ended its seven-year battle over SLHs by reaching an agreement with three entities that operate SLHs. However, in the meantime, Newport Beach went from having an estimated 86 residential facilities (both RTFs and SLHs) to 25 by February 2016: 15 RTFs licensed by DHCS and 10 unlicensed SLHs.

In *Horizon House Developmental Services, Inc.* v. *Township of Upper Southampton*, township officials enacted and then revised an ordinance governing group homes for the disabled four times, starting the distance requirement at 3,000 feet between group homes and then revising it to 2,500 feet, and then 1,000 feet, to address clustering of facilities. Horizon House complied with the ordinance but then later sued based on discrimination against the disabled. The court ruled in favor of Horizon House because the ordinance discriminated against the disabled and restricted their housing choices and capped the number of people who could live in the township based on disability. The court also found that the opposition to clustering was based largely on the community's fears of disabled individuals living in its neighborhoods.

In *Potomac Group Home Corp.* v. *Montgomery County, Md.*, a licensing regulation required a provider of a group home for the disabled to notify neighbors and civic organizations of the types of disabilities of those who intended to live in the home. The requirement was only imposed on group homes for the disabled. The court found that the notification requirement was void because it applied only to disabled individuals and was not supported by a legitimate governmental interest. The court also found that the notification requirement was further evidence of the county's efforts to treat the disabled differently than those without disabilities and that rather than promote integration the notification requirement galvanized opposition.

Growing national attention

It appears that much of the health insurance issues discussed in various news articles were association with PPO plans, where providers can be paid for services without a contract with the health insurance carrier. Several news articles ("How Some Southern California drug rehab centers exploit addiction," *Orange County Register*, May 21, 2017; "A Choice for Recovering Addicts: Relapse or Homelessness, *New York Times*, May 30, 2015; "California's Rehab System is in Crisis … " CityWatch Los Angeles, June 23, 2016; and

"Special Report: Two states with an ocean view, and an ethical cloud," Addiction Professional, March 18, 2013) highlight the issue of "patient brokering," whereby unscrupulous individuals (sometimes called "interventionists") lure clients seeking SUD treatment services, buy insurance policies for the clients or offer to pay their deductibles, and "sell" them to facility operators that do not provide any type of treatment services or regular monitoring, all the while billing the insurance plan. Some individuals involved in this practice have been quoted in news articles as acknowledging that the practice may be wrong; however, they also claim that the practice is so ubiquitous in California that they would have no clients at all if they did not engage. As a result, they keep interventionists on retainer, often for $5000-10,000 a month, regardless of how many clients an interventionist refers to them, in order to remain in business. After clients' insurance coverage is exhausted, unscrupulous facility operators have been allegedly dumping them in the streets where they continue their addictions. In many news articles, the issue is largely attributed to facilities that do not require state licensure or oversight, including SLHs and what New York refers to as "three-quarter houses," which are New York's equivalent to California's SLHs.

According to the *Orange County Register*, one of the industry's biggest players was the operator of Community Recovery of Los Angeles (CRLA). On November 10, 2016, CDI issued a press release about an investigation that resulted in the arrest of the operator of CRLA, who owned SLHs throughout Southern California. The operators were arrested on several felony counts of grand theft and identity theft for allegedly conspiring to defraud clients and insurers out of more than $176 million. Affected insurers included Anthem Blue Cross, Blue Shield, Cigna, Health Net, and Humana, which paid nearly $44 million before discovering the suspected fraud and stopping payments to CRLA. CRLA is accused of luring people with treatment marketing schemes and stealing patient identities to buy health insurance policies for people without their knowledge, as well as committing such acts as submitting claims for services not provided, falsely representing CRLA as a licensed RTF while not being licensed as such, and filing fraudulent health insurance policy applications. CDI Commissioner Dave Jones stated that this case was the first wave of indictments and charges in an ongoing investigation into one of the largest health insurance fraud cases in the state. CDI was assisted in the investigation by various local agencies, and DHCS accompanied detectives to ensure that patients in CRLA facilities were transferred to licensed RTFs.

On December 12, 2017, the federal House Energy and Commerce Committee held a hearing before the Oversight and Investigations Subcommittee entitled "Examining Concerns of Patient Brokering and Addiction Treatment Fraud." The committee heard testimony from criminal justice experts in Florida and Massachusetts, and from SUD providers who operate treatment facilities in Pennsylvania, Florida, and California. The testimony highlighted the growing need for SUD services as opioid use and abuse has become a national epidemic. Reports about patient brokering were discussed, as were barriers to enforcement of anti-kickback laws. The criminal justice experts acknowledged that state and local enforcement agencies lack the resources to prosecute national-level business that falsely advertise SUD services, suggesting that federal-level patient brokering and anti-kickback laws need to be enacted and enforced, as well as devoting federal-level enforcement resources to assist state and local government enforcement agencies in prosecuting those who exploit this vulnerable

population. Panelists also expressed a need for DOJ and HUD to clarify state and local governments' ability to impose restrictions on group homes, or to require group homes that provide housing for those with SUDs to meet a standard level of services. Panelists recognized that the FHA and the American with Disabilities Act both prohibit state and local governments from imposing restrictions on housing for the disabled, which includes those who are in recovery from an SUD. Many of the reports in the national media highlight the issue of unscrupulous individuals exploiting these federal protections and skirting state licensing requirements, and then falsely advertising as providing treatment services when in fact no services are offered at the housing site.

Conclusion

The issues that have been highlighted in this state and across the nation are complex and involve various industries. The rise in opioid use and abuse is sure to continue the great demand for SUD treatment services of all different modalities, including in licensed clinics; social-model RTFs, which help integrate those with SUDs into community settings; and group homes that are unlicensed but have been identified as being important to sustained recovery for those with SUDs who often lack housing options. The goal of this hearing is to examine the issues and to seek strategies and policies that will prevent unscrupulous individuals from exploiting the various industries that are supposed to help treat those with SUDs. It is equally important to recognize federal and state protections for those with disabilities, and to ensure that policies are not enacted, either at the local or state level, that will limit the number of treatment options for those who need them.