Legal Changes in California Behavioral Health and Addiction Treatment Industries: Key Takeaways

The 2019 California legislative session came to a close with a flurry of vetoes and signing of bills on Governor Newsom's desk impacting the addiction treatment and behavioral health community. Behavioral healthcare providers need to be paying attention to immediate compliance requirements coming into effect as a result of new laws, as well as several bills that didn't quite make it into law, but remain on the horizon for next year.

What are the key takeaways for providers?

1. Goodbye, Florida Model? Clarity on Housing and Transportation Costs

Questions around what is and is not permissible in housing and patient travel have been a persistent source of confusion in the addiction treatment and behavioral health industries. Many outpatient programs continue to utilize the so-called "Florida model" of providing free housing to clients while they participate in their insurance-covered PHP and IOP programs. These practices have raised concerns that legitimate treatment programs are inadvertently inducing patients to choose particular programs with offers of free housing and airfare, and that "bed vouchers" are being used to facilitate patient brokering.

With Governor Newsom's signing into law of Orange County Assemblymember Cottie Petrie-Norris' bill, AB 919, providers now have significantly more clarity as to what is and is not permitted when it comes to providing housing and travel for clients, including how they are to be funded and managed responsibly. We are pleased to have played a role in shaping the language of the bill to ensure that the law was consistent with our longstanding guidance.

Pursuant to AB 919, outpatient treatment programs that lease, manage, or own housing units that are offered to individuals who concurrently receive outpatient services must meet the following requirements:

a. There must be a separate lease agreement with the client;
b. The lease agreement must clearly state that payment for housing is the responsibility of the individual and does not depend on insurance benefits;
c. The lease agreement must include a repayment plan for any subsidized rent;
d. The program must make a good faith effort to collect the debt; and
e. The offer of housing to a client may not depend on the individual's agreement to receive services from the outpatient treatment program.

Additionally, AB 919 requires that licensed addiction treatment programs meet all of the following requirements before offering transportation services to individuals seeking recovery or treatment services:

a. Any ground transportation provided to an individual seeking services is for a distance of less than 125 miles.
b. Any air transportation provided to an individual seeking services includes a return ticket that may be used by the individual upon discharge.
c. A return ticket not used by an individual upon discharge is made available to the individual upon request for a period of one year following the individual's discharge.

The requirements of AB 919 regarding providing housing and transportation for clients are in addition to the requirements under federal law (EKRA).

2. AB 290 Criminalizes Activity Related to Funding

Patient Insurance Coverage

With the enactment of Assemblymember Jim Wood's AB 290, the insurance companies scored a huge victory in their longstanding battle with large dialysis providers (DaVita and Fresenius). These providers had funded nonprofit organizations (such as the American Kidney Fund) to cover the cost of premiums for patients for commercial health plans that reimbursed dialysis.

AB 290 requires that any third-parties who subsidize health insurance premiums on behalf of patients disclose to commercial health plans the names of those patients. The law sets forth standards governing the reimbursement of financially interested providers, and limits the ability of providers to direct patients to specific coverage options or health care service plans. While focused on dialysis, **AB 290 has significant implications for behavioral health by criminalizing activity related to funding patient insurance coverage.** The use of nonprofits to absorb insurance costs for people requiring addiction or other forms of behavioral health coverage has been a widespread practice that now requires attention to compliance.

3. No Licensing for Outpatient Programs (Yet)

As regulatory lawyers working across different states, perhaps the biggest oddity of California's regulation of behavioral health is the absence of any mandatory licensing requirements and limited standards to operate an outpatient addiction or mental health treatment program. The overwhelming majority of states require operators to be licensed and to meet specific standards. In California, an optional IOP certification is available (only for adult alcohol and drug treatment programs). Other outpatient programs (mental health, adolescent substance use disorder, etc.) do not have that option available, forcing operators to look to accreditation bodies, such as the Joint Commission or CARF, for standards that are missing in state law.

Our view is that California's failure to license outpatient programs is a legacy of a different era. Licensure is an important part of clarifying operating standards, improving patient safety, and bringing California into alignment with how the rest of the country operates. Assemblymember Cottie Petrie-Norris' AB 920 bill would have required the Department of Health Care Services (DHCS) to license addiction treatment outpatient programs as of 2021, standardizing rules and promoting safe and effective care. Among other things, outpatient programs would have been required to follow the American Society of Addiction Medicine (ASAM) criteria. AB 920 also would have opened the door to enabling DHCS to certify outpatient programs to provide incidental medical services (IMS), which current law does not permit.

Governor Newsom explained his veto on the basis that the licensing scheme was incomplete and needed further work to be more comprehensive. Our perspective is that, ultimately, outpatient licensure is inevitable, but, for now, it has been put off until at least 2020 (meaning implementation would likely be delayed until at least 2022). We can only hope that reaching a consensus on what outpatient licensing will look like will be a priority for the coming year. *Governor Newsom, you know where to find us.*

4. Bills to Watch For Next Year

The other big surprise of the legislative session was the Governor's veto of Orange County Senator Pat Bates' **SB 589**, which would have prohibited unauthorized advertising and call center activity in addiction treatment. The problem of online marketers "trolling" addiction treatment program identities online has lingered, with many people fooled into thinking that they are speaking with programs when in fact they are talking to call centers who redirect leads to programs that will pay for patients. Governor Newsome was expected to sign the bill, which received bipartisan support, but ultimately vetoed it on the ground that it would have exceeded the jurisdiction of the Department of Health Care Services. Irrespective of the jurisdictional issue, our perspective is that this issue will remain a problem compelling legislative attention.

Several other legislative efforts that were expected to reform addiction treatment ultimately failed in this legislative session, including **AB 1779**, which would have required counties receiving public funding for recovery residences (sober living facilities) to enforce standards of the National Association of Recovery Residences, and **AB 1468**, the "Penny A Pill" bill, that would established a fee on opioid manufacturers distributors to create a fund (est. $100M) for Opioid Use Disorder Prevention and Treatment. Expect these issues to resurface next year.

For more information on changing laws, regulations, and standards in addiction treatment and behavioral health, please contact:

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