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Regulatory Revolution: A New Era for Outpatient Rehab?

Regulatory Update

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For several years, the California Society of Addiction Medicine (CSAM) has been voicing concerns about the enormous regulatory disparity between residential treatment centers and outpatient programs with regard to Substance Use Disorders (SUD) treatment under existing California law.

Residential SUD facilities, a form of inpatient treatment (though non-medical in nature and distinct from the technical hospital category of "inpatient"), are highly structured environments where individuals stay full-time for a specified period. This type of care is typically more intense and includes onsite supervision, group therapy, individual therapy, and other ameliorative activities. Residential treatment, often recommended for those with severe SUD or those at risk in their current environment, allows individuals to focus wholly on recovery, free from everyday life distractions and triggers.

On the other hand, outpatient SUD programs are commonly structured to allow individuals to live at home or in another unmonitored residential setting (such as a recovery residence, the term covering what used to be more commonly called "sober living" or "transitional living" environments) with fewer hours in treatment, permitting the option of daily activities, such as work or school, alongside treatment sessions. These sessions may also include group therapy, individual counseling, and education about substance use disorders. The intensity of outpatient treatment can vary – some programs may require close-to-full-day daily sessions (commonly called "Partial Hospitalization Programs" (PHP) or multiple sessions weekly, typically three times week for 3-4 hours per day (commonly called Intensive Outpatient Program (IOP)) levels of care. Other lower level programs may be scheduled only once or twice per week (often referred to as Outpatient (OP) level of care).

Although both residential and outpatient programs can offer analogous services to a similar patient demographic, the degree of state supervision between the two markedly differs. Current law requires that residential facilities be licensed by the Department of Health Care Services (DHCS). To do so, the facility must adhere to key requirements regulated by DHCS, including safety and health standards, maintaining proficient and appropriately qualified staffing, offering evidence-based treatment services, preserving detailed patient records, and undergoing regular scrutiny and inspections. California offers an additional optional certification with additional requirements.

In contrast, outpatient Substance Use Disorder (SUD) programs have the option to apply to DHCS for certification voluntarily, but are not required to do so. (For outpatient mental health programs, there is not even the option of certification, a subject for another article.) Should outpatient programs aspire to attain the voluntary certification from the DHCS, these facilities are obliged to "surpass minimum service quality levels and demonstrate significant compliance with state program standards." Nevertheless, a considerable number of outpatient SUD treatment programs opt not to pursue this voluntary certification. While many programs seek accreditation from private sources (such as the Joint Commission or CARF), practically, this implies that such facilities aren't subject to governmental supervision, consequently increasing the probability of providing subpar care and posing potential risks to patient safety.

California's lenient approach towards outpatient programs is conspicuously out of step with its otherwise rigorous public policy in the area of healthcare licensing, generally marked by a robust emphasis on public safety. In hospital and nursing home licensing, for example, California requires nurse staffing ratios that are among the most rigorous in the country. The state has been a leader in many areas of healthcare regulation, for instance, responding proactively to the Affordable Care Act by establishing its own state-run health insurance exchange and being among the first to expand Medicaid. California also took decisive action to protect consumers from surprise medical bills and actively regulates health insurance rates. Despite these examples of robust regulation, the state's

treatment of outpatient Substance Use Disorder (SUD) treatment stands as a notable deviation, appearing significantly less stringent compared to the norms observed in other states. Several efforts have been made to address this disparity and require outpatient or “aftercare” facilities to seek DHCS certification. A 2019 bill (AB 920) garnered approval from both the California State Assembly and Senate, only to be vetoed by Governor Newsom. His reasoning, influenced by the Department of Healthcare Services’ expression of concerns, was that the bill failed to sufficiently consider the expenses necessary for the implementation and maintenance of “administrative oversight.” Though included in the state’s two-year legislative cycle, the bill eventually lost steam and was eclipsed by other legislative priorities.

Despite the failure of AB 920, movement is now afoot to establish mandatory standards for outpatient care in California. Earlier this year, the Department of Health Care Services (DHCS) put forth a Trailer Bill named “ Strengthening Oversight for Substance Use Disorder Licensing and Certification.” A “trailer bill” is a piece of legislation that complements the main budget bill. Its purpose is to initiate the statutory changes required to execute the provisions of the General Budget. This method of legislation allowed the bill to proceed with limited public attention.

Although Governor Newsom and the Legislatures reached a final agreement on California’s fiscal budget on June 26, 2023, legally, the state has until September 14th to pass any trailer bills. If the proposed language is approved, it will subsequently become official law. The principal alteration proposed is the mandatory certification of outpatient programs, which would bring regulatory supervision to facilities that were previously unregulated. The bill also proposes amendments to the fee structure of the Revenue and Oversight Fund for Programs Licensing and Certification (ROPLF).

The state acknowledges that the existing revenues of the Oversight Fund, predominantly derived from fees, fines, and penalties, fall short in covering the current staffing resources. This deficit is partly due to the fee waivers implemented during the initial year of the Covid-19 pandemic. Furthermore, the ROPLF has seen a steady decline in revenue as a result of program closures. To address this financial shortfall, the DHCS proposes a significant 75% fee increase for all licensed residential and certified outpatient programs. This would translate to a rise from $4,068 to $7,119 for combined residential licensure and mandatory certification. The increase was opposed by the CA Consortium of Addiction Programs and Professionals. Pointing to the financial strains many outpatient programs are already facing, such additional costs potentially accelerate the rate of closures.

Looking forward, the DHCS aims to adjust the fees according to projected costs for the upcoming fiscal year, with any surplus fees rolling over into the next year. Should there be a need to increase fees, the DHCS would be obligated to demonstrate a lack of sufficient assets in the ROPLF. The principal goal of these modifications is to enable the DHCS to alter fees autonomously, thereby circumventing the need for legislative approval. This change would bring DHCS’s fee adjustment approach more in line with the standard practices of other regulatory agencies.

Given the proposed changes, what might be the impact on outpatient facilities? For those already voluntarily certified, the effects are likely to be gradual. These facilities, accustomed to a certain degree of regulatory standards, may see an uptick in oversight and higher fees, but these are mostly extensions of existing norms. The real challenge lies for the hundreds of Substance Use Disorder (SUD) outpatient facilities operating without a license. For these centers, substantial adjustments will be necessary to meet mandatory certification standards, including adherence to health and safety regulations, the maintenance of qualified staff, the safeguarding of comprehensive patient records, and compliance with regular oversight and inspections. These facilities will also need to revise their financial strategies to accommodate potential fee increases under the revised ROPLF fee structure. Ultimately, this bill signifies a substantial and long-awaited expansion of the state regulatory agency’s influence, broadening its reach to include a wide array of facilities previously outside its direct oversight. This marks a new era in the standard of care within the SUD treatment sphere.

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