California Assembly Bill 848: Fixing the Disconnect in California Regulation of Health Professionals and Addiction Treatment

The interplay between residential addiction treatment and medical care in California has been a confounding topic for both drug treatment centers and doctors. After years of confusion, the good news for both sides is that a new California law significantly clarifies and cleans up what has been a muddled area.

In recent years, a series of patient deaths called attention to the safety risks in alcohol and drug treatment care. People who needed to be in hospitals were being admitted to residential facilities unsuited to manage them. In some cases, residents were fine upon admission, but subsequently during their stay/treatment had health issues emerge that needed medical attention, which they didn't receive.

In 2012, the problem received significant attention when the California Senate Office of Oversight and Outcomes published a report, entitled "Rogue Rehabs"," that drew a link between several patient deaths that were preventable and had occurred in the residential treatment context with widespread disregard for the corporate practice of medicine rules.

As an attorney who frequently advises both addiction treatment programs and physician organizations, I can attest to the disconnect. Addiction treatment program operators are often surprised to learn of the regulatory restrictions concerning their ability to contract with physicians that are mental health professionals, as well as the limitations on their ability to integrate clinical care into their treatment programs. Physicians, psychologists, clinical social workers, and others are also equally baffled when advised that their working relationships with addiction treatment programs are inconsistent with California law.

Confusion stems from the traditional corporate practice of medicine laws that govern healthcare professionals in the practice of their professions, from the confusing scope of services that most drug treatment programs are authorized to deliver, and from the way that addiction treatment has evolved into a larger sector with a diverse range of patients with medical needs. California adheres to "the corporate practice of medicine doctrine" (CPOM), which requires physicians, psychologists, and other licensed health professionals work only as sole proprietors, employees of other similarly licensed professionals, or through professional corporations. They are *strictly prohibited* from working for other business entities or for unlicensed people — *including most operators of addiction treatment programs*. As a result, while many states require drug treatment centers to employ doctors, California actually historically has prohibited the practice.

The other half of the problem relates to the scope of services provided by California addiction treatment. While the California Department of Public Health licenses certain categories of addiction treatment as healthcare facilities (such as chemical dependency recovery hospitals), most addiction treatment programs are licensed as non-medical, "social model" programs. These programs were conceived to focus on group and individual counseling and education as a pathway to recovery, primarily using the 12-Step Model pioneered by Alcoholics Anonymous promoting the alcohol abstinence model, a process of self-awareness, and ongoing peer support

through meetings focused on self-disclosure and self-learning. While they can also be licensed for detoxification, the category for residential treatment services is “non-medical detox” which “in theory” could be undertaken without a physician.

In the paradigm envisioned by California law, residential drug treatment centers had no authority to assess or treat patients’ medical needs. Instead, the most that they could do would be to encourage patients to seek the care of independent physicians, who would need to contract directly with the patients and provide care separate and apart from the residential treatment program. However, this structure created many questions: are programs supposed to evaluate patients and ensure that they were safe to admit from a medical perspective without input from a physician? How were patient’s medication needs and access supposed to be monitored without physician oversight? How are programs supposed to monitor important diagnostic information, such as toxicology tests, without a physician to order them? It was almost unavoidable that many drug treatment programs would be confused about the illogical separation between residential drug treatment from medical care. This presented significant risks for both drug treatment programs and health professionals, with both sides placing their licenses at risk in the course of trying to provide the best possible care for patients.

Perhaps the most absurd part of the regulatory model related to nonmedical detoxification was that in order to receive reimbursement for detoxification, the health insurance companies mandated that treatment programs have round-the-clock nurse staffing (typically 35-40 hours onsite and on call at all other times if needed). California’s corporate practice of medicine laws, made it problematic for a nurse to fulfill this function since nurses require physician supervision. This means that the insurance companies were demanding something that the state was implicitly prohibiting.

The level of inconsistency and confusion over the interplay between doctors and drug rehab was unsustainable. If there was a single “straw” that “broke the camel’s back,” it was the July 2015 indictment issued by a Riverside County grand jury against the Temecula drug rehab, A Better Tomorrow. While this was not the first case where a patient died in an addiction treatment facility, the case called national attention to the issue. A patient named Gary Benefield had been accepted into the facility without prior physician evaluation, despite serious health problems including chronic obstructive pulmonary disease, emphysema, and a recent hospitalization for pneumonia. Although he showed up at the facility with an empty oxygen tank (which might have been a red flag for a physician), he was permitted to stay and died in the night.

The indictment of the facility and its leadership called attention to other deaths in addiction treatment facilities, not only of medically unstable patients, but also suicides and overdoses following discharge. These sentinel events called attention not only patient endangerment in the current framework, but also the myriad of medical issues intertwined in addiction treatment that were not getting adequate attention due to the constraints of California law.

This past fall, Assemblyman Mark Stone introduced a bill, AB 848, taking these issues on and cleaning up the legal confusion. AB 848 became California law in October 2015, and while it may not be fully implemented by the California Department of Healthcare Services until 2018, it highlights a legally and medically safer route ahead for addiction treatment programs and health professionals.

The essential change in law authorizes addiction treatment programs to have physicians provide “incidental medical services” to patients, as defined in new Health and Safety Code Section 11834.026. While corporate practice of medicine limitations will still apply to general primary care, the range of “incidental” services where treatment programs can contract with physicians includes a wide range of medical issues associated with both detoxification from alcohol or drugs and provision of alcoholism or drug abuse recovery or treatment services. These include intake assessments, taking medical histories, monitoring health status and the potential need for transition to other care settings (i.e. urgent or emergent care), testing for detox, and oversight of patient self-administered medication. “The law gives the Department of Healthcare Services until 2018 to issue regulations for a forthcoming requirement (embodied in Health and Safety Code Section 11834.025) that health professionals (i.e. physician or non-physician practitioners, such as physician assistants or nurse practitioners) certify residents as a condition of providing incidental medical services.”

This significant modification in physician oversight and involvement in key medical issues inherent in addiction treatment has the potential to dramatically improve safety and the quality of care. Ironically, it may represent a reprieve for many treatment programs that have been “blissfully” ignorant of the legal prohibitions in place.

The immediate question for legally compliant treatment programs is whether to wait for the Department’s regulations or, alternatively, to expand the role of physician involvement now without waiting. Some may elect an intermediate solution such as requiring patients to select and contract with an approved physician and establishing

an independent patient-physician relationship that enables better medical screening and attention to health issues. No matter what path addiction treatment programs take on this specific issue, time is of the essence to in addressing gaps in evaluation of clients for medical appropriateness, suicide risk, and other health risks before, during, and after the residential stay.

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