Regulating Mental Health With or Without the Affordable Care Act

Orange County Bar Association
Health Law Section

DATE: April 13, 2017
TIME: 12 pm - 1:30 pm
PLACE: Newport Beach, CA

PRESENTER: Craig B. Garner

This Program Offers 1.0 Hour of MCLE Participatory Credit
Introduction

“Crazy’ is a term of art; “Insane” is a term of law. Remember that, and you will save yourself a lot of trouble.

-- Hunter S. Thompson
THE AGE OF THE ASYLUM

- In the twentieth century, the network of care facilities in the United States expanded from a mere 149 hospitals in 1873 to 6,665 by 1913.

- Included among these were a growing number of specialized institutions that catered to specific conditions that had only recently been diagnosed as illnesses.

- The burgeoning science of psychiatry and advances in the treatment of addiction were at the forefront of such change, creating a demand for stand-alone structures often based in rural settings.
MENTAL HEALTH IN CALIFORNIA

- California’s first state-run psychiatric hospital, Stockton State Hospital, opened in 1853.

- For the next 50 years, municipalities in California shifted the financial burden for psychiatric treatment to state institutions.

- Wealthy patients received treatment in secluded, private facilities.

- By 1959, California’s 14 state hospitals cared for a population of 37,500 (one doctor for every 300 patients).
THORAZINE TO THE RESCUE

- California’s inability to effectively and humanely treat these mental health patients necessitated change.

- New antipsychotic and anti-depression medication in the 1950s started to replace previous treatments like the lobotomy.

- The introduction of chlorpromazine (Thorazine) and other related medications created opportunities for community-based treatment.
The Lobotomy

- As early as 1890, German scientist Friederich Golz surgically removed the temporal lobe in dogs to make a canine calmer.

- By 1940, Dr. Walter Freeman convinced the world that the “icepick lobotomy” method worked, resulting in more than 18,000 lobotomies in the U.S. between 1939 and 1951.

- By the 1970s, many U.S. states had banned the procedure.

- The Soviet Union outlawed the lobotomy in 1940 because, according to Stalin, it turned “an insane person into an idiot.”
PRESIDENTIAL PROCLAMATION

World Suicide Prevention Day, 2016 (September 9)

- “The Affordable Care Act provides the largest expansion of mental health coverage in a generation, and it has helped increase access to quality, affordable health insurance for all Americans.”

- “The Act prohibits insurers from discriminating against people based on pre-existing conditions like depression, expands mental health and substance use disorder parity policies to more than 60 million Americans, and requires that Health Insurance Marketplace plans cover mental health and substance use disorder services.”
REPEAL AND REPLACE?

- The idea that the nation’s leaders on the right believed a mere 123 pages of legislation could replace not just the 906-page outline defining the ACA but also the tens of thousands of regulatory clarifications promulgated by the federal government over the past seven years is just as preposterous as the thought process of those leaders on the left who feared the American Health Care Act might actually survive.
- History is often overlooked as a necessary ingredient in constructing a better health care system, and the American political process can sometimes mask its presence.
MENTAL DISORDERS

The following are descriptions of the most common categories of mental illness in the United States:

- **Anxiety disorders** are characterized by excessive fear or anxiety that is difficult to control and negatively impacts daily functioning. An estimated 40 million people in the United States experience an anxiety disorder in any given year.

- **Attention deficit hyperactivity disorder (ADHD)** is defined by a persistent pattern of inattention and/or hyperactivity-impulsivity.
MENTAL DISORDERS (continued)

- Individuals with **bipolar and related disorders** experience atypical, dramatic swings in mood, and activity levels that go from periods of feeling intensely happy, irritable, and impulsive to periods of intense sadness and feelings of hopelessness.

- **Depressive disorders** are among the most common mental health disorders in the United States.
MENTAL DISORDERS (continued)

Other mental disorders include:

- Disruptive, impulse control and conduct disorders
- Obsessive-compulsive and related disorders
- Schizophrenia spectrum and other psychotic disorders
- Trauma and stressor related disorders
LEGISLATING MENTAL HEALTH

Madness is rare in individuals – but in groups, political parties, nations, and eras it’s the rule.

-- Friedrich Nietzsche
THE SHORT-DOYLE ACT

- In 1957 Congress passed the Short-Doyle Act, modifying funding responsibility and the provision of mental health care.
- Mental illness could be treated with medication in the community, thereby increasing availability and encouraging individuals to voluntarily seek treatment.
- The Short-Doyle Act provided 50% matching state funds to cities or counties for most mental health programs.
- In 1963 California increased its match for local Short-Doyle programs to 75% and broadened the scope for eligibility.
The Lanterman-Petris-Short Act

- The 1968 law required a judicial hearing be held to determine whether a person could be involuntarily hospitalized, thereby reducing dramatically the frequency of such events.
- Required all counties in California with populations over 100,000 to establish mental health programs (with the state funding match for local programs increased to 90%).
- Promotion of this trend to community-based care resulted in the closing of nine state hospitals.
- Between 1957 and 1984, the California state hospital population dropped 84%.
Medicaid was health insurance coverage for the “deserving” poor, including women, their children, the blind, the disabled and the impoverished elderly.

Medicaid reimbursements for mental health services covered psychiatric hospitalization, care in a nursing facility, and other services from psychologists and psychiatrists.

California created “Medi-Cal” during its 1965 Second Extraordinary Session “in order to establish a program of basic and extended health care services for recipients of public assistance and for medically indigent persons.”
MEDI-CAL (continued)

- Starting in 1971, counties could receive federal matching funds for some services Short-Doyle programs provided to Medi-Cal patients.
- Changes in 1988 and 1993 expanded the scope of coverage.
- Drug Medi-Cal Program refers to a clinic that is certified and has a contract with either the county or the state. Authorized to provide and be reimbursed for services that have been approved by a physician as medically necessary to an individual who is otherwise Medi-Cal eligible.
PROPOSITION 13

- When Proposition 13 capped property taxes in 1978, counties became more dependent on the State. At the same time, however, county responsibility for mental health care continued to surge.

- Programs for which counties needed to spend more than its 10% required match were closed while California implemented significant cuts in mental health funding.
The 1990 Bronzan-McCorquodale Act shifted control of mental health, social and health service programs to the counties while creating a stable revenue stream, in part, from taxes and vehicle registration fees.

The California Realignment Act had limited success due to the scope of California’s dysfunctional mental health system.

Proposition 63 (the 2005 Mental Health Services Act) brought additional changes to California’s mental health system, but still failed to create a long-term solution.
Mental Health Parity

When dealing with the insane, the best method is to pretend to be sane.

-- Hermann Hesse
MENTAL HEALTH TODAY

- Approximately one in five Americans experience mental illness.
- As of 2014, six percent of the population was living with a severe mental illness like schizophrenia, major depression or bipolar disorder.
- Mental health illness costs approximately $193.2 billion in lost earnings annually.
- Two-thirds of the individuals with “potentially diagnosable disorders avoid treatment due to costs.
MENTAL HEALTH TODAY (continued)

- Mental health is subjective, just as diagnosis of schizophrenia relies on a spectrum, psychotic examples range from hallucinations to speech impediments, and bipolar affective disorder by definition alternates between periods of elevated mood and depression.

- The International Statistical Classification of Diseases and Related Health Problems (ICD-10) contains more than 70,000 different physical health concerns, and the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) hovers close to 300 disorders from which to choose.
RERAINTS BY THE NUMBERS

- § 5150 (California Welfare and Institutions Code § 5150): Applies to involuntary psychiatric holds lasting three days.
- § 5250: Applies to involuntary holds lasting up to 14 days.
- § 5270: Applies to involuntary holds lasting up to 30 days.
- After 30 days, gravely disabled persons may require a conservatorship hearing (Section 5270.55).
- The maximum time for involuntary detention is 47 days.
THE MENTAL HEALTH PARITY ACT OF 1996

- First federal parity law passed by Congress.
- Provided parity with respect to lifetime and annual limits for mental health benefits.
- Only covered mental illness and not substance abuse or chemical dependency.
- Did not require insurance plans to offer mental health benefits.
The California legislature passed its own mental health parity laws in 1999.

The legislature found that coverage limitations resulted in inadequate treatment of mental illness, causing “untold suffering” for people with treatable conditions.

The legislature also found that the lack of mental health insurance resulted in increased expenses for local and state governments.
CMHPA (continued)

- CMHPA prohibited “discrimination against people with biologically based mental illnesses, dispel[ed] unsound distinctions between mental and physical illnesses, and require[d] equitable coverage to prevent adverse risk selection.”
- Provides the same coverage irrespective of age.
- Benefits include (1) outpatient services, (2) inpatient hospital services, (3) partial hospital services and (4) prescription drugs.
- Does not mention residential treatment.
MHPAEA

- The 2008 Paul Wellstone and Pete Domenici Mental Health Party and Addiction Equity Act (MHPAEA) became effective January 2010.
- MHPAEA prohibits financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans from being more restrictive than those placed on medical and surgical benefits.
- MHPAEA applies to health plans provided by employers with more than 50 employees and individual plans purchased through a Health Care Exchange.
MHPAEA (continued)

- Does not apply to Medicare or Medicaid.

- A qualified health plan must include at least ten essential health benefits, although certain states require more.

- California mandates “chemical dependency services” must be consistent with MHPAEA, including inpatient detoxification, outpatient evaluation and treatment for chemical dependency, transitional residential recovery services or chemical dependency treatment in a residential recovery setting.
Nothing recedes like progress.
-- Edward Estlin (e.e.) Cummings
TRICARE, MENTAL HEALTH AND SUBSTANCE USE DISORDER

The September 2016 federal regulations improved access to substance use disorder (SUD) treatment for TRICARE beneficiaries, with four main objectives:

- Eliminate unnecessary quantitative and non-quantitative treatment limitations on SUD and mental health coverage and align beneficiary cost sharing for mental health and SUD benefits with those applicable to medical/surgical benefits.

- Expand covered mental health and SUD treatment under TRICARE, to include coverage of intensive outpatient programs and treatment of opioid use disorder.
Streamline the requirements for mental health and SUD institutional providers to become TRICARE authorized providers.

Develop TRICARE reimbursement methodologies for newly recognized mental health and SUD intensive outpatient programs and opioid treatment programs.
The truth is rarely pure and never simple.

-- Oscar Wilde
Licensure of Treatment Facilities

- “Alcoholism or Drug Abuse Recovery or Treatment Facility” means any facility, building or group of buildings which is maintained and operated to provide 24-hour residential nonmedical alcoholism or drug abuse recovery or treatment services.

- The facility may provide housing and treatment services in the same building, or house residents in one building and provide services in another, provided that all of the buildings are: (1) integral components of the same facility; (2) under the control and management of the same licensee; and (3) licensed as a single facility. (9 CCR Section 10508)
SOBER LIVING

- Residential facility that does not provide alcohol or other drug services.
- Does not require licensure by DHCS.
- Includes cooperative living arrangements with a commitment or requirement to be free from alcohol and other drugs.
- Operators must comply with local zoning and occupancy ordinances.
The Department of Health Care Services ("DHCS") has sole authority to license facilities providing 24-hour residential nonmedical services to eligible adults who are recovering from problems related to alcohol or other drug misuse or abuse. Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, or alcohol or drug abuse recovery or treatment planning.

The Licensing and Certification Branch ("LCB") is responsible for assuring that quality services are provided to all program participants in a safe and healthful environment.
DHCS (continued)

- DHCS offers a voluntary facility certification to those programs that provide day treatment, outpatient and nonresidential detoxification.

- Certification is granted to programs that exceed minimum levels of service quality and are in substantial compliance with California program standards, specifically the Alcohol and/or Other Drug Certification Standards.

- Certification is available to both residential and nonresidential programs.
ALCOHOL AND/OR OTHER DRUG CERTIFICATION STANDARDS

- To ensure that an acceptable level of service quality is being provided to program participants.

- To encourage a variety of fiscal supports for quality alcohol and/or other drug services.

- To provide the basis for certification of alcohol and/or other drug programs.

- To contribute to the development of quality alcohol and/or other drug programs.
Today, The Joint Commission accredits more than 1,900 behavioral health care organizations including:

- Organizations involved in providing mental health care, treatment, or services (e.g., mental health centers, addictions treatment services, opioid treatment programs, eating disorders treatment).
- Providers of addictions treatment and/or services supporting recovery and resilience, opioid dependency programs, crisis stabilization, day programs (intensive outpatient services, day treatment programs, adult day care, partial hospitalization programs, outpatient behavioral health care programs, residential programs, group homes, among others).
JOINT COMMISSION (continued)

- Standards
- Accreditation process
- Benefits of accreditation
- Optional certification
- Cost

http://www.jointcommission.org/facts_about_behavioral_health_care_accreditation/
OTHER ENTITIES PROVIDING ACCREDITATION

- The National Committee for Quality Assurance ("NCQA")

- Commission on the Accreditation of Rehabilitation Facilities ("CARF")

DHCS recognizes the following National Commission for Certifying Agencies ("NCCA") accredited organizations to register and certify alcohol and other drug counselors in California:

- Addiction Counselor Certification Board of California (www.caade.org)
- California Association of DUI Treatment Programs (www.cadtp.org)
- California Consortium of Addiction Programs and Professionals (www.ccapp.us)
COUNSELOR CERTIFICATION ORGANIZATIONS (continued)

- Clinical Supervisor Credential
- California Certification Prevention Specialist
- Certified Addictions Treatment Specialist
- Certified Addictions Treatment Specialist Intern Level I
- Certified Addictions Treatment Specialist Intern Level II
- Certified Alcoholism and Other Drug Addictions Recovery Specialist

See also California Association of Drinking Driver Treatment Programs
COUNSELOR CERTIFICATION ORGANIZATIONS (continued)

California Association of Alcoholism and Drug Abuse Counselors ("CAADAC"):  

- Registered Student  
- Registered Recovery Worker  
- Registered Alcohol and Drug Intern  
- Registered Alcohol and Drug Technician II  
- Certified Alcohol Counselor and Drug Counselor I  
- Certified Alcohol and Drug Counselor II
CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

- Acupuncture Board
- Board of Behavioral Sciences
- Medical Board
- Bureau of Medical Cannabis Regulation
- Naturopathic Medicine Committee
- Osteopathic Medical Board
- Board of Psychology
If you have ten thousand regulations you destroy all respect for the law.

-- Winston Churchill
APPLICATION FOR LICENSURE

Applications made to Department of Alcohol and Drug Programs shall include:

- Maximum number of residents to be served
- Description of demographics of resident population
- Administrator and plan of operation
- Statement describing process for safeguarding personal property of residents
- Fire clearance
PLAN OF OPERATION

- Statement of program goals and objectives
- Outline of activities and services to be provided
- Statement of facility’s resident admission policies and procedures
- Assurance of nondiscrimination in employment practices
- Resident admission agreement
PLAN OF OPERATION (continued)

- Table of the administrative organization
- Staffing plan, job descriptions and minimum staff qualifications
- Sketch of the grounds, showing all spaces used by residents
- Floor plans
- Sample menus and schedule for one calendar week
- Consultant and community resources to be utilized
REVIEW OF APPLICATION

- Department shall review the application to determine completeness and compliance.
- Department shall complete a site visit to determine applicant’s ability to comply with all requirements.
- Department shall determine the number of residents for whom a license shall be issued, based on the available living and sleeping space.
- Department shall notify applicant within 45 days of receipt of application if complete or incomplete.
REVIEW OF APPLICATION (continued)

- Department shall notify applicant within 45 working days of receipt of application if complete or incomplete.
- If incomplete, applicant has 60 days to provide missing information or documentation.
- Department shall make final decision within 120 working days after determining the application is complete.
- Department may terminate the review of an application, but it will not constitute denial of licensure.
AUTOMATIC TERMINATION OF LICENSE

- Licensee sells or transfer ownership of facility (exception if transfer of ownership applies to stock in corporation).
- Licensee voluntarily surrenders license.
- Licensee moves operation to a new location (unless licensee submits new application at least 45 days before move and 60 days after in the event of emergency).
- Licensee dies.
- Licensee abandons (actual or constructive) the facility.
PERIOD OF LICENSURE

- A license is valid for two years unless extended.
- 120 days before expiration, Department shall send notice to licensee that licensure will be extended if licensee: (1) updates information; (2) pays fees; (3) pays any civil penalties; and (4) maintains a valid fire clearance.
- Department shall automatically extend the licensure if licensee complies with all four requirements.
- Exception exists if Department petitions court to enjoin operation of facility.
DEPARTMENT OF HEALTH CARE SERVICES LINKS

- Apply for an initial facility license (http://www.dhcs.ca.gov/provgovpart/Pages/FacilityLicensing.aspx)
- Apply for an initial facility certification (http://www.dhcs.ca.gov/provgovpart/Pages/Facility_Certification.aspx)
- Apply for a Drug Medi-Cal facility (re-)certification (http://www.dhcs.ca.gov/services/adp/Pages/Drug_MediCal.aspx)
- Submit a complaint (http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx)
The evolution of sense is, in a sense, the evolution of nonsense. -- Vladimir Nabokov
PROGRAM FINANCES

- Licensee shall maintain an annual line item budget which includes all revenues and operation costs necessary to achieve its stated goals and objectives.
- Licensee shall also maintain monthly financial operating statements which reflect the revenue and expenditure line items identified in the budget.
- Financial documentation shall be available for the Department’s review.
FACILITY ADMINISTRATOR QUALIFICATIONS

- Knowledge of the requirements for providing the type of treatment services needed by residents.
- Knowledge of laws and regulations.
- Ability to direct the work of others.
- Ability to develop and manage facility’s services and budget.
- Ability to recruit, employ, train and evaluate qualified staff, and to terminate employment of staff when necessary.
FACILITY STAFF QUALIFICATIONS

- Competent to provide the type of treatment services needed by residents and be adequate in numbers to do so.
- Department may require additional staff upon consideration of: (1) needs of the particular residents; (2) extent of services at the facility; and (3) physical arrangements of the facility.
- Staff shall have general knowledge of alcohol and/or drug abuse and alcoholism and the principles of recovery.
- Housekeeping and sanitation principles.
FACILITY STAFF QUALIFICATIONS (continued)

- Principles of communicable disease prevention and control.
- Recognition of early signs of illness and the need for professional assistance.
- Availability of community services and resources.
- Recognition of individuals under the influence of alcohol and/or drugs.
- Principles of nutrition, food preparation and storage, and menu planning.
FACILITY STAFF QUALIFICATIONS (continued)

- Program staff who provide counseling services shall be licensed, certified or registered.
- Program staff who provide counseling services shall comply with the code of conduct for the facility.
- Program staff shall be in good health.
- Personnel shall provide services without physical or verbal abuse, exploitation or prejudice.
- Licensee shall maintain appropriate personnel records.
PERSONNEL RECORDS

Personnel records shall be completed and maintained for each employee, shall be available to the Department for review, and shall contain the following information:

- Employee’s full name
- Driver’s license number (if employee is to transport resident)
- Date of employment
- Home address and phone number
- Past experience
- Duty statement
- Termination date (if applicable)
- Facility should retain personnel records for three years after termination
ADMISSION AGREEMENTS

Admission agreements shall specify the following:

- Services to be provided.
- Payment provisions, including amount assessed, payment schedule and refund policy.
- Those actions, circumstances or conditions which may result in resident eviction.
- The consequences when a resident relapses.
- Conditions under which the agreement may be terminated.
PERSONAL RIGHTS OF RESIDENTS

- Patient confidentiality is most important.
- Dignity in personal relationships with staff and other persons.
- Safe, healthful and comfortable accommodations.
- Free from intellectual, emotional and/or physical abuse.
- Informed by the licensee of the law regarding complaints.
- Free to attend religious services or activities.
OTHER REQUIREMENTS

- Telephones (9 CCR Section 10570)
- Transportation (9 CCR Section 10571)
- Health-related services (9 CCR Section 10572)
- Food service (9 CCR Section 10573)
- Activities (9 CCR Section 10574)
- Buildings and grounds (9 CCR Section 10581)
INVESTIGATION OF COMPLAINTS

- Any person may request an inspection of a treatment facility by contacting the Department.
- The Department shall not disclose the identity of the complainant unless so authorized in writing.
- Department shall initiate an investigation within 10 days of receipt of complaint.
- Investigation may include a site visit with or without notice.
- May include face-to-face or telephone interview with licensee.
NOTICE OF DEFICIENCY

The notice of deficiency shall specify:

- Statute or regulation violated.
- Location of the violation and the manner in which it occurred.
- The date by which each deficiency shall be corrected.
- The amount of civil penalty to be assessed.
- Class A deficiencies shall be corrected immediately.
- Class B deficiencies shall be corrected within 30 days.
CONSENT BY MINORS

A minor who is 12 years of age or older may consent to outpatient mental health treatment and counseling services, if in the opinion of the attending professional person, the minor is mature enough to participate intelligently in those services. “Professional Person” includes:

- Mental health professional (psychiatrist, psychologist, social worker)
- Marriage and family therapist
- Licensed educational psychologist
- Credentialed school psychologist
CONSENT BY MINORS, CONTINUED

As of 2017, while working under supervision of certain licensed professionals, “Professional Person” also includes:

- Marriage and family therapist trainee
- Licensed professional clinical counselor trainee
- Registered psychological assistant
- Psychology Trainee
- Associate clinical social worker
- Social work intern
HIPAA AND MENTAL HEALTH

The secret of being a bore . . . is to tell everything.

-- Voltaire
ADDED PROTECTIONS UNDER HIPAA

- Psychotherapy notes receive special protections under the HIPAA Privacy Rule.

- Section 164.510(b)(3) of the HIPAA Privacy Rule permits a health care provider, when a patient is not present or is unable to agree or object to a disclosure due to incapacity or emergency circumstances, to determine whether disclosing a patient’s information to the patient’s family, friends, or other persons is in the best interests of the patient.
Federal law refers to psychotherapy notes as excluded from access (45 CFR Section 164.524).

But California does not set aside psychotherapy notes. California law wants to provide access to such health care records by patients. There are limits to this disclosure, however (Health and Safety Code Section 123115 (b)).

Providers should make a determination if there would be a "substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient."
Make a written record, to be included with the mental health records requested, noting the dates of the request and explaining provider’s refusal to permit inspection or copying.

Include a description of the specific adverse or detrimental consequences to the patient that the provider anticipate.

Permit inspection by, or provide copies of the mental health records to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor, designated by request of the patient.
Inform the patient of the refusal to permit the inspection or obtain copies of the requested records, AND
Inform the patient of the right to require the provider to permit inspection by, or provide copies to, a licensed physician and surgeon, licensed psychologist, licensed marriage and family therapist, licensed clinical social worker, or licensed professional clinical counselor designated by written authorization of the patient.

Indicate in the mental health records of the patient whether the request was made as set forth above.
HIPAA AND EMTALA

- A health care provider’s “duty to warn” generally is derived by standards of ethical conduct and state laws/court decisions.
- HIPAA permits a provider to notify a patient’s family members of a serious and imminent threat to the health and safety of the patient or others if those family members are in a position to lesson or avert the threat.
- *Moses v. Providence Hospital and Medical Centers, Inc.*: Sixth Circuit decision held that the EMTALA obligation to stabilize and emergency medical condition survives inpatient admission. Also expands right to sue to include anyone who is injured as a “direct result” of the violation.

Authorizing statute (42 U.S.C. Section 290dd-2) protects the confidentiality of the identity, diagnosis, prognosis or treatment of any patient records which are maintained in connection with the performance of any federally assisted program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research.

Last update was 1987.
The laws and regulations governing confidentiality of substance abuse records were written out of great concern about the potential use of this information against individuals, causing them to avoid needed treatment.

Negative consequences of disclosure includes loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest and incarceration.

Proposed rule would make policy changes to the regulations to better align them with advances in the U.S. health care delivery system while retaining important protections.
FEBRUARY 2016 REGULATIONS (continued)

- Purpose is to modernize rules by facilitating the electronic exchange of substance use disorder information for treatment and other legitimate health care purposes while ensuring appropriate confidentiality protections for records that might identify an individual, directly or indirectly, as having or having had a substance use disorder.
- SAMHSA proposed to define the term “substance use disorder” in such a manner as to cover substance use disorders that can be associated with altered mental status that has the potential to lead to risky and/or socially prohibited behaviors.
“Treating provider relationship” means that, regardless of whether there has been an actual in-person encounter:

- A patient agrees to be diagnosed, evaluated and/or treated for any condition by an individual or entity, and
- The individual or entity agrees to undertake diagnosis, evaluation and/or treatment of the patient, or consultation with the patient, for any condition.
- An agreement might be evidenced, among other things, by making an appointment or by a telephone consultation.
Delete the definition of “detoxification treatment” and replace it with the definition of the currently acceptable term “withdrawal management.”

Expand the definition of “patient.”

Delete the speed with which information could identify a patient and focus only on the information.

Revise the definition of “Records” to include any information whether recorded or not, received or acquired by, an applicable program relating to a patient. This includes both paper and electronic records.
An alcoholic is someone you don’t like, who drinks as much as you do. -- *Dylan Thomas*
ILLICIT DRUG USE BY THE NUMBERS

- In 2014, an estimated 27 million Americans (10.2 percent of the population) aged 12 or older had used an illicit drug in the past month.
- In 2014, approximately 21.5 million people aged 12 or older had a substance use disorder (includes 17 million people with an alcohol use disorder, 7.1 million with an illicit drug use disorder, and 2.6 million who had both).
- Marijuana is the most used drug, with approximately 22.2 million current users in the United States (8.4% of the population aged 12 or older).
SAMHSA (www.samhsa.gov)

- SAMHSA is charged with improving quality and availability of prevention, treatment and rehabilitation services.
- SAMHSA Strategic Initiatives help provide treatment and services for people with mental and substance use disorders as well as support the families of people with mental and substance use disorders.
- SAMHSA acts through advisory councils or committees to advance its goals, and at the same time draws advice from public members and professionals in the field of substance abuse and mental health.
SAMHSA (continued)

SAMHSA advisory councils and committees:

- SAMHSA National Advisory Council
- Center for Mental Health Services National Advisory Council
- Center for Substance Abuse Prevention National Advisory Council
- Advisory Committee for Women’s Services
- Drug Testing Advisory Board
- Tribal Technical Advisory Committee
MHSUDS

- Department of Health Care Services’ (DHCS) Mental Health and Substance Abuse Services (MHSUDS) – Partners & Stakeholders webpage: http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD_Partners-Stakeholders.aspx

- MHSUDS is committed to ensuring the best possible planning, delivery and monitoring.
PROPOSITION 36

- California Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, allows qualifying defendants convicted of non-violent drug possession offenses to receive a probationary sentence in lieu of incarceration.
- As a condition of probation defendants are required to participate in and complete a licensed and/or certified community drug treatment program.
- If the defendant fails to complete this program or violates any other term or condition of their probation, then probation can be revoked.
REASONABLE AND CUSTOMARY

Reason has always existed, but not always in a reasonable form.

-- Karl Marx
WHAT CAN WE LEARN FROM HOSPITALS?

- The decision in *Children’s Hospital Central California v. Blue Cross of California* (2014) 226 Cal. App. 4th 1260 has been viewed as the culmination of conflict between providers and payers within the managed care system. This 40 year evolution in California offers significant insight when it comes to defining “reasonable and customary” in California.

- What are the reasonable and customary charges in mental health today?
- Are all mental health providers the same?
- How do demographics impact charges?
WHAT CAN WE LEARN FROM HOSPITALS? (continued)

- Since 2009 hospitals in California are prohibited from billing patients who are enrollees of a health care service plans for *post-stabilization* care, with the exception of copayments, coinsurance or other deductibles.
- Hospitals maintain a uniform schedule of the charges it bills for all procedures, services and goods provided to patients.
- In determining price increases, hospitals can look to factors such as overall cost structure, financial position and contracts.
Payer contracts provide for a discount from the hospital’s usual and customary charges.

Settlements with non-contracted payers are also indicative of reasonable and customary charges.

*Children’s Hospital* decision held that “relevant evidence would include the full range of fees that Hospital both charges and accepts as payment for similar services.”
DRUG TESTING

- What is the reasonable and customary charge for a urine test?

- THC, COC, AMP, mAMP, OPI, BAR, BZO, MDMA, MTD, OXY, PCP, BUP

- A twelve panel drug test should not have a price divisible by twelve.

- Strong push by payers to cut prices and recoup payments.
Craig B. Garner  Garner Health Law Corporation

- Craig is an attorney and health care consultant, specializing in issues pertaining to modern American health care and the ways it should be managed in its current climate of reform.
- Craig’s law practice focuses on health care mergers and acquisitions, regulatory compliance and counseling for providers. Craig is also an adjunct professor of law at Pepperdine University School of Law, where he teaches courses on Hospital Law and the Affordable Care Act.
- Between 2002 and 2011, Craig was the Chief Executive Officer of Coast Plaza Hospital in Norwalk, California. Craig is also a Fellow Designate with the American College of Healthcare Executive.
- Additional information can be found at www.garnerhealth.com.
THANK YOU

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