# HUSTLING HAPPENS WHERE THE SUNLIGHT DOESN'T REACH

Testimony by
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Thank you for the invitation to appear before the committee this afternoon. I am Al Senella, President of the California Association of Alcohol and Drug Program Executives, CAADPE and the President and CEO of Tarzana Treatment Centers in Tarzana California. CAADPE's membership is comprised of free-standing, non-profit community based substance use disorder services agencies. They provide the full spectrum/continuum of services from prevention, intervention, detoxification, residential, outpatient, to post-treatment recovery services for the public sector.

These substance use disorder services, until recently, have long been a low priority for public attention and funding even though the science and research, for years, has shown that a planned response to address the causes of substance use, implemented in concert with an ethical and comprehensive medical and behavioral approach to treating the disease, is effective, can reduce overall health care costs and, as our previous witness so eloquently described, offers individuals a path to reclaim their lives.

Drugs, especially opioids, are big business in the world, generating billions in profits. In trying to stem the growing epidemic, public demand and government response is devoting countless resources into the battle. Recovery is also now big business, creating a "gold rush" mentality on both sides of the issue.

Responsible substance use disorder treatment providers have been aware for some time of unethical practices of individuals and of some "for profit" corporations operating in our communities and have also advocated for solutions to the growing problems. We deeply regret, however, that recent news stories paint all treatment providers with

the same brush. We are disappointed that the good work that we do is degraded by fear mongering and dispersions cast in such a broad way.

The responsible SUD treatment service providers, including my agency, are proud of the work we do and the lives we have helped improve and save. It is our sincere hope to gain and keep the respect and support of the communities we are a part of. Don't get us wrong we are not trying to throw the private sector under the bus, there are many very good private providers, but much of what you read is in the private sector.

CAADPE has long worked with neighborhood residents, federal, state and local government entities, and with research and education institutions to insure that responsible, clinically sound and effective treatment centers are operating wherever needed. The focus needs to be on the solution to what has become a national and local crisis.

Regarding treatment best practices, there are many approaches. CAADPE advocates for an integrated care model that includes medication assisted treatment (MAT) delivered through a multi-disciplinary treatment team which utilizes evidence based practices.

CAADPE supported and worked closely with the Department of Health Care Services (DHCS) in designing the Drug Medi-Cal Organized Delivery System (DMC-ODS) under the state 1115 Medicaid wavier (Medi-Cal 2020) which fully embraces the model of care described above. The continuum of care developed under the DMC-ODS provides the needed treatment and recovery support services required for improved outcomes. The DMC-ODS requires use of the standardized and nationally recognized assessment and treatment placement tool known as ASAM (American Society of Addiction Medicine). Using these ASAM tools insures proper assessment of patient needs and placement in the appropriate level of care based on these needs, thus, affording patient protections and proper care. The DMC-ODS requires the use of evidenced based treatment practices. As more counites come on line under the DMC-ODS we will see more improvements for all.

CAADPE will continue to work closely with DHCS as it begins to work on the renewal of the 1115 wavier to further advance and improve the DMC-ODS.

There are many differences between public and private operators:

**Public operators** are largely community based non-profits. They are not only licensed but also certified by the state of California. Licensed and certified not-for-profit agencies under contract with counties must, in addition, adhere to all county contracting requirements. Agencies are subject to ongoing contract monitoring and auditing by counties; a requirement of public funding.

Staff in public agencies are licensed and or certified under state rules. All counselors must also be state certified. All direct care staff must also have NPI numbers and cleared by DHCS Medi-Cal rules.

The agencies by and large serve people whose health care is subsidized by state and federal funds through Medi-Cal, California Department of Corrections and Rehabilitation and County Probation offices. Agencies may also accept patients /clients from federal prisions and American Indian Tribes.

**Private residential and outpatient operators** are largely for-profit businesses, some of whom are publicly traded. There is far less state oversight as they do not as a rule contract with counties and serve clients whose SUD services are publicly funded

Private residential treatment operators are licensed by the state but have the option not to be state certified. Outpatient operators are not even required to obtain state licensure or certification. Because they do not contract with counties they do not undergo the same monitoring and oversight counties provide. They don't meet nationally recognized assessment and treatment standards. This should change.

There is a known pattern with many of these providers utilize third parties to recruit patients. This practice of "patient brokering" puts profits over the best interests of the

patient at a time when individuals are at their most vulnerable and the promise of “a cure” for their addiction is most seductive. CAADPE opposes this practice and supports legislative proposals to prohibit it.

Many for profit programs/businesses admit patients with more complex health and substance use disorder diagnoses then they and their staff are equipped to treat because the programs/businesses are seeking the revenue from self-pay and third-party insurance billing. Again this is not all, but many. There are very qualified for profits as well.

Many do not contract with insurance companies as “preferred providers”, but rather bill as “out of network” providers using rates far greater than would be possible if they were under contract.

Overcrowding/over concentration is also a factor. The committee may want to consider new rules that limit how close facilities can be to one another; a 300 foot separation between facilities might make sense.

CAADPE Recommendations:

- Oversight and enforcement is the responsibility of DHCS. This includes the responsibility to assure that non-compliers are brought into compliance or shut down. DHCS has in recent years appropriately stepped up these efforts with private and not for profit providers.

- CAADPE fully supports expanded regulatory and enforcement authority for DHCS to meet its regulatory responsibility. CAADPE has worked closely with DHCS to revamp residential licensing regulations which include providing DHCS with improved regulations that give DHCS more authority and tools to enforce rules governing residential providers; to include more specific regulations for detoxification and other medication assisted treatment. These improvements will help protect health and safety of patients.

- Regulations. Regulation is DHCS' responsibility. There is some confusion regarding regulation of residential facilities as current regulations mix recovery homes with treatment facilities. Recovery homes operate at a lower level of care than full blown treatment facilities. As such one set of regulations for both creates confusion and can mislead the public as to what services are provided. It would be better for all if recovery homes had a separate licensing and regulatory process. However, to accomplish this new legislation would be required.

- Sober living housing: Sober living housing is largely unregulated. We are familiar with the many attempts to regulate it, but also well aware of the protections under the law for these housing environments. We support and believe in these protections. However, we recommend DHCS be provided with resources and direction to form a workgroup that includes stakeholders to determine how we can develop statewide voluntary standards for sober living operators. A good model is the current statewide voluntary program certification rules. We believe doing so would create a path to legitimize these operators and provide needed consumer protections and transparency.

- Hospital detoxification.

  Detoxification is the gateway to treatment and the first access point to treatment. The legislature needs to provide resources for hospital detoxification to counties in the same manner it provided added resources for residential treatment under the DMC-ODS wavier Counties cannot effectively meet this need without additional dollars to do so.

Thank you and I welcome questions from the committee.

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