Date of Hearing: April 2, 2019

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1031 (Nazarian) – As Amended March 25, 2019

SUBJECT: Youth Substance Use Disorder Treatment and Recovery Program Act of 2019.

SUMMARY: Repeals the Adolescent Alcohol and Drug Treatment and Recovery Program Act of 1998 and enacts the Youth Substance Use Disorder (SUD) Treatment and Recovery Program Act of 2019. Requires Department of Health Care Services (DHCS) to establish community-based nonresidential and residential treatment and recovery programs to intervene and treat the problems of alcohol and drug use among youth under 21 years of age. Requires DHCS to update its Medi-Cal billing codes to include specified services, based on whether those services are medically necessary. Specifically, **this bill**:

1) Repeals the Adolescent Alcohol and Drug Treatment and Recovery Program Act of 1998 (became inoperative on July 11, 2013) which authorized DHCS to establish community-based nonresidential and residential recovery programs to intervene and treat the problems of alcohol and other drug use among youth.

2) Establishes the Youth Substance Use Disorder Treatment and Recovery Program Act of 2019. Requires DHCS to establish community-based nonresidential and residential treatment and recovery programs to intervene and treat the problems of alcohol and drug use among youth under 21 years of age.

3) Requires DHCS, in collaboration with counties and providers of SUD services to establish regulations on or before January 1, 2021, regarding community-based nonresidential and residential treatment and recovery programs to intervene and treat the problems of alcohol and drug use among youth under 21 years of age.

4) Requires DHCS, in collaboration with counties and providers of SUD services, to establish through regulation criteria for participation, programmatic requirements, treatment standards, and terms and conditions for funding. Requires the criteria to also include consideration of indicators of drug and alcohol use among youth.

5) Requires regulations developed under this bill to define and describe a comprehensive, evidence-based continuum of care to identify, treat, and support recovery from substance misuse for youth under 21 years of age. Requires the continuum of care to include, but not be limited to, the following health care services:
   a) Screening and assessment for substance use and co-occurring mental health conditions;
   b) Collaborative treatment planning between health professionals, youth, and their families, as appropriate;
   c) Outpatient substance use therapies, including substance use education, individual counseling, group counseling, and family therapy;
   d) Intensive outpatient programs;
   e) Partial hospitalization;
   f) Medications for addiction treatment when clinically indicated and offered in combination with counseling and case management;
   g) Residential treatment and detoxification;

h) Treatment for co-occurring mental health conditions;
i) Case management that strengthens linkages to other health, wellness, social, and supportive services; and,
j) Recovery services and supports for both youth and their families, so youth have access to continuing care outside a treatment environment and family needs are addressed.

6) Requires DHCS to consider encouraging the programs and services offered under the youth continuum of care to:
   a) Provide prevention strategies and early intervention opportunities;
   b) Provide care that is culturally and gender competent and trauma-informed;
   c) Provide nonstigmatizing care in a variety of environments including schools, homes, and other community-based locations;
   d) Prioritize family engagement;
   e) Support academic and work performance;
   f) Be delivered by professionals with expertise in treating substance use disorders in adolescents and young adults; and,
   g) Address co-occurring mental health conditions.

7) Allows for regional approaches to service delivery by counties, including the utilization of community-based nonresidential and residential programs.

8) Allows DHCS to implement and administer this bill through all-county information notices or similar written instructions until regulations are adopted.

9) Requires DHCS in collaboration with the counties and providers of SUD services, to report to the Legislature, during budget hearings, regarding the status of the implementation of this bill.

10) Requires DHCS beginning January 1, 2021, and for each year thereafter to report to the Legislature and publish on its website, utilization data relevant to services to youth under 21 years of age to include but not be limited to, all of the following:
   a) The number of unique Medi-Cal enrollees served;
   b) The number of unique Medi-Cal enrollees screened for SUDs;
   c) The number of assessments of youth for SUDs;
   d) The number of individual counseling services for youth with SUDs;
   e) The number of collateral services for youth with SUDs;
   f) The number of family therapy services for youth with SUDS;
   g) The number of group sessions for youth with SUDs;
   h) The number of intensive outpatient service sessions, meaning sessions lasting six to 19 hours, inclusive, provided to youth with SUDs.
   i) The number of partial hospitalization sessions, meaning sessions lasting 20 hours or more, provided to youth with SUDs;
   j) The number of medication assisted treatment services to youth with SUDs;
   k) The number of case management services provided to youth with SUDs;
   l) The number of parent or caregiver support services;
   m) The number of residential service episodes for youth with SUDs; and,
   n) The number of youth provided with inpatient services for treatment of detoxification or withdrawal.

11) Authorizes DHCS to seek funding from federal financial participation services covered by Medi-Cal, or from foundations or other nongovernmental sources.

12) States legislative intent that no more than 4% of funds available to DHCS from this bill may be expended for purposes of developing regulations, standards, and procedures to implement this bill.

13) Requires each county that administers this bill to continue to use current behavioral health funding sources as applicable, including but not limited to the Behavioral Health Subaccount of the Local Revenue Fund 2011 and Drug Medi-Cal (DMC) funds, including federal financial participation, to fund SUD treatment services for Medi-Cal beneficiaries under 21 years of age who access services under this bill.

14) Requires DHSC to update Medi-Cal billing codes based on what is medically necessary for individuals under 21 years of age to include all of the following:
    a) Screening for early identification and intervention;
    b) Assessment using the American Society of Addiction Medicine (ASAM) criteria;
    c) Residential treatment and withdrawal management;
    d) Outpatient substance use therapies, including substance use education and individual and group counseling;
    e) Family counseling;
    f) Intensive outpatient treatment;
    g) Medications for addiction treatment when clinically indicated;
    h) Case management; and,
    i) Recovery services and supports.

15) Authorizes DHCS without taking any further regulatory action, to implement, interpret, and make specific this bill by means of all-county letters, plan letters, plan provider bulletins, manuals, plan contract amendments, or similar instruction until regulations are revised or adopted.

16) Requires DHCS to revise or adopt regulations by July 1, 2022.

EXISTING LAW:

1) Establishes DHCS and grants it sole authority to license adult alcoholism or drug abuse recovery or treatment facilities.

2) Requires DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities and requires a licensee to maintain those standards with respect to the level of care to be provided by the licensee.

3) Requires DHCS to implement a certification program for alcohol and other drug treatment recovery services.

4) Establishes the Medi-Cal program, which is administered by the DHCS and under which qualified low-income individuals receive health care services.

5) Makes Medi-Cal eligible children up to age 18 with incomes up to 266% of the federal poverty level (FPL) and individuals age 19 to 65 up to 138% of the FPL eligible for Medi-Cal.

6) Establishes a schedule of benefits in the Medi-Cal program, which includes the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program for any individual under 21 years of age, consistent with the requirements of a specified EPSDT provision of federal Medicaid law.

7) Requires, under federal Medicaid law, EPSDT services to include screening, vision, dental, hearing and other Medicaid health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

8) Defines, under Medi-Cal for individuals 21 years of age or older, a service as "medically necessary," or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

9) Defines, under Medi-Cal and federal EPSDT, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in federal law Medicaid law, which requires coverage of such other necessary health care, diagnostic services, treatment, and other measures to "correct or ameliorate" defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under Medi-Cal.

10) Requires, through an amendment to the State Constitution enacted by Proposition 30 of 2012, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency (including counties) for programs or levels of service mandated by the 2011 Realignment Legislation (which includes DMC and Medi-Cal specialty mental health) to:

    a) Apply to local agencies only to the extent that the State provides annual funding for the cost increase; and,
    b) Prohibits local agencies from being obligated to provide programs or levels of service required by legislation above the level for which funding has been provided.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, experts agree that the unique needs of youth with SUDs are most effectively addressed in age-specific treatment settings that offer a continuum of care consisting of outreach, screening, assessment, counseling, residential treatment, family interventions, and recovery support systems. Unfortunately, California has not chosen to invest in a robust system of SUD care for uninsured and Medicaid-eligible youth. Although California counties manage publicly-funded treatment programs, they lack systemic guidance and dedicated financial resources to establish a comprehensive set of services for youth with SUDs. Prioritizing funding and developing a statewide program can provide critical support to existing Medicaid and federal block grant funds. The author continues by saying that this bill would require the DHCS to develop regulations for a comprehensive continuum of substance use disorder care for California. Lastly, the author notes, this bill is an important first step to expand public services to meet the needs of youth with SUDs.

2) BACKGROUND. According to the California Society of Addiction Medicine's (CSAM) "Standards of Care for Adolescence Substance Use," an estimate164,000 secondary students used marijuana 10 or more days each month (114,000 of whom used marijuana 20+ days per month) and an estimated 72,000 acknowledge binge drinking more than 10 days a month. A draft Youth Substance Use Disorder Treatment Services Needs Assessment from DHCS states that during fiscal year (FY) 2013-14 approximately 15,000 youth (aged 17 or younger)

were admitted to a SUD treatment program. The number admitted in FY 2014-15 was a little over 12,000. Multiple studies have established that adolescents are more vulnerable to alcohol, marijuana, tobacco (including e-cigarettes), and other drug-related problems than adults. The duration of adolescence is relatively short but contains all the physical and psychological changes necessary to transition from childhood to young adulthood. The pace of adolescent development is fast and the pitfalls presented by alcohol, marijuana, tobacco and other drugs can quickly become consequential. The majority of adults suffering from alcohol and other drug dependence developed a pattern of SUDs as youths (18 or under) or young adults (19-25). Adolescence presents complexities that require a different approach to drug education, prevention, early intervention and treatment of SUDs from that of adults. School performance needs to be supported, often involving assessment for learning disabilities, in order to encourage future achievement. Healthy psychological development needs to be encouraged. Attachments to family, school, health adult role models and community need to be strengthened. Resiliency factors need to be identified and enhanced. Families need stabilization, and recovery-sensitive environments need to be promoted in schools and local communities.

Adolescents require treatment in separate facilities from adults at all levels of care. Age-appropriate treatment goals require a developmental/maturation focus and uniquely trained staff. The complexities of adolescent development produce unique issues that are quite different from the usual care offered in adult treatment settings. Moreover, adolescents require safety and must not be exposed to adult predatory behaviors. Family engagement is essential. Since schools are the "workplace" for most teens, a close liaison between school-based programs such as Student Assistance Programs and the community-based outpatient treatment system is essential. California is lacking a public-sector treatment system for drug using adolescents.

a) Treatment Facility Licensing and Certification. DHCS has sole authority to license facilities that have seven or more treatment beds and provide 24-hour residential nonmedical services to eligible adults who are recovering from problems related to alcohol or other drug (AOD) misuse or abuse. Licensure is required when at least one of the following services is provided: detoxification; group sessions; individual sessions; educational sessions; or, alcoholism or other drug abuse recovery or treatment planning. Additionally, facilities may be subject to other types of permits, clearances, business taxes, or local fees required by the cities or counties in which the facilities are located. Many facilities licensed by DHCS are also certified by DHCS. Certification by DHCS identifies those facilities, either residential treatment facilities or AOD programs, as exceeding minimum levels of service quality and are in substantial compliance with state program standards, specifically the AOD Certification standards. DHCS does not license alcohol and drug residential treatment programs with six or less beds, known as "sober living homes."

b) EPSDT. This bill requires DHCS to establish DMC billing codes in the Short-Doyle Medi-Cal billing system for EPSDT-covered services for specified DMC treatment services.

EPSDT is the Medicaid benefit for children. The purpose of EPSDT is to discover and treat childhood health conditions before they become serious or disabling. The EPSDT benefit is more robust than the Medi-Cal benefit package provided to adults. For example, services that are optional benefits under federal law for adults in Medi-Cal

(such as dental, eyeglasses, physical and occupational therapy, and pharmacy) are required goods and services under EPSDT. The EPSDT benefit is designed to ensure that eligible members receive early detection and preventive care in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

The federal EPSDT law addresses when a covered service should be provided. The medical necessity standard for EPSDT in federal law is for services "necessary … to correct or ameliorate defects and physical and mental illnesses and conditions." This standard is broader than the current state Welfare and Institutions Code (WIC) Medi-Cal standard, which defines a service as medically necessary when the service is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."

c) DMC-Organized Delivery System (DMC-ODS) WAIVER. The DMC-ODS is part of a five-year pilot program approved by the Centers for Medicare and Medicaid Services (CMS) originally approved in 2015 under the Section 1115 Bridge to Reform Demonstration Waiver and continued under the current waiver (known as Medi-Cal 2020) to test a new method for the organized delivery of health care services for Medi-Cal-eligible individuals with an SUD. Elements of the DMC-ODS include providing a continuum of care modeled after the ASAM criteria for SUD treatment services.

Under DMC-ODS, counties can opt-in to the DMC-ODS by submitting an implementation plan for approval by DHCS and CMS. After approval of a plan, a county contracts with DMC-certified providers or offers county-operated services to provide all services available through the DMC-ODS. Counties are also permitted to contract with managed care plans to offer services to beneficiaries. In addition to standard DMC benefits,* counties that opt-in are required to provide additional services, among other requirements: recovery services to support an individual's recovery efforts, including counseling, education and job skills, and linkages to housing, transportation, and case management services; comprehensive assessment and periodic reassessment, referral services, and patient advocacy, such as linkages to physical and mental health care; and, physician consultation services, which are provided to DMC-certified physicians who seek expert advice on designing treatment plans for complex cases involving DMC-ODS beneficiaries.

According to the California Health Care Foundation (CHCF), as of December 2018, 40 of California's 58 counties had submitted implementation plans to participate in the DMC-ODS. The following 22 counties are now providing services: Alameda, Contra Costa, Imperial, Los Angeles, Marin, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Ventura, and Yolo. CHCF states that currently participating counties represent 75% of the state's Medi-Cal population, and that once all 40 counties begin providing services, nearly 97% of Medi-Cal beneficiaries will have access to DMC-ODS services. Of the 22 counties currently providing services, none are among those identified as having overdose and death rates of up to five times above the statewide average. The 18 counties that have not yet opted into the DMC-ODS are: Amador, Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lake, Madera, Mariposa, Mono, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

*DMC is a benefit available to all Medi-Cal-eligible individuals who have an SUD diagnosis. Available services include: narcotic treatment program services; outpatient drug-free treatment services; individual and group counseling; day care habilitative services, perinatal residential SUD services, and naltrexone treatment services. Per state regulations, room and board are prohibited from being reimbursable through DMC-ODS.

3) **SUPPORT.** The County Behavioral Health Directors Association (CBHDA), cosponsor of this bill states that in 2015-16, the National Survey on Drug Use and Health estimated 5% of California youth ages 12-17 were misusing alcohol or drugs; the rate of SUD among young adults ages 18-25 was nearly 15%. Like adults, most youth in need of SUD treatment do not receive care, with estimated treatment rates as low as one in 10. New data from the Centers for Disease Control and Prevention indicate that every two days a California youth dies from an opioid overdose, and data from the Nationwide Emergency Department Sample find that more children and youth being treated in emergency departments are dependent on opioids. The annual numbers have risen 54% over the last 10 years, leading researchers to define the problem as an emerging public health crisis. CBHDA states further that under the federal EPSDT benefit, Medicaid-enrolled youth are entitled to age-appropriate care for any identified behavioral health conditions, including substance use disorders. By requiring DHCS to implement EPSDT-specific billing codes in the DMC program, this bill will enable community-based providers of youth SUD treatment to be appropriately reimbursed for all covered EPSDT benefits, thereby helping to address this current gap in services.

4) **RELATED LEGISLATION.**

a) AB 888 (Low) extends the requirement for a prescriber, before directly dispensing or issuing to a minor the first prescription for a controlled substance containing an opioid in a single course of treatment, by making the requirement apply to any patient. Requires the prescriber to discuss the availability of nonpharmacological treatments for pain and after discussing the information requires prescriber to offer a referral for a provider of nonpharmacological treatments and to obtain informed written consent. Removes an exemption for a diagnosis of chronic intractable pain and adds an exemption for a patient receiving hospice care. AB 888 is pending in the Assembly Business & Professions Committee.

b) AB 1098 (O'Donnell and Wood) establishes procedures for the implementation and administration of programs funded by the Youth Education Prevention, Early Intervention, and Treatment Account aimed at providing substance abuse education and prevention programs and SUD treatment, including the identification of targeted outcomes with unspecified metrics, the establishment of a technical advisory committee, required information to be provided by applicants for program funding, and progress reports to the Legislature. Require that an unspecified portion of funds be used to test innovative practices through pilot programs. AB 1098 is pending in the Assembly Health Committee.

c) SB 445 (Portantino) requires DHCS to convene an expert panel on or before January 1, 2021, to advise DHCS solely on the development of youth SUD treatment quality standards, as specified. The bill would require DHCS, on or before July 1, 2022, to adopt regulations to establish youth SUD treatment quality standards, as specified. Define

youth SUD treatment services as including any publicly funded direct services intended to treat SUD for individuals from birth to 26 years of age, inclusive. SB 445 is pending in the Senate Health Committee.

5) PREVIOUS LEGISLATION.

a) SB 275 (Portantino) of 2018 was substantially similarly to SB 445 of 2019. AB 275 was vetoed by the Governor.

b) SB 191 (Beall) of 2018 would have allowed a county or a qualified provider, as specified, and a local educational agency to enter into a partnership to create a program that targets pupils with mental health and SUD. SB 191 would also have created the county and Local Educational Agency Partnership Fund from which moneys would be made available as specified, to fund the partnerships. SB 191 was held in the Senate Appropriations Committee.

c) SB 1019 (Beall) of 2018 would have required the Mental Health Services Oversight and Accountability Commission to allocate at least one-half of Investment in Mental Health Wellness Act of 2013 triage grant program funds to local educational agencies and mental health partnerships, as specified, to support prevention, early intervention, and direct services to children and youth.

6) POLICY COMMENTS. In their letter of support for this bill, the National Health Law Program (NHeLP) recommended further amendments to California's EPSDT statute contained in WIC, to also require DHCS to update Medi-Cal billing codes to include any additional services for individuals under 21 with SUD that may be identified through the regulatory process as required by this bill. As this bill moves forward, the author may wish to consider addressing this recommendation of NHeLP.

REGISTERED SUPPORT / OPPOSITION:

Support

California Psychiatric Association (cosponsor)
County Behavioral Health Directors Association (cosponsor)
California Council of Community Behavioral Health Agencies
California State Association of Counties
County Health Executive Association of California
National Health Law Program

Opposition

None on file.

Analysis Prepared by: Judith Babcock / HEALTH / (916) 319-2097