



Model Patient Protection and Treatment Ethics Act

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Table of Contents

3	Section I – <i>Short Title</i>
3	Section II – <i>Legislative Findings</i>
3	Section III – <i>Purpose</i>
4	Section IV – <i>Definitions</i>
5	Section V – <i>General Principle</i>
5	Section VI – <i>Truth in Marketing</i>
8	Section VII – <i>Lead Generator and Referral Marketing</i>
10	Section VIII – <i>Drug Testing</i>
11	Section IX – <i>Recovery Residences</i>
13	Section X – <i>Patient Brokering and Kickbacks</i>
18	Section XI – <i>Managed Care</i>
21	Section XII – <i>Responsibility, Transparency, and Accountability</i>

SECTION I. SHORT TITLE

This Act may be referred as the Model Patient Protection and Treatment Ethics Act.

SECTION II. LEGISLATIVE FINDINGS

- (a) The nation remains in the grips of an epidemic of substance use disorders.
- (b) The nation is blessed with countless excellent addiction treatment programs. These programs and their staff perform tireless and lifesaving work, much of it entirely outside the limelight, and much of it thankless, on an illness that is still far too stigmatized (a stigma that often extends to the very people trying to treat it). These are not the programs and people giving rise to this Act.
- (c) This Act is intended to create a level playing field that denies advantage to programs and personnel that engage in, or support, predatory, unsafe, and unethical practices. These practices create barriers to desperately needed treatment, and cause incalculable needless harm to desperate families and the communities they live in. Enacting legislation that sets forth, and provides for the enforcement of, uniform ethical standards for treatment programs benefits all residents of [name of state] by improving the availability of high-quality, ethical treatment, and by protecting families and individuals in crisis from misleading information and other unethical practices.

SECTION III. PURPOSE

This Act is designed to protect families and patients. It is the intent of the legislature that all provisions of this Act are to be construed in favor of maximizing protections for patients and families, and the communities in which they live.

SECTION IV. DEFINITIONS

- (a) “Recovery residence” means a shared living environment that is, or is intended to be, free from alcohol and illicit drug use and is centered on peer support and connection to services that promote sustained recovery from substance use disorders.
- (b) “Referral”. A person or entity shall be considered to have made a referral if the provider or recovery residence has informed a patient by any means of the name, address, or other identifying information for a licensed service provider or recovery residence.
- (c) “Treatment facility” means a facility or program that is, or is required to be, licensed, accredited, or certified to provide substance use disorder treatment services.
- (d) “Treatment provider” means an individual who is, or is required to be, licensed, accredited, or certified to provide substance use disorder treatment services and, for purposes of this Act, also includes treatment facilities.

Comment:

The definition of recovery residence includes housing where patients are using prescribed medications as part of medication-assisted treatment. Some stakeholders have observed that there is an appropriate role for shared housing that is entirely medication-free. This definition is not meant to, and does not, preclude or exclude housing where none of the users are receiving medication-assisted treatment. Housing that is free of any medication is (by definition) free of illicit drug use.

Some stakeholders have noted that housing that is entirely drug-free (that is, shared housing where none of the residents are receiving medication-assisted treatment) may violate the Americans with Disabilities Act. The point is well taken (although we take no substantive position on whether any particular shared housing arrangement violates the ADA). But we do not think it makes sense to permit violations of any federal law (the ADA being just one example) to remove any entity from the scope of this Act. To the extent that this Act reaches recovery residences that are not treatment providers—it does not do so directly, but it does establish certain standards for treatment providers in their dealings with recovery residences—it makes sense to include as broad a definition of recovery residence as possible. To put it another way, allowing recovery residences to avoid the scope of one set of laws (this Act) by violating another set of laws (the ADA) seems unwise.

The term recovery residence includes and encompasses recovery houses, sober homes, and Oxford houses.

SECTION V. GENERAL PRINCIPLE

Every treatment facility doing business in the State shall adopt, and make available to all patients and prospective patients, a written code of ethics that covers and ensures full compliance with the requirements set forth in this Act.

SECTION VI. TRUTH IN MARKETING

- (a) Any marketing or advertising materials published or provided by a treatment facility shall provide accurate and complete information, in plain language that is easy to understand, and shall include the following:
- (1) Information about the types and methods of services provided or used, and information about where they are provided, using the categories of treatment and levels of care identified in [the State’s licensing laws];¹
 - (2) The average lengths of stay during a preceding twelve-month period, for each of the treatment settings referred to in the preceding subparagraph;
 - (3) The treatment facility’s name and brand; and
 - (4) A brief summary of any financial relationships between the treatment facility and any publisher of marketing or advertising.
- (b) It is unlawful for any treatment provider to knowingly and willfully make a materially false or misleading statement, or provide false or misleading information about, the nature, identity, or location of substance use disorder treatment services or a recovery residence, in advertising materials, on a call line, on a website, or in any other marketing materials.
- (c) Any treatment facility providing outpatient services along with a housing component must clearly label its program as such, and must distinguish itself from licensed residential substance use disorder treatment.

¹ Not every state licenses every level of care, and some licensure taxonomies do not provide much detail. States should adopt an approach that clearly communicates treatment settings and levels of care to consumers. We also note that every level of care may include medication-assisted treatment, and anything suggesting that medication-assisted treatment is a separate, distinct level of care should be avoided because it risks confusing families and patients.

- (d) It is unlawful for any treatment provider to knowingly make a false or misleading statement about their status as an in-network or out-of-network provider.
- (e) It is unlawful for any person or entity to knowingly provide, or direct any other person or entity to provide, false or misleading information about the identity of, or contact information for, any treatment provider.
- (f) It is unlawful for any person or entity to knowingly include false or misleading information about the internet address of any treatment provider’s website, or to surreptitiously direct or redirect the reader to another website.
- (g) It is unlawful to suggest or imply that a relationship with a treatment provider exists, unless the treatment provider has provided express, written consent to indicate such a relationship.
- (h) It is unlawful for any person to knowingly make a materially false or misleading statement about substance use disorder treatment services.
- (i) Violating the provisions of this section constitutes a deceptive act or practice under the [State’s] Unfair Trade Practice and Consumer Protection Law, regardless of whether any consumer was actually misled or deceived.
- (j) Any person or entity that knowingly violates any provision of this section commits a felony of the third degree.

Comment:

Families in communities across [name of state], who are seeking substance use disorder treatment for a loved one suffering with a substance use disorder, are being widely victimized by the growing presence of deceptive and misleading information.

[Name of state] has enacted robust consumer protection laws [cite state consumer protection laws]. Those laws, however, have proven difficult to apply and enforce in this context, and therefore inadequate to provide meaningful protection to those who need it. There are both jurisdictional and substantive reasons for this.

A great deal of dangerous and misleading conduct happens on the internet. For a variety of reasons – resources, habit, expertise, and difficulty tracking down deceptive and predatory actors—state-level regulators have not vigorously enforced, in this context, the rules and standards that typically govern and apply to false advertising. In July 2018 the Federal Trade Commission—the federal agency with front-line responsibility for protecting consumers from false marketing—noted problems with unfair and deceptive practices surrounding substance use

disorder treatment, including patient brokering and lead generation. Letter from Commissioner Rohit Chopra to leadership of the House Energy and Commerce Committee (July 24, 2018). That letter stated that unfair and deceptive marketing by substance use disorder treatment facilities and lead generators “may violate” the FTC’s enabling statute. In the fall of 2018 Congress passed the SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. 2018 (“H.R. 6”), which expressly brought within the FTC’s enforcement jurisdiction any “unfair or deceptive act or practice with respect to any substance use disorder treatment service or substance use disorder treatment product”. H.R. 6, §§ 8021, 8023. It is too soon to tell how effective these changes will be. Moreover, the state of [name of state] has its own independent interest in protecting the residents of our state from unethical predatory conduct; state and local resources are also needed to protect our families from such conduct.

The proposed language places responsibility for advertising activities squarely on treatment providers, which brings these activities squarely within reach of state-level regulators.

Google uses an Addiction Treatment Certification program (sometimes referred to as Legit Script), which applies to substance use disorder treatment providers that use paid advertising on Google. We understand that Bing and Facebook (and almost certainly others) are also working with Legit Script. Legit Script requires advertisers to comply with licensing and other requirements, and requires advertisers to provide information that provides a certain degree of transparency. The project, however, is limited. It applies only to purchased advertisements – the material that appears at the top (and sometimes the bottom) of the page when you do a Google search. It does not apply to the results that come up in the map that appears (in the middle of the results page), or the results that appear in the bottom of the page (search results proper). Furthermore, the substantive requirements for Legit Script certification are necessarily limited. Legit Script is helpful, but is not a replacement for the other protections established in this Act.

This section requires treatment providers to include information about care provided, using terminology from the state’s existing licensure scheme. One of the reasons regulating this area has proven so difficult is because some websites deliberately obscure the services available. Instead of using a common, shared vocabulary that would effectively communicate to a patient or family in crisis what treatment, exactly, is being offered, they offer meaningless descriptors. Even the initiated can have a difficult time gleaning, from a website, what types of treatment and levels of care a facility offers. For example, references to “counseling and residential detox” mean the patient will likely have a very short detoxification stay, and then move to recovery housing. But almost nobody who is not already acquainted with the field would necessarily know that.

Nothing in this Model Act precludes providers from providing additional information about themselves (so long as it is truthful), above and beyond the categories of treatment as set forth in State licensure laws.

Some commenters have suggested that we extend the scope of this section to include marketing companies that are not treatment providers. We agree on the need for greater transparency and accountability when it comes to marketing companies. The regulation of marketing entities, however, is beyond the scope of this Act.

Subparagraph (i) refers to a change to the state's Unfair Trade Practice and Consumer Protection Law. The provision is placed here for the purpose of clarity; in most states, this particular provision would be placed within the state's Unfair Trade Practice and Consumer Protection law.

The criminal sanction is appended to the substantive standard in this submission for the sake of clarity. In some states, the statutory organization of the criminal code might counsel in favor of demarking criminal sanctions separately from the substantive standard.

Also, felony grading standards differ substantially from state to state; each state will need to make its own determination on this.

SECTION VII. LEAD GENERATOR AND REFERRAL MARKETING

- (a) Except as provided in subparagraph (b), it shall be unlawful for a treatment provider to enter into a contract with, or to provide any consideration to, a marketing provider who agrees to generate leads or referrals for the placement of patients with a treatment provider or recovery residence through a call center or website.
- (b) A contract for, or payment or other consideration for, advertising is not unlawful if:
 - (1) it is through a website operated or controlled by a treatment provider or an operator of a recovery residence;
 - (2) the entity that operates or controls the website is clearly identified in plain language on the website; and
 - (3) compensation paid to the entity that operates or controls the website is not based on the volume or value of referrals, clicks, or any similar metric.
- (c) In addition to any other punishment authorized by law, a person or entity that knowingly violates this section commits a felony of the third degree.
- (d) Nothing in this Act shall apply to websites relating to substance use disorders or substance use disorder treatment operated by federal, state, or local governmental entities.

Comment:

There has been a great deal of discussion and testimony surrounding the use of marketing entities—primarily call centers, internet aggregators, and navigators—that are not associated directly with a treatment program and are therefore not subject to the regulatory oversight mechanisms that treatment programs are. The drafters are of the view that the clearest way to address this problem is a bright-line rule that forecloses treatment programs from doing business with marketing-only entities. There are two reasons for this.

First, aggregators are supported by payments from treatment programs. It is difficult to reconcile this business model with a clear, powerful anti-kickback statute that bars treatment providers from paying for patients. Regardless of the particular mechanisms involved, the ultimate result is that aggregators get paid by treatment providers for sending them patients or calls from patients.

Second, any more nuanced standard would be, as a practical matter, unenforceable. For example, Utah’s anti-brokering statute, enacted in 2018, expressly permits payments to “information services” that provide information without charge to consumers, so long as the charges are set in advance and are not based on the potential value of patients to the treatment provider, and so long as the information service does not steer the patient based on monetary rather than clinical criteria. Utah Code Ann. § 62A-2-116(6)(e). This is a good idea, but it poses significant enforcement challenges.

While theoretically there could be a risk that our bright-line approach might starve out internet resources that would otherwise be helpful to be families in crisis, such a concern does not appear to be borne out by what is *actually* occurring. The most trusted and trustworthy resources are universally associated with government resources, longstanding programs with established reputations, or organizations that do not appear to rely on funding from providers. We are not aware of any evidence, or indeed any serious claim, that marketing-only call centers, aggregators, and navigators have proven to be important, credible sources of information for families in crisis. The evidence consistently has pointed to the opposite conclusion.

Some commenters who reviewed earlier drafts of this document have noted that Google adwords and other similar internet marketing approaches include payments made on a per-click basis. The current language does not proscribe such arrangements, because Google and its search-engine counterparts are not providing the clicks “through a call center or website”.

SECTION VIII. DRUG TESTING

- (a) A treatment facility, and a licensed health care professional providing care to patients at a treatment facility or a recovery residence, shall not refer drug tests to an out-of-network laboratory if an in-network laboratory is reasonably available to meet the patient's drug testing needs.
- (b) A treatment facility, and a licensed health care professional providing care to patients at a treatment facility, shall not order or perform confirmatory testing in the absence of a documented medical or legal need for such confirmatory testing.
- (c) Any person or entity who violates any provision of this section, where the amount billed for the drug test totals less than \$5,000, commits a felony of the fourth degree, and shall be ordered to pay a fine of \$5,000 per violation, in addition to full restitution to the parties adversely impacted.
- (d) Any person or entity who violates any provision of this section, where the amount billed for the drug test totals \$5,000 or more, commits a felony of the third degree, and shall be ordered to pay a fine of \$10,000 per violation, in addition to full restitution to the parties adversely impacted.
- (e) Any person or entity who violates any provision of this section, where the aggregate amount billed for drug tests referred, ordered, or performed in violation of this section over any twelve-month period is greater than \$100,000, commits a felony of the second degree, and shall be ordered to pay a fine of \$100,000, in addition to the full restitution to the parties adversely impacted.

Comment:

Patients and health insurance companies continue to be charged too much money by some treatment providers for needless drug tests. Drug tests should be conducted as needed to provide optimum clinical care for the patients, not to maximize the profits of a treatment facility or other provider that is operating unethically. The proposed language gets at both the cost problem and the quantity problem.

The sticker-shock prices almost invariably come from out-of-network laboratory providers. In-network prices are invariably a small fraction of the price for out-of-network users.

Every major health insurance plan has in-network laboratory providers in every state in the country (either directly, or through contracts that allow them to rent local networks), and the in-network laboratories are easy to identify for each health plan. Absent truly extraordinary circumstances, there is no reason to use out-of-network providers for drug testing, for patients who have in-network coverage.

Individuals in treatment often have little to no say in where their laboratory samples go. For this reason, responsibility should reside with the treatment facility, which does have a significant say in where laboratory samples go.

Apart from these issues, we are aware of more general concerns surrounding the overutilization of drug testing. The American Society of Addiction Medicine, for example, observed in 2017 that relatively cheap over-the-counter urine drug screens were often entirely appropriate and sufficient. American Society of Addiction Medicine, *Consensus Statement: Appropriate Use of Drug Testing in Clinical Addiction Medicine* (April 5, 2017).

Sometimes additional testing is needed to prevent legal harm from false positive results. A parole violation proceeding is one example of this. The reference to “documented medical or legal need” permits additional testing in these situations.

SECTION IX. RECOVERY RESIDENCES

- (a) A treatment facility shall not make a referral of a prospective, current, or discharged patient to a recovery residence unless the recovery residence holds a valid [certification/license/accreditation/registration]
- (b) Every treatment facility provider shall maintain records of referrals to or from recovery residences, including, where available, information about where a patient referred by a treatment facility elected to go.
- (c) A treatment facility shall not make a referral of a prospective, current, or discharged patient to a recovery residence if the recovery residence requires the patient to receive treatment from a particular treatment provider or treatment facility as a condition of staying at the recovery residence, unless:
 - (1) The recovery residence is subject to the oversight and control of the referring treatment facility;

- (2) The arrangements among and between the patient, recovery residence, and treatment facility are not in violation of section X of this Act;
 - (3) The recovery residence meets the standards set forth in subsection (a); and
 - (4) The recovery residence is located essentially contiguous with the referring treatment facility.
- (d) No government funds may be used to pay for recovery housing that does not meet the standards set forth in subsection (a).

Comment:

Most states do not regulate recovery housing (except through general health and safety regulations—building codes, local health and safety codes, etc.—that are applicable to essentially all buildings or to all buildings that are open to the public). Some states certify recovery housing, and have developed either developed standards or have endorsed or otherwise credited standards have been established by, and are available through, organizations such as the National Association of Recovery Residences (and their state affiliates) and Oxford Houses.

The landscape here is evolving rapidly. Government regulation of recovery housing and individuals who run recovery residences remains a long-term goal. In the meantime, it makes sense to credit and utilize those markers of competence and integrity that are currently in place. Where certification standards are in place, they should be used.

Anti-discrimination laws have often been mentioned as a barrier to enforcing recovery housing standards. We note that Delray Beach, Florida has enacted an ordinance that identifies certification by the Florida Association of Recovery Residences (essentially the Florida incarnation of NARR) as a reasonable accommodation. Delray Beach, Fla., Ordinance 25-17 (2017), <https://delraybeach.legistar.com/LegislationDetail.aspx?ID=3100473&GUID=B9DB85ED-6FCF-4479-A806-E6083032CAC9>. This seems a sensible approach that protects those who need good recovery housing, while also addressing legal concerns under federal antidiscrimination laws.

Subparagraph (d) connects directly to laws banning unlawful use of government funds. Every state has such laws already in effect. A particular state’s embodiment of this Model Act provision will make these connections explicit.

Some commenters who reviewed earlier drafts of this Model Act accurately noted that subparagraph (d) might be difficult to enforce. Establishing a violation of these substantive

provisions as a violation of laws governing misuse of government funds more generally will bring a variety of tested enforcement mechanisms to bear.

SECTION X. PATIENT BROKERING AND KICKBACKS

- (a) It is unlawful for any person, including any treatment provider or laboratory, to:
- (1) Offer or pay anything of value, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of a patient or patronage to or from a treatment provider or laboratory;
 - (2) Solicit or receive anything of value, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring a patient or patronage to or from a treatment provider or laboratory;
 - (3) Solicit or receive anything of value, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for the acceptance or acknowledgment of treatment from a health care provider or health care facility; and
 - (4) Aid or abet any conduct that violates this section.
- (b) This section shall not apply to any discount, payment, waiver of payment, or payment practice that is expressly authorized by 42 U.S.C. § 1320a-7b(b)(3) or regulations adopted thereunder.
- (c) This section shall not apply to reasonable contingency management techniques or other reasonable motivational incentives that are part of treatment provided by an accredited, licensed, or certified treatment provider.
- (d) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.
- (e) Any person who violates any provision of this section commits a felony of the third degree, and shall be ordered to pay a fine of \$50,000.
- (f) Any person who violates any provision of this section, where the prohibited conduct involves 10 or more patients but fewer than 20 patients, commits a felony of the second degree, and shall be ordered to pay a fine of \$100,000.

- (g) Any person who violates any provision of this section, where the prohibited conduct involves 20 or more patients, commits a felony of the first degree, and shall be ordered to pay a fine of \$100,000.

Comment:

Patient brokering and unlawful kickbacks lie at the heart of the problem as it emerged, first in Florida and then in other states. A kickback is paying someone to refer a patient. A recovery residence or patient broker would refer a patient to a particular treatment facility—a referral driven by financial incentives and not by valid clinical considerations and the patient’s best interest. In exchange, the recovery residence or patient broker would be paid, sometimes many hundreds of dollars a week, by the treatment facility. Patients were often required to attend a particular treatment program (the one paying the bribe) as a condition of continuing to stay in the recovery residence receiving the kickback.

Patient brokering is a particular type of kickback. The money goes to an individual—a patient broker—in exchange for sending patients to the treatment facility.

We know from the Florida grand jury report and many other sources that kickbacks and patient brokering are often directly associated with the worst abuses. Presentment of the Palm Beach County Grand Jury, Report on the Proliferation and Abuse in Florida’s Addiction Treatment Industry, (Dec. 8, 2016), http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/GrandJuryReport2.pdf (last visited June 26, 2019).

A recovery residence that relies on kickbacks from a treatment program for its very survival is not likely to put a patient’s clinical needs and safety first. Obviously, any meaningful solution needs to squarely address kickbacks and patient brokering.

Preliminarily, however, it is important to look at the broader context of private insurance and privately paid treatment. Recovery residences are not covered under private insurance, and patients in early recovery are often indigent and unable to pay. Certain commercial outpatient treatment facilities are using some of the funds they receive for providing treatment to create (or fund the creation of) substandard, unregulated “recovery housing”. Dollars flow from the licensed, regulated part of the treatment ecosystem to a largely unlicensed, largely unregulated part of the ecosystem. In terms of systems design, this invites corruption and requires constant vigilance. This issue is addressed below.

Kickbacks sometimes take the form of free air travel, free lodging, or payment of insurance premiums. These are benefits and remuneration that fall within the scope of the statutory language.

The Federal Landscape

When federal money is involved, a powerful and effective array of federal anti-kickback and antifraud rules apply. Kickbacks are prohibited under the federal anti-kickback statute, 42 U.S.C. § 1320a-7b; self-referrals are prohibited under the Stark Act, 42 U.S.C. § 1395nn. Violations of these statutes are felonies; they can result in exclusion from federal healthcare plans; they can bring significant civil monetary penalties; and they can give rise to significant liability under the federal false claims act. The federal government properly brings enormous resources to bear detecting and prosecuting these violations. They are joined in this mission by a vigorous plaintiffs' bar investigating and pursuing federal civil whistleblower cases against doctors and companies that engage in this misconduct.

While kickbacks remain a problem with federally funded healthcare, systemic violations that take place in plain sight are now rare and invariably short-lived. It is no accident that the majority of the abuses observed in Florida involved *private* payments and *private* insurance.

The federal opioid bill passed in late 2018, H.R. 6, included the Eliminating Kickbacks in Recovery Act of 2018 (“EKRA”), which made kickbacks involving substance use disorder treatment a federal crime even when no federal dollars are involved. H.R. 6, § 8122 (codified at 18 U.S.C. § 220). This is a sensible and salutary development. Importantly, however, EKRA does not provide for any civil monetary penalty or civil damages remedy; the only tool available for enforcement is a federal criminal prosecution.

Insurance Industry Efforts to Eliminate Unlawful Kickbacks

There are notable instances of private insurance companies pursuing affirmative litigation against healthcare providers involved in kickback schemes, but those cases are in fact somewhat rare, and only make economic sense when significant dollars are involved and recoverable. Experience counsels that claims by insurers and health plans are not a reliable and complete enforcement mechanism.

This Act does establish new claims and causes of action that will be available to a number of affected entities and persons, including in some instances payors (and therefore insurers and health plans). There is every reason to expect the basic structural dynamics that apply to claims by payors—namely, the need for significant and recoverable damages—will continue to apply; and there is no reason to expect the interests of payors and other actors—for example, law enforcement and patients—to align in every respect. As a result, there is a continuing need for other enforcement mechanisms.

The State Landscape

Before 2017, a majority of states had anti-kickback statutes roughly similar to the federal anti-kickback statute. Most of them only applied when *public* money was involved. A few,

however—including Florida—had anti-kickback statutes that applied to healthcare paid by *private* insurance and in some instances by patients and families. Florida had two: section 456.054 prohibited kickbacks generally, and applied to “any health care provider or provider of health care services”, Fla. Stat. § 456.054(2); section 817.505 prohibited kickbacks “to induce the referral of patients or patronage to or from a health care provider or health care facility,” Fla. Stat. § 817.505(1)(a).² A number of other states had similar anti-kickback laws that extended to private payors. *See, e.g.*, Cal. Health and Safety Code § 445 (“No person, firm, partnership, association or corporation, or agent or employee thereof, shall for profit refer or recommend a person to a physician, hospital, health-related facility, or dispensary for any form of medical care or treatment”); La. Stat. Ann. § 37:1745 (prohibition against payments for patient referrals; applicable to licensed professional counselors); Mass Gen. Laws Ch. 175H § 3 (prohibition against kickbacks whenever “payment is or may be made in whole or in part by a health care insurer”; applicable to “any person”); Mich. Comp. Laws § 752.1004 (prohibition against “kickback or bribe” in connection with goods or services paid by private insurance; applicable to “a[ny] person”); N.C. Gen. Stat. §§ 90-401, 90-402 (prohibition against providing and receiving compensation; applicable to health care providers, a term that includes licensed substance use disorder professionals); S.C. Code Ann. § 44-113-60 (prohibition against paying or receiving a kickback; applicable to health care providers, a term that includes licensed, certified, and registered health care providers); Tex. Occ. Code Ann. § 102.001 (prohibition against paying or receiving a kickback; applicable to any person licensed, certified, or registered by a state regulatory agency).

The penalties for violating these statutes were (and are) predominantly criminal.

These statutes did not, manifestly, prevent the problems with patient brokering and other kickbacks that emerged around privately insured and private-pay patients in need of substance disorder treatment. Some industry professionals have described patient brokering as the standard practice, not the exception. Florida of course proves the point: a clear, powerful anti-kickback statute and separate anti-brokering statute did not prevent the crisis.

Following an extensive investigation into the problem and its causes, as reflected in the report of an Investigative Grand Jury that was handed down on December 8, 2016, Florida changed its anti-brokering statute in two ways. First, it changed the definition of payment to add a “benefit”; this was intended to capture gifts and amenities that were often used to lure patients. Second, it dramatically increased the criminal penalties. Those penalties now increase in severity with the number of patients affected; brokering involving 20 or more patients is now punishable as a first degree felony, and carries a fine of \$500,000.

² This provision was originally enacted in 1996. *See* 1996 Fla. Sess. Law Serv. Ch. 96-152 (C.S.H.B. 283) (West.). It has since been modified, but the substantive core remains the same.

Equally important, Florida made a radical commitment to enforcing the law, by expanding enforcement jurisdiction to include the office of statewide prosecution (anti-brokering prosecutions were previously left to local authorities), and by devoting significant resources to investigations and enforcement.

Florida's efforts have gone a long way to fixing the problem. The problem has not disappeared from the national landscape; indeed, some of the worst actors have moved to states that have not taken these enforcement steps. In the words of one stakeholder, "the fleas have moved on to a different dog". Furthermore, our own fact gathering process has confirmed that patient brokering is still occurring.

We think there is an important lesson in Florida. Merely having a law on the books is not sufficient. Resources need to be devoted to enforcement. We also conclude, based on comparison of results at the federal level and the state level, that adding *civil* enforcement tools, including private civil enforcement tools, to the arsenal is critical. Properly incited civil plaintiffs bring monitoring and enforcement resources to bear at no cost to the government. Furthermore, civil remedies have a lower burden of proof (preponderance of the evidence—the archetypal tipping of the scales—as opposed to beyond a reasonable doubt); do not require the plaintiff to prove criminal intent; offer far broader discovery; and can have broader venue provisions that make it easier to bring all the participants in an unlawful enterprise into the same proceeding.

Self-Dealing in Referrals to Recovery Residences

Self-referrals in healthcare are the subject of considerable regulation. The federal ban that prevents doctors from referring patients to healthcare facilities that they own—generally, the Stark Act and its implementing regulations—is a centerpiece of federal health care law. The overwhelming majority of states have roughly similar laws. These laws are complicated and are replete with exceptions and safe harbors, because they have to strike a complicated balance between (a) the concern with self-dealing against (b) the legitimate need to let doctors and other clinicians participate (both professionally and financially) in the development of health care facilities that often require extensive capital.

We do not include a self-referral ban expressly directed to substance use disorder treatment, largely because self-referrals have not emerged as a significant problem in their own right in this area. (This stands in marked contrast to kickbacks and patient brokering, where changes in the law and enforcement strategies are clearly necessary.) We also note that state and federal Stark law restrictions remain in force.

There are, however, two ways in which referrals to facilities owned by the maker of the referral have emerged as a major concern: recovery residences that require their residents to use

a particular treatment facility; and excessive, overpriced drug tests. We have dealt with those concerns in Sections IV and V.

SECTION XI. MANAGED CARE

No treatment program shall enter into any contract or agreement with a third-party payor that includes any inducement or incentive to reduce or limit services to a level or duration below what is in the best clinical interest of the patient.

Comment:

Skewed funding drives much of the misconduct we are seeking to address in this model law.

For example, the strange practice of intensive outpatient programs paying hundreds of dollars a week to unregulated recovery residence operators is driven by payors not paying the treatment programs to house the patients themselves. For patients in early recovery, there is no clinical reason why it is better for the patient to sleep in a hotel or a rooming house instead of a room at the place they are receiving treatment, and there are serious clinical reasons why a hotel or rooming house could be worse for the patient.

This section does not take a position on the ongoing policy conversation about the appropriate role of residential substance use disorders.

Some voices in this conversation claim support for residential treatment in the literature, and in the accumulated wisdom and lived experience of the many people in strong recovery who found sobriety through meaningful residential treatment stays followed by less intensive, community-based care. Other voices in the conversation stress concerns about institutionalization for those with a stigmatized disease; stress the comparative importance of long-term community-based care for sustained recovery; and express concern with methodological flaws in studies that appear to support meaningful residential treatment stays.

Rather than take a position, this section both guarantees and requires that all treatment providers participate in those specific parts of the conversation that will shape the care of the provider's patients. This applies not only to residential treatment, but to all parts of the continuum of care.

Another way funding drives care is through the use of case rate contracts that reward facilities for providing less care, and penalize them for providing more care. As one national, multicenter provider of substance use disorder treatment explained in a recent 10-K, “third-party payors are beginning to carve out specific services, including substance abuse treatment and behavioral health services, and establish small, specialized networks of providers for such services at fixed reimbursement rates.” AAC Holdings, Inc., Annual Report (Form 10-K), at 15 (Feb. 23, 2018). Under these case rate contracts, the shorter the treatment, the more money the treatment facility makes. Also, facilities have incentives to turn away the sickest patients.

Case rate contracts are increasingly common, and there is anecdotal evidence that these case rates are based on an implicit length of stay that is dangerously short. Anecdotally, there is enormous pressure placed on treatment facilities to enter into these contracts if they want to be in-network.

Where public funding is involved, a contract between a hospital and a doctor intended to induce the doctor to reduce or limit medically necessary care would violate the federal anti-kickback statute. *See* 42 U.S.C. § 1320a-7a(b)(1) (barring payments made to a doctor “as an inducement to reduce or limit medically necessary services”). There is a regulatory exception that countenances these inducements, but that exception is carefully defined and tightly constrained. *See* 42 C.F.R. § 1001.952(u). The exception is designed to prevent, and indeed requires the contracting parties to actively monitor for, underutilization. 42 C.F.R. § 1001.952(u). The proposition that improperly constructed case rates can harm patient care is not a novel one, although it is perhaps an underappreciated one—particularly with diseases of denial. And if these contracts have the potential to harm patient care when public dollars are being spent, they have the potential to harm patient care when private dollars are being spent.

More generally, other authorities also recognize the potential link between reimbursement contracts and patient safety. *See, e.g.*, Health Benefit Plan Network Access and Adequacy Model Act § 6(F)-(I) (Nat’l Ass’n of Ins. Comms., 2015) 45 C.F.R. § 156.230 (network adequacy regulations for qualified health plans under the Affordable Care Act); Cal. Health & Safety Code §§1367.03, 1367(h)(1) (requiring contracts to be “fair [and] reasonable”); Fla. Stat. § 641.234(2)(a) (state office of insurance regulation review to ensure contracts with providers are not “detrimental to the subscribers”); Ga. Code Ann. § 33-20A-6(a) (“A managed care plan may not use a financial incentive or disincentive program that directly or indirectly compensates a health care provider or hospital for ordering or providing less than medically necessary and appropriate care to his or her patients or for denying, reducing, limiting, or delaying such care.”); 40 Pa. Stat. § 1554(b)(3) (Department of Health approval of contracts between HMOs and physician groups “which are found by the [S]ecretary [of Health] to provide adequate financial incentives for the provision of quality and cost-effective care”); 40 Pa. Stat. § 991.2112 (“No managed care plan shall use any financial incentive that compensates a

health care provider for providing less than medically necessary and appropriate care to an enrollee.”); 28 Pa. Code § 9.722(f)(3) (managed care regulation; to be approved by the Department of Health, provider contract must “include no financial incentive that compensates a health care provider for providing less than medically necessary and appropriate care to an enrollee”).

While it is critical that payors be required to offer contracts that are in the best interests of patients, it is also true that a payor-provider contract that is not proper for the *payor* is a contract that is not proper for the *provider*. No ethical treatment program should enter into an improper contract.

These contracts are invariably hidden from the view of patients and families, and almost always sit beyond the view of state and federal regulators. When form contracts are reviewed in connection with state or federal insurance regulation, case rate information almost always resides in schedules or attachments that are not part of that review. (The theoretical ability of regulatory personnel to obtain and review these schedules and attachments is, experience tells us, of little practical import.) And because these contracts move decisions about what care the patient receives from the managed care company to the provider, the practical mechanisms of managed care appeals—mechanisms that are supposed to form the backbone of patient protection—cannot even take hold. If a treatment program tells the patient that she is ready to go to sober housing after a four-day detox, there is no adverse benefit determination to appeal.

For this reason, it is essential that treatment facilities also assume responsibility for the safety of their managed care contracts. The proposed language does that.

Another way to underscore the point is to take a broader view of the Florida model, and managed care’s role in both enabling the model and failing to prevent its metastasis. Why did payors continue to pay for so much treatment, even after the problems in Florida were the subject of an investigative grand jury and extensive press coverage? When patients from out of state got on the plane to Florida, they were almost always heading to a treatment ecosystem limited to intensive outpatient or partial hospitalization (which is daytime only), and where they would have to pay for housing on their own. But these patients never received a denial letter from their health plan, telling them residential treatment was off the table. The language set forth here is hopefully the beginning of a broader and more transparent discussion that extends beyond treatment providers to other actors that play a significant role in determining whether or not patients can access the treatment they need to regain their health and achieve recovery.

These concerns are present across the continuum of care. Reimbursement should be fair and appropriate, and should not adversely affect patient care, at all levels of care.

Some commenters have noted that effective enforcement of the Mental Health Parity and Addiction Equity Act (“MHPAEA”), and the many State-law incarnations of that bill, would address many of the problems and concerns with managed care discussed here. We agree. But meaningful parity enforcement has not yet arrived, and there is no guarantee it will arrive anytime soon. We’re not waiting.

Similarly, some commenters have noted the need for more general improvements in the regulation of managed care organizations. We agree, but note that those changes are beyond the scope of this model law.

Some commenters suggested that we require both treatment and ethics providers to comply with recognized placement criteria, or with a particular set of recognized criteria (more precisely, ASAM). We do not think this is a workable solution, for several reasons. First, different funders use (and require the use of) different criteria, and requiring providers to use one set of a criteria when a funder is requiring them to use another one would place the provider in an impossible position. Second, different patient populations may require different criteria. Third, ASAM criteria (and similar criteria) determine placement; they do not directly establish or determine treatment. Fourth, reliance on ASAM criteria (or any private standards) raises serious constitutional concerns, because some state constitutions do not allow governments to delegate the creation of public standards to private standard-setting organizations. As a result, designating one particular set of privately-created criteria such as ASAM may prove an uncertain foundation for a statutory standard.

SECTION XII. RESPONSIBILITY, TRANSPARENCY, AND ACCOUNTABILITY

- (a) Every treatment facility subject to this Act shall, on or before the end of the first fiscal year commencing after the effective date of this Act, submit to the [licensing entity] the following:
- (1) an attestation, signed by a responsible corporate officer under oath, attesting that:
 - (A) the treatment facility has complied with the requirements of this Act, except as expressly noted in the attestation;
 - (B) the treatment facility has adopted, and is enacting and enforcing, policies and procedures designed and intended to ensure compliance with this Act; and
 - (C) the attestation is based on a reasonable investigation carried out at the direction of, and under the supervision and control of, the responsible corporate officer.

- (2) A detailed account of those areas where the treatment facility has failed to comply with the provisions of this Act, together with a corrective action plan designed to address any such deficiencies.

(b) Civil Remedies

- (1) A treatment provider shall not request, receive, or retain payment for substance use disorder treatment services provided to a patient by a treatment provider as a result of conduct declared unlawful under this Act.
- (2) Any person or entity who suffers any ascertainable loss of moneys or property, real or personal, as a result of the use or employment by another person of any method, act, or practice declared unlawful under this act or the act hereby amended and supplemented may bring an action or assert a counterclaim therefor in any court of competent jurisdiction, against the treatment provider who committed such violation and against any other person or entity who knowingly aided, abetted, or took part in such violation. In any action under this section the court shall, in addition to any other appropriate legal or equitable relief, award three times the damages sustained by any person in interest. In all actions under this section, the court shall also award reasonable attorneys' fees, filing fees and reasonable costs of suit.
- (3) The Attorney General, any District Attorney, [the appropriate licensing authority], or any other person with an ascertainable interest, may bring an action under the [state's declaratory judgment act] to declare that an act or practice violates this Act. Where the action is successful, in whole or in part, the court shall award attorneys' fees, costs of investigation and prosecution, costs of investigation and prosecution, filing fees, and all other reasonable costs of bringing the action, to the plaintiff.
- (4) The Attorney General, any District Attorney, [the appropriate licensing authority], or any other government entity or agency with an ascertainable interest, may bring an action to enjoin any person or entity who has violated, is violating, or is otherwise likely to violate any provisions of this Act. Where the action is

successful, in whole or in part, the court shall award attorneys' fees, costs of investigation and prosecution, filing fees, and all other reasonable costs of bringing the action, to the plaintiff.

- (5) The [appropriate licensing authority] may investigate allegations of violations of any provisions of this Act. Upon finding a violation, the [appropriate licensing authority] may do any or all of the following:
 - (A) Assess a penalty upon any licensed provider;
 - (B) Suspend or revoke the license of any licensed provider or deny an application for licensure; and
 - (C) Recommend disciplinary actions, including but not limited to termination of employment and suspension or revocation of a license.
- (6) Any person or entity who violates any provisions of this Act shall be subject to a civil monetary penalty of not more than \$10,000 for each violation.³
- (7) The Attorney General, any District Attorney, [the appropriate licensing authority], or any other government entity or agency with an ascertainable interest, may bring an action to recover any civil monetary penalty provided for in this Act. Where the action is successful, in whole or in part, the court shall award attorneys' fees, filing fees, and all other reasonable costs of bringing the action, to the plaintiff.

(c) Additional Criminal Accountability

- (1) Any person or entity who engages in or participates in a scheme to circumvent any of the provisions of this Act commits a felony of the second degree.
- (2) Where a person or entity has been convicted of a criminal offense under this Act, the court shall award to the prosecuting entity, as part of restitution, all of the costs of investigating and prosecuting the criminal case. Such restitution shall be in addition to any appropriate restitution ordered for payors, patients, patients' families, and other parties adversely impacted by the defendant's unlawful practices.

³ Civil money penalties under federal law range up to \$100,000 for each violation. 42 U.S.C. § 1320a-7a(a).

- (d) The provisions of this section are in addition to any other civil, administrative, or criminal actions provided by law and may be imposed against both corporate and individual defendants.

Comment:

States with whistleblower laws should ensure that these protections apply to individuals reporting violations of the substantive provisions of this Model Act.