Summary and Impact Analysis of State Laws Addressing Predatory and Unethical Substance Use Disorder Treatment Practices

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Background Discussion of the Problem

Harm to individuals caused by predatory and unethical substance use disorder (SUD) treatment practices has proliferated in recent years, to the point that federal and state policymakers have scrutinized and investigated the treatment industry.[1] Indeed, in both December 2017 and July 2018, Congress held hearings and received expert testimony about unethical treatment providers and suggested solutions.[2] Many people seeking solutions believe that the harmful practices are the unintended and unanticipated results of bad actors seeking financial gain through exploitation of the increased access to insurance coverage for SUD treatment provided by the Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act") and the Patient Protection and Affordable Care Act ("ACA").[3] Moreover, the bad actors' activities have been somewhat shielded from federal and state oversight because an individual in the midst of SUD recovery is protected from discrimination under the Americans with Disabilities and Fair Housing Acts ("ADA" and "FHA," respectively). Under these Acts, federal courts have held that mandatory conditions placed on housing for people in recovery from either state or sub-state jurisdictions, such as ordinances, licenses, or conditional use permits, are overbroad in application and can result in violations.[4]

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[1] An important comment about the treatment industry warrants mention up front. Skewed funding from third-party payers drives much of the problematic misconduct discussed in this document. For example, the practice— fraught with fraud potential— of intensive outpatient programs paying hundreds of dollars a week to unregulated recovery residence operators is driven by payers not paying treatment programs themselves to house the patients. In addition, quality care is marginalized by the use of "case rate" contracts that reward facilities for providing less care, and penalize them for providing more care.

[2] U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, "Examining Concerns of Patient Brokering and Addiction Treatment Fraud" (December 12, 2017) and "Examining Advertising and Marketing Practices within the Substance Use Treatment Industry" (July 24, 2018).

[3] *See* Presentment of the Palm Beach County Grand Jury, *Report on the Proliferation and Abuse in Florida's Addiction Treatment Industry* at 4, (Dec. 8, 2016), available at http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/GrandJuryReport2.pdf (last visited June 4, 2019).

[4] Florida House of Representatives, Final Bill Analysis of House Bill 807, at 8-10 (June 27, 2017).

Predatory and unethical SUD treatment practices exist in many states. Florida, however, is often identified as the "leader" in the area— first in terms of unethical practices, and subsequently in terms of state response.[5] This is due to the large number of treatment programs and recovery residences located in the state as well as the so-called "Florida model" of SUD treatment, *i.e.*, outpatient treatment combined with recovery housing (also known as "sober homes"), where such practices flourished. In a nutshell, Florida state policymakers describe the "Florida Shuffle" as where "rogue rehab and sober home owners encourage relapse over recovery . . . through insurance fraud, patient brokering, kickbacks and other illegal activity."[6] At its worst, the "Shuffle" involves a patient (particularly one with private, out-of-state insurance) being lured to an in-state outpatient treatment program via deceptive advertising by marketers who receive volume-based payments from owners for referrals. From there, the patient's insurance is billed for the treatment costs, sometimes at much higher out-of-network rates, and drug testing (sometimes exorbitantly) while the patient is housed in a recovery residence that has financial ties to the treatment program, testing lab, or both. In these cases, the recovery residence operator may charge the patient little or no rent, and instead rely on payments from the treatment program or lab to cover and often exceed operating costs. When the patient's (per-event) insurance benefits run out, it is, unfortunately, not unheard of for the treatment provider to encourage patient relapse in order to restart the process and insurance funding.

Acknowledging the seriousness of the problem and need for immediate action, the Florida Circuit Court covering Palm Beach County empaneled a Grand Jury in 2016, while policymakers convened a Palm Beach County Sober Homes Task Force ("Task Force") the same year. These entities began to investigate practices by the SUD treatment industry and recovery residences in the state. In conjunction with these efforts, the Florida Legislature appropriated $275,000 to Palm Beach County's State Attorney, Dave

[5] California is another state where there are reports of considerable unethical practice activity. *See* Lurie, Julia, *Mom, When They Look at Me, They See Dollar Signs*, Mother Jones (March/April 2019).

[6] Aronberg, Dave, Palm Beach County (Fla.) State Attorney, *What is the Florida Shuffle*, available at https://www.fixthefloridashuffle.com/florida-shuffle (last accessed June 4, 2019).

Aronberg, to use the Task Force to "conduct a study regarding strengthening investigation and prosecution of criminal and regulatory violations in the substance abuse treatment industry."[7] The National Alliance for Model State Drug Laws ("NAMSDL", "our", or "we") research indicates that these investigative efforts constitute the most comprehensive investigation of U.S. treatment industry problems and dissemination of potential solutions done at the state or local level.[8] It is worthwhile to note that the rise in unethical treatment practices in Florida over the past decade does not appear to be the result of Florida's then in-force laws being weaker as compared to other states. Indeed, for example and as discussed below, Florida was the only state with a "patient brokering" statute in effect prior to 2018. Rather, it appears that either the laws existing in Florida and most states at that time (such as state unfair trade practice acts and state anti-kickback/self-referral statues) were not up to the task of preventing the practices (and thus still are in many places), or states did not sufficiently support enforcement activities.[9]

[7] Bill Analysis, supra note 4.

[8] The U.S. Government Accountability Office ("GAO") issued a report in March 2018 about recovery housing regulation. Government Accountability Office, *Substance Use Disorder: Information on Recovery Housing Prevalence, Selected States' Oversight, and Funding*, GAO-18-315 (March 2018), available at https://www.gao.gov/assets/700/690831.pdf (last accessed on June 26, 2019). Based upon prevalence of opioid overdose deaths, SUDs in the population and recently enacted recovery housing-related legislation, GAO selected five states (Florida, Massachusetts, Ohio, Texas, and Utah) for review. Out of those five states, GAO noted that four of them (all but Texas) said that state agencies had conducted, or were in the process of conducting, "law enforcement investigations of unscrupulous behavior and potential insurance fraud related to recovery housing." While certainly not "knocking" the investigations in Massachusetts, Ohio, and Utah, upon initial review, it appears that Florida's review was the most robust.

[9] The landscape of federal and state anti-kickback/self-referral laws in existence when these troublesome predatory and unethical treatment practices emerged, along with the failure of these laws to prevent them, is discussed in some detail in the commentary to Section X ("Patient Brokering and Kickbacks") of NAMSDL's Model Patient Protection and Treatment Ethics Act. The commentary includes citations to such laws in Florida and seven other states (California, Louisiana, Massachusetts, Michigan, North Carolina, South Carolina and Texas).

In a report issued in December 2016, the Grand Jury recommended the following changes to Florida law and treatment industry practice to reduce predatory and unethical practices:

- Prohibit deceptive advertising.
- Provide disclaimers and other useful information to patients.
- Require marketing entities, marketers, and admissions personnel to be licensed.
- Require licensure and certification of commercial recovery residences.
- Eliminate the [Florida] statutory provision allowing patient referrals to an uncertified recovery residence owned by a substance abuse treatment provider.
- Prohibit patient referrals from an uncertified recovery residence to a substance abuse treatment provider.
- Treat substance abuse licensure as a privilege rather than a right.
- Provide better resources by raising license and service fees.
- Prohibit the solicitation or receipt of any "benefit" under the patient brokering statute.
- Increase criminal penalties and minimum fines for patient brokering.
- Create penalty enhancements for large-scale patient brokering.
- Add patient brokering to the Statewide Prosecutor's jurisdiction.
- Permit disclosure of patient records, for the purpose of an ongoing criminal investigation, without prior notice.
- Promote education and interagency collaboration with respect to investigations into the substance abuse treatment industry.[10]

[10] Presentment, *supra* note 3.

The Task Force's recommendations, issued one month later, largely followed the Grand Jury's report. In particular, the Task Force focused on desired changes to Florida's patient brokering statute, prohibitions on certain marketing practices, increasing restrictions on recovery residences, and increasing the capacity of the state's oversight agency to effectively regulate treatment providers.[11]

Using the Grand Jury and Task Force recommendations as a starting point, the Florida Legislature passed House Bill 807 ("Practices of Substance Abuse Service Providers") in the spring of 2017.[12] The law became effective on July 1, 2017.[13] While no single piece of legislation can address the entire scope of an issue, House Bill 807 comprehensively addressed many aspects of predatory and unethical treatment practices in Florida. Our research indicates that the bill is the most comprehensive state legislation directed at abuses in the SUD treatment industry enacted to date. In particular, House Bill 807:

- Expands the items that may not be used to induce a patient referral to include any "benefit".
- Adds patient brokering to the offenses that constitute "racketeering activities".
- Allows the [Florida] Office of Statewide Prosecution to investigate and prosecute patient brokering.
- Enhances penalties for higher volumes of patient brokering.
- Prohibits service providers, recovery residence operators, and third parties that provide advertising or marketing services from engaging in deceptive marketing practices and provides criminal penalties for violations.

11 Palm Beach County Sober Homes Task Force Report 2017, Jan. 1, 2017, available at http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/SHTFReport2017.pdf (last visited June 4, 2019).

12 Florida Laws Chapter 2017-173.

13 *Id*.

- Prohibits materially false or misleading statements or information about the identity, products, goods, services, or geographical location of a licensed service provider made to induce a person to seek treatment with that provider.
- Requires entities providing substance abuse marketing services to be licensed under the Florida Telemarketing Act.
- Expands current prohibitions on referrals between licensed treatment providers and certain recovery residences.
- Creates a new provision for applications for disclosure of patient records for individuals receiving substance abuse services in an active criminal investigation, which authorizes disclosure without prior notice.[14]

An analysis of the effect of House Bill 807 is largely anecdotal at this point, given the relatively short period since enactment. On the positive side, the Task Force chaired by State Attorney Aronberg remains active in Palm Beach County and, as of January 2019, reports nearly 70 arrests for unethical treatment practices since Task Force formation.[15] In February 2019, the Task Force was involved in the first patient-brokering case to go to trial since 2016, in which a jury found the defendant guilty of ten counts of patient brokering.[16] Other defendants have avoided trial through plea deals.[17] In addition, Aronberg credits the Task Force's work for helping to reduce the number of overdose deaths in the county by 41% from 2017 to 2018.[18] Nevertheless, several of the stakeholders in the treatment industry who NAMSDL contacted about this project indicated that House Bill 807 had not stamped out all unethical practices in Florida and that, not unexpectedly, some bad actors had left the state only to set up shop in other states without the increased regulatory focus.

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[14] *Id.*

[15] Martinez, A. and Remington, C., *Palm Beach County State Attorney Explains Success in Reducing Opioid Related Deaths*, www.wlrn.org (January 24, 2019).

[16] Hannah Winston, The Palm Beach Post, *Man convicted on 10 counts of patient brokering* (February 14, 2019).

[17] *Id.*

[18] *Id.*

Using House Bill 807 as a topical guide, this document describes the status of state laws addressing predatory and unethical treatment practices. At the outset, the document will review state laws that directly and expressly confront the treatment industry problems most associated with recent reports, such as patient brokering, deceptive marketing practices, and licensing of treatment marketers. Next, the document analyzes current state laws regulating recovery housing. Finally, the document addresses state regulations regarding the licensing of SUD treatment programs and professionals.

Patient Brokering

In the context of SUD treatment, the phrase "patient brokering" is the process by which a person or business, commonly referred to as a broker, provides or refers a patient to a treatment program or recovery house in exchange for money or other perk or compensation. Florida first enacted a law explicitly addressing patient brokering that included reference to brokering with respect to SUD treatment in 1996 (F.S.A. § 817.505). Unfortunately, it seems clear that the law as originally enacted did not prevent SUD-related patient brokering from flourishing over the past decade. As noted above, House Bill 807 modified § 817.505 in two ways, adding "benefit" to the list of prohibited practices and enhancing criminal penalties associated with violations, particularly where larger numbers of patients are brokered. The term "benefit" was added to the statute to explicitly make clear that patient brokering includes non-monetary compensation to the broker. Our research to date indicates that no states other than Florida expressly addressed SUD treatment patient brokering in statute until 2018. At present, five states (Arizona, California, New York, Tennessee, and Utah) have joined Florida in enacting patient brokering statutes. The table below summarizes key aspects of each state's law and shows that some of these laws, particularly with respect to prohibited conduct and stated exceptions, appear to be modeled after Florida. There is wide variability among the states in the penalties associated with violations. Florida, unsurprisingly, has the stiffest law.

State	Statute(s) (effective date)	Covered entities	Prohibited conduct	Stated exception(s)	Penalty for violation
Arizona	A.R.S. § 13-3730 (2018)	(1) person; (2) health care provider; (3) health care facility; (4) sober living home.	May not offer, pay, solicit or receive any commission, bonus, rebate, kickback or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever	Prohibition applies "when only providing or offering substance use disorder services."	Class 3, 4, or 5 felony, based on amount of consideration.
California	Cal. Health & Safety Code §§ 11831.6 – 11831.7 (2019)	(1) licensed alcoholism or drug abuse recovery and treatment facility ("licensed facility") or certified alcohol or other drug program ("certified program); (2) owner, partner, officer, director, or shareholder (> 10%) of licensed facility or certified program; (3) person employed by or working for licensed facility or certified program.	May not give or receive remuneration or anything of value for the referral of a person seeking recovery and treatment services	None.	(1) penalty assessed by Department of Health Care Services; (2) suspension or revocation of facility license, program certification, or counselor certification; (3) possible termination of employment.

State	Statute(s) (effective date)	Covered entities	Prohibited conduct	Stated exception(s)	Penalty for violation
Florida	F.S.A. § 817.505 (1996; last amended 2017)	Person, including health care provider or facility.	May not: (1) offer or pay a commission, benefit, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral; (2) solicit or receive a commission, benefit, bonus, rebate, kickback, or bribe, 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; (3) solicit or receive a commission, benefit, bonus, rebate, kickback, or bribe, 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; (4) aid, abet, advise, or otherwise participate in the conduct prohibited.	(1) discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. § 1320a-7b(b) or regulations; (2) compensation within a group practice so long as not with persons who are not members of the group practice; (3) payments to a health care provider or health care facility for professional consultation services; (4) commissions lawfully paid to insurance agents; (5) payments by a health insurer who reimburses SUD goods or services; (6) payments to or by certain health care providers that have contracted with other providers or Medicare/Medicaid to provide SUD services; (7) payments by certain health care providers to "a health, mental health, or substance use disorder information service that provides information upon request and without charge" if requirements stated in F.S.A. § 817.505(3)(i) are met; (8) other stated exceptions.	(1) if involves <10 patients, third-degree felony and $50,000 fine; (2) if involves 10 - 19 patients, second-degree felony and $100,000 fine; (3) if involves > 19 patients, first-degree felony and $500,000 fine.

State	Statute(s) (effective date)	Covered entities	Prohibited conduct	Stated exception(s)	Penalty for violation
New York	N.Y. Mental Hygiene Law § 32.06 (2018)	Provider or purported provider of SUD services.	May not: (1) intentionally solicit, receive, accept or agree to receive or accept any payment, benefit or other consideration in any form to the extent such payment, benefit or other consideration is given for the referral of a person as a potential patient; (2) intentionally make, offer, give, or agree to make, offer, or give any payment, benefit or other consideration in any form to the extent such payment, benefit or other consideration is given for the referral of a person as a potential patient.	(1) lawful payments by HMO or health insurer for SUD services; (2) lawful payments to or by a provider to an HMO or health insurer as payment or refund; (3) activity that, at time activity committed, would have been lawful; (4) any employee or representative conducting marketing activities, where the person "identifies the provider represented or for whom [he or she] works, identifies that [he or she] is a marketer and [a clinician] who can provide diagnostic, counseling or assessment services, and such marketing activities are limited to educating the potential patient . . . with no effort to steer or lead the potential patient"; (5) commissions, fees or other remuneration lawfully paid to insurance agents.	Misdemeanor and potentially subject to enforcement action.

State	Statute(s) (effective date)	Covered entities	Prohibited conduct	Stated exception(s)	Penalty for violation
Tennessee	T. C. A. §§ 63-1-159, 68-1-138 (2018)	(1) healthcare provider licensed under Title 63; (2) healthcare facility or prover licensed under Title 68.	(1) offer or pay a commission, benefit, rebate, kickback, or bribe, 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; (2) solicit or receive a commission, benefit, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referral of a patient; (3) solicit or receive a commission, benefit, rebate, kickback, or bribe, 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; (4) aid, abet, advise, or otherwise participate in prohibited conduct.	None.	Suspension or revocation of provider's license.

State	Statute(s) (effective date)	Covered entities	Prohibited conduct	Stated exception(s)	Penalty for violation
Utah	U.C.A. § 62A-2-116 (2018)	Individual	Unlawful if individual knowingly and willfully offers, pays, promises to pay, solicits, or receives any remuneration, including any commission, bonus, kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, or engages in any split-fee arrangement in return for: (1) referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for the treatment of a SUD; (2) receiving a referred individual for the furnishing or arranging for the furnishing of any item or service for the treatment of a SUD; or (3) referring a clinical sample to a person, including a laboratory, for testing that is used toward the furnishing of any item or service for the treatment of a SUD.	(1) discount, payment, waiver of payment or payment practice not prohibited by 42 U.S.C. § 1320a-7(b); patient referrals within a practice group; (3) payments by a health insurer who reimburses, provides, offers to provide, or administers "substance use disorder goods or services"; (4) payments to or by certain health care providers that have contracted with other providers or Medicare/Medicaid to provide SUD services; (5) payments by certain health care providers to "a health, mental health, or substance use disorder information service that provides information upon request and without charge" if requirements stated in U.C.A. § 62A-2-116(6)(e) are met; (6) certain payments by a laboratory to a person if the requirements in U.C.A. § 62A-2-116(6)(f) are met.	Class A misdemeanor

At this time, it does not appear that any state has added patient brokering to its definition of "racketeering activity" as is the case in F.S.A. § 895.02(8)(a)(34), pursuant to House Bill 807.

Deceptive substance use disorder treatment marketing practices

As part of House Bill 807, Florida enacted F.S.A. § 397.55 ("Prohibition of deceptive marketing practices") within the portion of Florida public health law pertaining to SUD treatment services. This law expands the types of deceptive practices prohibited beyond what is contained in Florida's general Deceptive and Unfair Trade Practices Act ("UTPA"), F.S.A. §§ 501.201 to 501.213, that applies to many industries. Again, the implication here is that Florida's UTPA, similar to unfair trade practice acts in many other states, was insufficient or, insufficiently enforced in the SUD treatment industry, to stop unethical practices. Under the expanded language in the law, the following four activities may not be undertaken by "a service provider, an operator of a recovery residence, or a third party who provides any form of advertising or marketing services to a service provider or an operator of a recovery residence":

- Making a false or misleading statement or providing false or misleading information about the provider's or operator's or third party's products, goods, services, or geographical locations in its marketing, advertising materials, or media or on its website.
- Including on its website false information or electronic links, coding, or activation that provides false information or that surreptitiously directs the reader to another website.
- Conduct prohibited by Florida's patient brokering statute.
- Entering into a contract with a marketing provider who agrees to generate referrals or leads for the placement of patients with a service provider or in a recovery residence through a call center or a web-based presence, unless certain specified information is disclosed to the prospective patient so that the patient can make an informed health care decision.

The expanded language also adds significant penalties for conducting any of the prohibited activities. The knowing and willful violation of the first, second, and fourth provisions of the statute is a first-degree misdemeanor. A violation of the third provision constitutes patient brokering, punishable as described above. In addition, House Bill 807 added F.S.A. § 817.0345 ("Prohibition of

fraudulent marketing practices") that makes it unlawful for any person "to knowingly and willfully make a materially false or misleading statement or provide false or misleading information about the identity, products, goods, services, or geographical location of a licensed service provider . . ., in marketing, advertising materials, or other media or on a website with the intent to induce another person to seek treatment with that service provider." Violation of this provision is a third-degree felony.

At this time, it appears that only Tennessee has enacted a provision similar to Florida law that expressly addresses deceptive practices in the SUD treatment industry. The statute, T.C.A. § 33-2-423, took effect in July 2018 and seems directly based upon F.S.A. § 397.55. As in Florida, the Tennessee statute prohibits the same four types of conduct by "a service provider of alcohol and drug services or an operator of an alcohol and drug treatment facility (ADTF)" except that patient-brokering activities are described, rather than incorporated by reference to the Tennessee law. In contrast to Florida law, the Tennessee law provides for civil causes of action and not criminal penalties. Violators in Tennessee may be subject to "suspension or revocation of the person or entity's license" and civil penalties of $250 to $500 for a first offense and $500 to $5,000 for a second or subsequent offense within 12 months.

Licensing of substance use disorder treatment marketers

As a result of House Bill 807, Florida added "an entity providing substance abuse marketing services" to its law requiring the licensure of telemarketers (termed "commercial telephone sellers"), F.S.A. §§ 501.605 to 501.606, effective July 2017. The law creates a process by which a SUD treatment marketing entity must apply for and obtain a license costing $1,500 from the state licensing agency, the Florida Department of Agriculture and Consumer Services. The license is for the entity as a whole and not individual marketers or salespersons who work for the marketing entity. Should a licensed entity be found to engage in fraudulent or deceptive practices, it will be subject to adverse licensure actions. As of this time, no other state appears to have a similar provision requiring SUD treatment marketing licensure. In theory, the institution of a licensure requirement gives the state an additional means to encourage compliance with state laws.

Laws addressing recovery housing oversight

The term "recovery housing", also known as recovery homes, recovery residences, three-quarter homes, and sober homes, refers to "residential environments that provide people in recovery a safe alcohol - and drug-free place to live as they transition back into the community."[19] The National Alliance for Recovery Residences ("NARR") classifies recovery residences in four levels of increasing levels of intensity of services and supports they provide: peer run (including "Oxford Houses," a well-known recovery residence model), monitored, supervised, and service provider.[20] Studies have shown that individuals in SUD recovery are helped by residing in a recovery residence. For example, in an Illinois study, Oxford House residents "had significantly lower substance use, significantly higher income, and significantly lower incarceration rates than those individuals who participate in usual group care."[21]

Traditionally, state regulation and oversight of recovery housing has been tepid. States' reluctance in this areas is due in part to concerns that over-regulation will be subject to lawsuits alleging violations of the ADA and FHA. In the Florida Legislature's analysis of House Bill 807, the issue is described succinctly as:

> An individual in recovery from a drug addiction or alcoholism is protected from discrimination under the ADA and FHA. Based on this protected class status, federal courts have held that mandatory conditions placed on housing for people in recovery from either state or sub-state entities, such as ordinances, licenses, or conditional use permits, are overbroad in application and result in violations of the FHA and ADA. Additionally, federal courts have invalidated regulations that require registry of

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[19] National Council for Behavioral Health and National Alliance for Recovery Residences, *Building Recovery: State Policy Guide for Supporting Recovery Housing* (2018).

[20] *See* NARR Levels of Recovery Support, available at https://narronline.org/wp-content/uploads/2016/12/NARR_levels_summary.pdf (last visited June 4, 2019).

[21] Bill Analysis, supra note 4.

> housing for protected classes, including recovery residences. Further, federal courts have enjoined state action that is predicated on discriminatory local government decisions.
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> State and local governments have the authority to enact regulations, including housing restrictions, which serve to protect the health and safety of the community. However, this authority may not be used as a guise to impose additional restrictions on protected classes under the FHA. Further, these regulations must not single out housing for disabled individuals and place requirements that are different and unique from the requirements for housing for the general population. Instead, the FHA and ADA require state and local governments to make reasonable accommodations necessary to allow a person with a qualifying disability equal opportunity to use and enjoy a dwelling. The governmental entity bears the burden of proving through objective evidence that a regulation serves to protect the health and safety of the community and is not based upon stereotypes or unsubstantiated inferences.[22]

Recent news reports documenting overdoses and other tragedies occurring in poorly-run recovery housing bring to light some of the concerns about continuing recovery housing as unregulated or lightly-regulated living environments.[23] To that end, the National Council on Behavior Health ("NCBH") published a policy guide in 2018 in conjunction with NARR (the "Policy Guide") that advocates for state legislation or regulation in this space, with the following essential aspects:

- A clear definition of recovery housing that includes the core functions of recovery housing and references nationally recognized standards such as NARR and Oxford House.
- Enforcement of recovery housing quality standards by making the receipt of referrals and/or state and local funds dependent upon meeting recovery housing quality standards.
- Data collection requirements.

[22] Bill Analysis, supra note 4 (footnotes citing to supporting authority omitted).

[23] *E.g.,* Lisa Riordan Seville, *Addicts who lived at Florida sober home called 'No Drug Zone' overdosed*, nbcnews.com (Jan. 23, 2018); Dirk Perrefort, "*Sober homes" draw scrutiny in wake of deaths*, NewsTimes (Danbury, CT) (Jan. 14. 2017).

- Inclusion of recovery housing as a highlighted element of the continuum of care for individuals with SUDs in every local community.
- Making a regularly updated registry of certified recovery housing and Oxford Houses available to the public.
- Allocation of resources to cover ongoing recovery housing costs and to support recovery homes' efforts to meet standards as well as training and technical assistance for recovery housing operators.[24]

The following table, which relies heavily on the Policy Guide augmented by our research, summarizes the current status of the 12 statewide laws addressing recovery housing. In many cases, the laws provide for a voluntary-type certification process that is accompanied by a state registry. States such as Arizona and Utah have attempted to institute mandatory licensing, although the Policy Guide notes that implementation of such laws has been delayed due to lawsuits alleging it violates ADA and/or FHA.

[24] National Council for Behavioral Health, *Building Recovery: State Policy Guide for Supporting Recovery Housing* (April 2018), available at https://www.thenationalcouncil.org/capitol-connector/2018/04/national-council-releases-first-ever-recovery-housing-guide-for-states/ (last accessed June 4, 2019).

State	Statute(s) (effective date)	Licensure or certification	Operational requirements	Penalty for violation
Arizona	A.R.S. § 36-2061, et seq. (2018)	Requires the state department of health services to "adopt rules to establish minimum standards and requirements for the licensure of sober living homes" in Arizona that includes certain specified minimum standards. One year term of licensure. Referrals by state agency or vendor, health care institution, state or county court, or licensed behavioral health provider may be made only to a certified or licensed sober living home. Only certified sober living homes are eligible for federal or state funding.	Standards must include a requirement that each sober living home "develop policies and procedures to allow individuals who are on medication-assisted treatment to continue to receive this treatment." The department may not disclose the address of a certified or licensed sober living home except to a local jurisdiction for zoning purposes, local law enforcement and emergency personnel.	Person operating an unlicensed sober living home can face civil penalty up to $1,000 per violation. Department can impose a civil penalty for failing to adhere to standards and impose additional sanctions, including revocation of license.
Arizona	A.R.S. §§ 9-500.40, 11-269.18 (2016; repealed upon implementation of A.R.S. § 36-2061, et seq. regulations)	Authorizes cities, towns, and counties to "adopt by ordinance standards for sober living homes that comply with state and federal fair housing laws and the Americans with disabilities act."	Standards developed by a locality can include supervision requirements and an operation plan.	Not specified.

State	Statute(s) (effective date)	Licensure or certification	Operational requirements	Penalty for violation
Connecticut	C.G.S.A. § 17a-716 (2018)	Allows a sober home operator to register with the state Department of Mental Health and Addiction Service if the home is "certified as a recovery residence by an affiliate of the National Alliance for Recovery Residences" or other recognized organization. The department will post on its website an updated list of registered homes and number of available beds at each.	Written or internet materials about the sober home must indicate that the home is not licensed or certified to provide SUD treatment services and is a type of voluntary housing.	Violating the written or internet material disclosure requirement constitutes an unfair trade practice under state law.
Florida	F.S.A. §§ 397.487 – 397.4873 (2015; amended 2017)	Creates voluntary recovery residence certification program to be managed by one or more "credentialing agencies" approved by the state department of public health. Certification is valid for one year. State operated, funded, or licensed treatment facilities can refer patients only to certified recovery residences.	A certified recovery residence must be actively managed by a "certified recovery residence administrator." The credentialing agency must establish recovery residence administrator core competencies, certification requirements, testing instruments, and recertification requirements.	Revocation of a recovery residence's certificate of compliance if the recovery residence provides false or misleading information to the credentialing entity at any time. Advertising that a facility is "certified' when it is not is a first-degree misdemeanor.
Hawaii	HRS § 321-193.7 (2014).	Requires state department of health to establish a voluntary clean and sober homes registry. Home operator cannot hold the property out as a "registered clean and sober home" unless the home is registered and in good standing with the registry.	Not specified.	Revocation of certificate of registration.

State	Statute(s) (effective date)	Licensure or certification	Operational requirements	Penalty for violation
Indiana	I.C. 12–7–2–158.2; 12–21–2–3(14); 12–21–5–1.5 (2017)	Provides that recovery residences must be certified as meeting NARR standards as well as any other standards developed in regulation in order to receive reimbursement for services from the family and social services agency.	Not specified.	Not specified.
Massachusetts	M.G.L.A. 17 § 18A (2014; last amended 2017)	Requires the state bureau of substance addiction services to establish and administer "a voluntary training and accreditation program for operators of alcohol and drug free housing" (certification). State-funded or operated treatment providers and re-entry agencies can only refer to certified homes.	Not specified.	Not specified.
Maryland	MD Code, Health - General, § 19-2501, et seq. (2016)	Requires the state department of health to "approve a credentialing entity to develop and administer a certification process for recovery residences" that is valid for one year.	Not specified.	Advertising or implying certification when not true subjects a person to a civil penalty of up to $1,000 per offense.

State	Statute(s) (effective date)	Licensure or certification	Operational requirements	Penalty for violation
Ohio	R.C. § 340.034 (2017)	Not addressed.	Community-based continuum of care must include recovery housing with "quality standards," no time limits for residency, and permission for residents to be on medication-assisted treatment and receive addiction treatment services while living in recovery homes.	Not addressed.
Oregon	O.R.S. § 90.243 (1995)	Not addressed.	In the context of landlord/tenant law, the statute spells out whether a dwelling unit qualifies as "drug and alcohol free housing."	Not specified.
Pennsylvania	71 P.S. § 613.11, et seq. (2018)	Requires the department of drug and alcohol programs to "license or certify drug and alcohol recovery houses." The license or certification lasts for one year. Referrals from state agencies or state-funded facilities may only be to licensed or certified houses. Only licensed or certified houses are eligible to receive federal or state funding. Courts must give "first consideration" to licensed or certified houses.	Regulations governing licensure or certification must include a "policy that no . . . recovery house owner, employee, house officer or individual related to [such person] shall directly or indirectly solicit or accept a commission, fee or anything of monetary or material value from residents, other related individuals, third party entities or referral sources, beyond specified rent established in writing at the time of residency."	A person operating an unlicensed or certified recovery house that receives federal or state funds a fine of up to $1,000 per violation.

State	Statute(s) (effective date)	Licensure or certification	Operational requirements	Penalty for violation
Rhode Island	R.I. Gen.Laws § 40.1-1-13(18) (2016)	Grants the state department of behavioral healthcare, developmental disabilities and hospitals with the duty to "certify recovery housing facilities directly, or through a contracted entity" using guidelines that adherences to NARR standards. Requires, at a future date, that all referrals from state agencies or funded facilities be to certified houses, and only certified recovery housing facilities shall be eligible to receive state funding.	Not specified.	Not specified.
Utah	U.C.A. § 62A-2-108.2 (2014)	Requires mandatory licensure for most recovery homes other than Oxford Houses and most NARR Level 1 residences. [Policy Guide indicates that this licensing program has not moved forward due to lawsuits alleging it violates the ADA and FHA.]	The 2014 legislation requiring licensure forms a Recovery Residences and Substance Abuse Treatment Committee to study, among other things, best practices for recovery housing. Subsequent legislation (2017 Utah Laws Chapter 315) directs the Utah Substance Use and Mental Health Advisory Council to "convene a workgroup to study the licensing and management of recovery residences." To date, no recommendations have been published.	Not specified.

State licensing, certification and regulation of substance use disorder treatment programs and counselors

In addition to implementing laws like those described above that are designed to discourage unethical SUD treatment practices, states can also encourage ethical SUD treatment practices through exercising their "police power"[25] to license[26] and regulate SUD treatment programs and professionals engaged in the practice of providing SUD treatment. In some ways, states regulate and license SUD treatment programs and professionals using many of the same mechanisms that the states use to regulate other healthcare practices and professionals, such as the practice of medicine and physicians. However, there is also a systemic difference between states' regulation of the SUD treatment profession and the practice of medicine that may explain why licensing and regulating the SUD treatment industry has proven to be elusive.

Over the past century and a half or so, the regulation of the practice of medicine has become a sophisticated, and increasingly homogenized, state-based regulatory environment, while the regulation of the practice of SUD treatment became recognized much more recently and is yet achieve the same level of sophistication in each state. For example, the practice of medicine is regulated by the medical board in each state based on the state's medical practice act, which a set of statutes that explicitly defines the practice of medicine.[27] Conversely, the sustained process of credentialing and licensing SUD treatment professionals did not begin until the

[25] Carolyn R. Cody, Professional Licenses and Substantive Due Process: Can States Compel Physicians to Provide Their Services, 22 Wm. & Mary Bill Rts. J. 941 (2014), https://scholarship.law.wm.edu/wmborj/vol22/iss3/7 (last accessed on Feb. 28, 2019) and J. Bruce Bennett, *The Rights of Licensed Professionals to Notice and Hearing in Agency Enforcement Actions*, 7 TEX. TECH ADMIN. L.J. 205, 210 (2006).

[26] "License" includes the issuance of a credential, certificate, license or other document indicating someone is able to engage in the practice of providing SUD treatment practices.

[27] Johnson, David. *The Past is Prologue: FSMB and the Evolution of Medical Regulation in the United* States. Federation of State Medical Boards (FSMB). Available at: https://www.ncsbn.org/201210_TriReg_Johnson_FSMBhistory.pdf (last accessed on Mar. 1, 2019).

1970s.[28] The relative newness of the field is evident in the variations in the fundamental methodologies that states use to license and regulate SUD treatment. From whether a state regulates SUD programs and professionals based on treatment modality and funding source to whether a governmental agency or a non-governmental non-profit is responsible for undertaking the licensing activities. In addition, there is significant variation among states regarding to whom the regulations apply, what modalities of treatment are regulated, what is required to obtain a license, and what are the practice requirements.

Given the wide variation, a thorough collection and analysis of all state licensing, certification and regulation of SUD treatment programs and treatment counselors would be a conceptually complex and considerably time-consuming endeavor. Perhaps the best published effort on this to date is a comprehensive overview published by the National Association of State Alcohol and Drug Abuse Directors ("NASADAD") in 2012 (the "NASADAD Report").[29] Even a cursory review of this 40-page resource document—condensed and summarized for ease of consumption, no less—leaves the reader with a sense of the multitude of variables that exist among state regulation schemes that make accurate analysis and comparisons difficult. These variables discussed in the Report include: (1) the respective state agency or agencies responsible for SUD treatment program licensure and SUD treatment licensure/certification; (2) SUD program licensure provisions; (3) the existence of staffing requirements for each SUD treatment modality; (4) the existence of required clinical procedures; (5) data reporting requirements; (6) state SUD counselor license/certification categories; and (7) the existence of certain education and training requirements for a middle-level counselor.

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[28] White, William. *Significant Events in the History of Addiction Treatment and Recovery in America*, available at: http://www.williamwhitepapers.com/pr/AddictionTreatment&RecoveryInAmerica.pdf (last accessed on Mar. 4, 2019).

[29] National Association of State Alcohol and Drug Abuse Directors, *State Regulations on Substance Use Disorder Programs and Counselors: An Overview*, Dec. 2012 (updated July 2013), available at: http://nasadad.org/wp-content/uploads/2010/12/State_Regulation_of_SUD_Programs_and_Counselors-7-26-13.pdf (last accessed on June 5, 2019).

A worthwhile next step for researchers with sufficient time and expertise would be to expand upon the solid baseline provided in the NASADAD Report.[30] For example, collecting data regarding state licensure actions against SUD treatment programs and professionals would enable a better analysis of the effects of licensing and regulating the practice. While there is some publically available data about adverse licensure actions against healthcare practitioners, there does not appear to be a comparable dataset available for SUD treatment programs and professionals. However, we will update this section with adverse licensing data if they become available.

[30] Indeed, it is our understanding from speaking with NASADAD as part of this project is that a more recent version of the NASADAD Report is completed, but awaits federal agency review and approval before it can be published for public use.