HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 807 Marketing Practices for Substance Abuse Services
SPONSOR(S): Children, Families & Seniors Subcommittee, Hager
TIED BILLS: **IDEN./SIM. BILLS:** SB 788

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	13 Y, 0 N, As CS	Langston	Brazzell
2) Criminal Justice Subcommittee	11 Y, 0 N	Merlin	White
3) Health & Human Services Committee		Langston	Calamas

SUMMARY ANALYSIS

Substance abuse affects millions of people in the U.S. each year. In Florida, heroin caused 733 deaths, fentanyl 705, oxycodone 565, and hydrocodone 236 in 2015. Deaths caused by heroin and fentanyl increased more than 75% statewide compared to 2014.

The Department of Children and Families (DCF) regulates substance abuse treatment under Chapter 397, F.S. Licensed service components include substance abuse prevention, intervention, and clinical treatment services. Individuals in recovery from substance abuse may reside in recovery residences (alcohol- and drug-free living environments) while they receive treatment services on an outpatient basis. Florida does not license recovery residences but allows voluntary certification for recovery residences and recovery residence administrators, implemented by private credentialing entities.

The Legislature appropriated funds for FY 2016-17 to the State Attorney for the Fifteenth Judicial Circuit to conduct a study of how to strengthen investigation and prosecution of criminal and regulatory violations within the substance abuse treatment industry. In its January 2017 report, the task force identified patient brokering and fraudulent marketing as key problems in the substance abuse treatment industry.

CS/HB 807 implements several task force recommendations to address these and other abusive practices in the substance abuse treatment industry. The bill:

- Expands the current prohibitions on referrals between licensed treatment providers and recovery residences that do not obtain voluntary certification from DCF.
- Prohibits a service provider, a recovery residence operator, or a third party who provides advertising or marketing services from engaging in deceptive marketing practices and provides criminal penalties for violations.
- 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, with the intent to induce a person to seek treatment with that provider.
- Expands the items that may not be used to induce a patient referral to include any “benefit” and adds patient brokering to the offenses that can be investigated and prosecuted by the Office of Statewide Prosecution and to the crimes that constitute “racketeering activities.” Additionally, the bill creates enhanced penalties for higher volumes of patient brokering.
- Creates a new provision for applications for disclosure of patient records for individuals receiving substance abuse services in an active criminal investigation, permitting the court, at its discretion, to enter an order authorizing the disclosure of an individual’s substance abuse treatment records without prior notice.

The bill also strengthens DCF’s substance abuse treatment provider licensure program and improve the regulation of service providers. DCF must draft rules on minimum licensure standards and require certain providers be accredited. The bill also expands DCF’s authority to take action against a service provider for violations on a tier-based system and includes fining authority.

The bill will have an indeterminate fiscal impact on state government.

This bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Substance Abuse

Substance abuse affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] Substance use disorders occur when the chronic use of alcohol and/or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] It is often mistakenly assumed that individuals with substance use disorders lack moral principles or willpower and that they could stop using drugs simply by choosing to change their behavior.[3] In reality, drug addiction is a complex disease, and quitting takes more than good intentions or a strong will. In fact, because drugs change the brain in ways that foster compulsive drug abuse, quitting is difficult, even for those who are ready to do so.[4]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[5] The most common substance use disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[6]

Opioid Abuse

Opioids are commonly abused, with an estimated 15 million people worldwide suffering from opioid dependence.[7] Drug overdose is now the leading cause of injury-related death in the United States.[8] In 2015, Florida ranked fourth in in the nation with 3,228 deaths from drug overdoses, and at least one opioid caused 2,566 of those deaths.[9] Statewide, in 2015, heroin caused 733 deaths, fentanyl caused 705, oxycodone caused 565, and hydrocodone caused 236; deaths caused by heroin and fentanyl increased more than 75% statewide when compared with 2014.[10]

Drug overdose deaths doubled in Florida from 1999 to 2012.[11] Over the same time period, drug overdose deaths occurred at a rate 13.2 deaths per 100,000 persons.[12] The crackdown on “pill mills” dispensing prescription opioid drugs, such as oxycodone and hydrocodone, reduced the rate of death

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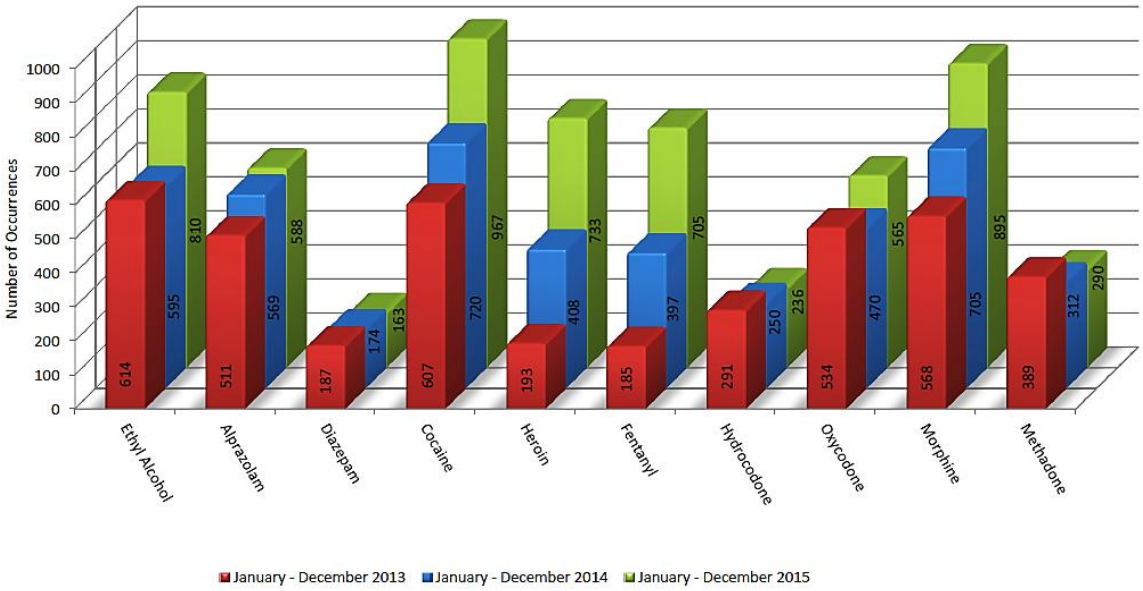
[1] WORLD HEALTH ORGANIZATION. *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 27, 2017).
[2] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited March 27, 2017).
[3] NATIONAL INSTITUTE ON DRUG ABUSE, *Understanding Drug Use and Addiction*, http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction (last visited March 27, 2017).
[4] Id.
[5] Supra, note 2.
[6] Id.
[7] WORLD HEALTH ORGANIZATION, *Information Sheet on Opioid Overdose*, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited March 27, 2107).
[8] 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 March 27, 2017).
[9] Id.
[10] Id.
[11] FLORIDA DEPARTMENT OF HEALTH, *Special Emphasis Report: Drug Poisoning (Overdose) Deaths, 1999-2012*, available at: http://www.floridahealth.gov/statistics-and-data/florida-injury-surveillance-system/_documents/CDC-Special-Emphasis-Drug-poisoning-overdose-1999-2012-B-Poston-FINAL.pdf (last visited on March 27, 2017).
[12] Id.

attributable to prescription drugs,[13] but may have generated a shift to heroin use, contributing to the rise in heroin addiction.[14]

Comparison of Drug Caused Deaths in Florida 2013 – 2015[15]



Substance Abuse Treatment

In the early 1970s, the federal government furnished grants for states to develop continuums of care for individuals and families affected by substance abuse.[16] The grants provided separate funding streams and requirements for alcoholism and drug abuse. In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[17] In 1993, legislation combined ch. 396 and ch. 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[18] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[19]

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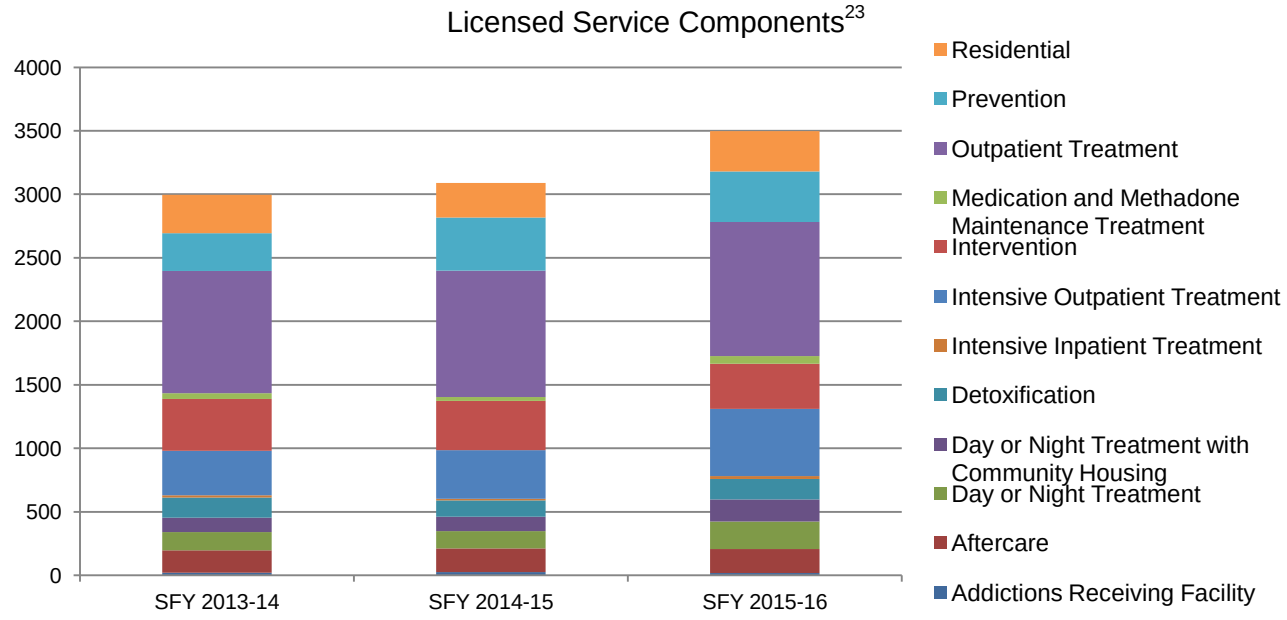
[13] FLORIDA DEPARTMENT OF LAW ENFORCEMENT. *Drugs Identified in Deceased Persons by Florida Medical Examiners-2015 Annual Report,* available at: https://www.fdle.state.fl.us/cms/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2015-Annual-Drug-Report.aspx (last visited on March 27, 2017).
[14] Supra, note 8.
[15] Supra, note 13 at p. 7.
[16] DEPARTMENT OF CHILDREN AND FAMILIES, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5. (on file with Health and Human Services Committee staff)
[17] Id.
[18] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.
[19] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance, and children at risk for initiating drug use.

Substance Abuse Treatment Service Regulation

DCF regulates substance abuse treatment by licensing individual treatment components under ch. 397, F.S. and ch. 65D-30, F.A.C. Licensed service components include a continuum of substance abuse prevention, intervention, and clinical treatment services.[20] Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle.[21] "Clinical treatment services" include, but are not limited to, the following licensable service components:

- Addictions receiving facility,
- Day or night treatment,
- Day or night treatment with community housing,
- Detoxification,
- Intensive inpatient treatment,
- Intensive outpatient treatment,
- Medication-assisted treatment for opiate addiction,
- Outpatient treatment, and
- Residential treatment.[22]

The most commonly licensed service components are outpatient treatment and intensive outpatient treatment. For FY 2015–2016, DCF issued 1,057 licenses for outpatient treatment and 529 licenses for intensive outpatient treatment.



All private and publicly-funded entities providing substance abuse services must be licensed for each service component provided, unless exempt. Exemptions are available for:

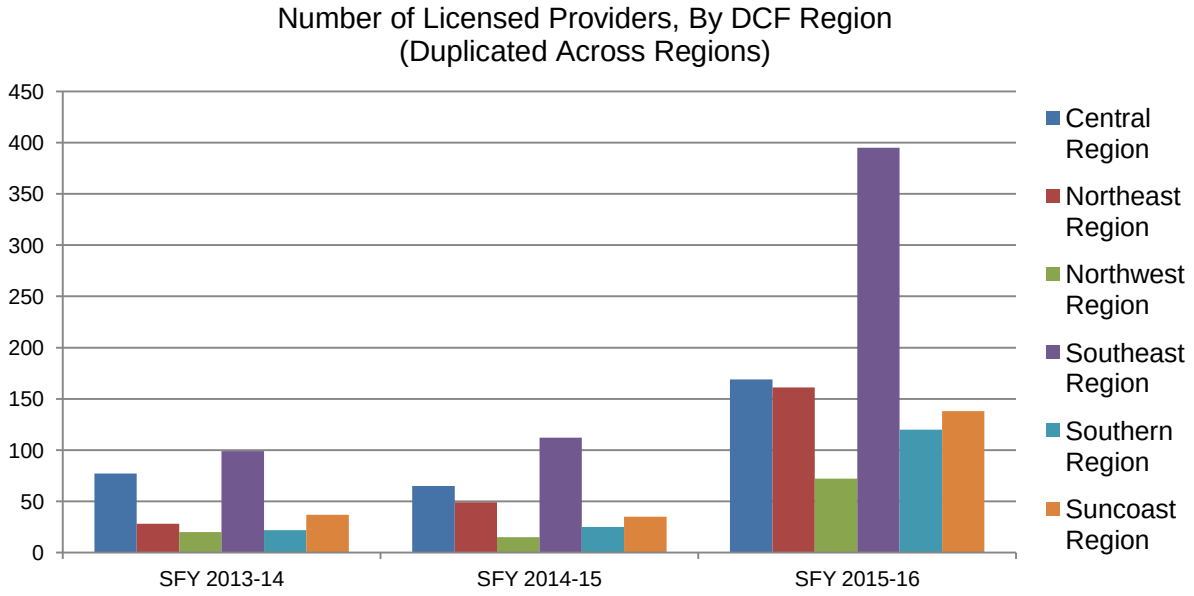
- Hospitals or hospital-based components licensed under ch. 395, F.S.;
- Nursing home facilities as defined in s. 400.021, F.S.;
- Substance abuse education programs established pursuant to s. 1003.42, F.S.;
- Facilities or institutions operated by the federal government;

[20] S. 397.311(25), F.S.
[21] Id.
[22] S. 397.311(25)(a), F.S.
[23] Department of Children and Families, *Licensure of Substance Abuse Services*, PowerPoint Presentation to Children, Families, and Seniors Subcommittee on February 16, 2017 (PowerPoint on file with Health and Human Services Committee staff).

- Physicians or physician assistants licensed under ch. 458 or ch. 459, F.S.;
- Psychologists licensed under ch. 490, F.S.;
- Social workers, marriage and family therapists, or mental health counselors licensed under ch. 491, F.S.;
- Facilities licensed under ch. 393, F.S., which, in addition to providing services to persons with developmental disabilities, also provide services to persons developmentally at risk as a consequence of exposure to alcohol or other legal or illegal drugs while in utero; and
- Facilities licensed under s. 394.875, F.S., as crisis stabilization units.[24]

Churches, nonprofit religious organizations, and denominations are also exempt from licensure, if their services are solely religious, spiritual, or ecclesiastical in nature.[25]

The number of substance abuse treatment providers providing treatment under those components has increased significantly over the last three years, particularly in the Southeast Region, which includes Broward, Indian River, Martin, Okeechobee, Palm Beach, St. Lucie Counties.



Licensure Process

Currently, providers must submit an application to DCF for each licensable component delivered at each service location; however, by June 1, 2017, licenses will no longer be location-specific, and providers will be required to submit an application for each component and list all locations at which that service will be provided.[26] An application for licensure must include:

- Name and address of the applicant service provider and its director, and also of each member, owner, officer, and shareholder, if any;
- Proof of satisfactory fire, safety, and health inspections, and compliance with local zoning ordinances;
- Proof of financial ability and organizational capability to operate in accordance with statutes;
- Proof of sufficient liability insurance coverage;
- Sufficient information to conduct a background screening[27] on any owner, director, or chief financial officer;

[24] S. 397.405, F.S.
[25] S. 397.405(8), F.S.
[26] S. 397.407, F.S.; see also, note 23.
[27] Level II background screenings are required for owners, directors, chief financial officers, and anyone working with children or adults with developmental disabilities. S. 397.451, F.S.

- A comprehensive outline of the proposed services; and
- Information establishing the competency and ability of the applicant service provider and its director to carry out the requirements of ch. 397, F.S.[28]

DCF may issue probationary, regular, or interim license.[29] A probationary license may be issued to a service provider applicant in the initial stages of developing services that are not yet fully operational upon completion of all application requirements listed above and upon demonstration of the applicant's ability to comply with all applicable statutory and regulatory requirements.[30] A probationary license expires 90 days after issuance and may be reissued once for an additional 90-day period if the applicant has substantially complied with all requirements for regular licensure or has initiated action to satisfy all requirements.[31]

In order to be issued a regular license, the applicant must be in compliance with statutory and regulatory requirements. DCF may issue a regular license to:

- A new applicant at the end of the probationary period;
- A licensed applicant that holds a regular license and is seeking renewal;[32] or
- An applicant for a service component operating under an interim license upon successful satisfaction of the requirements for a regular license.[33]

DCF may issue an interim license[34] to a service provider for a period not exceed 90 days if DCF finds that:

- A service component of the provider is in substantial noncompliance with licensure standards;
- The service provider has failed to provide satisfactory proof of conformance to fire, safety, or health requirements; or
- The service provider is involved in license suspension or revocation proceedings.[35]

An interim license expires 90 days after it is issued; however, it may be reissued once for an additional 90-day period in a case of extreme hardship in which the noncompliance is not attributable to the licensed service provider.

Licensure Fees

DCF must set its licensure fees to cover 50 percent of the cost of regulating the licensure program, and fees for public providers must be less than fees for private providers.[36] The fees range from $200-$325 per licensed service component for publically funded programs and from $250-$375 for privately funded programs.[37] Additionally, DCF discounts the fees based on volume; the discount for publically funded ranges from 10%-30% and 5%-25% for privately funded.[38]

[28] S. 397.403(1), F.S.
[29] S. 397.407(5), F.S.
[30] S. 39.407(6), F.S.
[31] During the probationary period DCF must monitor the delivery of services and may order a probationary licensee to cease and desist operations at any time it is found to be substantially out of compliance with licensure standards.
[32] An application for renewal of a regular license must be submitted to DCF at least 60 days before the license expires. A late fee of $100 applies to applications received after that deadline.
[33] S. 397.407(7), F.S.
[34] An interim license applies only to the licensable service component of the provider's services which is in substantial noncompliance with statutory or regulatory requirements.
[35] S. 397.407(8), F.S.
[36] S. 397.407(1), F.S.
[37] Rule 65D-30.003(5), F.A.C.
[38] Id.

Inspections

DCF has the right to enter and inspect a licensed provider at any time to determine statutory and regulatory compliance and may, with permission or warrant, inspect suspected unlicensed provider.[39] DCF must schedule periodic inspections of licensed service providers in order to minimize costs and the disruption of services; these inspections are done annually, unless a provider is accredited, in which case they are done triennially.[40]

Following licensing inspection, district offices shall prepare and distribute to providers a report includes a list of noncompliance issues, if any, with rule references and a request that the provider submit a plan for corrective action, including required completion dates.[41]

The number of inspections by DCF has increased from 1,953 in FY 2013-14, to 2,591 in FY 2016-16.[42]

Licensure Discipline

DCF may deny, suspend, or revoke license, or impose reasonable restrictions or penalties if the provider is not in compliance with all statutory and regulatory requirements.[43] However, DCF must give existing providers reasonable time, not to exceed one year, to compy with any new rules.[44] Additionally, DCF may impose a moratorium on admissions if a threat to the public health or safety.[45] The only fining authority DCF has is a $500 per diem fine for fire-, safety-, and health-related violations.[46] DCF has taken very few licensure discipline actions beyond the issuance of a corrective action plan.

Disciplinary Action by Fiscal Year[47]

Year	FY 2013-14	FY 2014-15	FY 2015-16
Corrective Action Plans	1213	1219	1672
Fines	0	0	0
Denials	80	107	204
Moratoria	0	0	0
Suspensions	0	0	0
Revocations	6	0	0

Recovery Residences

Recovery residences (also known as “sober homes” or “sober living homes”) are alcohol- and drug-free living environments for individuals in recovery who are attempting to maintain abstinence from alcohol and drugs.[48] These residences offer no formal treatment but perhaps mandate or strongly encourage attendance at 12-step groups; and are self-funded through resident fees.[49]

Section 397.311(36), F.S., defines a recovery residence as a residential dwelling unit, or other form of group housing, offered or advertised through any means, including oral, written, electronic, or printed

[39] S. 397.411, F.S.
[40] Id.
[41] Rule 65D-30.003(9)(a)5., F.A.C.
[42] Supra, note 23.
[43] S. 397.415(1), F.S.
[44] S. 397.401(5), F.S.
[45] S. 397.415(1), F.S.
[46] Id.
[47] Supra, note 23.
[48] Douglas L. Polcin, Ed.D., MFT and Diane Henderson, B.A., *A Clean and Sober Place to Live: Philosophy, Structure, and Purported Therapeutic Factors in Sober Living Houses,* J Psychoactive Drugs, Jun 2008; 40(2): 153–159,
[49] Id.

means, by any person or entity as a residence that provides a peer-supported, alcohol-free, and drug-free living environment.

Benefits of Recovery Residences

Multiple studies have found that individuals benefit in their recovery by residing in a recovery residence. Specifically, individuals in recovery residing in an Oxford House (OH), a very specific type of recovery residence, had significantly lower substance use, significantly higher income, and significantly lower incarceration rates than those individuals who participate in usual group care.[50]

A cost-benefit analysis regarding residing in Oxford Houses found variation in cost and benefits compared to other residences. The result suggests that the additional costs associated with OH treatment, roughly $3,000, are returned nearly tenfold in the form of reduced criminal activity, incarceration, and substance use as well as increases in earning from employment.[51] Additionally, another study found that residents of a recovery residence were more likely to report abstaining from substance use at a much higher rate:

- Residents at six months were 16 times more likely to report being abstinent;
- Residents at 12 months were 15 times more likely to report being abstinent; and
- Residents at 18 months were six times more likely to report being abstinent.[52]

Federal Law Applicable to Recovery Residences

The Americans with Disabilities Act (ADA) prohibits discrimination against individuals with disabilities.[53] The ADA requires broad interpretation of the term "disability" so as to include as many individuals as possible under the definition.[54] The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities.[55] Disability also includes individuals who have a record of such impairment, or are regarded as having such impairment.[56] The phrase "physical or mental impairment" includes, among others[57], drug

[50] An Illinois study found that those in the OHs had lower substance use (31.3% vs. 64.8%), higher monthly income ($989.40 vs. $440.00), and lower incarceration rates (3% vs. 9%). OH participants, by month 24, earned roughly $550 more per month than participants in the usual-care group. In a single year, the income difference for the entire OH sample corresponds to approximately $494,000 in additional production. In 2002, the state of Illinois spent an average of $23,812 per year to incarcerate each drug offender. The lower rate of incarceration among OH versus usual-care participants at 24 months (3% vs. 9%) corresponds to an annual saving of roughly $119,000 for Illinois. Together, the productivity and incarceration benefits yield an estimated $613,000 in savings per year, or an average of $8,173 per OH member. L. Jason, B. Olson, J., Ferrari, and A. Lo Sasso, *Communal Housing Settings Enhance Substance Abuse Recovery,* 96 AM. J. OF PUB. HEALTH 10, (2006), at 1727-1729.

[51] "While treatment costs were roughly $3,000 higher for the OH group, benefits differed substantially between groups. Relative to usual care, OH enrollees exhibited a mean net benefit of $29,022 per person. The result suggests that the additional costs associated with OH treatment, roughly $3000, are returned nearly tenfold in the form of reduced criminal activity, incarceration, and drug and alcohol use as well as increases in earning from employment… even under the most conservative assumption, we find a statistically significant and economically meaningful net benefit to OH of $17,800 per enrollee over two years." A. Lo Sasso, E. Byro, L. Jason, J. Ferrari, and B. Olson, *Benefits and Costs Associated with Mutual-Help Community-Based Recovery Homes: The Oxford House Model*, 35 EVALUATION AND PROGRAM PLANNING (1), (2012).

[52] D. Polcin, R. Korcha, J. Bond, and G. Galloway, *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcome,* 38 Journal of Substance Abuse Treatment, 356-365 (2010).

[53] 42 U.S.C. § 12101. This includes prohibition against discrimination in employment, State and local government services, public accommodations, commercial facilities, and transportation. U.S. DEPARTMENT OF JUSTICE, *Information and Technical Assistance on the Americans with Disabilities Act*, *available at* http://www.ada.gov/2010_regs.htm (last visited March 27, 2017).

[54] 42 U.S.C. § 12102.

[55] Id.

[56] Id.

[57] 28 C.F.R. § 35.104(4)(1)(B)(ii). The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV (whether symptomatic or asymptomatic), and tuberculosis.

addiction and alcoholism.[58] However, this only applies to individuals in recovery: ADA protections are not extended to individuals who are actively abusing substances.[59]

Additionally, the Fair Housing Amendment Acts of 1988 (FHA) prohibits housing discrimination based upon an individual's handicap.[60] A person is considered to have a handicap if he or she has a physical or mental impairment which substantially limits one or more of his or her major life activities.[61] This includes individuals who have a record of such impairment, or are regarded as having such impairment.[62] Drug and alcohol addictions are considered to be handicaps under the FHA.[63] However, current users of illegal controlled substances and persons convicted for illegal manufacture or distribution of a controlled substance are not considered handicapped under the FHA.

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.[64] Additionally, federal courts have invalidated regulations that require registry of housing for protected classes, including recovery residences.[65] Further, federal courts have enjoined state action that is predicated on discriminatory local government decisions.[66]

State and local governments have the authority to enact regulations, including housing restrictions, which serve to protect the health and safety of the community.[67] However, this authority may not be used as a guise to impose additional restrictions on protected classes under the FHA.[68] 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.[69] Instead, the FHA and ADA require state and local governments to make reasonable accommodations necessary to allow

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[58] 28 C.F.R. § 35.104(4)(1)(B)(ii).
[59] 28 C.F.R. § 35.131.
[60] 42 U.S.C. § 3604. Similar protections are also afforded under the Florida Fair Housing Act, s. 760.23, F.S., which provides that it is unlawful to discriminate in the sale or rental of, or to otherwise make unavailable or deny, a dwelling to any buyer or renter because of a handicap of a person residing in or intending to reside in that dwelling after it is sold, rented, or made available. The statute provides that "discrimination" is defined to include a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling.
[61] 42 U.S.C. § 3602(h).
[62] *Id*.
[63] *Oxford House, Inc. v. Town of Babylon*, 819 F. Supp. 1179, 1182 (E.D.N.Y. 1993).
[64] DEPARTMENT OF CHILDREN AND FAMILIES, *Recovery Residence Report*, Oct. 1, 2013, available at http://www.dcf.state.fl.us/programs/samh/docs/SoberHomesPR/DCFProvisoRpt-SoberHomes.pdf (last visited March 27, 2017). *See, e.g., Jeffrey O. v. City of Boca Raton*, 511 F. Supp. 2d 1339 (S.D. Fla. 2007); *Oxford House, Inc.*, 819 F. Supp. 1179; *Marbrunak v. City of Stow, OH.,* 947 F.2d 43 (6th Cir. 1992); *United States v. City of Baltimore, MD,* 845 F. Supp. 2d. 640 (D. Md. 2012); *Children's Alliance v. City of Bellevue*, 950 F. Supp. 1491 (W.D. Wash. 1997); *Oxford House-Evergreen v. Plainfield,* 769 F. Supp. 1329 (D.N.J. 1991); *Potomac Group Home, Inc.,* 823 F. Supp. 1285 (D. Md. 1993).
[65] *Recovery Residence Report,* supra note 64. *See, e.g., Nevada Fair Housing Center, Inc., v. Clark County, et. al.,* 565 F. Supp. 2d 1178 (D. Nev. 2008); *See, Human Resource Research and Management Group,* 687 F. Supp. 2d 237 (E.D.N.Y. 2010); *Community Housing Trust et. al., v. Dep't of Consumer and Regulatory Affairs et. al.,* 257 F. Supp. 2d 208 (D.C. Cir. 2003); *City of Edmonds v. Oxford House et. al.,* 574 U.S. 725 (1995); *Safe Haven Sober Houses, LLC, et. al., v. City of Boston, et. al.,* 517 F. Supp. 2d 557 (D. Mass. 2007); *United States v. City of Chicago Heights*, 161 F. Supp. 2d 819 (N.D. Ill. 2001).
[66] *Recovery Residence Report,* supra, note 64. *See, e.g., Larkin v. State of Mich.* 883 F. Supp. 172 (E.D. Mich. 1994), judgment *aff'd* 89 F.3d 285 (6th Cir. 1996); *Arc of New Jersey, Inc., v. State of N.J.*, 950 F. Supp. 637, D.N.J. 1996); *North Shore-Chicago Rehab., Inc. v. Village of Skokie*, 827 F. Supp. 497 (N.D. Ill. 1993); *Easter Seal Soc. of New Jersey, Inc. v. Township of North Bergen,* 798 F. Supp. 228 (D.N.J. 1992); *Ardmore, Inc. v. City of Akron, Ohio*, 1990 WL 385236 (N.D. Ohio 1990).
[67] 42 U.S.C. § 3604(f)(9).
[68] *Recovery Residence Report*, supra, note 64. *See, e.g., Bangerter v. Orem City Corp.,* 46 F.3d 1491, (10th Cir. 1995); *Ass'n for Advancement of the Mentally Handicapped, Inc. v. City of Elizabeth,* 876 F. Supp. 614 (D.N.J. 1994); *Pulcinella v. Ridley Tp.*, 822 F. Supp. 204 (E.D. Pa. 1993).
[69] *Bangerter v. Orem City Corp.,* 46 F.3d 1491 (10th Cir. 1995); *Human Res. Research and Mgmt. Grp, Inc. v. County of Suffolk*, 687 F. Supp. 2d 237 (E.D.N.Y. 2010); *Potomac Grp. Home Corp. v. Montgomery Cnty.*, *Md*., 823 F. Supp. 1285 (D. Md. 1993).

a person with a qualifying disability equal opportunity to use and enjoy a dwelling.[70] 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.[71]

Voluntary Certification of Recovery Residences in Florida

Florida does not license recovery residences, based on concerns about conflicts with the federal laws discussed above. Instead, in 2015 the Legislature enacted sections 397.487–397.4872, F.S., which establish voluntary certification programs for recovery residences and recovery residence administrators, implemented by private credentialing entities. Under the voluntary certification program, DCF approved two credentialing entities to design the certification programs and issue certificates: The Florida Association of Recovery Residences certifies the recovery residences and the Florida Certification Board certifies recovery residence administrators.

Sections 397.487 and 397.4871, F.S., set criteria for certification, including a requirement that the certified recovery residences be actively managed by a certified recovery residence administrator. Level 2 background screening is required for all recovery residence owners, directors and chief financial officers and for administrators seeking certification. Section 397.4872, F.S., allows DCF to exempt an individual from the disqualifying offenses of a Level 2 background screening if the individual meets certain criteria and the recovery residence attests that it is in the best interest of the program. Under s. 397.487, F.S., the credentialing entities must deny, suspend or revoke certification if a recovery residence or a recovery residence administrator fails to meet and maintain certain criteria. The credentialing entity must inspect recovery residences prior to the initial certification and during every subsequent renewal period, and must automatically terminate certification if it is not renewed within one year of the issuance date. It is a first degree misdemeanor[72] for any entity or person who advertises as a "certified recovery residence" or "certified recovery residence administrator", respectively, unless the entity or person has obtained certification under this section.[73]

While certification is voluntary, Florida law incentivizes certification. Since July 1, 2016, Florida has prohibited licensed substance abuse service providers from referring patients to a recovery residence unless the recovery residence holds a valid certificate of compliance and is actively managed by a certified recovery residence administrator or is owned and operated by a licensed service provider or a licensed service provider's wholly owned subsidiary.[74]

DCF publishes a list of all certified recovery residences and recovery residences administrators on its website.[75] As of March 1, 2017, there were 257 certified recovery residences in Florida.[76]

Grand Jury and Task Force by the Fifteenth Judicial Circuit

In 2016, the Circuit Court of the Fifteenth Judicial Circuit, in Palm Beach, empaneled a Grand Jury and convened a task force focusing on issues with recovery residences and the substance abuse treatment industry.

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[70] *Recovery Residence Report, supra,* note 64. 42 U.S.C. § 3604(f)(3)(B); 42 U.S.C. § 12131, *et. seq.,* 28 C.F.R. § 35.130(b)(7). To comply with the reasonable accommodation provisions of the ADA, regulations have been promulgated for public entities (defined by 28 C.F.R. § 35.104). This includes a self-evaluation plan of current policies and procedures and modify as needed (28 C.F.R. § 35.105). This is subject to the exclusions of 28 C.F.R. § 35.150. For judicial interpretation, s*ee, Jeffrey O.,* 511 F. Supp. 2d 1339; *Oxford House Inc., v. Township of Cherry Hill*, 799 F. Supp. 450 (D.N.J. 1992).

[71] *Oconomowoc Residential Programs, Inc., v. City of Milwaukee*, 300 F. 3d 775 (7th Cir. 2002); *Oxford House- Evergreen*, 769 F. Supp. 1329; *Cason v. Rochester Housing Auth.,* 748 F. Supp. 1002 (W.D.N.Y. 1990).

[72] A first degree misdemeanor is punishable by not more than one year imprisonment and not more than a $1,000 fine. Ss. 775.082, 775.083, F.S.

[73] Ss. 397.487 and 397.4871, F.S.

[74] S. 397.407, F.S.

[75] S. 397.4872, F.S.

[76] FLORIDA ASSOCIATION OF RECOVERY RESIDENCES, *Certified Residences*, http://farronline.org/certification/certified-residences/ (last visited March 27, 2017).

Grand Jury Findings

The Grand Jury found fraud and abuse occurring between recovery residences and certain providers within the substance abuse treatment industry[77] and that unregulated recovery residences harm their residences and the community.[78]

One of the main problems the Grand Jury focused on was deceptive marketing.[79] The Grand Jury heard testimony on how online marketers representing disreputable treatment providers use harmful practices, including using internet search terms to hijack the name and reputation of prominent respected treatment providers to route the person seeking treatment to an unrelated referral agency. Marketers also encourage individuals to seek the most intensive treatment possible, rather than the treatment in their best interest, in order to generate a larger fee.[80]

Another issue of focus was the illegal rent subsidies that some treatment providers paid to recovery residences for patient referrals. The Grand Jury heard testimony that many residents in recovery residences are in need of financial assistance for housing when they leave a residential treatment setting and move to outpatient; many of these individuals are from out-of-state and do not have jobs. In many instances, this leads to the treatment provider paying the resident's rent at a recovery residence in exchange for the referral by the recovery residence.[81]

Additionally, some recovery residences and treatment providers offer incentives to keep an individual at a particular provider or recovery residence; these incentives include gym memberships, scooters, cigarettes, clothes, and gift cards. Brokers frequently approach individuals offering incentives to get them to move to another treatment provider or recovery residence for the broker's benefit without regard to the needs of the individual.[82]

The Grand Jury also heard testimony about other problems in some recovery residences, including residents being given drugs so that they would fail drug tests and be able to re-engage in services generating insurance payments to providers, residents being sexually abused, and residents being forced to work in labor pools.[83]

Task Force Report

The Legislature appropriated $275,000 in nonrecurring general revenue funds for FY 2016-17 to the State Attorney for the Fifteenth Judicial Circuit to conduct a study regarding strengthening investigation and prosecution of criminal and regulatory violations within the substance abuse treatment industry. With the appropriation, the State Attorney established three groups: a Law Enforcement Task Force to investigate and arrest the rogue players in the treatment and recovery residence industries, using current laws; a Proviso Task Force, including members of organizations named in the legislative proviso, to study the issues and make specific recommendations for positive change through legislation and regulatory enhancements; and a third, larger and more inclusive group, to further study the problem and recommend solutions (the Task Force).[84] The Task Force submitted its report to the Legislature and the Governor on January 1, 2017.

Like the Grand Jury, the Task Force, identified patient brokering and fraudulent marketing as key problems with some providers within the substance abuse treatment industry. The Task Force found

[77] PRESENTMENT OF THE PALM BEACH COUNTY GRAND JURY, *Report on the Proliferation and Abuse in Florida's Addiction Treatment Industry*, (Dec. 8, 2016), *available at*, http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/GrandJuryReport2.pdf (last visited March 27, 2017).
[78] Id. at 5.
[79] Id. at 11, 16.
[80] Id. at 14.
[81] Id. at 18.
[82] Id.
[83] Id. at 17.
[84] Supra, note 8 at 2.

that the economic environment of the substance abuse treatment industry in Florida serving patients from out-of-state with private insurance creates the opportunity for abuses such as overbilling for services, deceptive marketing, patient brokering, and incentives to relapse.

With respect to patient brokering, the Task Force found that it was common practice for certain substance abuse treatment providers to pay a weekly fee or kickback to their patients' recovery residences, with the understanding that the recovery residences will allow the patients to live at the residence for free or at a greatly reduced rent while attending the provider's outpatient treatment program. The Task Force found that patient brokering, by providing kickbacks to the recovery residence in exchange for the delivery of a patient, is commonplace among certain treatment providers. Some treatment providers and recovery residences were also offering incentives such as gym memberships, scooters, weekly massages, chiropractic services, cigarettes, clothes, gift cards and more. As a result of patient brokering, there exists an economic incentive for the patient, the substance abuse treatment provider, and the recovery residence for the patient to continually cycle through treatment and relapse.[85] The task force found that this cycle at times ends in the patient's overdose and death.[86]

Recommendations to Address Abuses in the Substance Abuse Treatment Industry

Based on the testimony it heard, the Grand Jury made the following recommendations:

- 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[87] recovery residences;
- Eliminate the 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; and
- Promote education and interagency collaboration with respect to investigations into the substance abuse treatment industry.[88]

The Task Force made several in-depth recommendations.

1. <u>DCF Licensure.</u> The Task Force recommended that DCF increase its licensure fees and the number of staff it has for licensure inspection. It also recommended increasing DCF's authority to effectively regulate[89] substance abuse treatment providers.[90]

[85] Id. Often insurers are required to cover each relapse as a separate event; as a result, there is an economic incentive for bad actors in the industry to encourage relapse.
[86] Id.
[87] The Grand Jury differentiated between an OH recovery residence model and a "commercial" recovery residence that is a for-profit business operated by a third party; however, federal law applies to both models. See the discussion of Federal Law Applicable to Recovery Residences on pages 6-7, *infra*, for more detail.
[88] *Supra,* note 77, *passim.*
[89] The Task Force found that DCF lacks resources, including adequate staffing, and faces statutory limitations that undermine its ability to regulate substance abuse treatment providers.
[90] *Supra*, note 8 at 5-7.

2. Recovery Residence Referrals. The Task Force also recommended that recovery residence referrals be subject to greater restrictions. It recommended expanding the individuals subject to referral provisions and addressing referrals from recovery residences to treatment providers.

3. Patient Records. The Task Force also recommended that, the Legislature modify privacy requirements for patient records relating to criminal investigations to allow the court, at its discretion, to enter an order authorizing the disclosure of an individual's substance abuse treatment records without prior notice, so that providers and recover residence operators are not tipped off to an undercover criminal investigation.[91] Federal law requires adequate notice, but state law requires prior notice; at least one judge has rejected the state's argument that adequate notice does not require prior notice.[92]

4. Patient Brokering. The Task Force identified statutory changes to address patient brokering and recommended that the state impose greater penalties and make other enhancements to the patient brokering statute. It recommended that a licensed substance abuse treatment provider not be allowed to refer a "prospective, current or discharged patient to, or accept a referral from" a recovery residence unless the recovery residence is certified and actively managed by a certified recovery residence administrator.[93] It also recommended that the term "benefit" should be added to the prohibited items solicited or received in the patient brokering statute and that there should be enhanced penalties for multiple patient brokering offenses.[94] Additionally, for the prosecution of patient brokering, the Task Force recommended adding patient brokering to the enumerates list of offenses the Office of Statewide Prosecution,[95] within the Office of the Attorney General, may prosecute and adding patient brokering to the predicate offenses constituting racketeering activities.[96]

5. Marketing Practices. The Task Force recommended that the Legislature create a statutory prohibition of unethical marketing practices within ch. 397, F.S., and create criminal penalties for fraudulent marketing practices.[97]

Patient Brokering

Florida's patient brokering statute, s. 817.505, F.S., makes it unlawful for any person to engage in patient brokering. Patient brokering is paying to induce, or make a payment in return for, a referral of a patient to or from a health care provider or health care facility. Such payments include commissions, bonuses, rebates, kickbacks, bribes, split-fee arrangements, in cash or in kind, provided directly or indirectly.[98] A violation of the patient brokering statute is a third degree felony[99], and may also be remedied by an injunction or any other enforcement process. Private entities bringing an action under the patient brokering statute may recover reasonable expenses, including attorney fees.[100]

The patient brokering statute applies to any person regulated, or statutorily exempt from regulation, by the Agency for Health Care Administration or the Department of Health, who has a Medicaid provider

[91] *Id*. at 15.
[92] *Supra*, note 77.
[93] Id. at 12.
[94] Id.
[95] The Florida Constitution gives the Office of Statewide Prosecution concurrent jurisdiction with the state attorneys to prosecute violations of criminal laws set out in s. 16.56, F.S., that occur in two or more judicial circuits, or when any such offense is affecting or has affected two or more judicial circuits as provided by general law. Fla. Const. art. IV, s. 4(a).
[96] Id. at 14; s. 895.02(8), F.S. enumerates 50 crimes that constitute racketeering activities, several of which relate to fraud, and also incorporates the federal definition of racketeering activities in 18 U.S.C. s. 1961(1).
[97] Id. at 13-14
[98] S. 817.505(1), F.S.
[99] A third degree felony is punishable by not more than five years of imprisonment and not more than a $5,000 fine. ss. 775.082, 775.083, F.S.
[100] S. 817.505(4), (6), F.S.

contract, or who has a contract with DCF to provide substance abuse or mental health services under part IV of chapter 394. It expressly applies to "substance abuse providers" licensed under chapter 397.

The patient brokering statute has been used in cases involving split-fee arrangements; for example, an assignment of benefits scenario in which a non-provider suggested a patient go to a particular MRI facility, paid the facility for the MRI and billed the insurer a greater amount.[101] It has also been used in self-referral arrangements; for example, an arrangement by which a series of shell companies, nominee owners and independent contractors were used to conceal relationships that generated a high-volume of personal injury protection patients to a particular provider through a toll-free referral number.[102]

Arrests of Substance Abuse Treatment Provider and Recovery Residence Personnel

Since Fall 2016, law enforcement has arrested at least seventeen individuals for patient brokering in Palm Beach County.[103] The first arrest was the CEO of Whole Life Recovery, which provided intensive outpatient treatment.[104] By November 23, five more individuals had been arrested for patient brokering under s. 817.505, F.S.[105] In December 2016, six individuals were charged in a federal complaint that included patient brokering, insurance fraud, and allegations of human trafficking.[106] Most recently, the owner of Chapters Recovery, which provides outpatient treatment and intensive outpatient treatment, was arrested on 93 counts of patient brokering.[107] According to the arrest report, he paid $325,000 to three sober home operators who enrolled residents living in their sober homes in treatment programs at Chapters Recovery.[108] Most recently, the co-owner of Epiphany's Treatment Center in was arrested on 15 counts of patient brokering.[109]

Deceptive Marketing and Unfair Practices

The Florida Deceptive and Unfair Trade Practices Act[110] (FDUTPA) makes unlawful unfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce. Violations of FDUTPA are investigated and prosecuted by state attorneys, or the Department of Legal Affairs in the Office of the Attorney General if the violations affect more than one judicial circuit.[111] Violations may be remedied by declaratory judgment, injunction, or an action for actual damages; in addition, a court may order other legal or equitable relief.[112] In addition, a court may assess civil penalties of up to $10,000 per violation.[113] FDUTPA imposes larger penalties for willful violations against senior citizens (age 60 or older), persons with disabilities, and military service

[101] *Medical Management Group of Orlando, Inc. v. State Farm Mut. Auto. Ins. Co*., 811 So. 2d 705 (Fla. 5th DCA 2002).
[102] *State Farm Mut. Auto. Ins. Co. v. Physicians Group of Sarasota, L.L.C*., 9 F. Supp. 3d 1303 (M.D. Fla. Mar. 25, 2014) (denying motion to dismiss).
[103] Christine Stapleton, *Drug treatment CEO arrested on 93 counts of patient brokering*, PALM BEACH POST, Feb. 23, 2017, *available at*, http://www.palmbeachpost.com/news/breaking-news/drug-treatment-ceo-arrested-counts-patient-brokering/xHgSlIZlNiJZxjiqox57KP/ (last visited March 27, 2017).
[104] Lawrence Mower, *Boynton Beach addiction treatment center's CEO, operator arrested*, PALM BEACH POST, Oct. 25, 2016, *available at*, http://www.mypalmbeachpost.com/news/boynton-beach-addiction-treatment-center-ceo-operator-arrested/LlVfJDqWo4GXsyjEDTA4TK/ (last visited March 27, 2017).
[105] Ryan Van Velzer, *More arrests made in crackdown on illegal sober home activities*, SUNSENTINEL, Nov. 23, 2016, *available at* http://www.sun-sentinel.com/local/palm-beach/fl-more-arrests-sober-homes-bust-20161123-story.html (last visited March 27, 2017).
[106] John Pacenti, Christine Stapleton, Mike Stucka, PALM BEACH POST, Dec. 21, 2016, *available at*, http://www.palmbeachpost.com/news/crime--law/subject-post-investigation-arrested-sober-home-fraud/794mQ13ejXytKUgpdhoHOI/ (last visited March 27, 2017).
[107] Supra, note 103.
[108] Id.
[109] Julius Whigham II and Mike Stucka, *BREAKING: Former state House candidate arrested for patient brokering*, PALM BEACH POST, Mar. 21, 2017, available at, http://www.palmbeachpost.com/news/crime--law/breaking-former-state-house-candidate-arrested-for-patient-brokering/QssjemsJXX5gF3LEEvr1RI/ (last visited March 27, 2017).
[110] Ss. 501.201-501.213, F.S.
[111] S. 501.203, F.S.
[112] S. 501.207, F.S.
[113] S. 501.2075, F.S.

members and their families. In this context, a person with a disability is one who has a mental or educational impairment. The civil penalty for a violation of this sort is not more than $15,000.[114]

Courts have defined an "unfair practice" as "one that offends established public policy and one that is immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers."[115] Similarly, courts have defined a "deceptive act" as one in which there is a "representation, omission, or practice that is likely to mislead the consumer acting reasonably in the circumstances, to the consumer's detriment."[116]

FDUTPA has been used in cases involving similarly-named companies, which could lead consumers to believe them to be the same[117]; in "bait-and-switch" cases[118]; and instances of unreasonable pricing[119], among many other types of activities. FDUTPA applies broadly, to any person who engages in this conduct, and would apply to this conduct by substance abuse treatment providers and recovery residences.

Effect of the Bill

CS/HB 807 implements several of the recommendations from the Task Force to address the problems within the substance abuse treatment industry. The bill makes several changes to DCF's licensure program for substance abuse treatment providers in ch. 397.

Substance Abuse Licensure

The bill revises the licensure application requirements and process, requiring providers as part of the application to provide proof that they have obtained accreditation by the 2nd renewal. Providers must also provide detail in the application about the clinical services they will provide. DCF must set licensure fees sufficient to cover the cost of regulation. The bill limits DCF to issuing only one probationary license per provider and only when doing so would not place the health, safety, or welfare or individuals at risk. DCF is also prohibited from issuing a license if staff do not pass background screenings and subsequently fail to obtain exemptions.

The bill increases penalties for operating without a license, making it a third-degree felony punishable by up to five years in prison.

The bill addresses the quality of substance abuse treatment by specifying that clinical treatment may only be provided by a licensed or certified nurse, qualified professional, a recovery support specialist, or another professional pursuant to rule. The bill creates a definition for "recovery support specialist" as well as for "clinical supervisor" and requires the former to be certified by a credentialing entity and the latter to be background screened.

The bill creates s. 397.410, F.S., which requires DCF to draft rules on minimum licensure standards by January 1, 2018, that address administrative management; standards for clinical and treatment best practices; qualifications of all personnel, including staffing ratios; and service provider facility standards.

The bill authorizes DCF to inspect providers on announced or unannounced basis to see if minimum requirements are met and grants DCF more flexibility in scheduling inspections.

[114] S. 501.2077, F.S.
[115] *PNR, Inc. v. Beacon Prop. Mgmt.*, 842 So. 2d 773, 777 (Fla. 2003) (quoting *Samuels v. King Motor Co.*, 782 So. 2d 489, 499 (Fla. 4th DCA 2001)).
[116] Id. at 777 (quoting *Millennium Communs. & Fulfillment, Inc. v. Office of the AG, Dep't of Legal Affairs*, 761 So. 2d 1256, 1263 (Fla. 3d DCA 2000)).
[117] *See, e.g., Rain Bird Corp. v. Taylor*, 665 F. Supp. 2d 1258 (N.D. Fla. Sept. 10, 2009).
[118] *See, e.g., Fendrich v. RBF, L.L.C.*, 842 So. 2d 1076 (Fla. 4th DCA 2003).
[119] *See, e.g., Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265 (S.D. Fla. Nov. 17, 2006).

The bill also expands DCF's authority to take action against a service provider. DCF must classify violations by scope and nature. DCF must use a tier-based system of classifying violations and issuing fines or requiring other action. It allows for each day a violation occurs to be considered a separate violation. The bill authorizes use of corrective action plans; allows moratoria or immediate license suspensions for client health, safety or welfare; requires visible posting of notice of a moratorium or suspension; and allows DCF to deny, suspend, or revoke a license due to:

- False representation;
- An act affecting client health or safety;
- A violation of statute or rule;
- A demonstrated pattern of deficient performance; or
- Failure to remove personnel failing background screening.

The bill also reorganizes pt. II of ch. 397 by renumbering several sections. It also repeals s. 397.471, F.S., as its provisions are incorporated into new section s. 397.410, F.S. The bill also conforms cross-references.

Recovery Residence Referrals

The bill expands current prohibitions on referrals to address referrals from certified recovery residences to licensed service providers. Current law prohibits referrals by licensed service providers to uncertified recovery residences; the bill would prohibit referrals by uncertified recovery residences to licensed service providers. The bill also includes prospective patients in these referral prohibitions. After June 30, 2019, violators are subject to a $1,000 fine per occurrence.

The bill removes the exemption for referrals to a recovery residence that is owned and operated by a licensed service provider or its wholly owned subsidiary.

Patient Records

The bill creates a new provision for applications for disclosure of patient records for individuals receiving substance abuse services in an active criminal investigation. For criminal investigations, the court, at its discretion, will be able to enter an order authorizing the disclosure of an individual's substance abuse treatment records without prior notice. Existing law would continue to apply to applications filed alone or as part of a pending civil investigation.

Patient Brokering

The bill adds the term "benefit" to the list of items solicited or received that may not be used to induce the referral of a patient. The bill also adds patient brokering to the offenses that can be investigated and prosecuted by the Office of Statewide Prosecution and to the crimes that constitute racketeering activities.

The bill creates a $50,000 fine for patient brokering. Additionally, the bill creates enhanced penalties for higher volumes of patient brokering. For brokering of 10 to 19 patients, the crime is a second-degree felony punishable as provided in ss. 775.082 or 775.084, F.S., and includes a $100,000 fine. For brokering of 20 or more patients, the crime is a first-degree felony punishable as provided in ss. 775.082 or 775.084, F.S., and includes a $500,000 fine. The bill also adds patient brokering into the offense severity ranking chart; this will dictate the number of points that will be added to an offender's scoresheet for sentencing purposes.

Marketing Prohibitions

Deceptive Marketing

The bill expands the types of deceptive actions prohibited beyond those covered under FDUTPA, and provides criminal penalties. It makes a legislative finding that consumers of substance abuse treatment have disabling conditions and that such consumers and their families are vulnerable and at risk of being easily victimized by fraudulent marketing practices that adversely impact the delivery of health care.

Based on this finding, the bill prohibits 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 from engaging in any of the following marketing practices:

- Making a false or misleading statement or providing false or misleading information about the provider's, operator's, or third party's products, goods, services, or geographical locations in its marketing, advertising materials, or media or on its website. This is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, F.S.[120]
- 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. This is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, F.S.
- Conduct prohibited by the patient brokering statute, s. 817.505. F.S.
- 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 the service provider or the operator of the recovery residence discloses specified information to the prospective patient.[121] This is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, F.S.

Fraudulent Marketing

The bill 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, as defined in chapter 397, F.S., 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. Such fraudulent marketing is a felony of the third degree, punishable as provided in ss. 775.082, 775.083, or 775.084, F.S.[122]

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 16.56, F.S, relating to Office of Statewide Prosecution.
Section 2: Amends s. 397.311, F.S., relating to definitions.
Section 3: Amends s. 397.321, F.S., relating to duties of the department.
Section 4: Amends s. 397.401, F.S., relating to license required; penalty; injunction; rules waivers.
Section 5: Renumbers s. 397.405, F.S., relating to exemptions from licensure.
Section 6: Renumbers s. 397.406, F.S.
Section 7: Amends s. 397.403, F.S., relating to license application.
Section 8: Amends s. 397.407, F.S., relating to licensure process; fees.

[120] A first-degree misdemeanor is punishable by up to one year in jail and a $1,000 fine.
[121] If the marketing provider provides instructions that allow the prospective patient to easily (1) determine whether the marketing provider represents specific licensed service providers or recovery residences that pay a fee to the marketing provider and the identity of such service providers or recovery residences and (2) access lists of licensed service providers and recovery residences on the department website, it is exempt from this prohibition.
[122] A third-degree felony is punishable by up to five years in prison and a $5,000 fine.

Section 9: Renumbers and amends s. 397.451, F.S., relating to background checks of service provider personnel.
Section 10: Renumbers s. 397.461, F.S., relating to unlawful activities relating to personnel; penalties.
Section 11: Creates s. 397.410, F.S., relating to rules; licensure requirements; minimum standards.
Section 12: Renumbers s. 397.419, F.S., relating to quality improvement programs.
Section 13: Amends s. 397.411., F.S., relating to inspection; right of entry; classification of violations; records.
Section 14: Amends s. 397.415, F.S., relating to denial, suspension, and revocation; other remedies.
Section 15: Repeals s. 397.471, F.S., relating to service provider facility standards.
Section 16: Creates s. 397.4873, F.S., relating to referrals to or from recovery residences; prohibitions; penalties.
Section 17: Amends s. 397.501, F.S., relating to rights of individuals.
Section 18: Creates s. 397.55, F.S., relating to prohibition of deceptive marketing practices.
Section 19: Creates s. 817.0345, F.S., relating to prohibition of fraudulent marketing practices.
Section 20: Amends s. 817.505, F.S., relating to patient brokering prohibited; exceptions; penalties.
Section 21: Amends s. 895.02, F.S., relating to definitions.
Section 22: Amends s. 921.0022, F.S., relating to Criminal Punishment Code; offense severity ranking chart.
Section 23: Amends s. 212.055, F.S., relating to discretionary sales surtaxes; legislative intent; authorization and use of proceeds.
Section 24: Amends s. 394.4573, F.S., relating to Coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.
Section 25: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 26: Amends s. 397.416, F.S., relating to substance abuse treatment services; qualified professional.
Section 27: Amends s. 397.753, F.S., relating to definitions.
Section 28: Amends s. 409.1757, F.S., relating to persons not required to be refingerprinted or rescreened.
Section 29: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 30: Amends s. 985.045, F.S., relating to court records.
Section 31: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Indeterminate. DCF will experience additional fee revenue from raising the fees for each licensed service component to cover the cost of regulation. DCF may also experience additional revenue from the imposition of licensure fines under the new authority in the bill. The amount of additional revenue from licensure fees and fines depends on the amounts set by rule and the number of licensees paying them, which is indeterminate.

   Additionally, the Clearinghouse will receive $48 in revenue for each additional background check.[123] These fees will go into the Florida Department of Law Enforcement's Operating Trust Fund.[124]

2. Expenditures:

   Indeterminate. DCF will have to do rulemaking to establish the minimum standards for licensure and the classifications of licensure violations; these costs can be absorbed within existing resources.

[123] Florida Department of Law Enforcement, Agency Analysis of 2017 House Bill 807, (Mar. 20, 2017) (on file with Health and Human Services Committee Staff).
[124] Id.

DCF may have an increased workload associated with increased regulatory oversight of substance abuse treatment providers, including evaluation of compliance with minimum standards and increased background screenings,[125] which would be covered through the increase in licensure fees.

DCF may also have an increased workload associated with licensure discipline, including ch. 120, F.S. proceedings at the Division of Administrative Hearings, which would be covered through the increase in licensure fees.

DCF may eventually see a decrease in workload associated with inspections as providers of clinical treatment services become accredited; under current law, DCF must inspect accredited licensees triennially instead of annually.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local law enforcement may see an increase in cost associated with enforcing the new criminal penalties created by the bill.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If the changes to patient brokering statutes deter treatment providers and recovery residence operators from giving persons in recovery from substance abuse inducements such as gym memberships, scooters, cigarettes, clothes, and gift cards, these individuals will receive fewer such inducements.

Substance abuse treatment providers and recovery residence operators who are engaging in practices made illegal under the bill will be subject to monetary fines and criminal penalties unless they adapt their business practices.

Licensed service providers will need to pay for background screenings for clinical supervisors, unless these individuals are exempt, such as due to having already been screened within five years. The background check will cost $60 per individual.[126]

Licensed service providers of clinical services who are not already accredited will need to obtain accreditation by the second renewal. The cost of accreditation ranges from $7,500 to $15,00 and is valid for a three-year period.

Licensed service providers who commit certain violations will be subject to fines and other licensure actions such as moratoria, license suspension, revocation, and denial, which could have an economic impact on such providers.

D. FISCAL COMMENTS:

The volume and complexity of patient brokering cases that the Office of Statewide Prosecution may choose to prosecute is unknown. The Office of Statewide Prosecution can absorb these prosecutions.

[125] DCF is unable to estimate the number of clinical supervisors who would need to be background screened. The number of background screens impacts DCF's costs of conducting screenings and fees for participation in the Background Screening Clearinghouse administered by the Agency for Health Care Administration (AHCA); DCF will have to pay AHCA more if it needs more people background screened.

[126] Supra, note 123.

If the Office it elects to prosecute a large number of patient brokering cases, it may need to divert employees from prosecuting other offenses.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2017, the Children, Families, and Seniors Subcommittee adopted four amendments that:

- Removed the requirement that substance abuse marketers obtain a license from DBPR;
- Made a technical change to clarify a reference to patient brokering;
- Removed an erroneous cross-reference;
- Added patient brokering to the offense severity ranking chart for sentencing purposes in s. 921.0022, F.S.; and
- Increased licensure requirements for substance abuse service providers in ch. 397, F.S.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.