

LIQUID GOLD

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“ . . . all you have to do is pee in this cup . . . ”**

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** Gene Sullivan, chief financial officer and executive director at A New Start Inc. in Palm Springs. The full quote is: “The client brokers come and say all you have to do is pee in this cup, we will buy you food, buy you cigarettes.” John Pacenti, *Patient Brokering: A Festering Wound for Recovery Community*, PALM BEACH POST (Oct. 29, 2016, 12:01 AM), [https://www.palmbeachpost.com/news/local/patient-brokering-festering-wound-for-recovery-community/hTxetVZpPd2Lud2kV4evoM/\[https://perma.cc/KJ8V-5Z6A\]](https://www.palmbeachpost.com/news/local/patient-brokering-festering-wound-for-recovery-community/hTxetVZpPd2Lud2kV4evoM/[https://perma.cc/KJ8V-5Z6A]).

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INTRODUCTION

According to federal health and census data, addiction treatment is expected to be a \$42 billion industry in 2020.¹ It has doubled in size since 2003 when it was a \$21 billion business.² The opioid crisis has fueled the growth of the industry by increasing the demand for residential drug treatment programs³ and sober living homes.⁴ The industry has also become less fragmented in recent years with the infusion of capital from investors eager to consolidate web sites, call centers, rehabilitation facilities, drug-testing labs, and sober living homes under one corporate roof.⁵ Astronomical growth of an industry, however, often invites bad actors.

1. Teri Sforza, *Addiction Treatment: The New Gold Rush. 'It's Almost Chic,'* ORANGE COUNTY REG. (June 16, 2017, 5:13 PM), <https://www.oeregister.com/2017/06/16/addiction-treatment-the-new-gold-rush-its-almost-chic/> [<https://perma.cc/32QV-2D3H>].

2. *Id.*

3. Residential drug treatment centers provide 24-hour structured and intensive care that includes, *inter alia*, safe housing and counseling. *See infra* Part II.

4. Sober living homes are utilized by patients recovering from addiction. It is a supervised, drug-free living environment. *See infra* Part II.

5. Sforza, *supra* note 1 (explaining that in the past addiction treatment centers were “small mom-and-pop enterprises, which leaves tremendous room for consolidation and efficiencies. Unifying small centers into larger networks spreads administration costs over larger revenue bases, while more sophisticated operations can allow for investment in technology and data-mining that may better manage health and financial outcomes.”).

In 2014, a rehab chain called American Addiction Centers went public on the New York Stock Exchange, attracting investments from the likes of Morgan Stanley and BlackRock. Mergers and acquisitions related to drug and alcohol addiction programs doubled between 2013 and 2016, according to the Braff Group, and 48 private equity firms entered the market over the last

Bad actors have swarmed the residential drug treatment industry. One prominent example is Kenny Chatman, who ran several treatment centers and sober living homes in South Florida.⁶ His goal was not to help addicts become sober.⁷ Instead, his facilities encouraged drug use and prolonged treatment so that he could collect insurance reimbursements.⁸ Further, his centers ordered drug-addicted patients to provide urine samples for fictitious patients so that he could continue to collect insurance payments.⁹ In total, he collected at least \$16 million in reimbursements from insurance companies for treatment that was never aimed at helping his patients overcome their addiction.¹⁰ In 2017, Chatman pled guilty to federal charges of health-care fraud, money laundering, and human trafficking.¹¹ He was sentenced to twenty-seven years in prison.¹² After the case, two hundred additional sober homes were shut down in Florida.¹³ But, that was just the tip of the iceberg. Indeed, the crackdown in Florida simply encouraged fraudulent treatment centers to relocate to other states.¹⁴

Chatman was able to defraud patients and insurance companies due to insufficient regulation in the residential drug treatment industry. There is a lack of uniformity amongst the states concerning the accreditation and licensing requirements to open and maintain a residential drug rehabilitation facility. Some states have adopted the standards of care put forth by the National Alliance for Recovery Residences (NARR).¹⁵ Others have adopted standards put forth by the American Society of Addiction Medicine

five years.

Julia Lurie, "Mom, When They Look at Me, They See Dollar Signs," MOTHER JONES (Mar./Apr. 2019), <https://www.motherjones.com/crime-justice/2019/02/opioid-epidemic-rehab-recruiters/> [https://perma.cc/U7HD-7VZ2].

6. Scott Cohn, *Opioids' Hidden Epidemic—Fraudulent Drug Treatment Centers*, CNBC (June 29, 2018, 10:06 AM), <https://www.cnbc.com/2018/06/06/opioids-hidden-epidemic-fraudulent-drug-treatment-centers.html> [https://perma.cc/J9P2-KCA9].

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. Tony Saavedra, *Florida Prosecutor Dave Aronberg Sees Parallels in Rogue Rehabs in Florida and Southern California*, ORANGE COUNTY REG. (Mar. 27, 2018, 5:00 AM), <https://www.ocregister.com/2018/03/27/florida-prosecutor-dave-aronberg-sees-parallels-in-rogue-rehabs-in-florida-and-southern-california/> [https://perma.cc/QWD7-8AYV].

15. NARR is a non-profit organization that has a "mission . . . to support persons in recovery from addiction by improving their access to quality recovery residences through standards, support services, placement, education, research and advocacy." NAT'L ALLIANCE FOR RECOVERY RESIDENCES, www.narronline.org [https://perma.cc/KPF6-GABT].

(ASAM).¹⁶ Nevertheless, there are still many states that do not have standards of care that govern the operation of residential drug treatment centers. Fraudulent treatment centers, like the ones run by Chatman, thrive in these states. It is very difficult for a consumer to know whether they are going to a legitimate treatment facility or a fraudulent one.

This Article deals with fraudulent practices in the residential drug treatment industry. It will principally focus on the two related issues of quality of care and patient brokering. With respect to quality of care, this Article will address fraud and overutilization as well as poor care. The Mental Health Parity Act and the Affordable Care Act expanded coverage for residential drug treatment.¹⁷ As with other medical expenses, insurance companies cover the costs of drug rehabilitation on a traditional fee-for-service basis. Relapses,¹⁸ which are a normal part of recovery,¹⁹ are also covered.²⁰ Importantly, health insurance plans cover urinalysis to test for drugs as an essential service, with a very low deductible.²¹ Unfortunately, unethical treatment centers, like those run by Chatman, are not incentivized to provide cost efficient and effective care. To the contrary, their incentives are to drag out treatment for as long as possible and rack up insurance claims. Some treatment centers charge insurance companies \$1,000 or more per drug test and test patients repeatedly to ensure a steady stream of income for the treatment center.²² This practice constitutes overutilization. Other

16. *What Is the ASAM Criteria?*, AM. SOC'Y ADDICTION MED., <https://www.asam.org/Quality-Science/the-asam-criteria/about> [<https://perma.cc/C4P6-JPH7>].

17. *See infra* Part IV.

18. Relapse occurs when you have a period of sobriety followed by a period of resumed substance use.

19. "Treatment of chronic diseases involves changing deeply rooted behaviors, and relapse doesn't mean treatment has failed. When a person recovering from an addiction relapses, it indicates that the person needs to speak with their doctor to resume treatment, modify it, or try another treatment." NAT'L INST. ON DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION 23, <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/soa.pdf> [<https://perma.cc/C8GP-XLK8>].

20. Dave Aronberg, *Opportunists Are Exploiting the ACA to Prey on Opioid Addicts*, TIME (Sept. 20, 2017), <https://time.com/4950199/affordable-care-act-opioid-relapse/> [<https://perma.cc/6TVV-27C9>] ("Together, the Mental Health Parity and Addiction Equity Act of 2008 and the ACA ensure that drug relapse is always covered as an essential health benefit and cannot be excluded due to a pre-existing condition, and that children remain on their parents' policies until age 26. This has provided a financial incentive for rogue providers to keep patients of all ages in a cruel cycle of rehab."). Prior to the Affordable Care Act, drug abuse with recent treatment was considered a pre-existing condition for which insurers could decline coverage. Gary Claxton et al., *Pre-Existing Condition Prevalence for Individuals and Families*, KFF: HEALTH REFORM (Oct. 4, 2019), <https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/> [<https://perma.cc/4CAT-G6SN>].

21. The ACA requires that laboratory testing be included as an essential benefit. 42 U.S.C. § 18022(b)(1)(H) (2018).

22. *See infra* Part III.A.2.

treatment centers charge insurance companies for drug tests or other services that were never performed, which is fraud.²³

In addition, unethical treatment centers are involved in patient brokering, a practice whereby they recruit drug addicts with health insurance into their programs by offering everything from low rent to prepaid debit cards as incentives for participating.²⁴ Patients often search for residential drug treatment centers on the internet.²⁵ After finding a treatment center, they call the number listed on the internet believing that they are contacting a residential treatment center.²⁶ In reality, they are often calling patient brokers who misrepresent themselves on the internet as treatment centers.²⁷ Once the patient brokers convince a patient to receive treatment at a disreputable residential drug treatment center, they often transport patients hundreds of miles to the fraudulent providers. Patient brokers then receive kickbacks from the treatment centers for directing patients to their centers.²⁸ The problem, however, is that the patients do not receive the care that they need to beat their addiction to drugs.²⁹ And, once the insurers get wind of the fraud, they cease payments and the addicted patients are left untreated hundreds of miles from home.³⁰ Further, some addiction treatment centers are associated with sober living homes where they send their patients after addiction treatment.³¹ Some treatment centers have gone so far as to offer drugs to residents of sober living houses to make them relapse and start the treatment, or rather billing, cycle all over again.³² In short, unethical treatment centers are using the opioid epidemic as a means of exploitation for financial gain. Addiction treatment has become a multi-billion-dollar industry chiefly fueled by pee in a cup—Liquid Gold.

23. *Insurance Fraud*, ETHICS TREATMENT, <http://ethicsintreatment.com/insurance-fraud/> [https://perma.cc/T6U3-8RPM].

24. John Pacenti, *Patient Brokering: A Festering Wound for Recovery Community*, PALM BEACH POST (Oct. 29, 2016, 12:01 AM), <https://www.palmbeachpost.com/news/local/patient-brokering-festering-wound-for-recovery-community/hTxeTVZpPd2Lud2kV4evoM/> [https://perma.cc/KJ8V-5Z6A].

25. Cat Ferguson, *Searching for Help*, VERGE (Sept. 7, 2017, 8:00 AM), <https://www.theverge.com/2017/9/7/16257412/rehabs-near-me-google-search-scam-florida-treatment-centers> [https://perma.cc/c5JT7-C68P] [hereinafter Ferguson, *Searching for Help*].

26. *Id.*

27. *Id.*

28. Pacenti, *supra* note 24.

29. *See infra* Part III.A.1.

30. *See infra* Part III.A.1.

31. Susan Taylor Martin, *Addicts Say Recovery Program Stole Their Money*, TAMPA BAY TIMES (Nov. 19, 2012), <https://www.tampabay.com/news/addicts-say-recovery-program-stole-their-money/1261911/> [https://perma.cc/8KF2-NNWS]; Teri Sforza et al., *How Some Southern California Drug Rehab Centers Exploit Addiction*, ORANGE COUNTY REG. (May 21, 2017, 5:55 AM), <https://www.ocregister.com/2017/05/21/how-some-southern-california-drug-rehab-centers-exploit-addiction/> [https://perma.cc/TZ94-PYYR].

32. Martin, *supra* note 31; Sforza et al., *supra* note 31.

The lack of regulation in the residential drug treatment industry is practically an invitation for deceptive business practices such as patient brokering, insurance fraud, and substandard care. While many scholars have written articles addressing the opioid crisis and the best way to address it, this is the first article to address the corruption in the residential drug rehabilitation market. This Article argues that the government must address the crisis in the residential drug treatment industry with national legislation.

Part I addresses the diagnosis of substance and opioid use disorders. It also focuses on the origins of the opioid crisis. Part II addresses the types of treatment available for substance and opioid use disorders with a particular focus on residential drug treatment centers and sober living homes. Part II also examines the impact that expanded insurance coverage for substance use disorder (SUD) treatment has had on the drug rehabilitation market. Specifically, it argues that expanded coverage for SUD has motivated bad actors to enter the residential drug treatment market to exploit vulnerable patients and insurance companies. Part III examines fraud in the residential drug rehabilitation market. It sets forth the schemes that disreputable residential drug treatment centers utilize to defraud patients and insurers. In addition, it critiques the model of treatment at residential rehabilitation facilities that is based on abstinence and support groups. It argues that to ensure quality care, residential rehabilitation facilities must utilize evidence-based treatment and hire professionals with specialized training in addiction medicine.

Part IV employs the economics of information to understand the inability of consumers to choose a reputable treatment center. It argues that the quality of residential drug treatment centers is difficult to assess due to severe informational asymmetries in the residential drug treatment market. Part IV also examines the significant costs associated with fraudulent treatment centers such as decreased productivity, which leads to foregone earnings from employment, and higher costs to the criminal justice system due to an increase in opioid-related crime.³³ And, more importantly, an increase in the mortality rate because patients do not receive effective care at fraudulent treatment centers that places a huge burden on families and the economy in general due to lost potential earnings.³⁴

Parts V–VII explore three proposals to address the fraud and lack of quality care in the drug rehabilitation industry. Part V concentrates on the recently passed federal opioid legislation that prohibits patient brokering. It

33. WHITE HOUSE COUNCIL OF ECON. ADVISERS, THE UNDERESTIMATED COST OF THE OPIOID CRISIS 2 (2017), <https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf> [<https://perma.cc/2H3E-DV4V>].

34. *Id.*

argues that the federal legislation banning patient brokering is an important first step in addressing the fraud in the residential drug treatment market. The federal legislation does not, however, completely solve the problem. The legislation does not ensure quality care by mandating the use of evidence-based treatment. Nor does it correct the information asymmetry in the market by providing information on quality to consumers.

Part VI examines a proposal to abandon fee-for-service billing in the residential drug treatment market and replace it with outcome-based reimbursement that could properly account for the quality of the residential drug treatment center. Part VI finds that instituting outcome-based reimbursement has the potential to reward the best residential drug recovery centers and remove financial incentives currently in place for unethical centers. Nevertheless, it will be difficult to accurately define and assess quality health care. And, it will likely be an administrative headache to implement. Further, it fails to provide objective information about quality directly to vulnerable patients. It only provides that information to insurance providers. The success of this solution in addressing information asymmetries would rely upon insurance providers sharing quality information with consumers. Further, there is very little evidence that suggests that outcome-based reimbursement changes provider behavior or patient outcomes.

Finally, Part VII sets forth the author's proposal to adopt mandatory federal accreditation and licensing requirements for residential drug treatment centers and sober living homes. Part VII argues that mandatory federal accreditation of facilities and licensing of providers is necessary to ensure quality care and provide needed information to consumers. Federal accreditation standards should require that treatment centers provide evidence-based treatment and adhere to minimum standards of care. Licensing requirements must require specialized training in addiction medicine to enable counselors to utilize evidence-based treatment. Federal accreditation will promote transparency into the quality of residential drug treatment centers and sober living homes nationwide. Further, it will make it easier to keep disreputable residential drug treatment centers and sober living homes out of the market. This Article concludes that federal intervention through mandatory accreditation and licensing is the most effective way to solve the informational asymmetry in the market and ensure quality care.

I. BACKGROUND

A. Substance and Opioid Use Disorders

Millions of Americans suffer from substance use disorder.³⁵ The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association (APA), is the standard classification of mental disorders in the United States.³⁶ According to DSM-5, SUD occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.³⁷ SUD leads to changes in brain circuitry which may cause behavioral effects such as “repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli.”³⁸ To diagnose SUD, a trained clinician would look for evidence of impaired control, social impairment, risky use, and other pharmacological criteria.³⁹ In total, there are eleven symptoms associated with SUD.⁴⁰ For a clinician to diagnose a patient with SUD, the patient must meet the criteria for at least two or more symptoms.⁴¹

Although Americans who suffer from SUD may abuse many types of drugs, opioids have taken center stage in the prescription drug abuse problem. Opioids are synthetic drugs⁴² that have been manufactured to resemble the natural pain-relieving characteristics of opiates derived from the opium poppy.⁴³ Opioids bind to the body’s opioid receptors, which are

35. AM. SOC’Y OF ADDICTION MED., OPIOID ADDICTION: 2016 FACTS & FIGURES 1 (2016), <https://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf> [https://perma.cc/3C72-7CL5] (noting that of the 20.5 million Americans with SUD in 2015, 2 million were addicted to prescription pain medicine and 591,000 were addicted to heroin).

36. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5) (5th ed. 2013).

37. *Id.* at 482–83.

38. *Id.* at 483.

39. *Id.* at 483–84.

40. *Id.*

41. AM. PSYCHIATRIC ASS’N, *supra* note 36, at 484. A clinician would also assess the severity of the SUD from mild (2-3 symptoms) to moderate (4-5 symptoms) to severe (6+ symptoms). *Id.*

42. Synthetic drugs, as opposed to natural drugs, are chemically produced in a laboratory.

Their chemical structure can be either identical to or different from naturally occurring drugs, and their effects are designed to mimic or even enhance those of natural drugs. When produced clandestinely, they are not typically controlled pharmaceutical substances intended for legitimate medical use.

LISA N. SACCO & KRISTIN FINKLEA, CONG. RESEARCH SERV., R42066, SYNTHETIC DRUGS: OVERVIEW AND ISSUES FOR CONGRESS 1 (2016) (footnote omitted), <https://fas.org/sgp/crs/misc/R42066.pdf> [https://perma.cc/V7ER-XUJR].

43. Alanna Guy, *A Surging Drug Epidemic: Time for Congress to Enact a Mandate on Insurance Companies and Rehabilitation Facilities for Opioid and Opiate Addiction*, 31 CLEVELAND-MARSHALL

found in areas of the brain that control pain and emotion.⁴⁴ When opioid drugs bind to these receptors, they can drive up dopamine levels in the brain's reward circuit, producing a state of euphoria and relaxation.⁴⁵ Common prescription opioids on the market include Percocet, Oxycodone, Vicodin, and Methadone.⁴⁶ Typically, doctors prescribe opioids to treat acute or chronic pain, as well as pain caused by a terminal illness.⁴⁷ Unfortunately, prescription opioids are highly addictive drugs because they produce euphoria in addition to pain relief. Thus, even patients who take opioids by prescription can become dependent⁴⁸ on them or misuse them.⁴⁹

There are many physical and functional consequences associated with opioid use. People on opioids may suffer from severe constipation, impairment of visual acuity, and dry mouth and nose.⁵⁰ If an individual injects opioids, she may suffer from track and puncture marks on the lower portions of her arm.⁵¹ If an individual sniffs heroin or other opioids into the nose, she may develop irritation of the nasal mucosa or even perforation of the nasal septum.⁵² Further, after prolonged use, men can suffer from

J.L. & HEALTH 5, 6 (2018). "Opium itself can be extracted from the opium poppy and contains chemical compounds, including morphine and codeine. Thus, examples of opiates are morphine and codeine." Stephanie Labonville, *Opiate, Opioid, Narcotic – What's the Difference?*, INJURED WORKERS PHARMACY (Mar. 29, 2017, 8:00 AM), <https://www.iwpharmacy.com/blog/opiate-opioid-narcotic-what-s-the-difference> [<https://perma.cc/3MN7-YK4M>].

44. NAT'L INST. ON DRUG ABUSE, DRUG FACTS: UNDERSTANDING DRUG USE AND ADDICTION 2 (2018), <https://www.drugabuse.gov/publications/drugfacts/understanding-drug-use-addiction> [<https://perma.cc/H4B2-ETA8>] [hereinafter UNDERSTANDING DRUG USE].

45. NAT'L INST. ON DRUG ABUSE, *supra* note 19, at 5. Surges of dopamine in the brain's reward circuit cause repetition of behavior. *Id.* at 17 ("Just as drugs produce intense euphoria, they also produce much larger surges of dopamine, powerfully reinforcing the connection between consumption of the drug, the resulting pleasure, and all the external cues linked to the experience. Large surges of dopamine 'teach' the brain to seek drugs at the expense of other, healthier goals and activities."). "As a person continues to use drugs, the brain adapts by reducing the ability of cells in the reward circuit to respond to it. This reduces the high that the person feels compared to the high they felt when first taking the drug—an effect known as tolerance." UNDERSTANDING DRUG USE, *supra* note 44, at 2. The person might take more of the drug to obtain the high they felt when first taking the drug. *Id.* Long-term use also affects functions such as learning, judgment, decision-making, stress, memory, and behavior. *Id.*

46. Guy, *supra* note 43, at 6.

47. *Id.*

48. "Drug dependence occurs with repeated use, causing the neurons to adapt so they only function normally in the presence of the drug. . . . Some chronic pain patients are dependent on opioids and require medical support to stop taking the drug." NAT'L INST. ON DRUG ABUSE, DRUG FACTS: PRESCRIPTION OPIOIDS 3 (2019), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-prescriptionopioids.pdf> [<https://perma.cc/P4E5-4AZD>].

49. *Id.* at 1. Misuse of a prescription drug refers to taking the drugs in a manner or dose other than what the doctor prescribed, taking medications that the doctor prescribed for someone else, or taking the medicine for the purpose of getting high. *Id.* "[R]epeated misuse of prescription opioids can lead to a substance use disorder (SUD) . . ." *Id.* at 4.

50. AM. PSYCHIATRIC ASS'N, *supra* note 36, at 544.

51. *Id.* (explaining that "[v]eins sometimes become so severely sclerosed that peripheral edema develops, and individuals switch to injecting in veins in the legs, neck, or groin").

52. *Id.* at 545.

erectile dysfunction and women can suffer from disturbances of reproductive function.⁵³

Opioid use disorder involves “compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, . . . doses greatly in excess of the amount needed for [a] medical condition.”⁵⁴ For individuals with opioid use disorder, life is often “planned around obtaining and administering opioids.”⁵⁵ Patients with opioid use disorder may attempt to obtain opioids from a physician by falsifying or exaggerating medical symptoms or by obtaining multiple prescriptions from several physicians. In addition, patients may attempt to purchase opioids on the illegal market.⁵⁶ When patients misuse opioids, it can lead to addiction,⁵⁷ overdose incidents, and deaths.⁵⁸

When addicted patients can no longer obtain prescription opioids, they sometimes turn to illicit opioids such as heroin⁵⁹ and fentanyl⁶⁰ because they

53. *Id.*

54. *Id.* at 542. The diagnostic criteria for opioid use disorder include at least two of the following within a twelve-month period: (1) opioids taken in greater amounts or for longer periods than intended; (2) persistent desire for opioids or unsuccessful efforts to control opioid use; (3) spending a great deal of time to obtain, use, or recover from the opioids; (4) craving to use opioids; (5) opioid use interfering with ability to fulfill major obligations at home, school, or work; (6) opioid use in the face of recurrent social problems caused by opioid use; (7) abandoning or reducing important social, occupational, or recreational activities due to opioid use; (8) continued opioid use in physically hazardous situations; (9) continued opioid use despite physical or psychological problems caused by opioids; (10) tolerance; and (11) withdrawal. *Id.* at 541.

55. *Id.* at 542.

56. *Id.*

57. “Addiction is a chronic disease characterized by drug seeking and use that is compulsive, or difficult to control, despite harmful consequences.” UNDERSTANDING DRUG USE, *supra* note 44, at 1.

58. *Opioids*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids> [<https://perma.cc/RES8-F7F4>] (click on “Summary”).

59. “Heroin is a poisonous, illegal substance made from morphine, which has no legal medicinal use. It is typically a powdery substance that can vary from white to dark brown in color. Heroin . . . is most commonly used by mixing it with water and injecting it into the body.” Guy, *supra* note 43, at 11 (footnotes omitted). Heroin provides an “almost immediate ‘rush,’ or brief period of intense euphoria, that wears off quickly and ends in a ‘crash.’ The individual then experiences an intense craving to use the drug again to stop the crash and reinstate the euphoria.” NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 26 (3d ed. 2018) [hereinafter NAT’L INST. ON DRUG ABUSE, PRINCIPLES].

60. “Fentanyl is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent.” *Fentanyl*, NAT’L INST. ON DRUG ABUSE (Feb. 2019), <https://d14rmgtrwzf5a.cloudfront.net/publications/drugfacts/fentanyl> [<https://perma.cc/X372-UAL8>]. Non-pharmaceutical fentanyl is sold as powder, spiked on blotter paper, mixed with or substituted for heroin, or as tablets that mimic other, less potent opioids. DRUG & CHEM. EVALUATION SECTION, DIVERSION CONTROL DIV., DRUG ENF’T ADMIN., ACETYL FENTANYL 1 (2020), http://www.deadiversion.usdoj.gov/drug_chem_info/acetylfentanyl.pdf [<https://perma.cc/6G6V-6J6E>]. Fentanyl’s effects resemble those of heroin and include euphoria, drowsiness, nausea, confusion, constipation, sedation, tolerance, addiction, respiratory depression and arrest, unconsciousness, coma, and death. *Fentanyl*, *supra*.

are more easily obtainable and less expensive than prescription opioids.⁶¹ Heroin and fentanyl are good substitutes for addicted patients because they interact with the brain reward circuit in the same way as prescription opioids.⁶²

Because opioids have the potential for abuse or “psychological or physical dependence,”⁶³ the federal government regulates the manufacture, distribution, and use of prescription and illicit opioids through the Controlled Substances Act (CSA).⁶⁴ Through the CSA, the Drug Enforcement Administration (DEA) is able to regulate the lawful production and distribution of opioids and prevent diversion⁶⁵ of lawfully obtained opioids from legitimate purposes.⁶⁶

In addition, the CSA imposes penalties for unauthorized activities involving opioids.⁶⁷ Through registration requirements, the CSA creates a system where lawful distribution may only occur among registered handlers of controlled substances.⁶⁸ Under the CSA, registrants are required to keep complete and accurate records of all transactions involving controlled substances.⁶⁹ Further, they are required to report “every sale, delivery, disposal, or dispensing of any controlled substance.”⁷⁰ Pursuant to the CSA, only licensed medical practitioners may prescribe controlled substances to

61. Valarie K. Blake, *Engaging Health Insurers in the War on Prescription Painkillers*, 11 HARV. L. & POL’Y REV. 485, 491–92 (2017).

62. *Id.* (explaining that four out of five heroin addicts were first addicted to prescription opioids).

63. BRIAN T. YEH, CONG. RESEARCH SERV., R45164, LEGAL AUTHORITIES UNDER THE CONTROLLED SUBSTANCES ACT TO COMBAT THE OPIOID CRISIS, at Summary (2018), <https://fas.org/sgp/crs/misc/R45164.pdf> [<https://perma.cc/YU6N-5SCQ>].

64. 21 U.S.C. §§ 801–904 (2018).

65. “The DEA has explained that the term ‘diversion,’ used in the context of the CSA, refers to ‘the redirection of controlled substances which may have lawful uses into illicit channels.’” YEH, *supra* note 63, at 1 n.6. (quoting Controlled Substances Quotas, 83 Fed. Reg. 32,784 (July 16, 2018) (to be codified at 21 C.F.R. pt. 1303)).

66. *Id.* at 1.

The CSA imposes specific obligations on registrants in an effort to reduce the potential diversion of controlled substances out of legitimate distribution channels. In particular, the CSA imposes legal duties relating to (1) recordkeeping by registrants, (2) measures ensuring the secure storage of controlled substances handled by registrants, (3) reporting certain information to the DEA, (4) prescribing and dispensing controlled substance medications by registered doctors and pharmacists, and (5) the quantity of controlled substance that may be produced by manufacturers.

Id. at 10–11 (footnote omitted).

67. *Id.* at 1.

68. *Id.* (explaining that “drug manufacturers, wholesale distributors, exporters, importers, health care professionals, hospitals, pharmacies, and scientific researchers” must register with the DEA and keep records concerning their inventories and the distribution thereof).

69. “For example, a registrant must make a complete and accurate record of each substance manufactured, received, sold, delivered, or otherwise disposed of by the registrant.” *Id.* at 11 (citing 21 U.S.C. § 827(a)(3) (2018); 21 C.F.R. § 1304.21(a) (2018)).

70. *Id.* at 12 (citing 21 U.S.C. § 827(d) (2018)).

patients, and the prescription must be “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.”⁷¹

Unfortunately, a key contributor to drug abuse and addiction is diversion due to a registered entity’s failure to comply with the requirements of the CSA.⁷² This type of diversion can typically be seen in “pill mills”⁷³ where practitioners liberally prescribe opioids in the absence of a legitimate medical need.⁷⁴ It can also be found where manufacturers fail to report suspicious orders of controlled substances.⁷⁵

B. *The Opioid Crisis*

At any given time, there are around 100 million adults in the United States suffering from chronic pain.⁷⁶ Pain management is incredibly important because it has a huge impact on patient physiology and quality of life.⁷⁷ There has long been a concern in the medical community that treating chronic pain patients with morphine or other opioids would lead to tolerance and addiction.⁷⁸ Thus, physicians were hesitant to use opioids to treat chronic pain. In the 1970s and 1980s, however, specialists in palliative care began to use opioids to provide relief to terminal patients.⁷⁹ At the same time, the World Health Organization (WHO) included opioids in its cancer pain treatment guidelines and recognized that pain treatment was a

71. *Id.* at 14 (quoting 21 C.F.R. § 1306.04(a)(1) (2018)).

72. *Id.* at 2.

73. “The difference between pill mills and legitimate pain specialists is the volume of patients seen, prescriptions written, and limited medical exams. Most only accept cash payments.” Brian Krans, *More ‘Pill Mill’ Doctors Prosecuted Amid Opioid Epidemic*, HEALTHLINE (May 19, 2016), <https://www.healthline.com/health-news/pill-mill-doctors-prosecuted-amid-opioid-epidemic#1> [<https://perma.cc/6NUV-MZ52>].

74. YEH, *supra* note 63, at 2.

75. *Id.* at 35 (quoting Pub. L. No. 115-271, § 3272(a), 132 Stat. 3895, 3952 (2018)).

76. D. Andrew Tompkins, J. Greg Hobelmann & Peggy Compton, *Providing Chronic Pain Management in the “Fifth Vital Sign” Era: Historical and Treatment Perspectives on a Modern-Day Medical Dilemma*, 173 DRUG & ALCOHOL DEPENDENCE (SUPPLEMENT) S11, S12 (2017). Chronic pain is pain that has persisted for more than three months. *Id.* at S11.

77. As Yaksh and Wallace explain in *Goodman & Gilman’s the Pharmacological Basis of Therapeutics*:

Failure to adequately manage pain can have important negative consequences on physiological function, such as autonomic hyperreactivity (increased blood pressure, heart rate, suppression of GI motility, reduced secretions); and reduced mobility, leading to deconditioning, muscle wasting, joint stiffening, and decalcification; and can contribute to deleterious changes in the psychological state (depression, helplessness syndromes, anxiety).

Tony Yaksh & Mark Wallace, *Opioids, Analgesia, and Pain Management*, in GOODMAN & GILMAN’S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS 355, 379 (13th ed. 2018).

78. Tompkins, Hobelmann & Compton, *supra* note 76, at S13.

79. *Id.*

“universal right.”⁸⁰ In the 1990s, there was a heightened focus on pain management. There was a sense that patients with pain were not receiving the care that they needed.⁸¹

The American Pain Society (APS) began its “Pain, The Fifth Vital Sign” campaign, which argued that patients were undertreated because pain was not regularly assessed at hospitals or physician offices.⁸² During the campaign, opioids were described as a potential treatment option for pain patients.⁸³ The campaign also emphasized the need to reexamine the use of opioids for chronic pain and to improve quality at end of life.⁸⁴ The campaign was funded in large part by opioid manufacturers.⁸⁵ Former APS president, Dr. Russell Portenoy, has “admitted to overstating claims for the safety and effectiveness of opioids in order to break down what he regarded as unwarranted resistance within the medical profession to prescribing them.”⁸⁶ Purdue Pharma then paid Portenoy to help drive sales of OxyContin.⁸⁷ Ultimately, the Fifth Vital Sign campaign was very successful, and by the late 1990s it was well recognized that patients should be assessed and treated for pain.⁸⁸

The Joint Commission on the Accreditation of Healthcare Organizations (Joint Commission)⁸⁹ also made the treatment of pain a top priority.⁹⁰ It

80. *Id.*

81. Brian F. Mandell, *The Fifth Vital Sign: A Complex Story of Politics and Patient Care*, 83 CLEVELAND CLINIC J. MED. 400, 400 (2016).

82. *Id.* Vital signs are objective clinical measurements that indicate the state of a patient’s essential body functions which include: pulse rate, temperature, respiration rate, and blood pressure. Pain, on the other hand, is a “subjective feeling that is impossible to accurately and consistently quantify across patient populations.” Myles Gart, *Pain Is Not the Fifth Vital Sign*, MED. ECON. (May 20, 2017), <https://www.medicaleconomics.com/medical-economics-blog/pain-not-fifth-vital-sign> [<https://perma.cc/S86S-5ZBR>].

83. Tompkins, Hobelmann & Compton, *supra* note 76, at S13.

84. *Id.*

85. Chris McGreal, *US Medical Group that Pushed Doctors to Prescribe Painkillers Forced to Close*, GUARDIAN (May 25, 2019), <https://www.theguardian.com/us-news/2019/may/25/american-pain-society-doctors-painkillers> [<https://perma.cc/8CQF-FUTU>].

86. *Id.*

87. *Id.*

88. Tompkins, Hobelmann & Compton, *supra* note 76, at S13.

89. The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. *Facts About the Joint Commission*, JOINT COMMISSION, <https://www.jointcommission.org/about-us/facts-about-the-joint-commission/> [<https://perma.cc/LGQ8-4TC7>]. It is the “oldest and largest standards-setting and accrediting body in health care.” *Id.* It accredits over 22,000 health care organizations and programs in the United States. *Id.* Health care organizations accredited by the Joint Commission must abide by the Joint Commission standards in order to get reimbursed for care provided to Medicare and Medicaid patients. *Hospital Accreditation and Certification Options*, JOINT COMMISSION, <https://www.jointcommission.org/accreditation-and-certification/health-care-settings/hospital/learn/accreditation-options-certifications/> [<https://perma.cc/7KSY-2SBX>].

90. The Joint Commission first issued its standards on pain management in 2001. These standards, as they currently stand, are as follows:

conditioned the receipt of federal health care dollars for accredited health care settings on the assessment and treatment of pain for all patients.⁹¹ Because pain is subjective, however, providers needed to ascribe a numerical value to the pain to properly assess it.⁹² This led to the creation of the zero to ten pain scale.⁹³ In response to the Joint Commission's pain assessment and treatment requirement, many hospitals liberalized the use of opioids and physicians were encouraged to "use opioids to control pain quickly and as completely as possible."⁹⁴ Importantly, however, the Joint Commission's pain assessment and treatment requirement did not recommend or even mention opioids. Although the American Pain Society's Fifth Vital Sign campaign became conjoined with the Joint Commission's 2001 pain assessment and treatment standards, the Joint Commission maintains that it "does not endorse pain as a vital sign" and that this is not part of the accreditation standards.⁹⁵ Further, it states that its accreditation

Our foundational standards are quite simple. They are:

- The hospital educates all licensed independent practitioners on assessing and managing pain.
- The hospital respects the patient's right to pain management.
- The hospital assesses and manages the patient's pain.

Requirements for what should be addressed in organizations' policies include:

- 1) The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition.
- 2) The hospital uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand.
- 3) The hospital reassess and responds to the patient's pain, based on its reassessment criteria.
- 4) The hospital either treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect a patient-centered approach and consider the patient's current presentation, the health care providers' clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

Clemens, *Joint Commission Statement on Pain Management*, ANESTHESIA EXPERTS (Apr. 25, 2016), <https://anesthesiaexperts.com/uncategorized/joint-commission-statement-pain-management/> [<https://perma.cc/KR5H-8Z7C>].

91. "The . . . standards require that organizations establish policies regarding pain assessment and treatment and conduct educational efforts to ensure compliance." Press Release, Joint Comm'n, Clarification of April 13, 2016, Statement on Pain Management from David W. Baker (Apr. 18, 2016), https://jointcommission.new-media-release.com/2016_statement/downloads/April_2016_Pain_Statement.pdf [<https://perma.cc/3MBY-DFK7>]. The Joint Commission notes, however, that the standards "d[id] not require the use of drugs to manage a patient's pain." Matthew Perrone, *Painkiller Critics Take Aim at Hospital Surveys, Procedures*, AP NEWS (Apr. 13, 2016), <https://apnews.com/a48f0d9556c3442394da1f5b44e01692> [<https://perma.cc/EN6C-4KL5>] (quoting the Joint Commission).

92. Gart, *supra* note 82.

93. *Id.*

94. Tompkins, Hobelmann & Compton, *supra* note 76, at S14.

95. Press Release, Joint Comm'n, *supra* note 91.

standards “advocated for an individualized patient-centric approach” to pain rather than reliance on a pain score.⁹⁶

While pain was being touted as the Fifth Vital Sign, pharmaceutical manufacturers were aggressively marketing opioids for pain. In 1995, the Food and Drug Administration (FDA) approved Purdue Pharma’s drug OxyContin, a time-released version of oxycodone, for the treatment of moderate to severe pain.⁹⁷ From 1996 to 2001, Purdue Pharma aggressively marketed OxyContin as less addictive than other opioids.⁹⁸ Purdue Pharma’s own studies, however, showed that patients became addicted to OxyContin and suffered from withdrawal symptoms when they stopped using it.⁹⁹ The marketing campaign was incredibly successful. From 1997 to 2002, the number of prescriptions for Oxycontin went from 670,000 to 6.2 million.¹⁰⁰ OxyContin, however, was not the only opioid that had a sharp increase in prescriptions in the 1990s and 2000s. Indeed, the number of prescriptions for all opioids increased during that time.

The Fifth Vital Sign campaign, aggressive marketing of opioids, and liberal prescribing policies all contributed to the opioid crisis. More than 2.5 million Americans suffer from opioid use disorder.¹⁰¹ In 2014, there were 28,000 overdose deaths attributed to opioids.¹⁰² As a result of the opioid crisis, many more Americans are seeking treatment for substance and opioid use disorder.

II. SUBSTANCE AND OPIOID USE DISORDER TREATMENT

This Part discusses the treatment options for individuals suffering from substance or opioid use disorder. While the focus of the Article is on residential drug rehabilitation facilities and sober living homes, there is a continuum of treatment services for SUD patients. As individuals recover

96. *Id.*

97. *Timeline of Selected FDA Activities and Significant Events Addressing Opioid Misuse and Abuse*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/drugs/information-drug-class/timeline-select-d-fda-activities-and-significant-events-addressing-opioid-misuse-and-abuse> [https://perma.cc/2DZ8-JUUR] (last updated Dec. 20, 2019).

98. Katrice Bridges Copeland, *The Crime of Being in Charge: Executive Culpability and Collateral Consequences*, 51 AM. CRIM. L. REV. 799, 821 (2014) (explaining that Purdue Pharma “claimed that intravenous abuse was more difficult with OxyContin, that it created less risk of addiction than immediate release opioids, that patients would not develop a tolerance to the drug or experience withdrawal symptoms, and that it caused less euphoria than immediate-release opioids”).

99. *Id.*

100. Tompkins, Hobelmann & Compton, *supra* note 76, at S14.

101. NAT’L INST. ON DRUG ABUSE, EFFECTIVE TREATMENTS FOR OPIOID ADDICTION 1 (2016), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/policybrief-effectivetreatments.pdf> [https://perma.cc/MC5A-5CDY].

102. *Id.*

from SUD, they move through the range of services and sometimes need to transition to care that is greater or less intense, depending on their needs. For example, a SUD patient might begin at a detoxification center and then move to a residential drug rehabilitation program or an intensive outpatient care facility. Alternatively, a SUD patient might begin with outpatient care and realize that more intense care is needed and transition to a residential rehabilitation facility.

This Part also examines the role of public and private insurance in paying for treatment. Specifically, it addresses the expansion in coverage for SUD treatment due to the Mental Health Parity and Addiction Equity Act of 2008 and the ACA and its impact on the drug rehabilitation industry.

A. Treatment Options

Detoxification, or medically supervised withdrawal, focuses on the elimination of substance use.¹⁰³ Detoxification services use both medical and clinical procedures to assist patients as they withdraw from the effects of substance abuse.¹⁰⁴ Detoxification is only the first step of treatment.¹⁰⁵ If a patient only receives detoxification services, it is unlikely that the patient will achieve long-term abstinence from drug use.

The Drug Addiction Treatment Act of 2000¹⁰⁶ permits physicians to treat opioid use disorder with narcotic medications. Medication-assisted treatment (MAT),¹⁰⁷ as it is called, is the use of medications with counseling and behavioral therapies to treat SUD and prevent opioid overdose. Opioid treatment programs (OTPs) provide MAT for individuals diagnosed with opioid use disorder. OTPs must be accredited and certified by the Substance

103. *Treatment Options*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Oct. 2019), <https://findtreatment.gov/content/treatment-options/what-happens-next> [<https://perma.cc/SNF7-XE6R>].

104. *Id.*

105. NAT'L INST. ON DRUG ABUSE, UNDERSTANDING DRUG ABUSE AND ADDICTION: WHAT SCIENCE SAYS 24, <https://www.drugabuse.gov/node/pdf/1921/understanding-drug-abuse-and-addiction-what-science-says> [<https://perma.cc/2LEP-BH7D>] (last updated Feb. 2016).

106. Pub. L. No. 106-310, 114 Stat. 1222 (2000) (codified as amended at 21 U.S.C. §§ 823(g), 824 (2018)). The DATA expands access to patients by permitting certified physicians to prescribe FDA-approved drugs to treat opioid use disorder without being affiliated with a specialized treatment clinic. NAT'L INST. ON DRUG ABUSE, MEDICATIONS TO TREAT OPIOID USE DISORDER 6, <https://www.drugabuse.gov/node/pdf/21349/medications-to-treat-opioid-use-disorder> [<https://perma.cc/ADN3-M4WA>] (last updated June 2018) [hereinafter NAT'L INST. ON DRUG ABUSE, MEDICATIONS].

107. Unlike rehabilitation facilities, the use of MAT is heavily regulated and requires accreditation standards and certification processes. *Medication-Assisted Treatment: Statutes, Regulations, and Guidelines*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T HEALTH & HUM. SERVS., <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/legislation-regulations-guidelines> [<https://perma.cc/M2GR-D5GU>] (last updated Sept. 9, 2019).

Abuse and Mental Health Services Administration.¹⁰⁸ Approximately 10 percent of all treatment facilities offer OTPs.¹⁰⁹

The medications used to treat opioid use disorder are opiate agonists,¹¹⁰ partial agonists,¹¹¹ and antagonists.¹¹² Methadone, for example, is a synthetic opioid agonist that has been used for more than forty years to treat opioid use disorder.¹¹³ Studies have found methadone to be effective at reducing opioid use.¹¹⁴ Buprenorphine is a partial opioid agonist and has been found to be as “effective as methadone for treating opioid use disorders.”¹¹⁵ Although individuals who do not suffer from opioid use disorder could get high on methadone or buprenorphine because they interact with the brain’s opioid receptors, the effect on individuals who suffer from opioid use disorder is to minimize withdrawal¹¹⁶ symptoms and cravings. Patients who are treated with methadone or buprenorphine can “function normally, attend school or work, and participate in other forms of treatment or recovery support services to help them become free of their substance use disorder over time.”¹¹⁷ Naltrexone is an opioid antagonist that is used to prevent opioids from producing euphoria.¹¹⁸ Before a doctor prescribes naltrexone to a patient, the patient must go through full detoxification.¹¹⁹

108. *Id.*

109. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS): 2017, at 3 (2018), https://www.dasis.samhsa.gov/dasis2/nssats/2017_nssats_rpt.pdf [<https://perma.cc/TMB4-6DJX>] [hereinafter SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL SURVEY].

110. An opioid agonist attaches to opioid receptors in the brain but activates them more slowly than other opioids. When opioid agonists are used by an opioid-dependent person, the doses do not produce euphoria. Opioid agonists help to eliminate drug withdrawal symptoms and reduce drug cravings. NAT’L INST. ON DRUG ABUSE, MEDICATIONS, *supra* note 106, at 5–6.

111. A partial opioid agonist binds to the “same opioid receptors [as agonists] but activates them less strongly than full agonists do.” *Id.* at 5. They are used to “reduce cravings and withdrawal symptoms . . . without producing euphoria.” *Id.*

112. An opioid antagonist attaches to opioid receptors without activating them. *Id.* at 6. It works by blocking the activation of opioid receptors. *Id.* Thus, it does not control withdrawal symptoms or cravings. *Id.* Instead, it prevents an opioid drug from producing euphoria. *Id.*

113. *Id.* at 5.

114. *Id.* at 8.

115. *Id.* at 5–6.

116. Withdrawal refers to the symptoms that occur after ceasing the use of opioid drugs. AM. SOC’Y OF ADDICTION MED., OPIOID ADDICTION TREATMENT: A GUIDE FOR PATIENTS, FAMILIES AND FRIENDS 6 (2016), <https://eguideline.guidelinecentral.com/i/706017-asam-opioid-patient-piece/> [hereinafter AM. SOC’Y OF ADDICTION MED., OPIOID ADDICTION TREATMENT]. Withdrawal is often between three to five days, but can last up to ten days. *Id.* Withdrawal symptoms include vomiting, cramps, and sweating. *Id.*

117. NAT’L INST. ON DRUG ABUSE, MEDICATIONS, *supra* note 106, at 13.

118. *Id.* at 6.

119. *Id.* at 12.

Intensive outpatient programs provide care while the patient is able to maintain outside responsibilities such as working and attending school.¹²⁰ “[I]ntensive outpatient services include individual and group counseling, educational groups, occupational and recreational therapy, psychotherapy, MAT, motivational interviewing, enhancement and engagement strategies, [and] family therapy”¹²¹ This level of care provides “a support system including medical, psychological, psychiatric, laboratory, and toxicology services within 24 hours by telephone or within 72 hours in person.”¹²²

Residential treatment centers¹²³ “offer 24-hour structured and intensive care, including safe housing and medical attention.”¹²⁴ Residential treatment “focuses on developing personal accountability and responsibility as well as socially productive lives.”¹²⁵ Residential treatment centers often use a variety of therapeutic approaches with the goal of helping the patient lead a drug-free life following treatment.¹²⁶ The treatment for drug addiction typically includes both medical and mental health services.¹²⁷ Mental health services may involve cognitive-behavioral therapy which teaches patients to “identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse,”¹²⁸ behavioral counseling, as well as treatment for depression and anxiety.¹²⁹ Typically,

120. AM. SOC’Y OF ADDICTION MED., OPIOID ADDICTION TREATMENT, *supra* note 116, at 4; *Outpatient Drug and Alcohol Rehab*, HAZELDEN BETTY FORD FOUND., <https://www.hazeldenbettyford.org/treatment/models/outpatient> [<https://perma.cc/4TQV-ZPKX>].

121. MEDICAID INNOVATION ACCELERATOR PROGRAM, OVERVIEW OF SUBSTANCE USE DISORDER (SUD) CARE CLINICAL GUIDELINES: A RESOURCE FOR STATES DEVELOPING SUD DELIVERY SYSTEM REFORMS 7 (2017), <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf> [<https://perma.cc/T7AL-L54F>].

122. *Id.*

123. The American Society of Addiction Medicine (ASAM) breaks residential treatment programs into four sublevels that represent a range of intensities of service (low-intensity, population-specific high-intensity, clinically managed high-intensity, and medically monitored inpatient programs). *What Is the ASAM Criteria?*, AM. SOC’Y ADDICTION MED., <https://www.asam.org/resources/the-asam-criteria/about> [<https://perma.cc/7Z76-TK2Y>]. For purposes of this Article, however, all residential treatment centers are grouped together.

124. NAT’L INST. ON DRUG ABUSE, TREATMENT APPROACHES FOR DRUG ADDICTION 5 (2019), <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/drugfacts-treatmentapproaches.pdf> [<https://perma.cc/N7CT-M4A8>] [hereinafter NAT’L INST. ON DRUG ABUSE, TREATMENT APPROACHES].

125. NAT’L INST. ON DRUG ABUSE, PRINCIPLES, *supra* note 59, at 33.

126. NAT’L INST. ON DRUG ABUSE, TREATMENT APPROACHES, *supra* note 124, at 5.

127. *Id.*

128. NAT’L INST. ON DRUG ABUSE, PRINCIPLES, *supra* note 59, at 48. “Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations.” *Id.* at 48–49.

129. NAT’L INST. ON DRUG ABUSE, TREATMENT APPROACHES, *supra* note 124, at 2.

the programs at residential treatment centers are highly structured and require that the patient remain at the residence for six to twelve months.¹³⁰

Partial hospitalization programs are appropriate for patients who are living with unstable medical and psychiatric conditions.¹³¹ These programs involve a structured outpatient setting that offers direct access to psychiatric, medical, and laboratory services.¹³² These programs “provide 20 hours or more of clinically intensive programming each week to support patients who need daily monitoring and management in a structured outpatient setting.”¹³³

Many patients follow up their residential treatment with recovery housing, often termed soberliving homes, which provides supervised, short-term housing for patients as they transition to an independent and drug-free life.¹³⁴

B. *The Role of Public and Private Insurance*

Historically, individuals suffering from SUD were stigmatized because there was a general belief that people suffering from addiction caused their own illness and, as a result, did not deserve treatment.¹³⁵ Further, private health insurers either did not cover SUD treatment or did not fund it at the same level as other medical or surgical care.¹³⁶ There was a misconception that SUD treatment was too costly to include in insurance.¹³⁷ The cost of treatment is a substantial barrier for someone who is suffering from substance or opioid use disorder.¹³⁸ The Mental Health Parity and Addiction Equity Act and the Affordable Care Act, however, expanded coverage for

130. *Id.* at 5.

131. MEDICAID INNOVATION ACCELERATOR PROGRAM, *supra* note 121, at 7.

132. *Id.*

133. *Id.*

134. NAT’L INST. ON DRUG ABUSE, TREATMENT APPROACHES, *supra* note 124, at 5.

135. Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 557 (2014) (explaining that in addition to the self-stigma and societal stigma, there are also structural stigmas that harm people with SUD). “A ‘structural stigma refers to the rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups.’” *Id.* (quoting James D. Livingston et al., *The Effectiveness of Interventions for Reducing Stigma Related to Substance Use Disorders: A Systematic Review*, 107 ADDICTION 39, 39–40 (2012)).

136. Blake, *supra* note 61, at 501.

137. Barnes & Worthy, *supra* note 135, at 557–58 (explaining that in reality “it is more costly to let SUDs go untreated because SUD treatment reduces associated health and social costs by well over the cost of treatment itself”).

138. In 2013, 37 percent of those who sought but did not receive treatment cited lack of coverage and inability to afford the cost as the reason they did not receive treatment. PEW CHARITABLE TRS. & JOHN D. & CATHERINE T. MACARTHUR FOUND., SUBSTANCE USE DISORDERS AND THE ROLE OF THE STATES 11 (2015) [hereinafter PEW RESEARCH].

SUD under both public and private insurance. This expansion of coverage made it easier for patients to afford treatment.

I. Private Insurance

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)¹³⁹ and the Affordable Care Act (ACA)¹⁴⁰ have had a significant impact on SUD treatment. The MHPAEA was passed in 2008 and became effective in 2010. The MHPAEA requires group health plans and health insurance issuers (public and private) providing group health plans that offer mental health or SUD benefits to eliminate differences in treatment limits between mental health or SUD treatment and medical/surgical benefits.¹⁴¹ Thus, co-pays, deductibles, and visit limits must be the same. MHPAEA does not, however, mandate that a health insurance plan provide mental health or SUD benefits.

The ACA was passed in 2010 and became effective in 2014. The ACA extends MHPAEA to qualified health care plans,¹⁴² Medicaid non-managed care plans, and plans offered through the individual market.¹⁴³ The cornerstone of the ACA, the individual mandate, required individuals to obtain minimum essential health insurance coverage or pay a penalty for failure to do so.¹⁴⁴ SUD treatment is included as an essential benefit that private insurers who participate in the online health exchange must

139. Pub. L. No. 110-343, 122 Stat. 3881 (2008) (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C., 42 U.S.C.). In 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA), which eliminated differences in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. MHPAEA amends MHPA to include parity for SUD. 45 C.F.R. §§ 146–47 (2018).

140. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 18001–18122 (2018)).

141. 45 C.F.R. § 146.136 (2018). It should be noted, however, that in 2017 20 percent of states offered ACA plans that violated these parity requirements. CTR. ON ADDICTION, UNCOVERING COVERAGE GAPS II: A REVIEW AND COMPARISON OF ADDICTION BENEFITS IN ACA PLANS 3 (2019), <https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-ii-review-and-comparison-addiction-benefits-aca> [https://perma.cc/ZB9J-8FQ5].

142. Qualified health care plans are offered through exchanges and must meet specific statutorily defined requirements that include essential health benefits. AMANDA K. SARATA, CONG. RESEARCH SERV., R41249, MENTAL HEALTH PARITY AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010, at 5 (2011). 42 U.S.C. § 18021(a)(1) (2018) provides that a qualified health plan must: (1) have a certification that it meets the criteria in § 18031(c) of the ACA; (2) provide the essential health benefits set forth in § 18022(a) of the ACA; and (3) be offered by a licensed health insurer in good standing in the state where insurance is offered.

143. SARATA, *supra* note 142, at 4.

144. 26 U.S.C. § 5000A (2012). The Tax Cuts and Jobs Act, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017), repeals the penalty for failure to be covered by a health plan that provides minimum essential coverage.

provide.¹⁴⁵ Further, laboratory testing (including drug testing) is also an essential benefit.¹⁴⁶

In addition to the minimum essential coverage requirements, the ACA also changed dependent child coverage. Prior to the ACA, health plans could remove children from their parents' coverage when they became adults.¹⁴⁷ The ACA requires insurers that provide dependent child coverage to allow parents to keep their children on their policies until the age of twenty-six.¹⁴⁸ This is critical because according to the National Institute on Drug Abuse, "[y]oung adults (age 18 to 25) are the biggest abusers of prescription (Rx) opioid pain relievers, ADHD stimulants, and anti-anxiety drugs."¹⁴⁹ Thus, the ACA provided access to treatment to college students and graduates who would otherwise not be covered under their parents' health insurance plans.

Prior to this expanded coverage under the MHPAEA and the ACA, many treatment facilities only accepted direct payments.¹⁵⁰ Now, most patients pay with insurance.¹⁵¹ Insurance plans, however, vary with respect to the

145. 42 U.S.C. § 18022(b)(1)(E) (2018). It should be noted, however, that implementation of these expansions has not been perfect. According to the Columbia University Center on Addiction, over half of the states that offered ACA plans in 2017 failed to comply with the requirements for SUD coverage. CTR. ON ADDICTION, *supra* note 141, at 3. Further, the ACA does not specify which SUD benefits must be covered. *Id.* at 2. "Instead, each state selects a benchmark plan (the 'EHB benchmark plan') to serve as a template. The benefits offered in the EHB benchmark plan become the minimum level of SUD coverage that ACA plans sold in the state must cover." *Id.*

146. 42 U.S.C. § 18022(b)(1)(H) (2018).

147. *Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families FAQs*, U.S. DEP'T LAB., <https://www.dol.gov/agencies/ebsa/about-eb-sa/our-activities/resource-center/faqs/young-adult-and-aca> [<https://perma.cc/N8ZR-F3B2>].

148. 29 C.F.R. § 2590.715–2714(a)(1) (2018). To stay on a parent's plan, children do not have to live with their parents, attend school, be financially dependent on their parents, be unmarried, be ineligible for other coverage, or be unemployed. *See* 29 C.F.R. § 2590.715–2714(b) (2018).

149. *Abuse of Prescription (Rx) Drugs Affects Young Adults Most*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/trends-statistics/infographics/abuse-prescription-rx-drugs-affects-young-adults-most> [<https://perma.cc/B2UQ-MF7Y>] (last updated Feb. 2016). Indeed, adolescents are "particularly susceptible" to SUD because "the adolescent brain is learning patterns that persist into adulthood. If the disruptive patterns laid down by substance misuse during adolescence become dominant, the adult brain becomes 'wired' into them. The adult then finds it difficult, if not impossible, to respond appropriately to emotional, cognitive, and social environmental cues." David E. Smith, *The Evolution of Addiction Medicine as a Medical Specialty*, 13 AM. MED. ASS'N J. ETHICS 900, 903 (2011).

150. Rick Rifken & Judith A. Waltz, *Beyond the 12 Steps: Key Legal Issues for Substance Use Disorder Treatment Facilities*, 18 J. HEALTH CARE COMPLIANCE 15, 15 (2016). "As of 2008, about 40 percent of nonprofit substance abuse facilities did not accept private insurance or Medicaid. About half had no contracts with managed care plans. About 20 percent of substance abuse treatment facilities have no information systems to support appointment scheduling, billing, or medical records functions." PATRICIA BOOZANG ET AL., CTRS. FOR MEDICARE & MEDICAID SERVS., TECHNICAL ASSISTANCE BRIEF NO. 2, COVERAGE AND DELIVERY OF ADULT SUBSTANCE ABUSE SERVICES IN MEDICAID MANAGED CARE 4 (2014) (footnote omitted), <https://www.medicare.gov/sites/default/files/2019-12/cms-adult-substance-abuse-services-coverage.pdf> [<https://perma.cc/TTF6-LPFW>].

151. Patients receive treatment from rehabilitation facilities, but they do not pay for it directly. *See* John T. McLean & Vinay Datar, *Mastering the Chargemaster: Minimizing Price-Gouging and*

types of services carried, treatment limits, and which health and mental health providers are covered. Private residential treatment centers can cost from \$7,500 a month to as much as \$80,000 to \$120,000 per month based on location, length of time of treatment, type of treatment, and other amenities.¹⁵² “Most sober living houses are privately owned and will bill residents directly, though some accept insurance or Medicaid.”¹⁵³

In California, and other states that follow its model, patients suffering from SUD can purchase insurance the day they arrive in California from out of state through Covered California.¹⁵⁴ Once covered, the ACA requires that the insurer pay for addiction recovery. In some cases, the treatment center pays the premium of the patients newly signed up for health insurance.¹⁵⁵

2. Public Insurance

Federal health care programs, such as Medicare and Medicaid, provide assistance for individuals seeking SUD treatment. Medicare covers residential drug treatment centers, partial hospitalization, outpatient programs, and counseling.¹⁵⁶ Beginning in 2020, Medicare also covers MAT provided through OTPs.¹⁵⁷ In 2009, Medicare only accounted for 5 percent of SUD treatment.¹⁵⁸ Medicaid coverage varies by state. For those states that expanded Medicaid through the ACA, Medicaid includes SUD treatment and recovery services.¹⁵⁹ For states that did not expand Medicaid, there are limited services covered such as physician services and inpatient services (including medically necessary inpatient detoxification).¹⁶⁰ This means that in many states there is no coverage for residential treatment at

Exposing the Structural Flaws in the Healthcare “Market,” 9 PITT. J. ENVTL. & PUB. HEALTH L. 1, 19–20 (2014).

Because insured patients are only responsible for their deductible and co-pay, they are unlikely to know or be concerned with the cost of care. *Id.*

152. Buddy T, *The Costs of Alcohol and Drug Treatment*, VERYWELL MIND, <https://www.verywellmind.com/the-costs-of-alcohol-and-drug-treatment-67863> [<https://perma.cc/BSJ4-TPF3>] (last updated July 1, 2019).

153. *Paying for Treatment*, ADDICTION.COM, <https://www.addiction.com/get-help/loved-one/paying-treatment-for-loved-one/> [<https://perma.cc/8AFE-6YU9>].

154. Sforza et al., *supra* note 31.

155. Ferguson, *Searching for Help*, *supra* note 25.

156. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., MLN MATTERS SE1606, MEDICARE COVERAGE OF SUBSTANCE ABUSE SERVICES (2016), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf> [<https://perma.cc/4R9U-J6XX>].

157. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., MLN BOOKLET, MEDICARE MENTAL HEALTH 3 (2020), <https://www.cms.gov/files/document/medicare-mental-health-print-friendly.pdf> [<https://perma.cc/38M3-2KNE>].

158. PEW RESEARCH, *supra* note 138, at 11.

159. BOOZANG ET AL., *supra* note 150, at 1.

160. *Id.* at 2–3.

all.¹⁶¹ In 2009, Medicaid accounted for more than 20 percent of spending on SUD treatment.¹⁶²

In addition to federal assistance, state governments also provide funding for people without insurance.¹⁶³ Nearly a third of the money spent to combat SUD comes from state agencies and departments.¹⁶⁴ Some states have even set up their own treatment centers that offer inpatient and outpatient care.¹⁶⁵

The amount of money spent by private and public health insurers for the treatment of opioid use disorder is staggering. Private employer-based health insurers spent \$2.6 billion on the treatment of opioid use disorder in 2016.¹⁶⁶ Medicaid spent \$9.4 billion on enrollees with opioid use disorder in 2013, with nearly half of that money going towards treatment and laboratory services.¹⁶⁷ These figures do not include the amount of money spent on SUD in general.

III. FRAUD IN THE RESIDENTIAL DRUG REHABILITATION MARKET

With billions of insurance dollars at stake, fraud is rampant throughout the drug rehabilitation market. This Part examines the key problems in the

161. Cynthia Reilly & Samantha Arsenault, *Insurance Coverage for Substance Use Disorder Treatment Impedes Care*, PEW CHARITABLE TR. (Mar. 29, 2017), <https://www.pewtrusts.org/en/research-and-analysis/articles/2017/03/29/insurance-coverage-for-substance-use-disorder-treatment-impedes-care> [https://perma.cc/65LC-PBTP]. According to the Kaiser Family Foundation, only thirty-three states covered residential rehabilitation as part of Medicaid in 2018. *Medicaid's Role in Addressing the Opioid Epidemic*, KAISER FAMILY FOUND. (June 3, 2019), <https://www.kff.org/infographic/medicaids-role-in-addressing-opioid-epidemic/> [https://perma.cc/C6KU-B6T6].

162. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., SMA-15-4908, ANALYSES OF MAX CLAIMS: SAMHSA FEE-FOR-SERVICE SPENDING ESTIMATES, MEDICARE-MEDICAID ENROLLEE ANALYSIS, AND MANAGED CARE SUMMARY 1 (2015), <https://store.samhsa.gov/system/files/sma15-4908.pdf> [https://perma.cc/PEX4-BHFQ].

163. *Paying for Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Oct. 2019), <https://findtreatment.gov/content/paying-for-treatment/if-you-dont-have-insurance> [https://perma.cc/2L LG-NTS8].

164. PEW RESEARCH, *supra* note 138, at 7.

165. For example, New York directly operates twelve addiction treatment centers. Office of Addiction Servs. & Supports, *Treatment*, N.Y. STATE, <https://oasas.ny.gov/treatment> [https://perma.cc/XF4X-SRHJ].

166. Cynthia Cox, Matthew Rae & Bradley Sawyer, *A Look at How the Opioid Crisis Has Affected People with Employer Coverage*, PETERSON-KFF HEALTH SYS. TRACKER (Apr. 5, 2018), <https://www.healthsystemtracker.org/brief/a-look-at-how-the-opioid-crisis-has-affected-people-with-employer-coverage/#item-start> [https://perma.cc/TX3B-L74U] (noting the rise in costs from \$300 million in 2004 to \$2.6 billion in 2016).

167. Katherine Young & Julia Zur, Issue Brief, *Medicaid and the Opioid Epidemic: Enrollment, Spending, and the Implications of Proposed Policy Changes*, KAISER FAMILY FOUND. 2 (July 2017), <http://files.kff.org/attachment/Issue-Brief-Medicaid-and-the-Opioid-Epidemic-Enrollment-Spending-and-the-Implications-of-Proposed-Policy-Changes> [https://perma.cc/HV39-UCL9] (breaking down the spending as 31.9% to Managed Care organizations, 21.4% to inpatient treatment, 14.5% to outpatient treatment, 9.7% to prescription drugs, 8.3% to long-term care, 5.8% to physician, laboratory, and x-ray services, and 8.5% to other fee-for-service acute care services).

residential drug rehabilitation market. First, it addresses the fraudulent practices of patient brokering and the overutilization of drug tests. Rehabilitation facilities rely upon patient brokering to obtain patients through trickery and deceit. Once the facilities obtain the patients and pay patient brokers their fee, the facilities then proceed to overtest the patients for drugs through urine screenings to pad their insurance bills. Second, it scrutinizes the care that residential drug rehabilitation facilities are providing patients. It argues that patients are receiving poor care because residential drug treatment programs are focused on abstinence and the twelve-step program rather than evidence-based treatment.

A. Fraudulent Practices at Residential Drug Treatment Facilities

The well-intentioned expansion of health care coverage for SUD combined with the opioid epidemic encouraged many new treatment centers to enter the market to meet the demand for SUD treatment services.¹⁶⁸ Unfortunately, not all of the new entrants into the market are legitimate treatment centers. To remain profitable, these treatment facilities must have a steady stream of patients with insurance. Disreputable rehabilitation facilities have turned to patient brokering and excessive drug urinalysis testing to turn a profit. As NBC news has reported, “the country’s opioid epidemic ha[s] provided [rehabilitation facilities] with a trove of desperate people, many young and hooked on pills or heroin, and access to a deep pool of insurance dollars.”¹⁶⁹

1. Patient Brokering

Patient brokering occurs when a drug rehabilitation facility pays a third party (the patient broker) to recruit patients with insurance who are suffering from SUD.¹⁷⁰ Oftentimes, the patient brokers will offer cash or material

168. Rifenbark & Waltz, *supra* note 150, at 15.

169. Lisa Riordan Seville et al., *Florida’s Billion-Dollar Drug Treatment Industry Is Plagued by Overdoses, Fraud*, NBC NEWS (June 25, 2017, 11:46 PM), <https://www.nbcnews.com/feature/megyn-kelly/florida-s-billion-dollar-drug-treatment-industry-plagued-overdoses-fraud-n773376> [<https://perma.cc/RU36-4QB8>].

170. David Armstrong & Evan Allen, *The Addict Brokers: Middlemen Profit as Desperate Patients Are ‘Treated like Paychecks,’* STAT NEWS (May 28, 2017), <https://www.statnews.com/2017/05/28/addict-brokers-opioids/> [<https://perma.cc/8JRM-XYJW>] [hereinafter Armstrong & Allen, *Addict Brokers*]. As explained by Armstrong and Allen in another article on this issue:

Patient brokers, some of whom are themselves in recovery from drug addiction, are paid by marketers working for treatment centers eager to sign up patients with private insurance plans. For them, the most attractive plans to exploit are PPOs — which stands for preferred provider organizations. These plans often impose few limits on where people with addiction can seek treatment and often actually pay more for rehab provided out of their coverage area.

incentives (such as low rent or free housing, gift cards, prepaid debit cards, gym memberships, etc.) to patients in exchange for them seeking treatment at the facility that contracted with the patient broker.¹⁷¹ The patients operate under the misconception that “they are being referred by a responsible party who has their best interest at heart, but patient brokers and the addiction treatment centers that use them are primarily focused on their finances.”¹⁷² Some patient brokers charge fees ranging from \$500 to \$5,000 per patient and treatment centers pay it because they will receive reimbursements from insurance companies of \$25,000 to \$30,000 per patient per month.¹⁷³ Other patient brokers receive monthly fees from certain facilities but must meet a quota of patients every month.¹⁷⁴ This practice is unethical because patient brokers are motivated by financial incentives rather than the needs of the individual patient.¹⁷⁵

The marketing practices of patient brokers and treatment centers are also incredibly problematic. Prior to changes by Google, patient brokers were bidding on treatment-related keywords on Google such as “rehab near me,” which brought them to the top of Google search results for those terms.¹⁷⁶

HMOs and government insurance plans like Medicaid are shunned by treatment centers engaged in patient brokering because they either limit where treatment can be provided or pay much less than PPOs.

The patients are often enrolled through HealthCare.gov, the online insurance marketplace created by the Affordable Care Act that connects patients to insurers in dozens of states.

The brokers use phony addresses to sign up people immediately — a change of address is an exception to the usual limitation that customers can sign up only during the end-of-year open enrollment period — and to take advantage of the best-paying PPO plans in states in which they don't live. The brokers, patients' families, or marketers for the treatment centers pay the insurance premium. Within a few weeks, the insurer is billed tens of thousands of dollars for what is often subpar care.

David Armstrong & Evan Allen, *Desperate for Addiction Treatment, Patients Are Pawns in Lucrative Insurance Fraud Scheme*, STAT NEWS (July 7, 2017), <https://www.statnews.com/2017/07/07/opioid-insurance-fraud/> [<https://perma.cc/Z3DH-QRBQ>] [hereinafter Armstrong & Allen, *Desperate for Addiction Treatment*].

171. Pacenti, *supra* note 24; Seville et al., *supra* note 169.

172. Jim Peake & Christian Morris, *Patient Brokering in the Addiction Treatment Industry*, ADDICTION-REP NEWS (Apr. 20, 2018), <https://addiction-rep.com/blog/patient-brokering-in-the-addiction-treatment-industry/> [<https://perma.cc/63Q7-62F3>].

173. Pacenti, *supra* note 24; Peake & Morris, *supra* note 172.

174. Armstrong & Allen, *Addict Brokers*, *supra* note 170.

175. It is also illegal under the federal Anti-Kickback statute if the patient has health care through a federal health care program, such as Medicare or Medicaid. See *infra* Part V (discussing the reach of the Anti-Kickback statute).

176. Cat Ferguson, *Exclusive: Google Is Cracking Down on Sketchy Rehab Ads*, VERGE (Sept. 14, 2017, 7:51 PM), <https://www.theverge.com/2017/9/14/16309752/google-rehabs-near-me-search-ads-crackdown> [<https://perma.cc/SA8D-XERS>] [hereinafter Ferguson, *Sketchy Rehab Ads*]; see also Michael Smith et al., *Why It Took Google So Long to End Shady Rehab Center Ads*, BLOOMBERG BUSINESSWEEK (Sept. 26, 2017, 5:00 AM), <https://www.bloomberg.com/news/features/2017-09-26/why-it-took-google-so-long-to-end-shady-rehab-center-ads> [<https://perma.cc/4RDG-MF4J>]. On

The patient brokers or rehab centers paid Google every time someone clicked on their ads.¹⁷⁷ Some of the most unethical brokers were also editing the phone numbers on the web sites of legitimate rehabilitation facilities or creating web pages for non-existent rehabilitation facilities to redirect the calls to call centers.¹⁷⁸

The representatives at the call center will then get detailed information about the type of treatment needed and, most importantly, insurance information so that they can run a verification of benefits.¹⁷⁹ Once the representative has that information, she can calculate how much a policy will pay a facility per day.¹⁸⁰ At that point, the representative (many times a recovering addict herself) will do all that she can to convince the patient to go to a particular treatment center.¹⁸¹ Many treatment centers offer plane tickets and waivers of co-pays and coinsurance, but to get around issues of patient brokering they have patients sign promissory notes to pay them back.¹⁸² As a result of these marketing practices, thousands of addicts arrive in south Florida from Ohio, West Virginia, New Jersey, and Pennsylvania every year.¹⁸³ California residential drug rehabilitation facilities similarly use patient brokers to convince uninsured patients to come to California telling them that they have received a “scholarship” to go into drug rehab.¹⁸⁴ In reality, however, they are signing up for insurance through the California ACA exchange called Covered California.¹⁸⁵

There is simply no concern about whether the patients will ever use drugs again. Relapse is profitable for these treatment centers because insurance companies will pay for a higher level of care if an addict relapses.¹⁸⁶ According to Gene Sullivan, chief financial officer at A New Start Inc. in Palm Springs, legitimate rehabilitation centers have lost patients to patient brokers: “The client brokers come and say all you have to do is pee in this cup, we will buy you food, buy you cigarettes.”¹⁸⁷ Some of the most

September 14, 2017, Google announced that it would no longer accept ads for drug rehabilitation facilities. *Id.*

177. Ferguson, *Sketchy Rehab Ads*, *supra* note 176.

178. Ferguson, *Searching for Help*, *supra* note 25 (explaining that Google’s business listings have a link that says “Suggest an edit” and if a business has not claimed its listing, then it is possible to change the number). Sometimes, even when a business has claimed its Google listing, spammers could edit it anyway and Google did not inform business owners of the changes to their listings. *Id.*

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.*

183. Seville et al., *supra* note 169.

184. Sforza et al., *supra* note 31.

185. *Id.*

186. Pacenti, *supra* note 24.

187. *Id.*

unscrupulous patient brokers hang around sober living homes and wait or encourage a patient to relapse.¹⁸⁸ “The game plan is get these people who are early in recovery, vulnerable and will relapse. Relapse is good business for these flop houses.”¹⁸⁹ Relapse is also incredibly profitable for the patient brokers. Once previously referred patients have relapsed, patient brokers will either refer them back to the original rehabilitation facility or to another facility for a fee.¹⁹⁰ Thus, patient brokers stand to gain more from a patient who relapses because they can receive multiple referral fees.

Florida State Attorney Dave Aronberg has cracked down on patient brokering in the state of Florida. He describes the scam of patient brokering, insurance fraud, and the cycle of opioid dependence and relapse as the “Florida Shuffle.”¹⁹¹ Aronberg created the Sober Homes Task Force in Florida.¹⁹² Since July 2016, the Sober Homes Task Force has made more than ninety arrests and has obtained thirty-six convictions.¹⁹³ The concern is that the success of the Sober Homes Task Force “has sent some of the criminal element in the drug treatment and sober home industries scurrying to other communities and other states that are unaware and unprepared for the Florida Shuffle.”¹⁹⁴

2. *Overutilization of Drug Tests*

Residential drug rehabilitation facilities are often not providing the treatment that the patients need to fully recover from SUD and avoid relapse.¹⁹⁵ Instead of providing treatment, the rehabilitation centers are repeatedly drug testing patients because laboratory testing is included in insurance plans as an essential service.¹⁹⁶ John Lehman, President of the Florida Association of Recovery Residences, has explained it this way: “The only thing [treatment centers and sober living homes] want is for [a

188. *Id.*

189. *Id.*

190. Lurie, *supra* note 5.

191. Palm Beach County State Attorney Dave Aronberg launched a website, www.FixtheFloridaShuffle.com, to urge federal lawmakers to address the crisis in the treatment industry. *Let's Fix the Florida Shuffle!*, FIX FLA. SHUFFLE, <https://www.fixthefloridashuffle.com/> [<https://perma.cc/D57G-UKA7>].

192. *About State Attorney Dave Aronberg*, FIX FLA. SHUFFLE, <https://www.fixthefloridashuffle.com/about> [<https://perma.cc/NCR4-28ZH>].

193. *What Is the Florida Shuffle?*, FIX FLA. SHUFFLE, <https://www.fixthefloridashuffle.com/florida-shuffle> [<https://perma.cc/988Z-4RDS>].

194. *Id.*

195. Armstrong & Allen, *Addict Brokers*, *supra* note 170.

196. Cat Ferguson, *Pee Scams, Kickbacks, and Overdoses Plague South Florida Rehabs*, BUZZFEED NEWS (Sept. 15, 2015, 9:35 PM), <https://www.buzzfeednews.com/article/catferguson/the-rehab-scam> [<https://perma.cc/8MZT-WURL>] [hereinafter Ferguson, *Pee Scams*].

patient] to remain in the program so they can bill the insurance company for as many days as the insurance company will pay for services.”¹⁹⁷ Indeed, drug treatment centers in Florida and California have billed insurance companies for millions of dollars’ worth of treatment comprised of counseling and drug testing without helping the patients recover.¹⁹⁸

Drug testing, which uses a biological sample to detect specific chemical compounds (drugs) in the system, is often considered a necessary component of residential drug rehabilitation.¹⁹⁹ Typically, facilities do everything that they can to ensure that patients do not have access to addictive substances.²⁰⁰ During the intake procedure, the facility examines the patient’s belongings to make sure that the patient has not hidden any substances.²⁰¹ In addition, facilities often screen mail and packages to avoid substances entering the facility.²⁰² To be certain that the patient has not been using substances during her stay, the facility may perform random drug screening as part of the program.²⁰³ Residential drug rehabilitation centers

197. Pacenti, *supra* note 24.

198. Seville et al., *supra* note 169; Sforza et al., *supra* note 31.

199. AM. SOC’Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON DRUG TESTING AS A COMPONENT OF ADDICTION TREATMENT AND MONITORING PROGRAMS AND IN OTHER CLINICAL SETTINGS 1 (2010), https://www.asam.org/docs/default-source/public-policy-statements/1drug-testing--clinical-10-10.pdf?sfvrsn=1b11ac97_0#search=“drugtesting” [<https://perma.cc/AYN2-2WHL>] [hereinafter AM. SOC’Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON DRUG TESTING]. For a history of the use of drug testing, see AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE (2013) [hereinafter AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER] (on file with author).

200. *Will They Drug Test in Rehab?*, RECOVER (July 29, 2017), <https://www.therecover.com/will-they-drug-test-in-rehab/> [<https://perma.cc/3LE2-BSEG>].

201. *Id.*

202. *Id.*

203. *Id.* ASAM has explained the need for random testing as follows:

When drug testing is used in addiction treatment settings, it is best to use random, rather than scheduled, testing and to set the frequency of the random testing higher at the start of treatment, when patients are known to more frequently engage in continued drug use. When the patient has attained a substantial period of stable abstinence from drug use, the frequency of random drug testing can be lowered; however, random testing less frequently than once a month in addiction treatment is seldom wise, even for patients with established abstinence. It is important that the testing be unpredictable, even if it is infrequent, so the patient can be tested at any time, even the day after the prior test. It is also wise to vary the drug testing panels and the matrix used for the testing. These should be as unpredictable to the participant as the date and time of the test itself.

Cost-benefit analysis and risk stratification is necessary in deciding the frequency of drug test monitoring, balancing laboratory science (i.e. chromatographic testing) and behavioral science (i.e. to address deficits in self-monitoring in patients with substance use disorders). The emerging “best clinical practice” means increased cost of testing. The cost to society of not detecting a “slip” or “relapse” is unknown. Monitoring schedules and frequency of testing balance several considerations that constitute an individualized cost-benefit analysis for each patient. Risk and cost of failing to detect non-adherence and relapse is a consideration for the patient, healthcare professional and for society as a whole.

AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER, *supra* note 199, at 55.

often perform drug testing through urine screening.²⁰⁴ Urine screening is minimally invasive, and drugs have a longer detection time in urine than in blood or saliva.²⁰⁵ Drugs can be detected in the body for one to three days depending on the pharmacological characteristics of the drug.²⁰⁶ The window of detection can also depend on drug sensitivity, pattern of drug use, and urine concentration.²⁰⁷

ASAM states that “[u]rine drug testing is a key diagnostic and therapeutic tool that is useful for patient care in monitoring of the ongoing status of a person who has been treated for addiction.”²⁰⁸ Thus, ASAM recommends the use of drug testing in several phases of addiction treatment: (1) screening and diagnostic evaluation; (2) treatment; and (3) long-term monitoring.²⁰⁹ As ASAM has explained,

A knowledgeable clinician can use drug testing to verify self-reports, confirm diagnoses, identify denial and minimization of drug and alcohol use, enhance motivation for treatment, measure biological adaptation, assist in development of treatment planning, monitor treatment response, document treatment effectiveness and outcomes, support patient advocacy by validating abstinence from alcohol and drug use, and validate adherence in taking prescribed controlled substances.²¹⁰

In 2017, “[d]rug or alcohol urine screening was provided by 86 percent of all [drug rehabilitation] facilities.”²¹¹

ASAM similarly recommends random drug testing at sober living homes because drug use in that environment “compromises the recovery

204. AM. SOC’Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON DRUG TESTING, *supra* note 199, at 1.

205. AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER, *supra* note 199, at 23. The most commonly used biological matrices for drug testing include: urine, saliva, hair, blood, and sweat. *Id.* Prior to advancements in drug testing technology in the 1970s, the default testing matrix was blood. *Id.* Now, it is urine because it “is copious, easily and noninvasively collected, and does not require elaborate sample preparation before testing.” *Id.* Urine also has the benefit of being the least expensive matrix to analyze. *Id.* Urine, however, is vulnerable to “subversion” when patients are unmonitored. *Id.*

206. AM. SOC’Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON DRUG TESTING, *supra* note 199, at 1 (explaining that detection of drugs is possible “[b]ecause [due to] their water-solubility and lipid-solubility, alcohol and other drugs are rapidly distributed to virtually every tissue in the body”).

207. AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER, *supra* note 199, at 23.

208. AM. SOC’Y OF ADDICTION MED., PUBLIC POLICY STATEMENT ON DRUG TESTING, *supra* note 199, at 3.

209. AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER, *supra* note 199, at 48. Drug testing is important in diagnostic settings because health care professionals need objective evidence to determine whether the patient has recently used drugs and is suffering from SUD. *Id.*

210. *Id.* at 49.

211. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL SURVEY, *supra* note 109, at 25.

environment itself for *all* residents of the facility.”²¹² Drug testing in sober living homes can verify abstinence of the patient and help to “maintain the integrity of the sober residence for the group.”²¹³

The costs of drug tests can vary widely. In workplace and school settings, testing is relatively inexpensive because it occurs infrequently in a population without a high prevalence of SUD.²¹⁴ This testing involves checking for a small number of commonly used drugs.²¹⁵ In the clinical treatment setting where adherence to treatment is a concern, however, testing is more frequent and sophisticated due to the prevalence of designer drugs²¹⁶ used to avoid detection in drug tests.²¹⁷ Accordingly, much more advanced and expensive drug tests are needed in this setting.²¹⁸ Laboratories charge higher prices for analyzing the results of tests that require advanced testing technologies.²¹⁹ In addition, the cost of drug testing increases when the laboratory is checking for multiple drugs.²²⁰ Further, the cost rises due to expensive confirmation tests after an initial positive test.²²¹ The costs of drug testing are passed on to insurers (public and private) and patients.²²² There is not an agreed upon standard for the amount or type of drug testing necessary in residential drug rehabilitation.

While drug testing can be incredibly helpful in the residential treatment setting; it is also the source of fraud and abuse from overutilization. Residential drug rehabilitation centers treating an individual for opioid abuse might regularly test that individual’s urine for amphetamines, antidepressants, antipsychotics, or other drugs even when there is nothing in the patient’s history that would suggest use of those other drugs because it means higher reimbursement for the center.²²³

To maximize profits from drug testing, some residential drug treatment centers and sober living homes test patients two to four times a week.²²⁴

212. AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER, *supra* note 199, at 52.

213. *Id.*

214. *Id.* at 15.

215. *Id.*

216. Designer drugs are “designed to produce psychoactive effects similar to compounds familiar to drug users but to elude drug tests and drug laws.” *Id.* at 5.

217. *Id.* at 16.

218. *Id.*

219. *Id.*

220. *Id.* at 15–16.

221. Ferguson, *Searching for Help*, *supra* note 25.

222. AM. SOC’Y OF ADDICTION MED., DRUG TESTING: A WHITE PAPER, *supra* note 199, at 17.

223. David Segal, *In Pursuit of Liquid Gold*, N.Y. TIMES (Dec. 27, 2017), <https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html> [https://perma.cc/VW9T-NAMC] (discussing the urinalysis bill of a patient addicted to heroin who was inappropriately tested for amphetamines in addition to opiates for six months).

224. Ferguson, *Pee Scams*, *supra* note 196.

These treatment centers have also made deals with laboratories to run more expensive chemical tests on the urine to drive up the insurance bill from hundreds of dollars to thousands of dollars.²²⁵ In some cases, the recovery facilities also own the labs performing the drug tests.²²⁶ These drug testing practices turn a patient's "urine into his most valuable asset, generating insurance bills of more than \$1,000 a day in some cases."²²⁷ Once the disreputable facility cannot collect any more insurance money, the patient with SUD is "kicked out of the center and onto the streets, a practice so routine there's a name for it[:]' 'curbing.'"²²⁸

Private insurers have taken steps to crack down on overutilization and the high costs of drug testing.²²⁹ Some private insurers have imposed limitations on drug testing, and others have imposed caps on the reimbursement amount for drug testing.²³⁰ Insurers, such as Blue Cross Blue Shield of New Jersey, have even sued laboratories for medically unnecessary drug tests.²³¹ Similarly, Cigna (one of the largest health insurance companies) sued a laboratory over a kickback scheme.²³² But, the crackdown on fraud does not simply hurt the disreputable residential treatment centers and sober living homes; it also harms legitimate treatment centers and their patients. Indiscriminately reducing or capping coverage may go against legitimate medical judgment and prevent patients from receiving the care that they need. Cigna departed from Florida's health insurance exchange in late 2015, ahead of open enrollment for 2016.²³³ Cigna blamed its decision to withdraw on fraud and abuse and on "out-of-network substance abuse clinics and labs."²³⁴ Whether this explanation for withdrawing from the exchange is credible or not, there is no question that

225. *Id.*

226. Sforza et al., *supra* note 31.

227. *Id.*

228. *Id.*

229. In January 2017, for example, UnitedHealthcare sued Next Health (a network of laboratories) for \$100 million for medically unnecessary and overpriced urine tests as well as kickbacks and bribes to doctors. Segal, *supra* note 223.

230. *Id.*

231. PRNewswire, *Avee Laboratories Contests Lawsuit Filed by Horizon Blue Cross Blue Shield of New Jersey*, PROVIDENCE J. (Oct. 24, 2013, 5:01 PM), <https://www.providencejournal.com/article/20131024/News/310249969> [<https://perma.cc/A93T-AY97>].

232. Ken Alltucker, *Labs, Doctors Scrutinized over Lucrative Drug Tests for Pain-Pill Abuse*, USA TODAY: AZCENTRAL (Dec. 26, 2015, 5:02 PM), <https://www.azcentral.com/story/news/arizona/investigations/2015/12/26/labs-doctors-scrutinized-over-lucrative-drug-tests-pain-pill-abuse/77181470/> [<https://perma.cc/65NS-7WL8>].

233. Ron Hurtibise, *Citing Fraud by Substance Abuse Centers, Cigna Withdraws from Florida's Health Insurance Exchange*, SUN SENTINEL (Oct. 16, 2015), <https://www.sun-sentinel.com/business/consumer/fl-cigna-pullout-of-florida-health-insurance-exchanges-20151016-story.html> [<https://perma.cc/2LJR-AGH6>].

234. *Id.*

it hurt patients who were insured by Cigna and needed residential drug treatment.

B. Poor Quality of Care

As the need for residential drug treatment grows and new treatment centers enter the market, there is a concern regarding the quality of care that centers are providing patients with SUD. In California, one patient dies every sixteen days in a drug rehabilitation facility.²³⁵ And, hundreds more die after leaving rehabilitation centers while still addicted to drugs.²³⁶ Critics of the industry argue that these statistics reflect “poor care – sometimes nonexistent care – offered in many rehab centers” and that it can be more profitable to provide substandard than quality care.²³⁷ Reputable drug treatment centers find it “tough to stay in business while providing good medical care when a growing percentage of [their] competitors are profiteers.”²³⁸ And, it is difficult for patients to assess quality because nearly all treatment centers advertise success rates of 80 percent or higher without objective evidence to back up their claims.²³⁹

It is not clear that even legitimate residential drug rehabilitation facilities are providing quality care. Quality care requires both professionally trained and credentialed staff as well as evidence-based treatment practices.²⁴⁰ But, there are no national standards for either the facilities or the individuals who provide treatment. And, even in states that have standards, there is very little regulatory oversight.²⁴¹ In many ways, the drug rehabilitation industry is outside of the health care system. The National Center on Addiction and Substance Abuse at Columbia University explains it this way:

For just about all known diseases other than addiction, treatment is provided within a highly-regulated health care system. In contrast, patients with the disease of addiction are referred to a broad range of

235. Sforza et al., *supra* note 31.

236. *Id.*

237. *Id.*

238. *Id.*

239. Dan Munro, *Inside the \$35 Billion Addiction Treatment Industry*, FORBES (Apr. 27, 2015, 1:29 AM), <https://www.forbes.com/sites/danmunro/2015/04/27/inside-the-35-billion-addiction-treatment-industry/#328b605217dc> [<https://perma.cc/P7HV-FULN>].

240. NAT'L ASS'N OF ADDICTION TREATMENT PROVIDERS, NAATP GUIDE TO TREATMENT PROGRAM SELECTION 2, https://www.naatp.org/sites/naatp.org/files/NAATP.GuideToChoosingAddictionTreatment_0.pdf [<https://perma.cc/T97R-QBNY>].

241. Sforza et al., *supra* note 31 (“There are few bars to getting a license to run a rehab center in California, regardless of academic or criminal background. Physicians who have had their medical licenses revoked by the state serve as chairmen or chief executives of some centers. And with some state prison systems offering classes in rehab center management, it’s not unusual for ex-cons to serve as hands-on operators.”).

providers largely exempt from medical training and standards (for many of whom the main qualification may be that they themselves have a history of addiction) who work within a fragmented system of care with inconsistent regulatory oversight.²⁴²

The staff chiefly responsible for patient care in residential drug treatment centers are addiction counselors.²⁴³ Most states require addiction counselors to be licensed, but the licensing requirements may include nothing more than a high school diploma and some training on the twelve-step model of recovery.²⁴⁴ Quite simply, most addiction counselors “lack an education grounded in the science of addiction and are not equipped to deliver evidence-based treatments including appropriate medical care and treatment of co-occurring health conditions.”²⁴⁵ The lack of training for addiction counselors and others providing treatment to patients with SUD leads to inconsistent treatment and care for patients.²⁴⁶

While states have various licensing requirements for residential drug rehabilitation centers, very few states mandate the use of evidence-based practices in SUD treatment.²⁴⁷ Nor are evidence-based practices in common usage at addiction treatment centers.²⁴⁸ Evidence-based addiction medicine can be defined as “the use of current best evidence in making decisions about the care of individual patients. It combines clinical expertise with the best available research on a topic of concern gathered from various sources.”²⁴⁹ Unfortunately, there is not always a consensus on which

242. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., ADDICTION MEDICINE: CLOSING THE GAP BETWEEN SCIENCE AND PRACTICE 176 (2012), http://www.centeronaddiction.org/sites/default/files/Addiction-medicine-closing-the-gap-between-science-and-practice_1.pdf [https://perma.cc/HU5J-WLRD].

243. *Id.* at 178.

244. *Id.* The twelve-step model “involves a brief, structured and manual-driven approach implemented over the course of 12 to 15 sessions by a trained counselor or treatment provider.” *Id.* at 111.

245. *Id.* at 178.

246. *Id.* at 178.

247. *Id.* at 194 (explaining that a 2006 survey found that only three states have legislation that “mandate or encourage” evidence-based practices and one of the states only mandates their use for state-funded facilities).

248. Steve Gallon, Univ. of Wash. Alcohol & Drug Abuse Inst. & Nw. Frontier Addiction Tech. Transfer Ctr., *About Evidence-Based Practices*, EVIDENCE-BASED PRACTICES FOR SUBSTANCE USE DISORDERS (2013), <http://adaai.washington.edu/ebp/about.htm> [https://perma.cc/M88J-JKQ9] (explaining that oftentimes research literature does not provide adequate information to implement a practice and the evidence-based practice may require “policy adjustment, resource acquisition, procedural documentation, staff training and ongoing supervision to assure accurate implementation”). Further, a new practice may challenge existing philosophical values. *Id.*

249. STEWART B. LEAVITT, ADDICTION TREATMENT FORUM, CAN ADDICTION RESEARCH BE TRUSTED?: INTRODUCING EBAM 1 (2003), http://atforum.com/documents/EBAM_6_Pager.pdf [https://perma.cc/G7VJ-LDZH]. The most rigorous form of medical research is randomized controlled clinical trials (RCTs). In RCTs, “patients are carefully selected and then randomly assigned to Experimental and

practices have enough evidence to support their use in clinical settings. Many entities have competing lists of evidence-based practices to treat SUD. But, there are many practices that appear on nearly every list of evidence-based practices.²⁵⁰ In addition, the U.S. Substance Abuse and Mental Health Services Administration has an Evidence-Based Practices Resource Center that provides information on “clinically sound and scientifically based policies, practices and programs.”²⁵¹ The Resource Center is meant to be dynamic and capable of responding to changing science and evidence and is updated with guidance documents and other materials that provide the latest scientific evidence on SUD treatment.²⁵²

One prominent example of evidence-based treatment exists at the clinics of the Hazelden Betty Ford Foundation.²⁵³ The Hazelden Betty Ford Foundation has created an evidence-based treatment plan for opioid addiction called the Comprehensive Opioid Response with Twelve Steps (COR-12) that they have implemented at their clinics.²⁵⁴ Their program involves MAT, cognitive-behavioral therapy, motivational interviewing,²⁵⁵ and Twelve-Step Facilitation.²⁵⁶ All of these practices were extensively studied.

Control groups, which are followed for the outcomes of interest. The groups are equally matched demographically (e.g., age, sex, etc.) and any extraneous factors (confounders) are assumed to be equally distributed across groups.” *Id.* at 3. The most reliable scientific evidence involves a systematic review and meta-analyses of RCTs. *Id.* The most common studies in addiction medicine, however, are Cohort Studies. In Cohort Studies, a “single group may be involved, but usually two or more groups of patients (cohorts) are enrolled and either receive the treatment of interest (Experimental group) or do not (Controls). The groups are followed forward in time to observe outcomes of interest.” *Id.*

250. See, e.g., Univ. of Wash. Alcohol & Drug Abuse Inst. & Nw. Frontier Addiction Tech. Transfer Ctr., EVIDENCE-BASED PRACTICES FOR SUBSTANCE USE DISORDERS, <https://adai.uw.edu/ebp/> [<https://perma.cc/HNP7-GHN5>] (click “main search,” then “Browse All (A-Z)”) (listing cognitive-behavioral therapy and buprenorphine (i.e. MAT) in its list of evidence-based treatment); NAT’L INST. ON DRUG ABUSE, PRINCIPLES, *supra* note 59, at 6 (listing buprenorphine as a pharmacological treatment and cognitive-behavioral therapy in its list of evidence-based approaches to SUD treatment).

251. *About the Evidence-Based Practices Resource Center*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T HEALTH & HUM. SERVS., <https://www.samhsa.gov/ebp-resource-center/about> [<https://perma.cc/XRT6-WHTF>] (last updated Apr. 23, 2020).

252. *Id.*

253. HAZELDEN BETTY FORD FOUND., <https://www.hazeldenbettyford.org/> [<https://perma.cc/D7CG-QM72>].

254. *Joining Forces to Overcome the Opioid Epidemic*, HAZELDEN BETTY FORD FOUND., <https://www.hazeldenbettyford.org/recovery-advocacy/opioid-epidemic/joining-forces> [<https://perma.cc/2FR7-V5W4>].

255. “Motivational interviewing is an evidence-based treatment that addresses ambivalence to change. It is a conversational approach designed to help people identify their readiness, willingness, and ability to change and to make use of their own change-talk.” *Motivational Interviewing*, CASE W. RES. U.: CTR. FOR EVIDENCE-BASED PRACS., <https://www.centerforebp.case.edu/practices/mi> [<https://perma.cc/4BSV-CFKB>]. For people with SUD, it helps them “[d]iscover their own interest in considering and/or making a change in their life.” *Id.*

256. *Joining Forces to Overcome the Opioid Epidemic*, *supra* note 254. Twelve-Step Facilitation assists patients in becoming actively involved in a twelve-step based help group. It involves

It is possible that one of the reasons that the use of evidence-based treatments is not more widespread is the stigma associated with the disease. There is still a belief on the part of some that people with SUD have caused their own condition—the notion that being an addict is a “moral fail[ure].”²⁵⁷ The reality, however, is that SUD “is a brain disorder resulting in a chronic medical condition analogous to other chronic diseases like type 2 diabetes and high blood pressure.”²⁵⁸ The failure to view SUD as a chronic medical condition may cause some treatment centers to continue to focus on Twelve-Step programs²⁵⁹ and abstinence rather than evidence-based care.

Many facilities cling to the outdated model of abstinence and Twelve-Step programs. Approximately 90 percent of drug treatment facilities are based on abstinence, which for many years has been synonymous with the Twelve-Step recovery program²⁶⁰ of Alcoholics Anonymous.²⁶¹ Abstinence

12-sessions of individual therapy in which the therapist actively encourages engagement in AA, and walks the patient through the first four steps of the AA program. The therapist conveys the concept that addiction is a chronic, progressive, and potentially fatal illness for which the only successful strategy is abstinence achieved one day at a time by following a 12-step program of recovery.

DEP’T OF VETERANS AFFAIRS & DEP’T OF DEF., VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS 93 (2015), <https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf> [<https://perma.cc/NBK7-9J8V>].

257. Brendan Murphy, *4 Factors that Add to Stigma Surrounding Opioid-Use Disorder*, AM. MED. ASS’N (Sept. 13, 2018), <https://www.ama-assn.org/delivering-care/opioids/4-factors-add-stigma-surrounding-opioid-use-disorder> [<https://perma.cc/9SD4-64YZ>] (quoting Dr. Patrice Harris, chair of the American Medical Association’s Opioid Task Force).

258. *Id.*

259. A Twelve-Step program is one that adapts the twelve steps of AA to the specific needs of patients with SUD. One of the foundations of the program is group meetings with other people who are in recovery. “[M]eetings provide a safe place for people in recovery to meet, share their experiences, positive and negative, feel better about themselves, feel less lonely, and begin or continue the recovery process.” Michael Graubart, *Twelve Step Meetings FAQs*, HAZELDEN BETTY FORD FOUND. (June 23, 2017), <https://www.hazeldenbettyford.org/articles/sober-dad/12-step-meeting-faqs> [<https://perma.cc/7WXV-2KB9>]. Importantly, a Twelve-Step program is not the same as Twelve-Step Facilitation. Twelve-Step Facilitation assists patients in fully utilizing Twelve-Step programs once their treatment is complete as a way of successfully moving from treatment to recovery. It is used in combination with other evidence-based treatments. In contrast, some rehabilitation facilities use Twelve-Step programs as their chief mode of treatment. Twelve-Step programs are not, however, treatment for SUD. *See infra* note 273 and accompanying text.

260. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL SURVEY, *supra* note 109, at 26.

261. *What Is A.A.?*, ALCOHOLICS ANONYMOUS, https://www.aa.org/pages/en_US/what-is-aa [<https://perma.cc/2NKQ-TKAV>]. The twelve steps include:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

requires the complete cessation of drug use. Thus, those using MAT would not be considered abstinent and would be unable to participate in a residential drug treatment program that is based on abstinence. Indeed, “[o]ne of the key predictors of the underutilization of [MAT] is adherence of treatment providers to a strong 12-step ideology for addiction treatment.”²⁶² Some providers also question whether it is appropriate to use MAT to treat SUD because they believe that “it’s merely replacing one drug with another.”²⁶³ Given that MAT can cut the mortality rate for SUD patients by half,²⁶⁴ it is particularly problematic that the majority of providers reject MAT in favor of abstinence and Twelve-Step programs.²⁶⁵

Abstinence-based care became popular in the 1980s as the model for addiction treatment. Indeed, the Hazelden Betty Ford Foundation, which now leads the way in evidence-based treatments such as MAT, “used to subscribe almost exclusively to the abstinence-only model.”²⁶⁶ Abstinence-based treatment focuses on an individualized treatment plan, spirituality, family involvement, and group meetings common to Alcoholics Anonymous.²⁶⁷ Twelve-Step groups “provide a social network that supports

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6. Were entirely ready to have God remove all these defects of character.
 7. Humbly asked Him to remove our shortcomings.
 8. Made a list of all persons we had harmed, and became willing to make amends to them all.
 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
 10. Continued to take personal inventory and when we were wrong promptly admitted it.
 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

ALCOHOLICS ANONYMOUS, THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS (1981) (emphasis omitted), https://www.aa.org/assets/en_US/smf-121_en.pdf [<https://perma.cc/6WTD-X7UL>].

262. NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 242, at 206.

263. German Lopez, *There’s a Highly Successful Treatment for Opioid Addiction. But Stigma Is Holding It Back*, VOX (Nov. 15, 2017, 2:25 PM), <https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone> [<https://perma.cc/6DLU-C4QF>].

264. *Id.*

265. This is not to say, of course, that there are no risks associated with MAT or that MAT works for all patients. *Id.* (“One catch is that even these medications, though the best forms of opioid addiction treatment, do not work for as much as 40 percent of people with opioid addiction. Some patients may prefer not to take any medications because they see any drug use whatsoever as getting in the way of their recovery, in which case total abstinence may be the right answer for them. Others may not respond well physically to the medications, or the medications may for whatever reason fail to keep them from misusing drugs. This isn’t atypical in medicine. What works for some people, even the majority, isn’t always going to work for everyone.”).

266. *Id.*

267. *Id.*

recovery; they emphasize both the powerfully compulsive nature of addiction *and* the importance of harnessing an individual addict's personal responsibility."²⁶⁸

There are many criticisms of Twelve-Step programs²⁶⁹ and very little evidence to support their efficacy,²⁷⁰ but many people consider Twelve-Step programs to be essential to recovery maintenance.²⁷¹ It is important to remember that treatment for SUD must be individualized.²⁷² Thus, Twelve-Step programs may be critical to help some people remain sober and completely unnecessary for others. Most importantly, however, the Twelve-Step program, which is a support service, does "not qualify as treatment for a medical disease."²⁷³ Indeed, "[f]ew would argue that any other disease be treated solely via support groups composed of those who themselves have had the condition."²⁷⁴ SUD, like other medical diseases, requires

268. Annette Mendola & Richard L. Gibson, *Addiction, 12-Step Programs, and Evidentiary Standards for Ethically and Clinically Sound Treatment Recommendations: What Should Clinicians Do?*, 18 *AMA J. ETHICS* 646, 647 (2016).

269. Some criticisms include:

Several features of TS [Twelve-Step] programs make them a poor fit for some people who are seeking recovery. To begin with, some who eschew TS programs might find the emphasis on spirituality off-putting. AA maintains that the "Power greater than ourselves" can be construed as a non-theistic power, such as the power of the community, but this rings hollow for some recovery seekers. Additionally, TS programs promote the goal of abstinence, but moderation is a better goal for some people. Some people find that the emphasis on powerlessness erodes their confidence, and others dislike the group format inherent in TS. And some are bothered by the inconsistent, somewhat sloppy reasoning that runs through the TS philosophy. For example, AA's position that alcoholism is an illness or malady (akin to an allergy) seems out of step with its view that it's a spiritual problem; and the claim that alcoholism is not a moral failing seems at odds with phrases like make "a searching and fearless moral inventory of ourselves" and "remove all defects of character" found in Step 4 and Step 6.

Perhaps the most damning criticism of AA and other TS programs concerns the variability in adherence to core tenets from group to group. Since it is nonprofessional by design, quality control measures are minimal, and there is no way to ensure that every group adheres consistently to all of its principles. Thus, some criticisms of TS refer to beliefs and attitudes that can be found in some individual TS groups or members but that are inconsistent with the official position of AA. These include that it is a religious (specifically Christian) organization; that it shames addicts as being morally flawed; that members are not allowed to use medications to support sobriety; and that AA claims that it is the only way someone can get sober.

Id. at 648.

270. *Id.* at 647–48.

271. See, e.g., David Sack, *Why the Hostility Toward the 12 Steps?*, *PSYCHOL. TODAY* (Nov. 20, 2012), <https://www.psychologytoday.com/us/blog/where-science-meets-the-steps/201211/why-the-hostility-toward-the-12-steps> [<https://perma.cc/2DFN-ZNQH>] (arguing that "12-Step recovery is widely misunderstood and under-researched" and that "[r]ecover is not just about stopping one isolated behavior (drug use) but learning a new way of life – and this is the real value of 12-Step recovery").

272. NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 242, at 208.

273. *Id.* at 200.

274. *Id.* at 208.

individualized evidence-based medical treatment.²⁷⁵ As Dr. Shelly Greenfield of Harvard Medical School has stated, “[t]here is no other comparable example in medicine where you have evidence-based treatments that are not available” to patients suffering from a treatable medical condition.²⁷⁶ Thus, it is harmful for residential rehabilitation programs to be organized around nothing more than abstinence and the Twelve-Step program when there are effective evidence-based treatments available to treat the disease of addiction.

IV. ECONOMICS OF INFORMATION IN THE DRUG REHABILITATION MARKET

This Part employs economic theory to understand and assess the inability of patients to choose and receive quality care. Specifically, it looks at information about quality as a good that drug rehabilitation consumers have difficulty acquiring due to severe informational asymmetries in the market.

A. Information and Residential Drug Treatment Centers

Consumers often do not have the information they need to assess the quality of goods and services prior to purchasing them. This is particularly true when it comes to assessing the quality of residential drug treatment centers. Very little federal or state information is publicly available concerning the quality of services provided by residential drug treatment facilities. In addition, consumers cannot rely upon the information that they receive from largely unregulated drug rehabilitation facilities. This is in stark contrast to other goods where quality can be readily assessed either before or after purchase. Further, as addiction is a chronic disease,²⁷⁷ it is difficult to assess quality of care even after receiving care at a drug rehabilitation facility because that may only be one component of the care needed to treat the disease. The lack of information is compounded by the fact that the drug rehabilitation industry is not squarely placed in the

275. *Id.* (“Whereas research clearly indicates that to be effective interventions should be tailored not only to the stage and severity of a patient’s illness but also to a patient’s co-occurring conditions and other personal characteristics and life circumstances that might affect treatment outcome, most health professionals and addiction treatment programs follow a one-size-fits-all approach to treatment. . . . Having patients pass through a rigid, time-limited treatment program that assumes uniformity in disease symptoms and severity simply burdens patients with unnecessarily extensive interventions or with interventions that are too brief or superficial to have a significant impact on their symptoms.”).

276. *Id.* at 207.

277. UNDERSTANDING DRUG USE, *supra* note 44.

healthcare field despite the fact that addiction is a chronic disease.²⁷⁸ This Part argues that information concerning the quality of care at drug rehabilitation facilities is a credence good. Once it is established that quality of care at these facilities is a credence good, the need for government intervention to protect vulnerable consumers becomes clearer.

When discussing goods and services, economists tend to group them into three categories based on their attributes: (1) search goods and services; (2) experience goods and services; and (3) credence goods and services.²⁷⁹ For search goods and services, quality can easily be discerned prior to consumption.²⁸⁰ For example, a consumer can go to a drug store and examine band aids prior to purchase to see if there are some in the size that she needs. Thus, the size of the band aids becomes the search attribute and the consumer can use that attribute to determine if the price is fair prior to purchase.

If a product has experience attributes, however, it means that the consumer cannot judge the product until she experiences it, which occurs only after purchase.²⁸¹ A consumer cannot tell if the band aid that she purchased will stick well to her skin just by examining the size. Therefore, she cannot assess the band aid's value to her based on stickiness until purchase and consumption. If the consumer is a repeat purchaser of band aids and has acquired knowledge about which brand's band aids stick best to her skin, then that will mitigate her information problem.²⁸²

When products have credence attributes, the consumer may not be able to determine the quality of the goods and services even after purchase and consumption.²⁸³ Information on the quality of residential drug rehabilitation

278. See *supra* Part III.B; Lurie, *supra* note 5 (“The rehabs themselves exist in a quasi-medical realm where evidence-based care is rare, licensed medical staffers are optional, conflicts of interests are rampant, and regulation is stunningly lax.”).

279. Henry N. Butler & Jason S. Johnston, *Reforming State Consumer Protection Liability: An Economic Approach*, 2010 COLUM. BUS. L. REV. 1, 59, 62; Phillip Nelson, *Information and Consumer Behavior*, 78 J. POL. ECON. 311, 312–15 (1970).

280. Nelson, *supra* note 279, at 312; see also Butler & Johnston, *supra* note 279, at 59 (explaining that “[w]ith search goods, consumers can learn about quality, and reward high-quality providers with higher prices if the cost of searching and observing quality is sufficiently low that they will continue to search—by moving on to another store—if they observe unexpectedly low quality. Indeed, with search goods, high prices may themselves signal high quality” (footnote omitted)).

281. George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 490–91 (1970); see also Butler & Johnston, *supra* note 279, at 59–61 (explaining that it is more costly to determine the quality because the consumer must buy and use the product for some period of time, and that with experience goods the ability to base future purchasing decisions on quality will vary with the type of good and the speed that consumers can learn about quality and act on it).

282. Ariel Katz, *Pharmaceutical Lemons: Innovation and Regulation in the Drug Industry*, 14 MICH. TELECOMM. & TECH. L. REV. 1, 19 (2007).

283. Michael R. Darby & Edi Karni, *Free Competition and the Optimal Amount of Fraud*, 16 J.L. & ECON. 67, 68–69 (1973).

programs has credence attributes for two reasons: (1) the severe information asymmetry between the rehabilitation center and the patient and (2) the unique position of drug rehabilitation programs in the medical industry.

1. Asymmetric Information Problems

The drug rehabilitation market is rife with asymmetric information problems. Bad actors in the market take advantage of the information gap between residential drug rehabilitation facilities, patients, and third-party payers. This prevents patients from making the best drug treatment decision and causes inefficiency in the market.

The information asymmetry occurs because the residential drug rehabilitation facilities, whether reputable or not, have important information “that would materially affect” the patient’s care decision, but the rehabilitation facilities are either concealing that information or it is costly for the patient to acquire it.²⁸⁴ Specifically, the patient has difficulty obtaining objective information concerning the quality of care at particular rehabilitation facilities. It is an industry norm to “offer little objective, independent data on how well their programs work over the long haul.”²⁸⁵ Even if a provider wanted to provide objective data, “there are no industry-accepted standards for elastic terms such as ‘sobriety’ or ‘relapse’ or ‘success.’”²⁸⁶ This permits “disreputable providers to charge the consumer for goods or services never provided, or provide the wrong quantity or type of goods or services to the consumer (under- or over-providing).”²⁸⁷

Indeed, one of the key problems in the drug rehabilitation market is providing the wrong quantity or type of goods or services to the consumer. Due in part to patient brokering, many drug rehabilitation centers are over-providing drug tests and under-providing counseling services and evidence-based treatment to patients who need those services to fully recover and avoid relapse. Because the patients are already vulnerable and suffering from SUD, there is little chance that they can accurately judge the quality of the care even after they have received it.²⁸⁸ A person with SUD would simply not have the expertise to determine whether the treatment was inadequate or whether she had not done enough to benefit from the

284. Patrick A. McLaughlin et al., *Regulatory Reform in Florida: An Opportunity for Greater Competitiveness and Economic Efficiency*, 13 FLA. ST. U. BUS. REV. 95, 111–13 (2014).

285. Sforza et al., *supra* note 31.

286. *Id.*

287. Butler & Johnston, *supra* note 279, at 63.

288. See, e.g., Kristin Madison, *Regulating Health Care Quality in an Information Age*, 40 U.C. DAVIS L. REV. 1577, 1583 (2007) (explaining that health care “[p]atients often cannot assess the quality of care they receive, either before or after it is delivered”).

treatment. This uncertainty with respect to quality distinguishes the drug rehabilitation market from perfectly competitive markets.²⁸⁹ Further, “[b]ecause consumers have trouble assessing the quality of the service, providers of such services may have little incentive to maintain or improve the quality of their services, causing failure of ‘the market for ‘high’ quality services.’”²⁹⁰

Simply put, disreputable residential drug rehabilitation centers and sober living homes have no incentive (financial or otherwise) to provide quality services. Record numbers of patients are seeking treatment for SUD and many are falling prey to internet and call center scams because they do not have the ability to determine which drug rehabilitation centers and sober living homes are legitimate.²⁹¹ Further, in states like California, it is easier to obtain consumer information, including complaints, about restaurants and auto repair shops, than it is to obtain consumer information on residential drug treatment centers.²⁹² In addition, because patient brokers often send patients away from their home state, there is no opportunity to visit the facility beforehand to determine if it is a reputable treatment center. Further, some treatment facilities contract with sober living homes and the sober living homes offer drugs to the patients so that they get addicted again and go back to the rehabilitation center to start treatment all over again.²⁹³ Thus, there is no feasible means for patients to obtain information to judge quality and no incentive for disreputable treatment centers to provide information. There is no reason to believe that the market can self-correct the informational asymmetry.

The information gap in the drug rehabilitation market may evidence an even larger problem in the market. As Butler and Johnston have explained, “[w]ith incomplete consumer information about product quality, market existence itself becomes an issue.”²⁹⁴ In a market with asymmetric

289. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951 (1963) (explaining the product uncertainty with respect to quality that exists with medical care generally).

290. McLaughlin et al., *supra* note 284, at 112 (quoting CAROLYN COX & SUSAN FOSTER, BUREAU OF ECON., *THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION* 6 (1990)).

291. The Editorial Board, *Opioid ‘Patient Brokers’ Who Prey on the Addicted Finally Get the Treatment They Deserve*, USA TODAY (Oct. 23, 2018, 6:17 PM), <https://www.usatoday.com/story/opinion/2018/10/23/opioid-patient-brokers-finally-get-treatment-they-deserve-editorials-debates/1671792002/> [<https://perma.cc/T9B7-BGWE>] (explaining that “[a]ddicted individuals and their worried loved ones are easy prey because finding effective, professional treatment is so difficult and confusing” and that “[i]n a country with 2.1 million people suffering from opioid addiction, [the patient brokering] business is booming”); Lurie, *supra* note 5 (discussing the increase in addiction rates and the corresponding demand for treatment).

292. Sforza et al., *supra* note 31.

293. *Id.*

294. Butler & Johnston, *supra* note 279, at 55.

information (such as the residential drug rehabilitation market), where buyers cannot properly judge the quality of services, buyers may only understand the average quality of the services.²⁹⁵ As a result, high-quality sellers have difficulty differentiating themselves from low-quality sellers.²⁹⁶ If high-quality sellers cannot identify themselves, buyers “will think every seller’s good is of average quality, and they will not pay more than the value of average quality.”²⁹⁷ Because high-quality providers cannot charge a higher price, they do not make a profit.²⁹⁸ Under these market conditions, high-quality sellers may leave the market.²⁹⁹ “But when the very highest quality sellers drop out of the market, the average quality falls and the new highest quality sellers may lose money, causing them to leave the market, leading to market disequilibrium.”³⁰⁰ In this situation, low-quality services can drive out high-quality services.³⁰¹ This is known as the lemons market problem.³⁰²

In the context of the drug rehabilitation market, low-quality providers have flooded the market and captured market share through dishonest tactics. As John Lehman, director of the Florida Association of Recovery Residences, has noted:

The scammers have made it difficult for the ethical, and sorely needed, treatment centers and sober homes to survive The broad brush of bad actions and illegal activity is painting across everybody So the good guys are having trouble keeping their beds full. And the bad guys are saying you want to shoot dope in the bathroom, go ahead.³⁰³

Lehman’s assessment is anecdotal.³⁰⁴ Thus, it is too soon to tell whether high-quality residential drug rehabilitation providers will be driven from the market based on these conditions. High-quality providers have strong incentives to provide information concerning quality to potential patients. But, low-quality providers have strong incentives to hide information concerning quality to potential patients. Under these conditions, high-quality providers may change their advertising tactics or join or create trade

295. *Id.* at 55–56.

296. *Id.*

297. *Id.* at 56.

298. *Id.*

299. *Id.*

300. *Id.*

301. *Id.*

302. *Id.* at 55–56 (explaining that the name comes from low-quality cars which are termed lemons).

303. Seville et al., *supra* note 169.

304. *Id.*

groups that can attest to the quality of their services.³⁰⁵ The risk of the drug rehabilitation market becoming a lemons market is real and must be addressed through government regulation.

2. *The Unique Position of Drug Rehabilitation in the Medical Industry*

In the medical industry, the lack of information about quality is more pronounced than in the industry of any other important commodity.³⁰⁶ As Kenneth Arrow has explained:

Recovery from disease is as unpredictable as is its incidence. In most commodities, the possibility of learning from one's own experience or that of others is strong because there is an adequate number of trials. In the case of severe illness, that is, in general, not true; the uncertainty due to inexperience is added to the intrinsic difficulty of prediction. Further, the amount of uncertainty, measured in terms of utility variability, is certainly much greater for medical care in severe cases than for, say, houses or automobiles, even though these are also expenditures sufficiently infrequent so that there may be considerable residual uncertainty.³⁰⁷

This is compounded in the drug rehabilitation industry because consumers cannot expect the same level of regulation and protection that they are accustomed to in the medical industry.

Medical professionals must meet minimum education requirements, be certified by the American Medical Association (in the case of doctors), and be licensed in their state before they can treat patients.³⁰⁸ These requirements exist to ensure quality and protect patients.³⁰⁹ Most importantly, they prohibit non-trained individuals from providing medical services through the threat of criminal sanctions.³¹⁰ Even though the

305. See, e.g., SHATTERPROOF, <https://www.shatterproof.org> [<https://perma.cc/LN5H-KWQ4>]. Shatterproof is a national nonprofit organization formed to transform addiction treatment in America. *Id.* Some insurance companies have contributed to the funding of Shatterproof. *Our Partners*, SHATTERPROOF, <https://www.shatterproof.org/our-partners> [<https://perma.cc/2D8F-7L9A>]. Shatterproof created National Principles of Care and sixteen insurance companies have pledged to abide by the principles. *Shatterproof National Principles of Care*, SHATTERPROOF, <https://www.shatterproof.org/shatterproof-national-principles-care> [<https://perma.cc/5JGE-BATV>]. Shatterproof has also created a pilot called ATLAS to assess the quality of drug treatment programs. *About ATLAS*, SHATTERPROOF, <https://www.shatterproof.org/atlas-about> [<https://perma.cc/K9YA-LBVK>]. The pilot will begin in six states. *Id.*

306. Arrow, *supra* note 289, at 951.

307. *Id.*

308. *Id.* at 952.

309. *Id.*

310. *Id.*

treatment at drug rehabilitation facilities clearly involves medical treatment of the disease of addiction, the American Medical Association does not govern the certification of health care professionals at these facilities. Nor do state medical boards grant licenses to these professionals.

As explained in Part III.B, the drug rehabilitation industry is on the outside of the highly regulated health care system. At the same time, however, for purposes of public and private insurance it is treated the same as other medical providers. Without streamlined care, it is incredibly difficult for consumers to obtain reliable information about the quality of a particular facility.

B. Costs of Failed Rehabilitation Facilities

The costs of the opioid crisis are staggering. The White House Council of Economic Advisers estimates that in 2015, the economic cost of the opioid crisis was \$504 billion, which amounts to 2.8 percent of the gross domestic product (GDP) for that year.³¹¹ The economic cost comprises both the cost of opioid-related overdose deaths and the cost of nonfatal opioid misuse.³¹²

The Council quantified the costs of opioid-related overdose deaths based on the value of a statistical life (VSL).³¹³ They used a VSL of \$5.4 million. The Council also found that officially reported opioid-involved overdose deaths were underestimated because opioids are underreported on death certificates. The Council estimated that opioid-involved overdose deaths were 24 percent higher than official reports suggested.³¹⁴ Thus, they found that in 2015, there had been 41,033 opioid-related overdose deaths. The fatality cost for 2015 was \$221.6 billion.³¹⁵

Next, the Council estimated the cost of nonfatal opioid misuse.³¹⁶ These costs include increases in healthcare and substance abuse treatment costs, criminal justice costs, and reductions in productivity.³¹⁷ To determine the cost of nonfatal opioid misuse, the Council estimated the per-person measure of costs of opioid misuse for those who did not die within the year and multiplied that by the number of individuals with an opioid use disorder

311. WHITE HOUSE COUNCIL OF ECON. ADVISERS, *supra* note 33, at 1.

312. *Id.*

313. *Id.* at 3 (explaining that federal agencies rely on VSL when estimating the expected fatality risk-reduction benefits of a proposed regulation, policy, or program and that the valuations are based on how individuals trade off wealth for reduced mortality risks).

314. *Id.* at 6.

315. *Id.*

316. *Id.* at 7.

317. *Id.*

in 2015.³¹⁸ The Council estimated the per-person measure of costs of opioid misuse at \$30,000³¹⁹ and multiplied that by the 2.4 million people with opioid use disorders, resulting in a total cost of \$72.3 billion for non-fatal consequences.³²⁰

The Council's report demonstrates the economic toll that the opioid crisis is having on the United States. At this juncture, it is not possible to segregate out the costs of the opioid crisis that are attributable to disreputable residential drug rehabilitation facilities and sober living homes. Nor is it the goal of this project to do so. Nevertheless, many patients check into residential rehabilitation facilities multiple times and some of those visits are likely to disreputable facilities.³²¹ The danger for patients treated at disreputable rehabilitation facilities is heightened—"Patients weaned from opioids at disreputable facilities exit with a lower tolerance for such drugs. If they relapse, which happens all too often, they can easily overdose on an amount they previously tolerated."³²² Further, patients who leave drug rehabilitation without the proper care are unlikely to be productive members of society.³²³ These patients are in a much worse position than they would have been if they received proper care at a reputable residential drug rehabilitation facility.³²⁴ Undoubtedly, the corruption in the drug rehabilitation market is contributing to the costs of the opioid crisis. And, as the demand for drug rehabilitation services increases, the costs will continue to mount.

V. ELIMINATING PATIENT BROKERING

In October 2018, Congress passed and the President signed into law the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT Act).³²⁵ Sections 8121 and 8122 of the SUPPORT Act contain the Eliminating Kickbacks in Recovery Act of 2018 (EKRA).³²⁶ The goal of

318. *Id.*

319. *Id.* To reach this number, the Council added the increased healthcare and substance abuse treatment costs (\$29.4 billion) to the criminal justice costs (\$7.8 million) and the reduced productivity of those who did not die from an overdose (\$20.8 billion) for a total of \$58 billion. *Id.*

320. *Id.*

321. Lurie, *supra* note 5 (explaining how patients are shuffled from one rehab to another at the behest of patient brokers).

322. The Editorial Board, *supra* note 291.

323. *See, e.g.*, WHITE HOUSE COUNCIL OF ECON. ADVISERS, *supra* note 33, at 7 (discussing the costs of lost productivity for those who misuse opioids).

324. This is not to say, of course, that drug rehabilitation is always successful on the first attempt. Addiction is a life-long disease and treatment is likely to take place over a lifetime.

325. SUPPORT for Patients and Communities Act of 2018, Pub. L. No. 115-271, 132 Stat. 3894.

326. *Id.* §§ 8121–8122, 132 Stat. at 4108–4110 (codified as amended at 18 U.S.C. § 220 (2018)).

EKRA is to eliminate the practice of patient brokering.³²⁷ This Part examines EKRA and its ability to combat patient brokering and address the informational asymmetries in the residential drug treatment market.

EKRA's text is very similar to the federal health care program anti-kickback statute (the AKS).³²⁸ The AKS was enacted to prevent payments to doctors in exchange for patient referrals to other health care providers.³²⁹ The concern with these types of payments is that the healthcare provider may make care decisions based on financial incentives rather than the best interests of the patient.³³⁰ There is also the concern that "financial rewards to providers for patient referrals might drive up [federal health care] program costs by encouraging the provision of unnecessary or inordinately expensive medical care."³³¹ The AKS makes it unlawful to: (1) knowingly and willfully; (2) offer or pay, solicit or receive; (3) any remuneration; (4) to induce the referral of an individual to another person or entity for the "furnishing of any item or service," or to induce the purchasing or ordering

327. 164 CONG. REC. H9244 (daily ed. Sept. 28, 2018) (statement of Rep. Pallone) ("I know this proposal is well-intentioned in addressing the serious problem of patient brokers who are taking advantage of individuals with opioid use disorders and referring them to substandard or fraudulent providers in exchange for kickbacks.").

328. 42 U.S.C. § 1320a-7b(b) (2018). The Anti-Kickback statute provides:

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$100,000 or imprisoned for not more than 10 years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$100,000 or imprisoned for not more than 10 years, or both.

Id.

329. *Id.*

330. BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 707 (6th ed. 2008).

331. *Id.*

of such item or service; (5) payable “in whole or in part” by a federal health care program, such as Medicare and Medicaid.³³²

The AKS appears to be an ideal statute to combat the problem of patient brokering. A patient broker who accepts kickbacks from drug rehabilitation centers in exchange for sending insured patients to those drug rehabilitation facilities would clearly violate the command of the AKS. The problem, however, is that the AKS only applies to federal health care programs. Thus, it would not reach patient brokers and drug rehabilitation facilities that have defrauded private insurance companies. With the expansion of coverage for drug rehabilitation in the ACA and the Mental Health Parity Act, patient brokerage schemes extend well beyond federal health care programs and, thus, the reach of the AKS.³³³

EKRA attempts to remedy the shortcoming in the AKS regarding private insurance. EKRA applies to health care benefit programs, defined as “any public or private plan or contract, *affecting commerce*, under which any medical benefit, item, or service is provided to any individual.”³³⁴ The health care benefit program must be “*in or affecting interstate or foreign commerce*.”³³⁵ This provision is necessary to make the legislation constitutional under the Commerce Clause.³³⁶ Congress has the authority “[t]o regulate Commerce . . . among the several States.”³³⁷ And, as the Supreme Court has explained, “[w]here economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained.”³³⁸ As explained in Parts I and III, both the opioid epidemic and the problems in the drug rehabilitation industry span across the United States. Further, as noted in Part II, both public and private insurance is being used across state lines to pay for drug rehabilitation services.

EKRA goes further than simply expanding the AKS to apply to private insurance. EKRA provides:

[W]hoever, with respect to services covered by a health care benefit program, in or affecting interstate or foreign commerce, knowingly

332. 42 U.S.C. § 1320a-7b(b). For the history of the evolution of the AKS from a lenient statute to an extremely stringent one, see Anne W. Morrison, *An Analysis of Anti-Kickback and Self-Referral Law in Modern Health Care*, 21 J. LEGAL MED. 351 (2000).

333. See *supra* Part II.B.

334. 18 U.S.C. § 24(b) (2018) (emphasis added).

335. 18 U.S.C. § 220(a) (2018) (emphasis added).

336. U.S. CONST. art. I, § 8, cl. 3; see *United States v. Se. Underwriters Ass’n*, 322 U.S. 533, 553 (1944) (“No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.”).

337. U.S. CONST. art. I, § 8, cl. 3.

338. *United States v. Lopez*, 514 U.S. 549, 560 (1995).

and willfully—

(1) solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient or patronage to a recovery home, clinical treatment facility, or laboratory; or

(2) pays or offers any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) to induce a referral of an individual to a recovery home,³³⁹ clinical treatment facility,³⁴⁰ or laboratory; or

(B) in exchange for an individual using the services of that recovery home, clinical treatment facility, or laboratory,

shall be fined not more than \$200,000, imprisoned not more than 10 years, or both, for each occurrence.³⁴¹

EKRA defines laboratory as it is defined in the Public Health Service Act.³⁴² The Public Health Service Act defines laboratory as a “facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.”³⁴³ Nothing in this definition of laboratories limits EKRA’s application to laboratories that are involved in drug testing for SUD clinical treatment centers or recovery homes.

The failure to limit laboratories for the purposes of EKRA may be the result of inartful drafting. Interestingly, EKRA did not originally apply to laboratories.³⁴⁴ It only applied to clinical treatment facilities and recovery

339. Under EKRA, a recovery home is “a shared living environment that is, or purports to be, free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders.” 18 U.S.C. § 220(e)(5). Sober living homes would fall under the definition of a recovery home under EKRA.

340. Under EKRA, a clinical treatment facility means “a medical setting, other than a hospital, that provides detoxification, risk reduction, outpatient treatment and care, residential treatment, or rehabilitation for substance use, pursuant to licensure or certification under State law.” 18 U.S.C. § 220(e)(2). Thus, any non-hospital provider who provides treatment for substance use is within the ambit of the law. That would certainly include residential drug treatment centers.

341. 18 U.S.C. § 220(a).

342. 18 U.S.C. § 220(e)(4).

343. 42 U.S.C. § 263a(a) (2018).

344. S. 3254, 115th Cong. § 220(a) (2018).

homes.³⁴⁵ It appears that laboratories were a last minute addition to EKRA when it was passed as part of the SUPPORT Act. Further, EKRA as a whole was not initially included in the SUPPORT Act.³⁴⁶ Representative Pallone expressed his concerns regarding the addition of EKRA:

Mr. Speaker, there is one provision that is concerning and that I do want to mention. It did not go through regular order and was not properly vetted. In fact, it was added at the very last minute. That is a proposal by Senator Rubio to create a new criminal antikickback statute.

I know this proposal is well-intentioned in addressing the serious problem of patient brokers who are taking advantage of individuals with opioid use disorders and referring them to substandard or fraudulent providers in exchange for kickbacks. This is an issue, but since the bill was introduced last Tuesday night, multiple stakeholders have raised concerns that the language does not do what we think it does. It may have unintended consequences.

Mr. Speaker, I hope this is a good lesson to all of us that passing legislation that has not been properly vetted, and that the public has not had an adequate chance to review, is unwise.³⁴⁷

Given the legislation's failure to limit the categories of laboratories subject to EKRA's provisions, there is a very real danger that EKRA could be used to prosecute laboratories for relationships that would be excepted from the AKS. This is significant because the penalty for a violation of both the AKS and EKRA is up to ten years in prison, with fines of up to \$100,000 and \$200,000, respectively.³⁴⁸

The AKS has safe-harbor provisions that except certain financial arrangements from its broad prohibitions.³⁴⁹ Although EKRA also has safe-harbor provisions,³⁵⁰ there are considerably less of them. In addition, where

345. *Id.*

346. SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2018).

347. 164 CONG. REC. H9244 (daily ed. Sept. 28, 2018) (statement of Rep. Pallone).

348. *Compare* 18 U.S.C. § 220 (2018), with 42 U.S.C. § 1320a-7b(b) (2018).

349. 42 U.S.C. § 1320a-7b(b)(3).

350. Under the statute, EKRA's prohibitions do not apply to:

- (1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity;
- (2) a payment made by an employer to an employee or independent contractor (who has a bona fide employment or contractual relationship with such employer) for employment, if the employee's payment is not determined by or does not vary by—
 - (A) the number of individuals referred to a particular recovery home, clinical treatment facility, or laboratory;
 - (B) the number of tests or procedures performed; or

the AKS and EKRA safe-harbor provisions overlap, EKRA is more restrictive. One prominent example involves employees. Rather than using a third-party referral service and paying for referrals, health care providers may hire an employee to work as a sales representative. If the employee receives a commission for referrals, the arrangement could easily run afoul of the AKS. Thus, the AKS has a safe harbor for a “bona fide employ[ee].”³⁵¹ Under the AKS, the bona fide employee safe harbor excepts from the AKS’s reach “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.”³⁵² EKRA similarly has an exception for a “bona fide employ[ee],” but the employment arrangement will run afoul of EKRA if the employee’s payment is determined by or varies based on the number of individuals referred, the number of tests or procedures performed, or the amount billed to or received from a health care benefit program.³⁵³ There are no such

(C) the amount billed to or received from, in part or in whole, the health care benefit program from the individuals referred to a particular recovery home, clinical treatment facility, or laboratory;

- (3) a discount in the price of an applicable drug of a manufacturer that is furnished to an applicable beneficiary under the Medicare coverage gap discount program under section 1860D-14A(g) of the Social Security Act (42 U.S.C. 1395w-114a(g));
- (4) a payment made by a principal to an agent as compensation for the services of the agent under a personal services and management contract that meets the requirements of section 1001.952(d) of title 42, Code of Federal Regulations, as in effect on the date of enactment of this section;
- (5) a waiver or discount (as defined in section 1001.952(h)(5) of title 42, Code of Federal Regulations, or any successor regulation) of any coinsurance or copayment by a health care benefit program if—
 - (A) the waiver or discount is not routinely provided; and
 - (B) the waiver or discount is provided in good faith;
- (6) a remuneration described in section 1128B(b)(3)(I) of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)(I));
- (7) a remuneration made pursuant to an alternative payment model (as defined in section 1833(z)(3)(C) of the Social Security Act) or pursuant to a payment arrangement used by a State, health insurance issuer, or group health plan if the Secretary of Health and Human Services has determined that such arrangement is necessary for care coordination or value-based care; or
- (8) any other payment, remuneration, discount, or reduction as determined by the Attorney General, in consultation with the Secretary of Health and Human Services, by regulation.

18 U.S.C. § 220(b).

351. 42 U.S.C. § 1320a-7b(b)(3)(B).

352. *Id.* Under the statute, an employee is any worker that satisfies the common law rules for establishing an employer-employee relationship. *Id.* Under the common law, courts will often look to employer control, supervision, and training to determine whether someone is an employee. *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323–24 (1992). Once it is established that someone is an employee, the courts will also analyze thirteen factors to determine whether someone is a bona fide employee. *Id.*

353. 18 U.S.C. § 220(b)(2).

restrictions under the AKS. Thus, a payment arrangement for an employee that involves commissions for referrals could be legal under the AKS but illegal under EKRA. This difference between the AKS and EKRA is even more important given that EKRA is not limited to laboratories doing business with clinical treatment facilities or recovery homes. Thus, any laboratory that hires an employee as a sales representative and pays that employee a commission based on the number of individuals referred, tests performed, or the amount billed to insurance could be in violation of EKRA. It seems unlikely that Senator Rubio intended that outcome when he sponsored EKRA³⁵⁴ because that would be a huge expansion of liability.

EKRA will likely be a very useful tool for prosecutors to pursue unethical treatment providers who rely upon patient brokering to obtain patients. There are concerns about the reach of the statute beyond the rehabilitation market, but hopefully prosecutors will exercise discretion and choose not to upend the financial arrangements of every laboratory. While it is too early to tell whether EKRA will help prosecutors eliminate fraud in the market, it is already clear that it will not do anything to address the informational asymmetries that exist in the market or ensure quality care. Nothing in EKRA's provisions helps consumers to discern which providers use evidence-based practices and require staff training in addiction science. Thus, while EKRA is an important first step in cleaning up the residential drug rehabilitation market, there is still more work to be done to ensure adequate information to consumers and quality care.

VI. VALUE-BASED REIMBURSEMENTS

In the United States health care system, insurance companies predominantly pay health care providers on a fee-for-service basis (FFS).³⁵⁵ In other words, each doctor visit and service provided (i.e. lab test, imaging scan, etc.) are billed separately.³⁵⁶ With FFS, providers are paid for seeing patients, regardless of clinical outcome. This Part examines the costs and

354. S. 3254, 115th Cong. § 220(a) (2018).

355. Dale B. Thompson, *The Next Stage of Health Care Reform: Controlling Costs by Paying Health Plans Based on Health Outcomes*, 44 AKRON L. REV. 727, 730 (2011); Cody Vitello, *Transforming the Way We Pay Doctors*, 19 ADVANCE DIRECTIVE 34, 38–39 (2009).

356. Thompson, *supra* note 355, at 730; Vitello, *supra* note 355, at 38–39. As Vitello explains:

When third parties are responsible for paying the bill, such as insurance companies, they either reimburse the physician based off of predetermined schedules or the customary, prevailing, and reasonable (CPR) reimbursement method. Fee schedules are established by surveying the average charges for a certain procedure or negotiated with the physician to establish the maximum the third party is willing to pay. The CPR method establishes a separate fee schedule for each physician and reimburses services based on the lowest actual charge, customary charge, or the geographic area's prevailing charge.

Id. at 39 (footnotes omitted).

benefits of the FFS model and Aronberg's proposal for outcome-based reimbursement for drug rehabilitation services.

A. Substituting Outcome-Based Reimbursement for FFS

FFS “encourages over-utilization, discourages primary and secondary prevention, and fails to promote integrated, coordinated care.”³⁵⁷ For example, because insurance providers provide reimbursement for each urinalysis a residential drug treatment center performs, disreputable treatment centers test their patients as often as possible.³⁵⁸ Multiple urine tests in a week are not contributing to the outcome that patients seek—sobriety. But FFS incentivizes this behavior because profits “increase consistently with greater quantities” of provided services.³⁵⁹ Similarly, profits increase from more costly services.³⁶⁰

Some scholars have advocated for changing the insurance reimbursement system to a value-based approach.³⁶¹ This would change the focus from the services provided to a specific outcome. A value-based approach would increase performance pressures on providers. One challenge that comes along with a value-based reimbursement system is assessing performance. There would have to be well-defined targets that providers are expected to meet and a means of measuring performance against those targets. Further, the level of payment would also have to be tied to the performance targets.

Aronberg argues that the ACA's FFS reimbursement model should be changed to an outcome-based model to prevent exploitation by corrupt drug treatment providers.³⁶² Aronberg notes that the “ACA changed Medicare to

357. TOM LATKOVIC, *THE TRILLION DOLLAR PRIZE* 15 (2013).

358. Ferguson, *Searching for Help*, *supra* note 25.

359. Thompson, *supra* note 355, at 730. Thompson further explains that:

[T]he fee-for-service system creates incentives by rewarding volume but not quality or outcomes. This leads to a number of problems: provision of a substantial amount of care with little value, under-provision of other care with higher value, perverse incentives for poor quality care as services to correct for earlier errors lead to higher levels of compensation, excessive use of high technology equipment, an oversupply of hospital beds, and insufficient incentives for managing and educating patients through low-cost ways of improving their health. In the end, this payment system rewards health care providers more if their patients are less healthy.

Id. at 734.

360. *Id.*

361. *See, e.g., id.* at 746–53 (advocating for a payment system based on health outcomes); David A. Hyman & Charles Silver, *You Get What You Pay for: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001) (arguing that health care providers are more likely to provide high quality care if they are paid to do so).

362. *Change the Affordable Care Act's Fee-for-Service Reimbursement Model to Outcome Based Reimbursement*, FIX FLA. SHUFFLE, <https://www.fixthefloridashuffle.com/issues/ACA> [<https://perma.cc/T46H-CPZY>].

reduce payments to hospitals with high readmission rates while providing bonuses to providers that achieve high scores on patient outcome and care experiences.”³⁶³ He argues that Medicare’s outcome-based reimbursement model should be applied to private insurers who pay for drug rehabilitation services.³⁶⁴ Further, Aronberg argues that switching to an outcome-based reimbursement model would “reward the best recovery centers while shuttering rogue operators who give false promises and illicit benefits to patients, then siphon precious resources into treating and then encouraging repeated relapses.”³⁶⁵

There are no further details on Aronberg’s proposal, but the idea deserves serious consideration. In discussing Medicare’s outcome-based reimbursement,³⁶⁶ Aronberg presumably references the Center for Medicare and Medicaid Services’ (CMS) hospital value-based purchasing plan (VBP). The initiative “rewards acute-care hospitals with incentive payments for the quality care provided to Medicare beneficiaries.”³⁶⁷ Specifically, it rewards hospitals based on the quality of care, how closely best clinical practices are followed, and how well hospitals enhance patients’ experience of care during hospital stays.³⁶⁸ As Aronberg mentions, hospital reimbursements are reduced if the healthcare system experiences a certain percentage of readmissions that are deemed to have been preventable by the hospital.³⁶⁹

Under the program, CMS no longer pays hospitals based on the quantity of services provided.³⁷⁰ CMS assesses achievement and improvement scores for each Hospital VBP measure.³⁷¹ CMS then employs a threshold and benchmark to determine how many points to award for the achievement and improvement scores. Hospitals are gauged on several measures of outcome:

363. *Id.*

364. *Id.*

365. *Id.*

366. For a history of quality assessment in Medicare, see Eleanor D. Kinney, *The Affordable Care Act and the Medicare Program: Linking Medicare Payment to Quality Performance*, 68 N.Y.U. ANN. SURV. AM. L. 567 (2013).

367. MEDICARE LEARNING NETWORK, CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL VALUE-BASED PURCHASING 2 (2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPPurchasing_Fact_Sheet_ICN907664.pdf [https://perma.cc/F4U8-V6YE].

368. *Id.* at 3.

369. *Change the Affordable Care Act’s Fee-for-Service Reimbursement Model to Outcome Based Reimbursement*, *supra* note 362.

370. MEDICARE LEARNING NETWORK, CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 367, at 3.

371. *The Hospital Value-Based Purchasing (VBP) Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html> [https://perma.cc/76H8-L7U4] (last updated Jan. 6, 2020).

(1) mortality and complications; (2) healthcare-associated infections; (3) patient safety; (4) patient experience; (5) process; and (6) efficiency and cost reduction.³⁷² The idea is that if a hospital has its reimbursements reduced because of its poor care, the hospital will make improvements.³⁷³ Indeed, the hope is that “[v]alue-based purchasing will encourage providers to reorganize in ways that promote efficiency and collaboration with other types of providers toward the same end.”³⁷⁴

There is no doubt that if value-based reimbursement works properly, then transitioning from an FFS to a value-based reimbursement model would largely remove fraudulent treatment centers’ incentives to take part in the residential drug rehabilitation market. If these facilities could no longer run up the insurance bills by billing for duplicative and unnecessary services, there would be no financial gain. But, getting the program to work properly will be an “immensely difficult task” because “[q]uality has multiple dimensions and is often highly subjective, making ‘quality care’ impossible to define uniformly for diverse populations. Even when it is possible to settle on a reasonable definition of quality, measures can be difficult to translate into financial incentives.”³⁷⁵ In addition, there is very little evidence to support the idea that these financial incentives actually change provider behavior or, perhaps more importantly, improve patient outcomes.³⁷⁶

B. Assessing the Quality of Care

Medical care quality can be measured based on outcomes, process, structural factors, and patient satisfaction.³⁷⁷ Because of the problems

372. *Id.*

373. Karen Kane, Note, *How Much Does Quality Cost? Analyzing the Patient Protection and Affordable Care Act’s Value-Based Purchasing Provision and How It Could Affect the Delivery of Care by Hospitals*, 14 DUQ. BUS. L.J. 69, 91 (2011).

374. Kinney, *supra* note 366, at 601.

375. Michael F. Cannon, *Pay-for-Performance: Is Medicare a Good Candidate?*, 7 YALE J. HEALTH POL’Y L. & ETHICS 1, 4 (2007).

376. Eric T. Roberts et al., *The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities*, 168 ANNALS INTERNAL MED. 255, 261 (2018) (evaluating CMS’s Value-Based Modifier program and finding that it was ineffective in improving performance on average and that “pay-for-performance programs with weak incentives and inadequate risk adjustment could contribute to health care disparities without eliciting a behavioral change that improves care on average”); Aaron E. Carroll, *The Problem with ‘Pay for Performance’ in Medicine*, N.Y. TIMES (July 28, 2014), <https://www.nytimes.com/2014/07/29/upshot/the-problem-with-pay-for-performance-in-medicine.html?partner=rss&emc=rss> [<https://perma.cc/M3QK-HYKJ>] (evaluating multiple studies on pay for performance).

377. Cannon, *supra* note 375, at 4; Avedis Donabedian, *Evaluating the Quality of Medical Care*, 83 MILBANK Q. 691, 694–95 (2005).

previously noted concerning patient assessment of quality,³⁷⁸ this Article will focus on outcome, process, and structure.

I. Outcomes

In the drug rehabilitation market, it will be difficult to accurately measure outcomes. First, measuring outcomes requires the ability to determine desirable and undesirable results. The undesirable result that immediately comes to mind is relapse. But, relapse is a normal part of treatment. Further, patient relapse is not completely within the control of the rehabilitation facility. There are many factors beyond the rehabilitation center that play into whether someone relapses. As Karen Kane has argued:

Outcome measurements examine the result of the treatment on the individual patient with a particular illness or condition. Such results are considered by many to be less reliable because of the many factors that may affect the patient's condition "outside the provider's control." Specifically, some outcomes are subjected to influences that are not within the control of medical intervention, including the severity of the patient's condition, his compliance to medical treatment, and the nature of the condition. Additionally, the outcome that is desired is questioned because every patient and provider may view this differently. While quality outcomes are the goal of most healthcare providers, linking reimbursement to quality outcomes is challenging and may lead to a less reliable method of assessment.³⁷⁹

Thus, it may be inappropriate to reduce reimbursement to a residential treatment center based on the relapse rate when that rate may be influenced by the severity of the illness, the patient's support system, job prospects, mental health, and other factors beyond the control of the facility. Another undesirable result is death due to overdose. But, if that is going to be part of the calculus in deciding reimbursement rate, then how long after treatment will this outcome be measured? And, much like examining the relapse rate, the mortality rate "might indicate good or bad care in the aggregate," but it does not "give an insight into the nature and location of the deficiencies or strengths to which the outcome might be attributed."³⁸⁰

Second, gathering the data would likely be more difficult than what is required for the hospital value-based purchasing plan. Unlike typical health

378. See *supra* Section IV.A.1.

379. Kane, *supra* note 373, at 75 (footnotes omitted) (quoting Anne B. Claiborne et al., *Legal Impediments to Implementing Value-Based Purchasing in Healthcare*, 35 AM. J.L. & MED. 442, 466 (2009)).

380. Donabedian, *supra* note 377, at 694.

care patients who receive treatment and any subsequent follow-up care near their homes, individuals with SUD travel all over the United States to receive treatment, stay at sober living homes, and then return home. This will make it more challenging to track patients and measure outcomes.

2. Process

If quality of care cannot be accurately measured solely based on outcomes, then perhaps the process of care could be considered. Process measures would allow us to assess the extent to which rehabilitation facilities are utilizing evidence-based practices.³⁸¹ The American Medical Association (AMA) has published principles for pay-for-performance programs³⁸² and process appears to be the most important measure of quality.³⁸³ It is the AMA's expectation that "[e]vidence-based quality of care measures must be the primary measures used" in value-based reimbursement programs.³⁸⁴ It should be noted, however, that process-based quality measures are likely to be "less stable and less final than those that derive from the measurement of outcomes."³⁸⁵ At the same time, however, they may "be more relevant to the question at hand: whether medicine is properly practiced."³⁸⁶ A process-based quality measure would be particularly helpful in the drug rehabilitation setting because it would incentivize more providers to use evidence-based practices to treat their patients.

381. As Avedis Donabedian has stated, measuring quality by the process of care would allow us to determine "whether what is now known to be 'good' medical care has been applied." *Id.*

Judgments are based on considerations such as the appropriateness, completeness and redundancy of information obtained through clinical history, physical examination and diagnostic tests; justification of diagnosis and therapy; technical competence in the performance of diagnostic and therapeutic procedures, including surgery; evidence of preventive management in health and illness; coordination and continuity of care; acceptability of care to the recipient and so on. This approach requires that a great deal of attention be given to specifying the relevant dimensions, values and standards to be used in assessment.

Id.

382. Pay-for-performance is another name for value-based reimbursement. *See generally* Cannon, *supra* note 375.

383. AM. MED. ASS'N, PAY-FOR-PERFORMANCE PRINCIPLES AND GUIDELINES H-450.947 (2018).

384. *Id.* at 2. The principles specify that programs should ensure quality of care, foster the patient/physician relationship, offer voluntary physician participation, use accurate data and fair reporting, and provide fair and equitable program incentives. *Id.*

385. Donabedian, *supra* note 377, at 694.

386. *Id.*

3. *Structure*

Finally, structural quality measures are aimed at assessing the setting in which care takes place and “the instrumentalities of which it is the product.”³⁸⁷

It is concerned with such things as the adequacy of facilities and equipment; the qualifications of medical staff and their organization; the administrative structure and operations of programs and institutions providing care; fiscal organization and the like. The assumption is made that given the proper settings and instrumentalities, good medical care will follow.³⁸⁸

Although structural quality measures may initially seem appealing, there are limitations that may render this measure less effective.³⁸⁹ As Michael Cannon has noted, “[t]he mere availability of sophisticated human and physical capital offers no direct evidence of whether those resources are being used optimally. Meeting structural quality measures can also require large investments, which raise costs and may undercut cost-effectiveness.”³⁹⁰ In the drug rehabilitation industry, however, focusing on structure as one measure of quality would likely benefit patients because it would prevent run-down facilities without properly trained staff from receiving reimbursements.

C. *Implementation and Effectiveness*

Assuming arguendo, that accurate quality measures could be determined, implementation may be difficult. There would be high administrative costs for insurers and providers associated with transforming the billing and reimbursement system. There would also be substantial costs for providers associated with structural and process-based quality reforms because of the need to train and hire qualified staff and utilize evidence-based practices. It is possible that, in the long run, the costs could be mitigated by cost-savings that would result from the shift from FFS to value-based care. In the short term, however, it is likely that these costs would be passed on to consumers.

Aside from high administrative costs, it is not clear that this proposal will alleviate the informational asymmetries in the residential drug treatment market. The change in billing from FFS to value-based reimbursement will

387. *Id.* at 694–95.

388. *Id.* at 695 (footnotes omitted).

389. Cannon, *supra* note 375, at 7.

390. *Id.*

provide a great deal of information to insurers concerning the quality of care. But, it does not provide that information directly to consumers. It may take some time for a fraudulent center to shutter its doors due to reimbursement reductions. In the meantime, consumers have no way of knowing whether they are at a reputable residential drug treatment center. It is certainly possible that the government or insurers would make the information publicly available,³⁹¹ but there is nothing in the proposal that would guarantee that outcome. Finally, even if this information is publicly available it may not be used by healthcare consumers due to “difficulty in locating it, constraints on the ability of patients to make choices . . . even if quality information is available (e.g., limited choice in selecting health plans, or healthcare providers within a plan), and the belief that quality data are not as trustworthy as word of mouth.”³⁹²

VII. CORRECTING INFORMATIONAL ASYMMETRIES THROUGH ACCREDITATION AND LICENSING OF DRUG REHABILITATION FACILITIES

The key problem that needs to be addressed is the severe informational asymmetries that exist in the drug rehabilitation market.³⁹³ This Part argues that the most effective means of accomplishing the goal of alleviating information asymmetries is mandatory accreditation and licensing requirements.

For asymmetries of information, neoclassical economics would advocate that the government intervene through disclosure mandates,³⁹⁴ government

391. For example, the United States Department of Health and Human Services created a website to help Medicare patients shop for hospital care based on quality and price. *See* Claiborne et al., *supra* note 379, at 449.

392. *Id.* at 467.

393. *See supra* Section IV.A.1.

394. Mandated disclosure is a heavily used regulatory technique. Ben-Shahar and Schneider argue that mandated disclosure fails because it is rare that lawmakers, disclosers, and disclosees properly play their parts. Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. PA. L. REV. 647, 679 (2011). For lawmakers, mandatory disclosure is appealing

because it resonates with two fundamental American ideologies. The first is free-market principles. Mandated disclosure may constrain unfettered rapacity and counteracts caveat emptor, but the intervention is soft and leaves everything substantive alone: prices, quality, entry. Instead of specifying outcomes of transactions or dictating choices, it proffers information for making better decisions. . . . It supposes that people make better decisions for themselves than anyone can make for them and that people are entitled to freedom in making decisions.

Id. at 681 (footnote omitted). The appeal of mandated disclosures “lead lawmakers to mandate disclosure too often and too broadly.” *Id.* at 684. But, even if lawmakers require the correct amount of disclosures, there is still the possibility that the disclosers will have difficulty understanding or complying with the requirements. Further,

mandated disclosure rests on false assumptions: that people want to make all the consequential decisions about their lives, and that they want to do so by assembling all the relevant

production, and dissemination of information, or even behavioral mandates.³⁹⁵ In addition, the government should intervene for the purpose of consumer protection.³⁹⁶ Consumer protection laws are needed to correct distortions in the marketplace. They are intended to ensure that consumers can choose effectively among competitive options, “with their critical faculties unimpaired by . . . deception or the withholding of material information.”³⁹⁷

In the drug rehabilitation market, consumer deception is rampant. As explained in Part III, the goal of disreputable residential drug rehabilitation facilities is to deceive desperate and vulnerable people suffering from SUD to come to their facilities so that the facility can overbill Medicare and Medicaid or private insurance companies. There is no question that consumers are unable to choose effectively among competitive options. This is exactly the type of situation where the government must intervene to protect vulnerable consumers. As Eleanor D. Kinney argues, “[t]he more vulnerable, dependent, and mentally compromised the patients are, the greater the danger that these patients might be endangered if regulatory oversight of the safety and quality of their care is limited.”³⁹⁸ Information on the quality of drug rehabilitation facilities is a credence good.³⁹⁹ Thus, the goal of any regulation should be to signal quality to the consumer. One of the most effective ways to accomplish that goal is to require accreditation and licensing.

A. Accreditation

Accreditation is ideally suited to signal quality because accreditation of a residential drug treatment center would mean that the treatment center meets a rigorous set of standards that are focused on quality of services and

information, reviewing all the possible outcomes, reviewing all their relevant values, and deciding which choice best promotes their preferences. These assumptions so poorly describe how human beings live that mandated disclosure cannot reliably improve people’s decisions and thus cannot be a dependable regulatory mechanism.

Id. at 705.

395. Ryan Bubb & Richard H. Pildes, *How Behavioral Economics Trims Its Sails and Why*, 127 HARV. L. REV. 1593, 1602 (2014).

396. Neil W. Averitt & Robert H. Lande, *Consumer Sovereignty: A Unified Theory of Antitrust and Consumer Protection Law*, 65 ANTITRUST L.J. 713, 714 (1997).

397. *Id.* at 713–14. Consumer protection laws are not, however, enacted to ensure that consumers have perfect information or that their decisions are perfectly rational. *Id.* at 717.

398. Eleanor D. Kinney, *Private Accreditation as a Substitute for Direct Government Regulation in Public Health Insurance Programs: When Is It Appropriate?*, LAW & CONTEMP. PROBS., Autumn 1994, at 47, 67.

399. *See supra* Section IV.A.

evidence-based practices.⁴⁰⁰ “A traditional rationale for accreditation (and professional self-regulation in general) is that it promotes competition by providing information about quality to a market where such information is usually unavailable, thereby helping consumers make informed decisions and instilling market confidence in the services offered.”⁴⁰¹

Accreditation serves two critical tasks. First, it sets quality standards. Second, it ascertains organizational compliance with the standards and determines whether accreditation should be awarded.⁴⁰² One prominent example of private accreditation in the health care field involves hospital accreditation. The Joint Commission has played a significant role in certifying hospitals for participation in Medicare and Medicaid. “When Congress enacted Medicare in 1965 it required hospitals to meet minimum health and safety requirements for participation in the program . . . and looked to private accreditation as a quality assurance tool.”⁴⁰³ Thus, when the Joint Commission accredits a hospital, it is deemed to be in compliance with Medicare’s conditions of participation.⁴⁰⁴ In developing quality standards, the Joint Commission seeks input from “health care professionals, providers, subject matter experts, consumers, and government agencies (including the Centers for Medicare & Medicaid Services).”⁴⁰⁵ There are more than 250 standards that are regularly updated

400. See, e.g., Kinney, *supra* note 398, at 49 (“The basic purpose of accreditation is to establish that an organization has met and continues to meet specified standards. Accreditation serves as an assurance of quality for consumers of the organization’s services.”).

401. Marina Lao, *Discrediting Accreditation?: Antitrust and Legal Education*, 79 WASH. U. L.Q. 1035, 1079 (2002).

402. Kinney, *supra* note 398, at 49.

403. Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 610 (2000).

404. *Id.* at 610–11. The process has been described this way:

Health facility accreditation is a systematic, multidisciplinary inspection of the physical and organizational structure of the facility or program and the functioning of its component parts. Factors measured include staff qualifications, facilities, organization, record keeping, and continuing education of staff.

The process of accreditation requires a request for accreditation from the board of governors of the hospital or health facility, implying acceptance of the standards of the commission. The accreditation process includes a self-assessment, an on-site survey, and follow-up action for correction of deficits and improvements. The commission is invited to conduct a survey, and resurvey as it sees fit. The hospital pays a fee and commits itself to provide all data requested and to cooperate with the site visit. The commission issues a confidential report, giving the accreditation rating and interim statement of deficiencies, and requests progress reports in correcting deficiencies. It is also empowered to carry out follow-up inspections and resurveys.

Theodore H. Tulchinsky & Elena A. Varavikova, *Health Technology, Quality, Law, and Ethics*, in *THE NEW PUBLIC HEALTH* 771, 788–89 (3d ed. 2014), <https://www.sciencedirect.com/topics/nursing-and-health-professions/hospital-accreditation>.

405. *About Our Standards*, JOINT COMMISSION, <https://www.jointcommission.org/standards/about-our-standards/> [<https://perma.cc/882Z-7M8G>].

to reflect advances in health care and medicine.⁴⁰⁶ The Joint Commission visits accredited hospitals once every three years to perform an accreditation survey to evaluate compliance.⁴⁰⁷ In addition, the Joint Commission issues Quality Reports on all of its accredited health care organizations and makes them available online.⁴⁰⁸

The federal government could use hospital accreditation as an example to follow in creating an accreditation program for drug rehabilitation facilities. The federal government need not take on the difficult task of setting standards and determining compliance itself. Instead, it could use private standard setting and accreditation bodies to fulfill this crucial task. One possibility is to work with the American Society of Addiction Medicine (ASAM), which has developed criteria for the operation of residential drug treatment centers, and the Commission on Accreditation of Rehabilitation Facilities (CARF) to create an accreditation process for drug rehabilitation facilities. The ASAM Criteria sets guidelines for the “placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions” and is required in more than thirty states.⁴⁰⁹ Although the ASAM Criteria are required in more than thirty states, there is no body

406. *Joint Commission FAQs*, JOINT COMMISSION, <https://www.jointcommission.org/about-us/facts-about-the-joint-commission/joint-commission-faqs/> [<https://perma.cc/H8D4-VT6W>] (“The hospital accreditation standards number more than 250, and address everything from patient rights and education, infection control, medication management, and preventing medical errors, to how the hospital verifies that its doctors, nurses, and other staff are qualified and competent, how it prepares for emergencies, and how it collects data on its performance and uses that data to improve itself.”).

407. *Id.*

During the survey, surveyors select patients randomly and use their medical records as a roadmap to evaluate standards compliance. As surveyors trace a patient’s experience in a health care organization, they talk to the doctors, nurses, and other staff who interacted with the patient. Surveyors also observe doctors and nurses providing care, and often speak to the patients themselves.

Id.

408. *Id.*

409. Am. Soc’y of Addiction Med., *ASAM and CARF Reshape Addiction Care with Landmark Treatment Delivery Certification*, CARF INT’L (Oct. 15, 2018, 5:30 AM), <http://carf.org/LOC-certification-news/> [<https://perma.cc/AU3D-ZWUG>].

Addiction treatment programs use the criteria to conduct a multi-dimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided. The criteria focuses on six dimensions of patient care to create a holistic, biopsychosocial assessment of an individual. This assessment is used for service planning and treatment across all services and levels of care.

Id. Those six dimensions include: (1) Acute intoxication and/or withdrawal potential; (2) Biomedical conditions and complications; (3) Emotional, behavioral, or cognitive conditions and complications; (4) Readiness to change; (5) Relapse, continued use, or continued problem potential; and (6) Recovery/living environment. AM. SOC’Y OF ADDICTION MED., *THE ASAM CRITERIA*, https://www.asamcontinuum.org/wp-content/uploads/2019/03/The-ASAM-Criteria_2017_pg1n2_PRINT_FINAL_v9_small-1.pdf [<https://perma.cc/7FT9-KJTB>].

charged with ensuring compliance with the ASAM Criteria. ASAM and CARF are partnering on a pilot program to provide ASAM Level of Care Certification to drug rehabilitation facilities that comply with the ASAM Criteria.⁴¹⁰

In addition to certification of compliance with the ASAM Criteria, it would also be important to ensure that providers are using evidence-based treatment as the foundation of their drug rehabilitation programs. The weakness in the ASAM Criteria is that it focuses on the process of care by looking at the frequency of clinical treatment within the facility.⁴¹¹ Standing alone, a process-oriented measure will not guarantee quality care. Ideally, any accreditation process would examine both the process and type of care provided.

Some may argue that setting federal accreditation standards would prevent states from acting as laboratories of experimentation and developing their own requirements for residential drug treatment centers because it would standardize care.⁴¹² While important, this argument carries less weight in the face of a nationwide opioid crisis. Vulnerable patients need to be protected as they seek treatment for SUD. In addition, the accreditation requirements would simply set minimum standards for residential drug treatment centers. States could impose more restrictive requirements for residential drug treatment centers in their respective states. Finally, by requiring minimum standards, disreputable treatment centers will not be able to move from state to state to defraud consumers.

There are likely to be significant costs associated with accreditation. If accreditation is mandatory, there may be some rehabilitation facilities that are unable to afford compliance with the accreditation standards. This could be because the cost of applying for accreditation is high or because the facility would need to undergo significant changes to meet the accreditation standards. Either way, some facilities may be forced to leave the market. It is certainly possible that there will be some quality facilities that will close

410. Am. Soc’y of Addiction Med., *supra* note 409.

411. See NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 242, at 196 (“Accreditation of health care facilities tends to focus on structural measures (e.g., physical plant adequacy, nursing ratios, certification of providers, availability of certain services). While patient outcomes (e.g., survival, function, quality of life) are in many ways the most important variables, they are difficult to collect and analyze. Patient outcomes may be affected by factors independent of the quality of a specific health care service delivered, including co-occurring conditions, patient compliance and lifestyle. Outcome data also are subjective and vary according to the setting and the particular instruments used to measure them. Given these barriers, quality assurance efforts tend to focus on the process of care, which examines the frequency with which interventions known to correlate with positive outcomes are performed.”).

412. See, e.g., Lao, *supra* note 401, at 1076–78 (explaining the anticompetitive effect of accreditation).

their doors. Although that would be an unfortunate outcome, it does not outweigh the risk that disreputable facilities will flourish in the absence of government intervention.

B. Licensing

Licensing standards go hand in hand with accreditation, especially in the medical context. In order for drug rehabilitation treatment facilities to provide care that meets the standards of medical practice, those who provide care will need training in addiction treatment and specialized education. Without training and education requirements, it is unlikely that treatment facilities will utilize evidence-based treatment. Further, the federal government should mandate that the professionals who treat patients with SUD should be treated the same as other medical professionals in the state.

Licensure laws are often justified as a means to protect the public from service providers without expertise in the given field. Thus, only those individuals who have met the education and training requirements for their field may obtain licenses.⁴¹³ In the medical profession, licensure laws play a prominent role and have been consistently upheld when challenged in court.⁴¹⁴

In addition, licensure laws are well-suited to address the quality of care at residential drug treatment facilities. As Kristin Madison has explained in the context of medical professional licensing:

State licensure frameworks protect ill-informed patients against poor quality care in two ways. First, state statutes impose minimum licensure qualifications to practice medicine and prohibit the unauthorized practice of medicine. The licensure requirement works prospectively to protect patients against poor quality care: if the prohibition against unauthorized practice is enforced, patients will be unable to contract with providers who do not fulfill licensure requirements. The prohibition prevents uninformed patients from mistakenly selecting unqualified practitioners they would have avoided, had they been more informed. Properly designed licensure requirements will prevent those most likely to deliver poor quality care from providing services to patients.

Second, state statutes create professional oversight boards responsible not only for overseeing the licensure process, but also for

413. Mary Anne Bobinski, *Law and Power in Health Care: Challenges to Physician Control*, 67 *BUFF. L. REV.* 595, 599 (2019).

414. *Id.* at 600–03 (explaining the history of challenges to medical licensure).

disciplining licensed professionals for unprofessional conduct and incompetence. This regulatory approach differs from the prohibition on unauthorized practice in the sense that it is retrospective; it responds to poor quality practice that has already occurred, rather than the mere probability of poor quality practice.⁴¹⁵

If low quality providers are eliminated through state licensing, the average quality of providers will increase.

One criticism of licensing is that it limits access and can be used to “protect the economic interests of professionals against both potential outside competitors seeking entry into the profession and those within the group itself.”⁴¹⁶ This is a valid concern of licensure laws in general. In this context, however, it is important to keep in mind the fraudulent practices and the poor quality of care delivered to SUD patients in the absence of regulation. Protecting SUD patients from incompetent providers should be the highest priority. It is the lack of regulation that has welcomed disreputable providers into the market. Thus, the focus needs to be on raising the standards to ensure a minimum level of quality across the board. Further, addiction is a brain disease for which there are evidence-based treatments available. There is no reason to exclude the professionals providing care from the stringent qualifications that apply to other medical professionals.

CONCLUSION

The United States is in the midst of an opioid crisis and people are relapsing, committing drug-related crimes, and dying after receiving poor care at disreputable residential drug rehabilitation facilities and sober living homes. Patients often lack critical information about what quality drug rehabilitation looks like, how to find it, and whether they are receiving it. As the demand for residential drug rehabilitation increases, these problems will only be further pronounced without government action. Although EKRA was an excellent first step in dealing with corruption at disreputable drug rehabilitation centers and sober living homes, there are serious questions about the reach of the statute. Further, there is still additional work to be done to ensure quality care. Public and private insurers need to incentivize providers to provide quality care. One way to properly incentivize providers is to change from a fee-for-service reimbursement model to a value-based reimbursement model because reimbursement will

415. Madison, *supra* note 288, at 1587 (footnotes omitted).

416. Claudia E. Haupt, *Licensing Knowledge*, 72 VAND. L. REV. 501, 515 (2019).

be tied to positive outcomes rather than the number of urine tests performed. Finally, to ensure quality care, the federal government needs to establish mandatory accreditation and licensing standards that require evidence-based treatment at facilities treating substance use disorder. All of these policy changes are necessary to protect those impacted by the opioid crisis who are bravely seeking treatment.