Meeting Agenda – June 19, 2018
Proviso

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      i. Role of 211: Presentation
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   c. FAU Abstract – Oral Presentation to APHA
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3. Utilization of Tax Credits for the Treatment Industry: Presentation

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United States Obtains $114 Million Judgment Against Three Individuals for Paying Kickbacks for Laboratory Referrals and Causing Claims for Medically Unnecessary Tests

On May 23, 2018, the United States District Court in the District of South Carolina entered judgment for the United States in the amounts of $111,109,655.30 against defendants LaTonya Mallory, Floyd Calhoun Dent III and Robert Bradford Johnson, and for an additional $3,039,006.56 against Johnson and Dent, the Department of Justice announced today. The judgment follows the January 31, 2018, jury verdict finding the three individuals liable for violating the False Claims Act (FCA) by paying remuneration to physicians in exchange for patient referrals, in violation of the Anti-Kickback Statute, and causing two laboratories to bill federal health care programs for medically unnecessary testing.

“Improper financial relationships between physicians and laboratories can distort a physicians’ best judgment for their patients, in addition to undermining patient health and trust,” said Acting Assistant Attorney General for the Justice Department’s Civil Division Chad Readler. “Executives and other individuals who break the law will be held personally accountable for their actions.”

During a two-week jury trial held in Charleston, South Carolina, the government introduced evidence that the defendants paid physicians remuneration disguised as processing and handling fees of between $10 and $17 for each patient they referred to two blood testing laboratories: Health Diagnostics Laboratory Inc. (HDL), of Richmond, Virginia; and Singulex Inc., of Alameda, California. The government also introduced evidence that the kickback scheme resulted in physicians referring patients to HDL and Singulex for medically unnecessary tests, which were then billed to federal health care programs.

The jury found Mallory, HDL’s former CEO, and Johnson and Dent, who marketed and sold HDL’s and Singulex’s tests, jointly and severally liable for causing the submission of 35,074 false claims, worth $16,601,591, submitted to Medicare and TRICARE by HDL. The jury also found defendants Dent and Johnson jointly and severally liable for an additional 3,813 false claims, worth $467,935, submitted by Singulex. As provided by the FCA, the Court trebled those damage amounts, offset settlement payments received from HDL and Singulex for the same claims, and awarded $63.8 million in penalties requested by the United States, for a total judgment of $114,148,661.86.

The Anti-Kickback Statute prohibits offering, paying, soliciting or receiving remuneration to induce referrals of items or services covered by federally funded programs. The Anti-Kickback Statute is intended to ensure that a physician’s medical judgment is not compromised by improper financial incentives and is instead based on the best interests of the patient.

“The Court’s damages award in this case recognizes the seriousness of what these defendants did,” said Sherri A. Lydon, U.S. Attorney for the District of South Carolina. “Paying kickbacks to cause unnecessary tests injures patients, the Medicare Program, and American taxpayers and the District of South Carolina will continue to pursue those who participate in such conduct.”
“This judgment affirms that individuals who cheat Medicare and TRICARE will not be allowed to enjoy their ill-gotten gains,” said U.S. Attorney for the District of Columbia Jessie K. Liu. “This office joins with its Department of Justice colleagues in our mutual commitment to investigate misconduct and recover funds unlawfully obtained from federal healthcare programs.”

“Laboratories that pay kickbacks to physicians in exchange for referrals of business exploit patients and taxpayer-funded health care programs,” said Special Agent in Charge Derrick L. Jackson, U.S. Department of Health and Human Services, Office of Inspector General. “Our agency is dedicated to investigating such corrosive kickback schemes, as they undermine the public’s trust in medical professionals, and the integrity of government health care programs.”

“The FBI will continue to aggressively investigate allegations of criminal misconduct between companies and individuals who engage in kickback schemes at the expense of the U.S. government,” said Acting Assistant Director of the Criminal Investigative Division Chris Hacker. “We recognize the importance of those who came forward and brought allegations to light and realize that we cannot do our work without the public’s help.”

The claims resolved by the court’s order were originally brought in three lawsuits filed by Dr. Michael Mayes, Scarlett Lutz, Kayla Webster, and Chris Reidel under the qui tam, or whistleblower, provisions of the False Claims Act. Under the Act, private citizens can bring suit on behalf of the government for false claims and share in any recovery. The Act permits the United States to intervene in and take over the whistleblower suit, as the United States did, in part, in the three consolidated actions against Mallory, Dent, Johnson and others in August 2015. The whistleblowers’ share of any recovery has yet to be determined.

The cases were litigated by the Civil Division’s Commercial Litigation Branch, and the U.S. Attorneys’ Offices for the District of South Carolina and the District of Columbia. The U.S. Attorney’s Office for the Middle District of North Carolina, HHS-OIG, the FBI’s Columbia Field Office and FBIHQ’s Major Provider Response Team, the U.S. Office of Personnel Management’s Office of Inspector General, and the Department of Defense’s Office of Inspector General Defense Criminal Investigative Service assisted with the investigation.

Letters to Eight Call Aggregators Regarding their Practices and Reports of Patient Brokering

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Excerpt: “One of the ways that patient brokers can generate leads on potential clients is through phone hotlines that connect to call centers or call aggregators. During the course of the Committee’s investigation into patient brokering, the Committee received testimony from the President and CEO of a treatment facility who said call aggregators ‘are essentially collecting leads for treatment centers who are willing to pay a price’ and that the call centers will prescreen potential patients with the goal to ‘ultimately sell the patient’s information to the highest bidder.’ Some treatment facilities and marketers are upfront about their use of call aggregators and disclose the names of companies or facilities that answer potential patients’ calls. Others reportedly engage in deceptive tactics to hide the fact that they refer patients to treatment facilities that pay for referrals or to facilities owned by the same company that is operating the hotline.”
Mr. Michael T. Cartwright  
Chief Executive Officer and Chairman of the Board of Directors  
American Addiction Centers  
200 Powell Place  
Brentwood, TN 37027

Dear Mr. Cartwright:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is continuing to examine the opioid epidemic in the U.S. that is taking 115 American lives per day. On December 12, 2017, the Subcommittee on Oversight and Investigations held a hearing examining concerns of patient brokering and addiction treatment fraud. The Subcommittee heard testimony about problems that stem from the dramatic surge in the number of substance use disorder treatment facilities and sober living homes, recovery residences, or halfway houses (hereinafter referred to as “sober living homes”) in states across the country.

The hearing followed letters from the Committee to the Department of Health and Human Services and six states as well as numerous media reports, about the practice of patient brokering—through which individuals known as patient or body brokers exploit men and women who are seeking treatment for their opioid addictions. These patient brokers allegedly rely, in

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1 Centers for Disease Control and Prevention, Opioid Overdose, Understanding the Epidemic, available at: https://www.cdc.gov/drugoverdose/epidemic/index.html/.
part, on call centers and call aggregators to generate leads on potential patients. Rather than focus on the health needs of the individuals who are seeking treatment, however, the emerging patient brokering industry views potential patients as commodities that can be bought, sold, or traded. As part of the Committee’s oversight into the role that call aggregators play in patient brokering, the Committee is seeking information from your business.

Individuals and their loved ones who are seeking treatment for substance use disorders are recruited and directed by these patient brokers to seek treatment at certain treatment facilities. In exchange for steering patients towards specific facilities or sober living homes, patient brokers receive generous financial kickbacks from the facilities or sober living homes.

One of the ways that patient brokers can generate leads on potential clients is through phone hotlines that connect to call centers or call aggregators. During the course of the Committee’s investigation into patient brokering, the Committee received testimony from the President and CEO of a treatment facility who said call aggregators “are essentially collecting leads for treatment centers who are willing to pay a price” and that the call centers will prescreen potential patients with the goal to “ultimately sell the patient’s information to the highest bidder.” Some treatment facilities and marketers are upfront about their use of call aggregators and disclose the names of companies or facilities that answer potential patients’ calls. Others reportedly engage in deceptive tactics to hide the fact that they refer patients to treatment facilities that pay for referrals or to facilities owned by the same company that is operating the hotline.

Patient brokers are predominantly paid in one of two ways, a per-head fee that can range from $500 to $5,000 for each patient who successfully enters a treatment center, or monthly treatment facility fees that are based on the broker meeting a quota of patients and can result in earnings in the tens of thousands of dollars. According to some reports, in an effort to lure

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patients to these facilities, perks are sometimes offered, such as “scholarships” to go into rehab, free housing, discounted groceries, daily yoga sessions, money to go to the movies, and free cigarettes, among other enticing benefits.\textsuperscript{10} Further, it is unclear if these patient brokers or call aggregators have any medical background or necessary training to assist or make medical decisions for potential patients. The Committee is concerned about these practices as they appear to be motivated by profit, rather than what is most clinically appropriate for individuals.

Perhaps most disturbing is the allegation that some patient brokers follow these individuals with substance use disorder after their release and provide them with drugs to induce relapse so that the entire process can be repeated.\textsuperscript{11} This scheme creates an incentive for relapse and profit rather than treatment and, ultimately, sobriety.

The exploitative tactics employed by patient brokers and some call aggregators have been deployed amid a perfect storm. More than 20 million people over the age of 12 reported a substance use disorder in 2016, including 1.8 million people whose disorder involved prescription pain pills.\textsuperscript{12} As the opioid epidemic has ravaged the country, individuals with substance use disorders who are vulnerable and desperately in need of help have continued to search for treatment options. The business of advertising and recruiting for substance use disorder treatment requires greater scrutiny, and those battling addiction deserve a safe and dependable environment when seeking treatment. These schemes are harming individuals and their loved ones.

To assist the Committee in its efforts, please provide written answers to the following questions, as well as the requested documents, no later than June 12, 2018.

1. Does your call center refer, connect, or recommend individuals seeking treatment for substance use disorder with substance use disorder treatment facilities, detox centers, and/or sober living homes (hereinafter referred to as “facilities”)?

   a. If so, please provide a list of the facilities to which you offer these services.

   b. If so, when did your call center open and begin referring or connecting individuals for treatment?

   c. If so, do these facilities pay your company for these services?

      i. If so, what is the payment structure (per patient, per month, per year, etc.) and how much do they pay you?

\textsuperscript{10} Id.


\textsuperscript{12} Substance Abuse and Mental Health Services Administration, \textit{Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health}, available at https://store.samhsa.gov/shin/content//SMA17-5044/SMA17-5044.pdf.
d. If so, did you approach the facilities to offer services or did the facilities solicit your services?

e. If so, how many individuals have you referred, connected, or recommended to each facility?

f. Please provide all contracts your business, or any related businesses, have executed with facilities.

2. How does your company determine the facility to which it will refer an individual?

   a. What types of questions are asked of an individual when they call seeking treatment?

   b. Do you require the individuals who are answering the phone calls to disclose where a call has been routed or who the individual answering the call works for during intake calls?

   c. Please provide all policies and procedures referring or relating to the placement of individuals seeking treatment at a facility.

3. Does your company assist individuals in obtaining or signing up for health insurance? If so, please describe the role that your company has in assisting individuals in that process.

4. Is your company a standalone entity or do you have affiliations with other companies or facilities; including but not limited to, other call centers, lead generators, websites, substance use disorder treatment facilities, detox centers, sober living homes, etc.?

   a. If you have affiliations with other companies, please provide a description of each affiliation, including but not limited to the name of the facility, the owner and management of the facility, and the nature of the relationship.

   b. If calls are routed to an affiliated entity, is the call taker required to disclose that relationship during the intake call?

5. What, if any, websites do you own or operate to advertise your call center?

   a. Are there any disclosures on your website that provide information about what company or entity answers the phone when someone calls the advertised hotline number?

6. Has your company paid any of the internet search engines for ad optimization of your website or any of the websites affiliated with your company?
a. If so, please provide the name(s) of the search engine(s) and describe the payment structure (per click, per month, per year, etc.) and how much your company paid for that service.

7. Please provide a breakdown of the number of calls that your company has received and/or routed to any facilities by month, from January 2013 to present.

8. Are there requirements for those who work at your call center(s) to have any certification or training to ensure that they are qualified to help individuals who are seeking assistance in deciding which treatment facility is most appropriate for them? If so, please describe any such certifications or trainings.

   a. Please provide all training materials provided to your employees.

9. Have any facilities that you have connected patients with, owned, or operated had a license revoked or been shut down? If so, for each such facility, why was a license revoked or the facility shut down?

   a. Were any of those facilities found to be participating in patient brokering or similar fraudulent activities? If so, how many and when?

   b. Please provide all documents, including emails or other communications, related to any facilities that you have connected patients with, owned, or operated that had a license revoked or were shut down.

10. Have any criminal charges been brought against individuals employed by your company or any affiliated treatment facilities in relation to work done for the companies? If so, please list the individuals and charges and indicate whether the individuals are still employed by the company.

   a. Have any lawsuits been brought against your company or any affiliated treatment facilities? If so, please provide a list of each lawsuit and the case outcome, the related court case numbers, as well as the court each lawsuit was filed in.

Please also make arrangements to provide a briefing to Committee staff to review your response by June 12, 2018. An attachment to this letter provides additional information about complying with the Committee’s request. If you have any questions, please contact Brittany Havens, Andrea Noble or Brighton Haslett with the Majority staff at (202) 225-2927 or Christina Calce or Kevin McAlloon with the Minority staff at (202) 225-3641. Thank you for your prompt attention to this matter.
Letter to Mr. Cartwright
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Sincerely,

Greg Walden
Chairman

Frank Pallone, Jr.
Ranking Member

Gregg Harper
Chairman
Subcommittee on Oversight and Investigations

Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

Gene Green
Ranking Member
Subcommittee on Health

Attachment
May 29, 2018

Greetings:

As a licensed substance abuse service provider, we thank you for the service you deliver for people seeking recovery from substance use disorders. We would like to take this opportunity to remind you of the passage of House Bill 807 creating s. 397.4873 of the Florida Statutes, which reads:

Referrals to or from recovery residences; prohibitions; penalties.

(1) A service provider licensed under this part may not make a referral of a prospective, current, or discharged patient to, or accept a referral of such a patient from, a recovery residence unless the recovery residence holds a valid certificate of compliance as provided in s.397.487 and is actively managed by a certified recovery residence administrator as provided in s.397.4871.

(2) Subsection (1) does not apply to:

(a) A licensed service provider under contract with a managing entity as defined in s.394.9082.

(b) Referrals by a recovery residence to a licensed service provider when the recovery residence or its owners, directors, operators, or employees do not benefit directly or indirectly, from the referral.

(c) Referrals made before July 1, 2018, by a licensed service provider to that licensed service provider’s wholly owned subsidiary.

(3) For purposes of this section, a licensed service provider or recovery residence shall be considered to have made a referral if the provider or recovery residence has informed a patient by any means about the name, address, or other details of a recovery residence or licensed service provider, or informed a licensed service provider or a recovery residence of any identifying details about a patient.

(4) A licensed service provider shall maintain records of referrals to or from recovery residences as may be prescribed by the department in rule.

(5) After June 30, 2019, a licensed service provider violating this section shall be subject to an administrative fine of $1000 per occurrence. Repeat violations of this section may subject a provider to license suspension or revocation pursuant to s. 397.415.

(6) Nothing in this section requires a licensed service provider to refer a patient to or accept a referral of a patient from a recovery residence.

We encourage you to review House Bill 807 in its entirety, available at: https://www.flsenate.gov/Session/Bill/2017/807/BillText/er/PDF

1317 Winwood Boulevard, Tallahassee, Florida 32399-0700

Mission: Work in Partnership with Local Communities to Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency
The definition of Recovery Residence may be found in s. 397.311(37), F.S., which reads:

"Recovery residence" means a residential dwelling unit, or other form of group housing, that is offered or advertised through any means, including oral, written, electronic, or printed means, by any person or entity as a residence that provides a peer-supported, alcohol-free, and drug-free living environment.

Specifically, please be mindful of the requirement of s.397.4873(2)(c), F.S., that after June 30, 2018, referrals made to, or accepted from, a licensed service provider's wholly owned subsidiary, may only be made to, or accepted from, a recovery residence that holds a valid certificate of compliance as provided in s.397.487, F.S., and is actively managed by a certified recovery residence administrator as provided in s.397.4871, F.S.

The responsibility to maintain the integrity of our substance abuse treatment and recovery system lies with all of us. We encourage you to help us ensure the practices addressed in House Bill 807 are enforced, as they will help put our industry into a positive light and improve public confidence in the important work that you do. If you have reason to believe that any illegal or unethical activity is occurring in your area, please contact the substance abuse licensing staff at your regional DCF office.

If you have additional questions regarding this letter, please contact Mr. Chris Weller at 850-717-4286 or at Chris.Weller@myflfamilies.com.

Thank you again for the work you do.

Respectfully,

[Signature]

Ute Gaziolo
Director, Substance Abuse and Mental Health

cc: John N. Bryant, Assistant Secretary for Substance Abuse and Mental Health
Regional Substance Abuse and Mental Health Directors
Meeting Agenda – June 20, 2018 -SHTF

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Andrew Burki, MSW, Contributor

Macro Level Social Worker and CEO of Life of Purpose

Fixing a Broken System: Inability to Access Care, The Plight of Families, and the Uphill Fight for Functional Warm Handoff Programs

01/17/2018 09:06 am ET Updated Jan 17, 2018

I recently published an article proposing how we could legislatively structure tax credits to immediately increase access to quality treatment for substance use disorder and address the opioid crisis (https://www.huffingtonpost.com/entry/how-to-fight-the-opioid-epidemic-and-reduce-insurance_us_5a1c8fade4b07bcab2c69932). Before going into further detail on the “how” of the subject, allow me to briefly cover the “why.”

What price would you pay for your child to have one more shot at life while you watched them slip further and further away? Would you pay it twice? Three times? Seventeen? That’s the choice American families face every single day whenever someone starts the uphill battle against substance use disorder under the current system. It’s never a matter of whether quality help is available, it’s just a matter of if quality help is affordable. It’s not that we can’t treat the substance use disorder crisis in our country, it’s that we, as a society, still choose not to. It’s not that countless souls couldn’t be turned back from the graveyard at any number of hospital emergency rooms on the way—it’s that, often, they’re simply sent back to the street without a second thought or shred of empathy. The absurdity of our inaction would be laughable if we didn’t have to bury our fellow citizens, by the hundreds, every single day. Don’t let all the beautiful memorial services and pretty flowers fool you, this is a mass grave in which we keep tossing our brothers and sisters. The fact that everyone gets their own epitaph doesn’t atone for the scale of our society’s failure—it just makes that failure more palatable on the surface.

That’s the America we live in, whether you’re willing to acknowledge it yet or not. There is never a waiting list for jail, nor a shortage of taxpayer dollars to cover its cost for decades in some cases. Just think about how outrageous it is that our government will pay upwards of three million dollars to lock a suffering young person with a substance use disorder up for two decades at $75,000 dollars per year after getting caught, but can’t find a dime to help that individual’s family get help for their loved one for years leading up to that point. That’s not tough on crime. That’s fiscally irresponsible even if you are a heartless monster. Similarly, insurance doesn’t insufficiently cover half of quadruple bypass surgery after you pay your deductible and out of pocket max. We don’t consider withholding insulin from a diabetic because, “they’re probably just going to eat cake again.” We don’t offer aspirin instead of chemo for cancer. It’s only with substance use disorder that we take the cheaper to let them die approach to public policy with lip service and hollow promises from our politicians to placate grieving families while the death toll skyrockets year after year.

That’s why we need to fix our broken system.

How we begin the process of solving this complex problem is incredibly simple. Get people with substance use disorders off the streets and into the treatment that they desperately need. It doesn’t require anything beyond common sense to know that people not using drugs while receiving treatment for a substance use disorder are less likely to die from the drugs that they are not currently using than people suffering from an active substance use disorder are from the drugs that they are currently using. If one of us has a reoccurrence of use, send us back to treatment. What about a second reoccurrence of use? Send us back to treatment again. We don’t stop fighting on any other chronic and persistent illness while there’s still a fight left to have. I highly doubt anyone has ever told the spouse of someone whose cancer has come out of remission, “This is the third time she’s had cancer. When is it going to be enough already? You just need to set your boundaries and accept that she’s never going to get better.”

Lastly, we absolutely have to stop pretending that it is too expensive to treat people. It’s too expensive not to. Recovery is cheap. Active addiction is expensive. Help is cheap. Punishment is expensive. Love is cheap. Spite is expensive. The
economic impact of substance use disorder in America will exceed one trillion dollars in 2018. As little as a 10% reduction in that figure would pay for every single individual suffering from a substance use disorder to receive some form of clinical support for the entire year, and we would still have money left over to redo the crumbling infrastructure of a few major cities.

Which brings us to legislatively crafting tax credits to fund substance use disorder treatment for every single person who needs it in our country. Tax credits are vastly cheaper than continuing to foot the bill for not properly addressing this crisis in our society, (a crisis, which I might add, we also pay for with taxes) because ER visits cost money, ambulance rides cost money, naloxone costs money, jails cost money, prisons costs money, etc.

Tax credits can be used to support and sustain individuals in recovery at vastly less expensive subacute levels of care for extended periods of time along a comprehensive continuum of care. Not only is this the morally right thing to do and the clinically most effective thing to do—it’s the cheaper thing to do. Most importantly though, tax credits can be legislatively structured so that they can be sold to other industries at a slightly discounted rate to immediately provide resources to treat individuals suffering from substance use disorders. This could effectively fund our public sector and nonprofit treatment facilities, as well as our private sector treatment facilities. This could immediately be used to remove the financial burden from over stretched families and insurance payers alike. This could be used to help pull struggling towns and communities fighting this plague up from underwater. This could be used to save lives.

The day Comcast can eliminate 1 billion dollars of tax liability for 950 million dollars is the day our markets will go up and our body count will start to come down. The day that Amazon can eliminate a billion dollars of tax liability for 950 million dollars is the day we can afford treatment for every single citizen who needs it.

Because at the end of the day, would we ever really give up on a single American if the help that we keep promising, as a society, was actually delivered?
The best option for any family fighting a substance use disorder is always going to involve getting people out of harm’s way and into the care they so desperately need. Access to high quality care, though, is becoming increasingly difficult to obtain and increasingly expensive for the families and individuals who need it. There are several reasons for this systemic failure of an entire branch of our healthcare system, but the single most significant one is the combination of insurance fraud and the insurance companies’ reaction to that fraud. Florida State Attorney Dave Aronberg wrote an excellent op-ed for Time in which he covers fraudulent exploitation of the Affordable Care Act by human traffickers masquerading as substance use disorder treatment providers. Poorly funded regulatory agencies have been no match for the scale of this insurance fraud, which has led to numerous critical failures at a time when we need every aspect of the system firing on all cylinders to take on both the opioid epidemic and our larger substance use disorder and mental health concern crisis in this country. There exists a myriad of ways in which this fraud occurs, but one of the simplest to understand is pseudo facilities illegally buying insurance policies for uninsured or underinsured individuals. This often comes alongside additional criminal acts in the form of inducements such as plane tickets, waving of deductibles and waving of out-of-pocket maximums required by insurance providers. Unfortunately, with the sole exception of Florida, states have yet to put substantive legislative safeguards in place for vulnerable families and/or enforce the ones already on the books. This process has been further slowed and made more dangerous for those seeking care, as legitimate providers nationally, have been deterred from advocating for corrective action by the onslaught of negative press that fighting for and establishing protections for families has brought down on the legitimate treatment industry in Florida. Additionally, the insurance companies’ response to this fraud has been to increase out-of-pocket costs for desperate families year after year and decrease coverage for legitimate treatment providers right alongside the traffickers’ pseudo facilities to make up for their losses. In doing so, they have inadvertently created a dynamic in which more families are willing to break laws to access what they believe to be behavioral healthcare (i.e. try to save their loved one’s life) and more people are unintentionally ending up in pseudo treatment facilities as a result. Even fixing the problem in Florida has yielded limited results as enforcement of laws and protections for families do little good if the traffickers just divert individuals to pseudo facilities in any of the other 49 states where such protections don’t yet exist. The human traffickers specifically target insurance policies with higher reimbursements to fraudulently purchase for their victims who have been diverted from the legitimate behavioral healthcare industry. This criminal behavior going unchecked, of course, triggers even more drastic responses from the insurance industry, which in turn results in even more families backed into a corner where access to quality care seems inaccessible. The most catastrophic of all the fallout from this downward spiral has been large insurers pulling out of entire markets which were heavily targeted by these human traffickers.

At a time when it is absolutely critical to get every single person with a substance use disorder off of the streets and into substance use disorder treatment due to the increased lethality of a fentanyl laced opioid supply that is only getting stronger due to widespread diversion and misuse of buprenorphine for the purpose of “bridging,” bureaucratic barriers to inpatient treatment are pushing up the death toll. Major efforts are underway in the public sector to remove Institution for Mental Disease (IMD) exclusions and increase access to inpatient systems of care that provide the foundation for longer term solutions, but most importantly immediately higher levels of safety. While these efforts are a tremendous step in the right direction, they are insufficient to address the sheer scale of the crisis at hand.
One immediate solution would be the utilization of tax credits in the private behavioral health treatment industry to treat uninsured and underinsured individuals. Governments small and large in our country regularly utilize tax credits for everything from filming movies in their region to moving jobs back and forth between Kansas City, Missouri and Kansas City, Kansas. Over 300 million dollars in tax credits and incentives were given on just that one squabble between just those two states last year. Do you know what else happened in the same timeframe? It became harder for families on both sides of the Kansas City state line to access desperately needed treatment for their children with substance use disorders. Tax credits are a particularly easy way to “pay” for things on which you don’t want to spend money. If tax credits are particularly well structured during their design phase, they can even be sold to companies in other larger industries that have gargantuan tax liabilities for a reduced rate. Why, you might ask, is any of this necessary? Because in the midst of a national emergency, where 60,000 people a year are dying from opioid overdoses alone, our leaders still can’t find money for anything substantive to address this problem. We’re happy to spend $50,000 to $75,000 per year per inmate to incarcerate sick individuals for nonviolent drug charges if we catch them (just to put that in perspective, we’ll drop up to 3 million dollars on keeping a kid locked up for two decades if they get caught with the wrong drug in the wrong place), but we can’t find Lady Liberty’s pocket change when millions upon millions of desperate American families are begging for help year after year. I get that we’re still stigmatized. I get that you don’t think we’re worth saving. I get that those in power on both sides of the aisle still hate people with substance use disorders because for all your lip service that’s what your inaction clearly communicates to a battered nation ... I’m just hoping that you hate taxes even more than us because we need to get a million people off the streets before they end up in body bags, and this is one quick way to do it.
Recovery Guidance is the only website developed to provide a solution for the addiction epidemic by providing consumers direct access to treatment providers who can help them as well as informing them about the quality of care they can expect from those providers. Unique features:

- **Comprehensive directory** of addiction and mental healthcare at no cost to consumers
- **Advanced technology** with simple navigation that’s easy to understand and use
- **Directory includes** providers across the full spectrum of treatment and care required for long term recovery success
- **Full-page provider profiles**: Google map-assisted provider profiles include services, areas of expertise, photos, insurance information, and patient experience of care reviews
- **Provider’s annual subscription fee** allows providers to submit their customized profiles and receive requests from patients at no cost
- **Safe and direct access** for consumers: RG is not a referral site. Consumers will not receive solicitation calls from providers nor will any attempts be made to place the consumer with any provider **No 800 numbers or ads**
- **Elastic search** so consumers can search for treatment services through key words, categories, and nearest location
- **Basic assessment questionnaire** helps consumers to select the category of providers to begin their search
- **Unbiased review system** allows consumers to submit experience of care reviews. Reviews can be submitted even if providers have not activated their listings
- **Informed consumers** can compare the quality and success of care they can expect from treatment providers

Recovery Guidance is more than a website with a vast database and the features listed above. With a few lines of code, the **RG widget** can be added to any website. Taking up only a tiny space on an insurance website and without interfering with any other information provided on the site, insureds can instantly have the full database of Recovery Guidance in an open, interactive portal that automatically delivers all the providers nearby, or across the nation. The widget can be white labelled, and the landing page can be customized. An example of the RG widget can be viewed on **Reach Out Recovery**.
Item 4

ASSESSMENT TOOL
GEO DIRECTED
DIRECT ACCESS
ALL PROVIDERS
CONSUMER REVIEWS

RECOVERY GUIDANCE
Logic will get you from A to B. Imagination will take you everywhere.

- Albert Einstein
OUR FOCUS GROUP is actual consumers affected by addiction.

Multiple Injuries

1 Patient

Dad  Dad  Sister  Coach  Teacher  Boss  Girlfriend  Aunt  Grandpa  Co-Worker  Friend  Cousin  Neighbor  Neighbor  Pastor

120 MILLION PEOPLE AFFECTED
Platform designed to provide treatment information and consumer reviews for everyone impacted by addiction.
MOST COMPREHENSIVE WEBSITE
Direct access to the full spectrum of addiction & mental health treatment providers

NAVIGATE YOUR OWN RECOVERY
Explore Your Treatment Options Without The Pressure To Choose
Unbiased Reference. No affiliations. No referrals.

Search Recovery Centers

Search by city, state, or zip code

33,000+ Recovery Centers
1,000+ Recovery Physicians
4,400+ Recovery Physicians
How To Navigate Your Recovery

Find the care you need throughout your recovery journey: Recovery from addiction and mental illness require different kinds of treatment over a long period of time. Recovery is a lifelong process that doesn’t end with rehab. The Surgeon General’s Report on Addiction (November 2016) reports on 30 years of research that show there are many paths to recovery. RG was developed so that you can have direct access to all the professionals near you. RG believes you should consult a psychiatrist, psychologist, or therapist for a professional assessment of your situation so that you can make the plan that’s right for you. Not everyone needs inpatient rehab. RG has aggregated the widest range of addiction and mental healthcare providers on the Internet. It is a free resource for consumers, and a subscription site for providers. Licensed providers detail their services so you know how they can help you. After you have been treated, you are invited to review your experience of care to help others make informed decisions about their care.

Ten Questions To Begin Your Search

Recovery Guidance lists every kind of recovery in your area and nationwide. It is truly comprehensive. The categories are broad to allow you to find surprising results. Recovery Centers, for example, is not limited to treatment centers alone. It includes every kind of addiction and mental healthcare, so you can be creative in your searches and find exciting results you didn’t expect so close to home.

If you are a suicidal call the national hotline now. If you are a Veteran call the national hotline.

Mental Health Solutions

1. Are you depressed, worried about a loved one’s substance use, grieving for a loss, need counseling for the family or have any mental health issues that need addressing?

Click on Mental Health, Family Counseling, Mental Health Services.

2. Do you need help for a child?

Click on Professionals to find therapists, counselors, psychologists.

Click on Physicians for a diagnosis and treatment.

Or type your request in the search for anything box on the left column.
ELASTIC SEARCH

Find providers by location, name, city, specialty, services offered, and facility type.
Providers set themselves apart and shine.

It’s the first step in developing a relationship with the patient.
Florida Center's Reviews

Like to Recommend Florida Center?

5.0

Based on 1 total reviews.

How welcome and valued were you during that treatment experience?

How helpful was the medical care you received during that treatment experience?

How helpful was the counseling you received during that treatment experience?

Overall, how helpful was the care you received during that treatment experience?

LEAVE A REVIEW

REVIEWS

The Florida...

The Florida Center did a complete, day long, evaluation on my adopted son who has Fetal Alcohol Syndrome. They are a fantastic resource for this under served population.
Brings you:

- The industry’s largest database
- The most advanced technology in any field
- Research opportunities
- Potential for standardization of patient care
- Four years of development
TWO LINES OF CODE

Brings the power of the RG interactive portal to your website

Get help now

Are you concerned about...

your substance use?

a loved one's substance use?
Congress Focuses on Addiction Treatment Ethics

Today the House Energy and Commerce Committee announced, in a press release, that it is investigating call aggregators as they focus on ethical problems with some addiction treatment providers. Letters requesting detailed information regarding business practices were sent to eight entities known to aggregate calls from individuals seeking substance use disorder treatment.

NAATP has been working with the House Committee for months. We have met with committee staff numerous times and a prominent NAATP member CEO testified at one on their public hearings. We support efforts by Congress to identify and address ethical and quality issues in the field. This investigation undertaken by Congress on a bi-partisan basis, is welcomed by NAATP leadership. The Association has received considerable attention since the enhanced ethics policy for NAATP members has been implemented.

According to the Committee, “the letters are the latest step in the committee’s ongoing bipartisan investigation into patient brokering, the practice of individuals serving as intermediaries and profiting from the recruitment of patients seeking treatment for addiction. Reports about such behavior have shone a spotlight on vulnerable patients being wooed by free rent or manicures, while patient brokers receive financial kickbacks.”

Letters were sent to: Addiction No More, Addiction Recovery Now, American Addiction Centers, Elite Rehab Placement, Intervention Allies, Redwood Recovery Center, Solutions Recovery Center, and Treatment Management Company.

The Committee went on to say that, “those battling addiction deserve a safe and dependable environment when seeking treatment.” The National Association of Addiction Treatment Providers agrees and we will continue to work with Congress as they address this critical issue to achieve the goal of access to quality treatment for anyone with substance use disorder.

Mark Dunn
NAATP Director of Public Policy
Washington, DC
Public Policy Statement on Ethical Promotion and Patient Recruitment by Addiction Treatment Programs

Background

As addiction treatment has evolved, different models of treatment have been created. The evolution of treatment models has not guaranteed access to evidence-based care. Insurance coverage has expanded, and more people can now find treatment in many different forms and settings. Entrepreneurs have entered the field and profit-driven treatment models are becoming more common. For the purposes of this policy statement, an addiction treatment program is defined as an entity that claims to provide evaluation, treatment, or referral for substance-related and other addictive disorders. Treatment programs may be free standing or part of a larger healthcare organization. Among the benefits of an effective treatment program is the delivery of multidisciplinary services in a coordinated manner. In general, private, profit-driven treatment programs are subject to less regulation and oversight than publicly funded programs.

As the number and type of treatment programs have proliferated, marketing efforts to attract patients have become increasingly competitive and sophisticated. While ASAM believes that most addiction treatment programs engage in ethical marketing practices, false advertising, misleading internet search engine results and websites, and deceptive representation of services offered have been well described in investigative reporting and government hearings. Payment for referrals and financial incentives for patients offered by programs are unethical and have led to lawsuits and criminal charges being filed. In addition, patients are sometimes given misleading information on the extent to which insurance will cover services. This is particularly unethical in the case for billing for uncovered services which have little or no evidence of effectiveness (e.g., unnecessary brain scans or nutritional supplements). These circumstances contribute to a public perception of a system rife with abuse, may make patients less inclined to engage in what could be life-saving treatment, and subject ethical, evidence-based treatment programs to unfair suspicion.

ASAM recognizes that individuals with addiction as well as their families and others who assist them to access treatment are vulnerable and at high risk for exploitation, particularly at times of crisis when treatment is sought. As such, treatment programs should be held to the highest standard of ethical practice in the marketing of their services and recruitment of patients.
Recommendations

The American Society of Addiction Medicine recommends that addiction treatment programs should adhere to the following standards related to the marketing of their services and recruiting of patients:

1) Accurately represent their ability to provide specific services and accurately identify services that are not supported by scientific evidence.
2) Clearly communicate the treatment program’s status with respect to licensing, certification, and compliance with regulatory requirements.
3) Accurately represent the competence, education, credentialing, and licensure of the program personnel.
4) Advocate for ethical guidelines and federal and state legislation to prohibit patient brokering and payment for referrals, and other inducements for patient recruitment.
5) Avoid marketing strategies that rely on disparaging claims made against differing treatment models or against other addiction treatment programs.
6) Respect patient privacy and not exploit this vulnerable population in marketing efforts. The practice of using patient testimonials in marketing merits particular examination. In most cases, such testimonials serve the needs of the treatment program rather than the patient.
7) Include scientific evidence to support claims about the success and efficacy of the treatment services they provide in marketing materials.
8) Provide accurate estimates about the cost and extent of insurance coverage for treatment and for specific services.
9) Distinguish educational programs from marketing programs.
10) The use of social media and search engine optimization in marketing and program promotion should not be deceptive or violate any of the other ethical standards set forth in this Policy.
11) Eliminate the use of multiple feeder web sites and informational web sites that do not identify the company or center as the origin of information provided.
12) Establish collaborations with ASAM, the National Association of Addiction Treatment Providers (NAATP), consumer groups, Single State Agencies, the Substance Abuse and Mental Health Services Administration (SAMHSA), and other stakeholders to develop appropriate legislative measures and evaluation tools to ensure that all consumers have adequate access to accurate information and appropriate care.
Additionally, ASAM recommends that:

1) State and federal governments develop and make available materials for consumers to detect potential fraudulent marketing and patient recruiting practices.

2) The Substance Abuse and Mental Health Services Administration (SAMHSA) should maintain its Evidence-Based Practices Resource Center as a dynamic tool to help addiction treatment stakeholders identify which treatment approaches are evidence-based.a

3) Individual clinicians providing evaluation, treatment, or referral for treatment of substance-related and other addictive disorders should be held to the same standards for ethical promotion and patient recruitment as are treatment programs.

Adopted by the ASAM Board of Directors 5/25/18

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a The Evidence-Based Practices Resource Center can be found at https://www.samhsa.gov/ebp-resource-center

*Color indicates a change from the previous month to this month.  **Green is an increase.  Orange is a decrease.

**CERTIFIED RECOVERY RESIDENCES WITH CERTIFIED RECOVERY RESIDENT ADMINISTRATORS**  
June 5, 2018

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Certified Recovery Residences with Certified Recovery Residence Administrators
(Data Source: FARR Posted on DCF Website)

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<td>413</td>
<td>N/A</td>
<td>23</td>
</tr>
<tr>
<td>Nov-17</td>
<td>271</td>
<td>2233</td>
<td>1075</td>
<td>579</td>
<td>3887</td>
<td>194</td>
<td>47%</td>
<td>23</td>
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<tr>
<td>Dec-17</td>
<td>275</td>
<td>2248</td>
<td>1075</td>
<td>607</td>
<td>3930</td>
<td>43</td>
<td>22%</td>
<td>23</td>
</tr>
<tr>
<td>Jan-18</td>
<td>287</td>
<td>2390</td>
<td>1136</td>
<td>627</td>
<td>4153</td>
<td>223</td>
<td>519%</td>
<td>23</td>
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<tr>
<td>Feb-18</td>
<td>314</td>
<td>2621</td>
<td>1205</td>
<td>660</td>
<td>4486</td>
<td>333</td>
<td>149%</td>
<td>24</td>
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<tr>
<td>Mar-18</td>
<td>340</td>
<td>2783</td>
<td>1299</td>
<td>683</td>
<td>4765</td>
<td>279</td>
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<td>25</td>
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<tr>
<td>Apr-18</td>
<td>342</td>
<td>2765</td>
<td>1314</td>
<td>713</td>
<td>4792</td>
<td>27</td>
<td>10%</td>
<td>25</td>
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<tr>
<td>May-18</td>
<td>363</td>
<td>2998</td>
<td>1330</td>
<td>1058</td>
<td>5386</td>
<td>594</td>
<td>2200%</td>
<td>25</td>
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<tr>
<td>Jun-18</td>
<td>368</td>
<td>3022</td>
<td>1446</td>
<td>1030</td>
<td>5498</td>
<td>112</td>
<td>19%</td>
<td>25</td>
</tr>
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</table>
397.311(26)(a)3. “Day or night treatment with community housing” means a program intended for individuals who can benefit from living independently in peer community housing while participating in treatment services for a minimum of 5 hours a day for a minimum of 25 hours per week.

397.311(37) “Recovery residence” means a residential dwelling unit, or other form of group housing, that is offered or advertised through any means, including oral, written, electronic, or printed means, by any person or entity as a residence that provides a peer-supported, alcohol free, and drug-free living environment.

397.4873 Referrals to or from recovery residences; prohibitions; penalties

(1) A service provider licensed under this part may not make a referral of a prospective, current, or discharged patient to, or accept a referral of such a patient from, a recovery residence unless the recovery residence holds a valid certificate of compliance as provided in s. 397.487 and is actively managed by a certified recovery residence administrator as provided in s. 397.4871.

(2) Subsection (1) does not apply to:

(c) Referrals made before July 1, 2018, by a licensed service provider to that licensed service provider’s wholly owned subsidiary.

Rule 65D-30.0081 F.A.C.

In addition to Rule 65D-30.004, F.A.C., the following standards apply to day or night treatment with community housing.

(1) Description. Day or night treatment with community housing is appropriate for clients who do not require structured, 24 hours-a-day, 7 days-a-week residential treatment. This component allows clients to live in a supportive, community housing location while participating in treatment. This means that no treatment takes place in the housing where the clients live and that the housing is utilized solely for the purpose of assisting clients in making a transition to independent living. Clients who are considered appropriate for this level of care:

(a) Would not have active suicidal or homicidal ideation or present a danger to self or others;
(b) Are able to demonstrate motivation to work toward independence;
(c) Are able to demonstrate a willingness to live in supportive community housing;
(d) Are able to demonstrate commitment to comply with rules established by the provider;
(e) Are not in need of detoxification or residential treatment; and
(f) Typically need ancillary services such as transportation, assistance with shopping, or assistance with medical referrals and may need to attend and participate in certain social and recovery oriented activities in addition to other required clinical services.