

EXAMINING CONCERNS OF PATIENT BROKERING AND ADDICTION TREATMENT FRAUD

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS

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EXAMINING CONCERNS OF PATIENT BROKERING AND ADDICTION TREATMENT FRAUD

TUESDAY, DECEMBER 12, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:16 a.m., in Room 2322, Rayburn House Office Building, Hon. Gregg Harper [chairman of the subcommittee] presiding.

Present: Representatives Harper, Griffith, Burgess, Brooks, Barton, Walberg, Walters, Costello, Carter, DeGette, Castor, Tonko, and Ruiz.

Also Present: Representative Bilirakis.

Staff Present: Jennifer Barblan, Chief Counsel, Oversight and Investigations; Samantha Bopp, Staff Assistant; Adam Buckalew, Professional Staff Member, Health; Kelly Collins, Staff Assistant; Adam Fromm, Director of Outreach and Coalitions; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Brittany Havens, Professional Staff, Oversight and Investigations; Katie McKeogh, Press Assistant; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Alan Slobodin, Chief Investigative Counsel, Oversight and Investigations; Everett Winnick, Director of Information Technology; Christina Calce, Minority Counsel; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; C.J. Young, Minority Press Secretary; and Theresa Tassey, Minority Health Fellow.

OPENING STATEMENT OF HON. GREGG HARPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. HARPER. The subcommittee will come to order.

I want to thank each of the witnesses for being here with us today.

The subcommittee today holds a hearing entitled, "Examining Concerns of Patient Brokering and Addiction Treatment Fraud. This is another chapter of the subcommittee's ongoing extensive look at the opioid epidemic and the toll that it's taken on countless lives across our Nation.

The most recent data from the Centers for Disease Control and Prevention notes that opioids killed more than 33,000 people in 2015, more than any year on record. What's worse, it's estimated that 91 Americans die every day from opioid overdose. Not only has the epidemic lead to record numbers of overdoses and overdose deaths, but it has also resulted in an increased need for treatment. In a recent Washington Post article, it is estimated that there are 2.6 million Americans with opioid addiction. 2.6 million.

Sadly, today we are here to examine a newer side of the opioid epidemic that is impacting individuals who are seeking treatment for their substance use disorder. Earlier this year, news reports began surfacing of patient or addict brokers that profit by recruiting individuals suffering from a substance use disorder and luring them to treatment facilities and sober living homes, oftentimes in other states. The individuals who are brokered are lured into these schemes by promises of scholarships for treatment, a free plane ticket, free housing, along with other incentives such as free cigarettes, movie tickets, and even yoga. The patient brokers themselves receive generous financial kickbacks from facilities. The incentive is not to find an evidence-based treatment option that meets the needs of the individual, but instead to simply fill beds with heads.

These brokers often send individuals to treatments in states with higher numbers of treatment facilities and sober living homes per capita, such as Florida and California. The sales pitch tout the warm, sunny weather of these states in luring individuals away from their homes and out of their states of residence. Florida and California to be the two states hit hardest by these practices. But that doesn't mean that other states aren't starting to face these challenges as well. Concerns have been raised that other states, including Arizona and Texas, are starting to face these issues. Some have said that this is already becoming a national problem.

Whether it's where the treatment facility or sober living home are physically located or it's where the individual is recruited from, these schemes are happening all over our nation, frequently crossing state lines. That's why we're here today. This isn't just a state issue. It has become and is becoming a national issue.

These schemes are often very complex. They can include deceptive marketing practices, kickbacks, overbilling for treatment and urine drug tests, low-quality treatment or, in some cases, no treatment. The most concerning allegation is that patient brokers or, in some cases, people that work for a treatment facility or are affiliated with a sober living home, provide drugs to an individual so that they can relapse. This unethical practice keeps the individual in treatment and allows those involved in the scheme to restart the billing cycle and continue racking up bills.

These practices are immoral but are even more monstrous because they prey on people that are already in a very vulnerable state. These individuals with substance use disorders get caught in a scheme that incentivizes relapse and profit rather than treatment and, ultimately, recovery.

It's important that we shed light on the fraud and abuse in the substance use disorder treatment industry. Make no mistake, we want those who are suffering from addiction to seek treatment and

the treatment that is most appropriate for them. We also want to ensure that when individuals or their loved ones are looking for a treatment option, that they're well-equipped to find a legitimate provider that meets their needs so that they don't fall victim to this inexcusable and unacceptable practices that are prioritizing profits over recovery and, in some instances, life.

We thank our panel of witnesses for joining us this morning who are on the front lines of this issue and provide invaluable perspectives that we'll hear from you today.

My hope for today's hearing is for us to learn about patient brokering and related fraud and abuse within the treatment industry. This discussion will help us identify potential solutions that will allow us to better protect individuals who are seeking treatment for themselves or their loved ones.

We thank you for appearing before the subcommittee today and look forward to hearing your testimony.

The chair will now recognize the ranking member, Ms. DeGette, for the purposes of an opening statement.

[The prepared statement of Mr. Harper follows:]

PREPARED STATEMENT OF HON. GREGG HARPER

The Subcommittee will come to order.

Today is my first hearing as the Chairman of the Oversight and Investigations Subcommittee. I want to thank Chairman Walden for his confidence and look forward to working with Ranking Member DeGette, Vice Chairman Griffith and all members of the subcommittee in the coming year.

Today, the Subcommittee holds a hearing entitled, "Examining Concerns of Patient Brokering and Addiction Treatment Fraud." This is another chapter of the Subcommittee's ongoing extensive look at the opioid epidemic and the toll that it has taken on the countless lives across our nation. The most recent data from the Centers for Disease Control and Prevention notes that opioids killed more than 33,000 people in 2015, more than any year on record. What's worse—it's estimated that 91 Americans die every day from an opioid overdose.

Not only has the epidemic led to record numbers of overdoses and overdose deaths, but it has also resulted in an increased need for treatment. In a recent Washington Post article, it is estimated that there are 2.6 million Americans with an opioid addiction. 2.6 million. Sadly, today we are here to examine a newer side of the opioid epidemic that is impacting individuals who are seeking treatment for their substance use disorder.

Earlier this year, news reports began surfacing of "patient" or "addict" brokers that profit by recruiting individuals suffering from a substance use disorder and luring them to treatment facilities and sober living homes, often times in other states.

The individuals who are brokered are lured into these schemes by promises of "scholarships" for treatment, a free plane ticket, free housing, along with other incentives such as free cigarettes, movie tickets, and yoga.

The patient brokers themselves receive generous financial kickbacks from facilities. The incentive is not to find an evidence-based treatment option that meets the needs of the individual, but instead to simply "fill beds with heads."

These brokers often send individuals to treatment in states with high numbers of treatment facilities and sober living homes per capita, such as Florida and California. The sales pitches tout the warm, sunny weather of these states in luring individuals away from their homes and out of their states of residence. Florida and California appear to be the two states hit hardest by these practices, but that doesn't mean that other states aren't starting to face these challenges as well.

Concerns have been raised that other states including Arizona and Texas are starting to face these issues. Some have said that this is already becoming a national problem. Whether it's where the treatment facility or sober living home are physically located, or it's where the individual is recruited from—these schemes are happening all over our nation, frequently crossing state lines. That's why we are here today. This isn't just a state issue, it's becoming a national issue.

These schemes are often very complex. They can include deceptive marketing practices, kickbacks, overbilling for treatment and urine drug tests, low-quality

treatment or, in some cases, no treatment. The most concerning allegation is that patient brokers, or in some cases people that work for a treatment facility or are affiliated with a sober living home, provide drugs to an individual so that they will relapse. This unethical practice keeps the individual in treatment and allows those involved in the scheme to re-start the billing cycle and continue racking up bills.

These practices are immoral, but are even more monstrous because they prey on people that are already in a very vulnerable state. These individuals with substance use disorders get caught in a scheme that incentivizes relapse and profit rather than treatment and, ultimately, recovery.

It's important that we shed light on the fraud and abuse in the substance use disorder treatment industry. Make no mistake, we want those who are suffering from addiction to seek treatment, and the treatment that is most appropriate for them. We also want to ensure that when individuals or their loved ones are looking for a treatment option, that they are well equipped to find a legitimate provider that meets their needs so that they don't fall victim to these inexcusable practices that are prioritizing profit over recovery, and in some instances life.

We thank our panel of witnesses for joining us this morning. You are on the frontlines of this issue and provide invaluable perspectives. My hope for today's hearing is for us to learn more about patient brokering and related fraud and abuse within the treatment industry. This discussion will help us identify potential solutions that will allow us to better protect individuals who are seeking treatment for themselves or their loved ones. We thank you for appearing before the Subcommittee today and look forward to hearing your testimony.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman, and welcome. We're happy to have you as the new chairman of the Oversight and Investigations Subcommittee. And in what I hope is not a rare incidence, I'm just going to associate myself with everything you said in your opening statement. I agree with you that this issue is a bipartisan and national concern. I'm glad that we're having this hearing today.

As we have been exploring in this subcommittee and the full Energy and Commerce Committee, we're in the midst of the worst addiction crisis in the United States' history. And substance use disorder has ravaged the families and communities. In Colorado, my home state, more people died from overdoses than from car wrecks last year, just to put this in some kind of context.

And as people are seeking addiction treatment services for themselves and their loved ones, it really, really puts a punctuation point on the fact we need to make sure that they're getting services that are useful and that are actually treating them and that we don't have fly-by-night operations that are just taking advantage of families' desperation.

High-quality, evidence-based treatment, both inpatient and outpatient, is a key part of recovery from substance use disorder. And in a lot of cases, it does involve recovery residences also known as sober living homes. As SAMHSA said, properly managed recovery residences, quote, empower people by providing support as they transition towards living independent and productive lives in their respective communities.

But, Mr. Chairman, as you said, some of these patient brokers and some sober homeowners and treatment providers are fraudulently exploiting coverage of addiction treatment services in order to defraud insurers. I'd really like to know, and I'm hoping our panel can help us today, just exactly what the extent of this prob-

lem is or how widespread it is. I've seen the media accounts, like you have, and I was just as appalled as you were. But we really need to understand the scope of the problem so that we can determine what laws, rules, and regulations we need to look at to effectively deal with the issue.

As you said, the reports say that patient brokers solicit desperate individuals and direct them towards deceitful providers who offer substandard treatment or sometimes even no treatment at all. They push people to live at these sham sober homes even though they know, in many cases, drugs and alcohol are readily available at these houses. And, of course, as you said, they've got these deceptive websites. They promise a vacation-like atmosphere in warm locales. They buy people airline tickets, and they help people get insurance just to cover the cost of these sham houses. So it's a problem.

The fraudulent treatment centers are no better. Reports suggest that these facilities treat patients as commodities, not people. For example, insurance companies told us that these centers require people to take daily urine tests for which the treatment facilities bill insurers thousands of dollars per day. How is it that a facility can bill thousands of dollars a day for urine tests, which based on all the reports, are almost never clinically necessary? Also, the facilities bill for addiction treatment that they do not actually provide. I'd like to know how a presumably licensed treatment facility can get away with this.

And, finally, and perhaps most disturbing, we heard that patient brokers push individuals with substance use disorders to live at particular sober homes where they know the drugs and alcohol are available. So, apparently, the goal is to keep them addicted so that they can continue to get reimbursements.

Now, as I said earlier, Mr. Chairman, I hope we can get a scope of this problem as it relates to drug treatment. I'd like to hear what the panel's views are on how we can reduce this. What do the states need to police treatment providers and sober home living? What does optimal evidence-based treatment look like? And how do we ensure these families get it?

I hope we can add some context to the problem because I really don't have any idea how extensive it is. And I'm one that doesn't think we should overreact but, on the other hand, this is a serious problem.

With that, I know that Congresswoman Castor has a constituent here she'd like to introduce, and I'll yield the balance of my time to her.

Ms. CASTOR. Well, thank you, Ranking Member DeGette.

I'd also first like to congratulate my friend and colleague, our new chairman, Gregg Harper.

Congressman, you're a very thoughtful Member of Congress. I've enjoyed working with you in the past and look forward to working with you on the oversight committee.

I'd like to thank the State Attorney for the 15th Judicial Circuit, Dave Aronberg, and the Chief Assistant, Alan Johnson, for their work and welcome them here to the committee. They are the ones that have been at the forefront of protecting families and taking on this issue in the State of Florida, including leading to the adoption

by the state legislature of our patient brokering act. Thank you for being here today, and thank you for your public service.

Mr. HARPER. The gentlelady yields back.

The chair will now recognize Dr. Burgess for purposes of an opening statement.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Chairman. And let me add my congratulations to your position. You reference that we're on the front lines of this debate, and the subcommittee that I chair, the Health Subcommittee, and your Subcommittee of Oversight and Investigations, yes, we are partners in this and very much on the front lines of this.

I also want to thank Morgan Griffith for ably stepping in and keeping a firm hand on the tiller during the transition. That was very helpful as well.

This hearing is important. We're here to examine the possibility, the likelihood of unethical behavior in our substance abuse treatment system. In the past few years, Congress has worked to find thoughtful and effective ways to respond to the opioid epidemic. In fact, in the Health Subcommittee, we did have our first oversight hearing of the Comprehensive Addiction and Recovery Act. It's been about a year since it was enacted, and we thought it was appropriate to take a look at how the agencies were responding to the legislation that Congress passed.

And, additionally, we held sort of an open forum, a Members' Day, where any Member, not just on the Health Subcommittee, not just on the Energy and Commerce Committee, but any Member of Congress, from both sides of the dais, could come and talk about problems that they were seeing in their districts. And we also were interested in hearing the solutions that people had in mind. So out of that very thoughtful day, where over 50 Members of Congress came and testified to the subcommittee, out of that exercise, we are looking forward to developing some legislation.

I think the other lesson—and I do appreciate so much the testimony that was provided by our witnesses, and I appreciate them being here. You certainly opened or broached the subject that I had wondered about in the past, and that was seeing the law of unintended consequences was on full display with some things. And having been on this subcommittee now for 12 years, and having been on the Energy and Commerce Committee a like amount of time, certainly saw many of those things as they were enacted in 2008, 2009, 2010, watched the rules come through the agency in 2012 on setting the parameters with which several of you have acknowledged now becomes—it was done with the best of intentions, but now it's adding to the problems.

The Comprehensive Addiction and Recovery Act in the 21st Century Cures Act included provisions that increased access to treatment for individuals suffering from opioid addiction and providing communities with additional prevention grants. That's a good thing. Now we want to be certain in this oversight exercise that that is all being used to the highest purpose for the patients it was intended to serve.

Thank you, again, Mr. Chairman, for the recognition. I'll be happy to yield to any other member on this side of the dais or yield back to you.

Mr. HARPER. The gentleman yields back.

I ask unanimous consent that the members' written opening statements be made part of the record.

Without objection, will be entered into the record.

Additionally, I ask unanimous consent that Energy and Commerce members not on the Subcommittee on Oversight and Investigation be permitted to participate in today's hearing.

Without objection, so ordered.

Finally, we welcome non-Energy and Commerce Committee members who may be with us today. Pursuant to House rules, Members not on the committee are able to attend our hearings but cannot ask questions.

I would now like to introduce our witnesses for today's hearing. And I will start by yielding to Mr. Costello of Pennsylvania to introduce our first witness.

Mr. COSTELLO. Thank you, Mr. Chairman.

I am very proud to introduce Douglas Tieman, President and CEO of Caron Treatment Centers in Berks County, Pennsylvania, in my congressional district. I have visited the Caron Treatment Center and I can say with confidence that it provides lifesaving addiction and behavioral healthcare treatment. And they make a tremendously positive impact, both in southeastern Pennsylvania and across this country, with the services they provide and the leadership that they provide.

I look forward to hearing Mr. Tieman testify this morning about standards for quality treatment, ways to improve our healthcare system to better treat the millions of Americans struggling with substance abuse disorder, and obstacles that Caron and other organizations face as bad actors, as Ms. DeGette has suggested or raised, as bad actors seek to take advantage of vulnerable individuals seeking help.

Thank you, and I yield back.

Mr. HARPER. The gentleman yields back.

Today we also have Pete Nielsen, who is the CEO of the California Consortium of Addiction Programs and Professionals. Next is Mr. Dave Aronberg, the State Attorney for the 15th Judicial District in Palm Beach, Florida. Then we have Mr. Alan Johnson, the Chief Assistant State Attorney for the 15th Judicial Circuit in Palm Beach and the head of the Palm Beach County Sober Homes Task Force. And finally, we have Mr. Eric Gold, the Assistant Attorney General and the chief of the healthcare division for the Office of the Massachusetts Attorney General.

Thank you all for being here today and providing testimony. We look forward to the opportunity to discuss concerns of fraud and abuse in the treatment industry, and I know it'll be very helpful testimony.

You're aware that the committee is holding an investigative hearing. And when doing so, we have had the practice of taking testimony under oath. Does anyone have any objection to testifying under oath?

The chair then advises you that under the rules of the House and the rules of the committee, you're entitled to be accompanied by counsel. Do you desire to be accompanied by counsel during your testimony today?

Seeing no one, in that case, if you would, please rise and raise your right hand, and I will swear you in.

[Witnesses sworn.]

Mr. HARPER. Thank you. You are now under oath and subject to the penalties set forth in Title 18, section 1001 of the United States Code. You may now give a 5-minute summary of your written statement.

You have a light system in front of you that'll be green for 4 minutes. It'll turn yellow for the final minute and red when it's time to bring it in for a landing. So we look forward to that.

So at this point, we will recognize Mr. Tieman for 5 minutes to summarize his opening statement.

TESTIMONY OF DOUGLAS TIEMAN, PRESIDENT AND CEO, CARON TREATMENT CENTERS; PETE NIELSEN, CHIEF EXECUTIVE OFFICER, CALIFORNIA CONSORTIUM OF ADDICTION PROGRAMS AND PROFESSIONALS; DAVE ARONBERG, STATE ATTORNEY, 15TH JUDICIAL CIRCUIT; ALAN S. JOHNSON, CHIEF ASSISTANT STATE ATTORNEY, 15TH JUDICIAL CIRCUIT; AND ERIC M. GOLD, ASSISTANT ATTORNEY GENERAL, CHIEF, HEALTHCARE DIVISION, OFFICE OF THE MASSACHUSETTS ATTORNEY GENERAL

TESTIMONY OF DOUGLAS TIEMAN

Mr. TIEMAN. Representative Costello, thank you for the introduction and the service to our community.

Mr. Chairman and distinguished members of the House Energy and Commerce Committee, thank you for the opportunity to testify on behalf of patients and families seeking help with their substance use disorder.

As Representative Costello mentioned, I am the CEO of Caron Treatment Centers. We are a nonprofit addiction and behavioral healthcare provider based in Pennsylvania and Florida, with more than 60 years of experience in treating substance use disorder. We are one of the oldest and largest nonprofit addiction treatment centers in our country. And over the past six decades, we have helped more than 100,000 individuals begin a life of recovery.

I personally have been in this field for 35 years, so I have some sense of perspective. During the first 30 years of my career, I was mostly proud of the treatment sector and the work that all of our peers in the field were undertaking to help families suffering from this chronic illness. However, in the past 5 years, I've become increasingly disappointed as it has become clear that many are now putting profits ahead of a life that they're supposed to be saving.

As stated, we're all well aware in our nation that we're facing an opioid epidemic and an addiction crisis. Opiates, along with alcohol and other drugs, are part of a chronic illness that is called substance use disorder, a disorder that affects one out of every three families in our country.

Substance use disorder is a chronic and progressive brain chemistry disease that, unless treated, oftentimes leads to death. Last year, 155,000 Americans lost their life to this disease. What you may not know is that of all chronic illnesses, substance use disorder is the most effectively treated, a fact to which the more than 23 million Americans living in recovery today can attest, leading sober, productive lives.

But here's the problem. When the pain and suffering that a family is experiencing and they finally overcome what I call the misery index, it becomes so high that they finally overcome the stigma and denial and cobble together the necessary financial resources to seek help, the question is: Where do we go? For any other illness, it's simple. You go to your doctor. They do an assessment and evaluation and send you on an appropriate clinical path.

Rarely does that happen with substance use disorder. So they turn to the internet. And there are a whole host of abuses, such as call aggregating, website piracy, patient brokering, kickbacks, insurance fraud, and the list goes on. The bottom line is that when a suffering family looking for help reaches out on the phone and think that they are receiving clinical help, they are actually talking to a telemarketer who is incented by placing them in the place where they and the company they represent gets the biggest payback. This feels a whole lot more like vacation timeshare marketing rather than healthcare promotion. Deceptive and disgraceful.

So what can we do? To restore trust in the treatment sector, I have four recommendations. The first is around law enforcement. We must enact the laws that are currently on the books. And we need to come up with other regulations that specifically address website accuracy and transparency.

Number two, the treatment field needs to work with our associations to establish ethical standards for marketing, evidence-based treatment, and ethical billing. The National Association of Addiction Treatment Providers and the American Society of Addiction Medicine are already working towards that and, in 2018, we will have a list of those providers. More importantly, we will also have a list of those that are violating those policies.

Three, we need to educate consumers so that they know where and how to get help. We need to work with government, particularly SAMHSA, so that there is an effective way to identify an appropriate treatment center. Caron Treatment Centers, along with Hazelden Betty Ford centers, has actually established such a mechanism. We also have a bill of rights, which you'll see up on the screen, that we think everyone needs to be aware of so that they can know how to get help and what they can expect when they're in treatment.

And fourth, within the healthcare, we need to make sure that healthcare now includes substance use treatment so that when people go to the doctor, they are assessed and screened appropriately. We have a model. The UNAIDS PROJECT developed the 90-90-90 goal, which means that 90 percent of the people with the AIDS virus get screened, 90 percent of the people screened get help, and 90 percent of the people who get help get well. That's what we need to have for addiction treatment as well.

The 23 million Americans who are living today are living proof that treatment works. I am one of those 23 million Americans. Thank you.

[The prepared statement of Mr. Tieman follows:]

US House Committee on Energy and Commerce

Subcommittee on Oversight and Investigations

Hearing “Examining Concerns of
Patient Brokering and Addiction
Treatment Fraud”

Testimony of

Douglas Tiegan, President & CEO of Caron Treatment Centers

December 12, 2017

Summary

1. It is a privilege to be a trusted and integral part of a person's recovery from addiction. Most providers in the behavioral health and substance use disorder treatment sector take this responsibility seriously, and are fully invested in and dedicated to the recovery of our patients and their families. However, the state of the treatment sector today is disconcerting, as profiteering begins to outweigh this sacred trust of families in crisis.
2. Regulations for substance use treatment providers vary state by state – and in some states regulations are virtually non-existent. This lack of regulation and standards within the sector makes it hard for families and individuals to identify quality treatment programs, and creates a fertile environment for deceptive business practices, fraud, patient neglect and, ultimately, treatment malpractice.
3. As substance use disorder treatment providers, we have a responsibility to act in the best interest of patients and families to prevent any abuse. Our health care sector is developing quality controls for providers to identify and address ethical abuses including: Patient Brokering, Predatory Web Practices, Urinalysis Abuse, Up-charging and Overutilization, Bait & Switch Out of Network Schemes, Kickbacks, Clinical Misrepresentations, and Paid Call Center/Directory/Call Aggregation.
4. Indicators of excellence in substance use disorder treatment include Accreditation, Qualified Clinicians, Evidence-Based Treatment, a Full Continuum of Care from initial assessment through recovery support services, and Sound and Ethical Business Practices.
5. Initial Screening, Comprehensive Assessment, Withdrawal Management, Treatment Planning and Management, Treatment Transitions, and Comprehensive Continuing Care are all elements of essential standards of the addiction treatment continuum.
6. Substance use disorder patients have the right to the same quality of care that is provided for other chronic diseases and recovery maintenance.

Opening

Chairman Gregg Harper, Congresswoman Diana DeGette, members of the committee, I appreciate the opportunity to testify before you on the important matter of patient brokering and addiction treatment fraud.

Today in America, one in three households live with addiction as part of their families. The clinical term for addiction is substance use disorder (SUD) – a chronic, treatable disease affecting the brain that is fatal when left untreated or under-treated. Yet, less than 11% of the nearly 22 million Americans who meet the criteria for a SUDs receive the specialized treatment they need to live in recovery.ⁱ The sad fact is, our health care systems, insurance providers, communities, schools and work places are ill prepared to deal with the scope of this disease, especially with the mounting issues associated with the opioid epidemic. In addition, the stigma surrounding this disease and the continued prejudice towards persons who suffer from SUDs and their families acts as barriers to making informed decisions about treatment and successfully connecting them with the ongoing care they need to live full, productive lives.ⁱⁱ We know that the treatment and management of SUDs works because of the more than 23 million Americans living in recovery today.ⁱⁱⁱ

With 60 years of experience in the addiction treatment sector, Caron Treatment Centers knows that quality treatment works. Caron has provided the care needed to help thousands of patients and their families begin lifelong recovery. Although there is a woeful lack of addiction treatment outcome studies, Caron has been a leader in developing research to generate and implement evidence-based programs. As a non-profit treatment provider, Caron is not bound by investor or profit motives. This frees us to invest in treatment, research, prevention, and charity care, all in the best interest of the patient. With our focus on patient-centered care, treatment protocols, outcome measures, and research, Caron has helped set the standard of care for quality treatment.

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It is a privilege to be a trusted and integral part of a person's recovery from addiction. Most providers in the behavioral health and addiction treatment sector take this responsibility seriously, and are fully invested in and dedicated to the recovery of our patients and their families. However, the state of the treatment sector today is disconcerting, as profiteering begins to outweigh this sacred trust of families in crisis.

Background

As the nation's addiction and overdose crisis has escalated, we have seen a rapid increase in profit-driven rather than patient-focused care. While every organization, whether for-profit or not-for-profit, must be in a solid financial position to offer its services effectively, all of us are medical providers treating a disease. Increasingly, this focus on revenue and profit has led to poor or inappropriate treatment for individuals and their families. Someone suffering from an SUD should have the same opportunity for high quality, evidence-based health care that is routinely offered for other chronic diseases such as heart disease and diabetes. We should never lose sight of that – quality of care comes first.

Furthermore, the combined storm of the opioid crisis, the increase of private equity dollars in SUD treatment providers (i.e. \$2.9 billion in 2016^{iv}), and the accessibility of treatment through the Affordable Care Act has been accompanied by an increase in unethical practices across the continuum of addiction treatment. I am deeply troubled when I see facilities cutting corners in treatment and pushing ethical boundaries in marketing and sales practices.

Regulations for addiction treatment providers vary state by state – and in some states regulations are virtually non-existent. This lack of regulation and standards within the sector makes it hard for families and individuals to identify quality treatment programs, and creates a fertile environment for deceptive business practices, fraud, patient neglect and, ultimately, treatment malpractice.

It can be difficult to make the distinction between ethical and unethical treatment centers when looking from the outside. This is especially true for those seeking treatment for the first time and are in a state of crisis or desperation. Many turn to the internet to find a treatment center. Instead of finding accurate and thorough information about their disease and treatment, they are often inundated by call aggregators who take advantage of their desperation, sometimes with tragic results. Call aggregators are essentially collecting leads for treatment centers who are willing to pay a price for every generated lead. These aggregators may prescreen potential patients for insurance coverage and location placement and then ultimately sell the patient's information to the highest bidder.⁴ Call aggregators are not referring patients based on their individual medical needs, but on their insurance plans.

In addition, addiction treatment centers are competing for the more than \$36 billion that will be spent on SUDs in 2017^{vi}, leading to increasingly aggressive marketing efforts. These include emphasizing the amenities available to patients, rather than the clinical modalities and quality of care provided, and thereby doing a disservice to the public. Features such as proximity to the beach, sheet thread counts, and a spa environment, while nice, have little to do with appropriately credentialed staff, verified research, access to medications, course of care, and treatment outcomes. Many individuals and families seeking treatment are left with the question: Is this health care or a vacation time share?

As a treatment provider, we understand how difficult it is for patients and their families to find and receive the care they need. From overcoming issues of stigma and denial, to lack of understanding about the medical aspects of this disease, to restrictions based on location and lack of resources, patients and families have many barriers to overcome when seeking treatment. As a sector, we need to do a better job for patients and their families.

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Defining the Problem

Beyond our individual efforts, Caron has partnered with other like-minded reputable treatment centers to begin to address the unethical and illegal practices within our sector. Caron has worked diligently with other treatment providers to help draft and support the National Association of Treatment Providers (NAATP) Quality Control Initiative. This program identified and seeks to address the following specific ethics abuses^{vi}:

- **Patient Brokering** – An illegal act where a patient, or a lead relating to a prospective patient, is traded to a treatment provider in exchange for money and/or perks. In some cases, a “broker” will approach a provider with a lead on a prospective patient, soliciting a kickback in exchange; in other cases, a program or sober home will recruit a third party to send patients to their facility in return for a kickback or fee.
- **Predatory Web Practices** – Manipulation of websites or online search results designed to deceive prospective patients and families, or to obscure the source of treatment advice provided. This can take the form of hijacking Google search results for specific treatment provider names or by utilizing complex corporate ownership trails to obscure relationships between online treatment referral sources and the providers owned by the same parent company. This may be done by changing, disguising, or hiding the phone number associated with a specific provider to that of a competing provider or call aggregator with the intent of redirecting prospective patients.
- **Urinalysis Abuse** – A form of insurance fraud in which a treatment provider or recovery residence performs unnecessary urinalysis tests on patients. The provider then bills the patient’s or the patient’s family’s insurance plan for the tests.
- **Up-charging and Overutilization** – Any form of fraudulent servicing that manipulates the fee-for-service model to perform excessive or unnecessary services to increase the amounts billed to patients or insurance providers.

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- **Disguised “Treatment” Billing** – A bill-packing scheme using deliberately unusual or unclear terms on billing forms to describe unnecessary or excessive charges with the intent to obfuscate or reduce billing transparency.
- **Bait & Switch Out of Network Schemes** – A scheme where a provider may advertise or report to potential patients that it accepts certain insurance coverage plans and confirms that treatment will be regarded as in-network while deliberately obscuring certain complications that may lead to a patient choosing to seek addiction treatment elsewhere. In some cases, individual doctors contracted to see patients at a given facility may be “out-of-network,” even when the facility itself is in-network. In other cases, patients may find a treatment facility on their insurer’s list of in-network facilities, but are told by the provider themselves (often after the billing process is complete) that they do not accept the specific form of insurance program the patient carries, resulting in a bill that includes non-negotiated rates.
- **Kickbacks** – An illicit remediation of money or perks provided in exchange for a patient referral, often via patient brokering.
- **Clinical Misrepresentations** – Descriptions of medical services that do not match the capabilities of the facility or present the services offered inaccurately.
- **Paid Call Center/Directory/Call Aggregation** – A potentially predatory web practice where a highly efficient search engine optimization (SEO) website is established by an organization owned by the parent company of multiple treatment centers. These sites often advertise “free consultations” that can help place a prospective patient at a treatment facility with available beds. In reality, prospective patients or families may end up reaching call centers that only search the facilities owned by the parent company, and cannot guarantee a good geographic or clinical fit for the patient. Additionally, the free consultations offered may be conducted by call center staff who are not clinically trained to assess a potential patient’s appropriate treatment level of care.

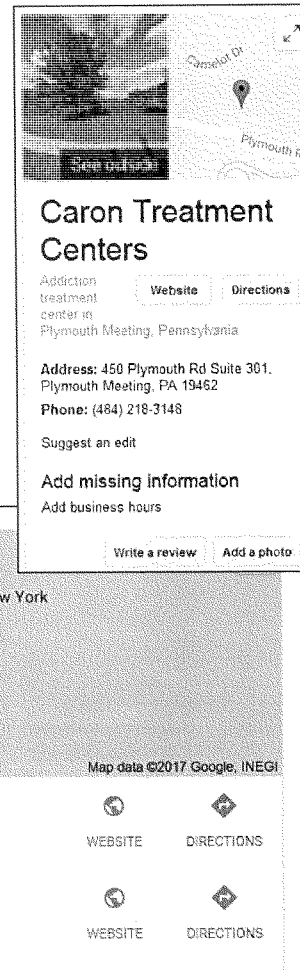
To put this in context and to demonstrate how pervasive these problems are, it is important to note that unethical marketers have taken advantage of Caron, as well. Caron's name, built on innovative, evidence-based addiction treatment, research, and prevention practices for 60 years, has been used to lure unsuspecting individuals to other websites where someone seeking treatment is provided phone numbers not affiliated with Caron Treatment Centers. We learned of these issues through individual reporting directly to Caron facilities and by our own diligent efforts to search and report inconsistencies found online.

The Internet is a source of information and referrals for Caron. For Caron's FY17, [Caron.org](#) and [CaronOceanDrive.org](#), Caron's two owned and managed websites, averaged nearly 105,000 visits per month, along with an average of 1,150 online live chats and over 2,500 inbound calls per month.

While Caron does utilize and internally manage web-based marketing, we have refused solicitations from call aggregators to engage their services. Unfortunately, it is impossible to know how many individuals and families thought they were contacting Caron, only to be misdirected to another facility due to false and unethical online marketing.

Piracy of Caron Philadelphia

This is a screen shot of when Caron's Google local listing for our Philadelphia Regional Office was "hijacked". Another entity claimed Caron's listing, changed the phone number, and calls were routed to an unknown call center that turned out to be a lead aggregator. We were unable to determine the call center name or what entity changed the number, but Caron was able to switch the number back. The screen shot below highlights the non-Caron number that was included with the correct Caron Philadelphia location information.



Caron Treatment Centers

Addiction treatment center in Plymouth Meeting, Pennsylvania

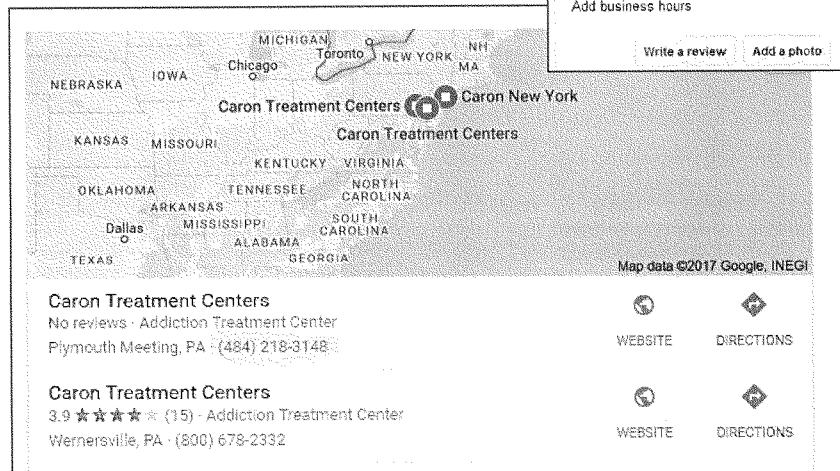
Address: 450 Plymouth Rd Suite 301, Plymouth Meeting, PA 19462

Phone: (484) 218-3148

[Website](#) [Directions](#)

[Add missing information](#)

[Write a review](#) [Add a photo](#)



Caron Treatment Centers

No reviews · Addiction Treatment Center

Plymouth Meeting, PA · (484) 218-3148

Caron Treatment Centers

3.9 ★★★★★ (15) · Addiction Treatment Center

Wernersville, PA · (800) 678-2332

[Website](#) [Directions](#)

Piracy of Caron New York

Please note in the image in this instance that there are three different phone numbers in this screen shot that was sent to Caron's leadership from our Caron New York office on 11/09/2017. None of the phone numbers included in the listing are affiliated with Caron Treatment Centers. Melissa Gettler, VP of Marketing at Caron, called the number pictured in the middle. The person who answered told Ms. Gettler that they work for or with DrugRehabs.org.



Caron did not set up the directory, nor did we request to be included in it. Caron was advised by our search engine optimization (SEO) partner that this is a byproduct of "lead aggregators". He shared with Caron that, "Sites like this are like my arch enemy. They basically take every recovery facility listed in the US and create profiles for them, but their main intent is to get people to call the number listed (which isn't the number to the facility listed, it's a call aggregator). I have tried contacting sites like these for another treatment provider in the past to get info either removed or even just edited and have had absolutely no luck (not even a response)."

As Caron prepared to provide this testimony today, we came across more distressing examples. In what appears to be a HUD-related recovery housing policy brief, recovery.org is listed among the resources. The brief was found at: <https://www.hudexchange.info/>

[resources/documents/ Recovery-Housing-Policy-Brief.pdf](https://www.hudexchange.info/resources/documents/Recovery-Housing-Policy-Brief.pdf) by following a link from here: <https://www.hudexchange.info/resources/documents/Recovery-Housing-Policy-Brief.pdf>.

When followed, the link from the resource page of the policy briefing leads to a page on the [recovery.org](http://www.recovery.org) website. From there, we entered “Caron” in the website’s search bar and found several listings for

HUD and the U.S. Interagency Council on Homelessness also intend to provide more guidance regarding the alignment of *Recovery Housing* programs within communities’ overall approach, strategies, and systems for addressing substance use.

VII. Resources

- Substance Abuse and Mental Health Services Administration: www.samhsa.gov/ (see Recovery and Recovery Support and Bringing Recovery Supports to Scale Technical Assistance Center Strategy)
- [Recovery.org: www.recovery.org/topics/recovery-homes/](http://www.recovery.org/topics/recovery-homes/)
- National Alliance for Recovery Residences: www.naronline.org
- CSH: Substance Use and Housing National Leadership Forum Convening Report: www.csh.org/resources/substance-use-and-housing-national-leadership-forum-convening-report/#sthash.LFSMh5B4.dpuf
- World Health Organization Quality of Life Measures: www.who.int/mental_health/publications/whoqol/en/

Caron, prominently including phone numbers that do not connect callers to Caron. It is important to note that the [recovery.org](http://www.recovery.org) website is owned by a treatment center not affiliated with Caron.

In addition to the issues of call aggregation, in many cases patients are not receiving the care they desperately need. In some cases, treatment centers are ill-equipped to address a patient’s specific clinical and medical needs. Sometimes patients and their payers are charged for unnecessary diagnostic and medical services. In other instances, unethical treatment providers and sober homes may collude to bill for services that were never actually provided. We have a strong partnership with Independence Blue Cross of Philadelphia (IBC) and have been working together on different ways to address this crisis. IBC notes that in many instances their investigations have found brokers working with sober homes to enroll patients with SUDs in Affordable Care Act (ACA) exchange plans using false information to ensure a higher reimbursement than they might otherwise receive under government programs. Specifically, in IBC’s comments to the Centers for Medicare and Medicaid Services (CMS) this year, IBC highlighted a scheme of financially linked non-profits making premiums payments

on behalf of 86 individuals who were not eligible for their coverage (lived outside the coverage area). In some cases, premium payments were made with prepaid debit cards to hide the identity of who is paying for them. A special investigation by STAT and the Boston Globe reported, “The fraud is now so commonplace that brokers use a simple play on words to describe how it works: “Do you want to Blue Cross the country?”^{xiii}

Working in the Solution

An individual or family in crisis should not have to guess and hope that the information they find on the internet is correct. As an addiction treatment provider, Caron believes we have a responsibility to act in the best interest of patients and families to prevent any abuse. If the addiction treatment sector wants to be recognized as a legitimate field in today’s health care, then we need to act like one. Caron is working with other leading treatment providers to define a standard of ethics and outcomes that will help families in distress determine which providers are acting in good faith. In *Defining a Center of Excellence: An Addiction Treatment Model*, a white paper co-authored by Caron Treatment Centers and Hazelden Betty Ford Foundation, the criteria necessary to deliver quality addiction treatment include:^x

- **Accreditation** – It is important to maintain state licensure and accreditation from national regulatory organizations such as the Joint Commission (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF), to meet rigorous standards for quality care, organizational performance, and meet these expectations at the highest standard of care.
- **Qualified Clinicians** – Well-trained and accredited therapists, psychologists, psychiatrists, and physicians, all with the appropriate degrees and licensure, are critical to providing quality care and should be on staff at treatment centers.
- **Evidence-Based Treatment** – Behavioral therapies are shown to be effective in addressing SUDs, including Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), among others.

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- **Care for Co-Occurring Disorders** – Psychologist, psychiatrists, and physicians should be part of the patient’s treatment team.
- **Full Continuum of Care** – Patients require a full range of services from treatment providers, including the ability to assess, treat, and provide recovery support services.
- **Sound and Ethical Business Practices** - Marketing, advertising, and promotional activities should be ethical, truthful, and legal. This applies to billing and insurance practices, as well.

In addition, Caron suggests that treatment centers provide verifiable outcomes, making this information available to all prospective patients and their families.

The Caron Patient’s Bill of Rights

A patient’s journey to recovery is not easy. It is complicated by a health care model that is broken. As a chronic disease, addiction has periods of remission and relapse, marked by acute episodes. Treatment for SUDs typically begins with an acute onset or episode of symptoms, resulting in an emergent event that could include a visit to the emergency room. That patient may then be sent for medically-managed withdrawal, more commonly referred to as “detox”. In most cases, a patient will be released from detox without proper evaluation, diagnosis or treatment for addiction and other co-occurring disorders. This insufficient and inadequate treatment typically results in a relapse of symptoms, another emergency room visit and, even death.

An outline of what we can and should expect from the appropriate treatment of addiction for individuals with SUDs can serve as a benchmark for physicians, payers, policymakers, patients and their families alike as they seek to provide, pay for, regulate, and receive the highest quality care.^x Based on feedback from Caron’s team of clinical experts, as well as information from other sources, Caron recommends the following elements be implemented as a guide to the essential standards of the addiction treatment continuum:^{xi}

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1. **Initial screening** to gather information,
2. **Comprehensive assessment** to create a patient-centered treatment plan,
3. **Withdrawal Management** to medically supervise detoxification to manage symptoms and stabilize overall health,
4. **Treatment Planning and Management** to review and modify treatment to build a solid foundation for recovery,
5. **Treatment Transitions** to provide support during changing levels of care, and
6. **Comprehensive Continuing Care** to sustain recovery and provide the tools necessary to maintain it.

Receiving treatment for an adequate period of time is critical. Research indicates that most addicted individuals need at least 3 months in treatment and that continuing care is an essential part of ongoing recovery.^{xii} As with other chronic illnesses, recovery from addiction is a long-term process and may require multiple episodes of treatment.

To achieve this patient experience, patients and their families need to be informed about and understand the level of care and quality of treatment they have the right to receive. Consequently, Caron has developed a Patient's Bill of Rights that we encourage all serious addiction treatment providers to immediately adopt.

The Caron Patient's Bill of Rights states:^{xiii}

- Patients have the right to be treated with the honesty, dignity, and respect that any person with a life-threatening, chronic illness should be afforded.
- Patients have the right to know what to expect from treatment including:
 - Involvement in the development of their treatment plan,
 - How the treatment is measured and evaluated, and

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- The expected outcomes of that treatment.
- Patients have the right to be treated by physicians, psychiatrists, psychologists and other licensed and/or certified professionals as needed throughout their continuum of care.
- Patients have the right to receive researched and evidence-based treatment on demand.
- Patients have the right to be treated for co-occurring behavioral health conditions simultaneously.
- Patients have the right to an individualized, outcomes-driven treatment plan that includes:
 - Complete medical evaluation and biopsychosocial assessment to determine level of care,
 - Medically-managed detoxification,
 - Intensive counselling including of medically- or clinically-appropriate inpatient and/or outpatient therapy, including appropriate lengths of stay and therapeutic sessions,
 - Medications,
 - Ongoing aftercare and recovery support services, and
 - Relapse prevention, intervention and management.
- Patients have a right to have access to treatment for their families and loved ones.
- Patients have the right to be treated in a setting that is safe and committed to ethical practices.

Access to Medications to Treat Substance Use Disorders

Addiction is chronic disease and all tools, including medications, should be considered for treatment.

Medication-Assisted Therapy (MAT) is medication to treat and manage SUDs. At Caron, we are committed to removing obstacles that obstruct access to one's sustainable and progressive recovery journey. To that end, Caron utilizes evidence-based principles to guide addiction treatment.

Given the prescription opioid and heroin epidemic we are currently facing as a society, Caron understands and endorses the utilization of MAT as another important tool in treating this chronic, progressive, and potentially fatal disease.

Whether a treatment facility or licensed prescriber chooses MAT in the form of Methadone, Buprenorphine (e.g., Suboxone), or injectable Naltrexone Extended Release (Vivitrol) to address opioid use disorders, it is important to stress that medication alone is not a panacea. Medication must be used as a supportive tool and managed by a qualified health care professional in collaboration with treatment specialists as part of a comprehensive therapeutic program.

At Caron, we utilize a multi-disciplinary approach to address the co-occurring disorders often found with substance use. This extensive approach also incorporates various treatment modalities, such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT), as well as utilizing psychological testing, medical evaluations and 12-Step integration. Therefore, it is imperative that health care professionals not lose sight of the clinical protocols needed for patients to succeed. In other words, it's essential to ensure that MAT is only one facet of a comprehensive treatment and recovery plan.

Of the available FDA-approved MAT strategies, Caron utilizes Naltrexone Extended Release (XR) or Buprenorphine maintenance. Through a diligent and thoughtful process, Caron's medical and clinical professionals chose Naltrexone XR as a primary choice because it is a non-mood altering opioid receptor antagonist with no euphoric effect, no withdrawal syndrome and no abuse or overdose potential. It is administered as a monthly injection, thus, increasing compliance. Additionally, if a patient relapses on heroin or opioid prescription medications while taking Naltrexone XR, he or she would not be in imminent danger of respiratory arrest.

We have an ever-growing referral database for addiction medicine specialists who will continue administering Naltrexone XR after discharge from Caron. If Naltrexone XR is not the right choice for the patient, we begin Buprenorphine maintenance and refer to an addiction medicine specialist in the outpatient setting to continue Buprenorphine MAT.

It's important to understand that if you administer Methadone, Buprenorphine or Naltrexone XR in the face of active heroin or other opioid use, you will precipitate withdrawal and the need for medical management. We need to give doctors and patients choices for MAT, because no one solution is best for all.

From day one, Caron's medical professionals begin the conversation with our patients about cravings and relapse risks, and continue to address these issues throughout our patients' episode of care. We educate all patients about the disease concept of addiction and the importance of implementing evidence-based practices to sustain a meaningful and healthy recovery.^{xiv}

Continuum of Care to Support Recovery

Because addiction is a chronic disease, treatment does not end when a patient leaves an inpatient or outpatient provider. To fully support recovery maintenance, a long-term management plan must be in place for each patient. This includes accessibility to MAT, if appropriate, continued counselling and, in some cases, longer lengths of care including extended care programs, structured sober living, and sober living as defined below:

- Extended Care Programs are an opportunity to live in a drug-free, healthy environment with staff and in-house recovery meetings. This type of housing often includes ongoing treatment and additional structure.

- Structured Sober Living is similar to Extended Care Programs, but with less intensive programming and treatment with a residence-related outpatient counselor off-site. Residents can work or go to school, and may stay for three to six months, sometimes up to a year.
- Sober Living offers very little structure in a recovery supportive environment. Some community recreation and house meetings may be available. Any additional treatment or therapy is found outside of the residence and from various providers.

At Caron, a patient's treatment team makes sure everyone who completes treatment at a Caron facility has a support system in place, an accountability plan established, and the necessary tools needed to maintain recovery for life. Family members also receive a continuing care plan to support their own recovery.

Caron considers several factors when vetting transitional living arrangements prior to referring our patients:

- Are the staff and leadership of the recovery residence clinically aligned with Caron's treatment and MAT philosophies? It is of the utmost importance that the residence will follow and support Caron's recommendations for patients leaving inpatient treatment.
- Is the recovery residence affiliated with a strong outpatient treatment provider?
- Does the recovery residence collaborate with an appropriately credentialed psychologist and psychiatrist when applicable?
- Partnering with the right recovery residences means Caron will be advised about the progress of our former patients and that the safety net of returning to treatment is available should an individual need stabilization or a more structured level of care to ensure ongoing recovery.

Caron believes in visiting sober living facilities and inviting their staff to visit our treatment facilities, as well:

- We ask questions about their programming and educate them about Caron's as part of finding the right fit for our patients.
- When Caron staff visits recovery residences, we ensure the physical environment is safe, nurturing, and embracing of alcohol- and drug-free living, including the surrounding area or neighborhood.
- Caron also explores the surrounding recovery community for support, such as 12-Step meetings, job networking opportunities, and other quality of life encouraging factors to help Caron's post-treatment patients build or rebuild their lives.

Recovery residences that meet these terms for Caron tend to develop a proven track record among our former patients, and we are often pleased to find them supporting each other in ongoing recovery in these communities.

In Conclusion

In the midst of an addiction and overdose death public health emergency projected to claim 64,000 lives this year due to drug use and likely 88,000 more as result of excessive alcohol use,^{xv} it is unconscionable that some in this health care sector continue to take advantage of individuals and families in crisis. While no single type of treatment for substance abuse is appropriate for everyone, the lack of standards in our sector makes it difficult for patients and families to know what good treatment looks like and how to find it. Matching interventions, treatment settings, and services to a patient's particular diagnosis and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.^{xvi}

A model strategy to consider as we address our nation's SUD public health crisis is the 90-90-90 treatment target plan of the United Nations Programme on HIV/AIDS (UNAIDS). There is indisputable evidence regarding the

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remarkable success over the past two decades in reducing HIV associated morbidity, mortality, transmission, stigma and improving the quality of life of people living with HIV. However, a high rate of new infections continues to fuel the HIV epidemic.^{xvii} The target of the 90-90-90 strategy is that by 2020:

- 90% of people who are living with HIV will be screened and diagnosed.
- 90% of all people who are diagnosed will be appropriately treated.
- 90% of those who are treated will have viral suppression, meaning the amount of virus in an HIV-positive person's blood is reduced to an undetectable level.

UNAIDS emphasizes that the only way to achieve this ambitious target is through approaches grounded in principles of human rights, mutual respect and inclusion, and *it will be impossible to end the epidemic without bringing HIV treatment to all who need it.*^{xviii}

To end this addiction crisis, the SUD treatment health care model needs to be fixed. If our country hopes to end the addiction and overdose public health emergency, first, we must reduce the stigma surrounding the diagnosis of chronic SUDs. Second, we must ensure that SUD screening is routinely performed, similar to regular height, weight, and blood pressure checks. Plus, it is imperative that these screenings be completed by clinically or medically trained experts, not by internet marketers or call center operators. With improved screening, the chances for referrals to appropriate levels of care and treatment improves. Third, the addiction health care model requires a system that funds all levels of treatment to ensure access for all who need it, supported by the enforcement of penalties to prevent fraudulent billing. Lastly, we must certify evidence-based treatment standard practices and outcomes, and treatment providers to safeguard that individuals and families seeking SUD care are receiving the medical attention needed to manage recovery of this chronic disease. In other words, we must approach and inform SUD treatment as we would any other public health epidemic. We need to fix the system that we are all here to provide testimony on today. A system that is currently taken advantage of to

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provide fraudulent, deceptive, and misleading addiction information and treatment to lure people who are in crisis into facilities that are not concerned about recovery for life.

Evidence-based, quality treatment is available and millions of Americans live in recovery through effective chronic disease management. According to the National Institute on Drug Abuse (NIDA), there are more deaths, illness, and disabilities from substance use than from any other preventable health condition.^{xix} Caron stands with other treatment providers in support of the efforts of NAATP, the American Society of Addiction Medicine (ASAM), IBC, advocacy groups, and patients and their loved ones to identify and address the ethics abuses plaguing our sector of health care. Despite, or because of, Caron's history, innovative experience, knowledge, resources, ethical standards, research, and leadership, we have not escaped becoming a target of unethical marketing practices. As an SUD treatment provider, Caron believes we have a responsibility to act in the best interest of all patients, families, and ethical treatment providers to take steps to prevent further abuses in our sector.

In addition to the Caron Patient's Bill of Rights and Center of Excellence Addiction Treatment Model, we propose educating the treatment industry sector to implement a consistent ethical perspective to define ethical treatment and marketing practices. Caron recommends educating the public about addiction as a chronic disease, patients' rights, and what to look for in an SUD treatment center. We support transparency of relationships between providers and call aggregators, as well as enforcement of existing state and federal penalties for deceptive marketing, kickbacks, and patient referral practices. We strongly encourage bringing an end to patient brokering and human trafficking under the guise of SUD treatment and recovery housing with enforcement of heavy penalties. We encourage the passage of necessary state and/or federal regulations to make it illegal to knowingly provide false or misleading information about substance use treatment providers intended to lure or misdirect individuals or family members seeking care. Treatment providers at all levels of

care and recovery support services should be appropriately credentialed or licensed, and inspected by unbiased entities. Finally, we need to identify or expand prohibitions on referrals between licensed treatment providers and recovery residences that do not meet minimum standards of care and safety.

In closing, all treatment providers must collaborate to rebuild trust in our communities and in the nation. As health care providers, our cooperation is needed to assist in addressing this public health emergency to define quality care, effective treatment, and recovery outcomes. Thank you for the opportunity to present this testimony to the US House of Congress Committee on Energy and Commerce Subcommittee on Oversight and Investigations.

Respectfully submitted by

Douglas Tieman, President & CEO

Caron Treatment Centers

Patients have the right to:

- 1. Be treated for the life-threatening, chronic disease of addiction with honesty, respect and dignity.**
- 2. Know what to expect from treatment, and the likelihood of success.**
- 3. Be treated by licensed and certified professionals.**
- 4. Evidence-based treatment.**
- 5. Be treated for co-occurring behavioral health conditions simultaneously.**
- 6. An individualized, outcomes-driven treatment plan.**
- 7. Remain in treatment as long as necessary.**
- 8. Treatment for their families and loved ones.**
- 9. A treatment setting that is safe and ethical.**





What to Look for in an Addiction Treatment Center

Choosing a drug or alcohol rehab center is an incredibly important decision with many factors to consider.

Before choosing a treatment center, ask the following questions:

- Does this treatment center treat addiction as a chronic disease and, as such, strive for continuity of care?
- Does the center provide on-site assessment?
- Will the facility develop a comprehensive treatment plan for the patient: one that will be constantly monitored, updated and modified as treatment progresses?
- Is the facility safe?
- How experienced and credentialed are members of the treatment team?
- Is the facility location ideal for the patient?
- What will treatment cost? Is the cost covered by my insurance or non-reimbursed medical plan?
- Are financial aid or financing options available?
- Is the program geared toward the patient's age, gender and addiction severity?
- Is the center able to provide comprehensive treatment to address all aspects of addiction?
- Does the center collaborate with hospitals and research groups to keep it on the leading edge of addiction treatment practices?
- What treatment approaches does this program use regarding detoxification; abstinence; individual, family and group therapy; medication-assisted treatment; cognitive-behavioral therapy; endorsement or inclusion of 12-step programs or other mutual-help groups; relapse education and prevention; and long-term recovery?
- Is the facility equipped to assess and treat co-occurring disorders?
- Does the center have programs in place to include or treat a patient's family?
- Is the family involved in decision-making, the treatment process and the recovery phase?
- What type of ongoing treatment does the facility provide?
- Does the program provide outpatient, inpatient, residential and short-stay options, and recovery care?
- Is the center included on the state's licensure website, such as the Department of Health?
- Has the program received any major citations?
- Is the treatment center facility and location accredited by an independent behavioral health body demonstrating the provider's commitment to continuously improve service quality and to focus on best practices in treatment?

For help finding a program that suits your needs, please [contact Caron Treatment Centers.](http://www.caron.org)
www.caron.org | 800-678-2332

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Mr. HARPER. Thank you, Mr. Tieman, for that incredible testimony.

Mr. Nielsen, we now recognize you for 5 minutes for the purposes of an opening statement.

TESTIMONY OF PETE NIELSEN

Mr. NIELSEN. Good morning, Chairman Harper and Ranking Member DeGette, as well as the entire subcommittee. My name is Pete Nielsen, and I am the CEO of CCAPP, the California Consortium of Addiction Programs and Professionals, the largest statewide consortium of community-based substance use disorder treatment agencies and addiction-focused professionals, providing services to over 100,000 Californian residents annually in residential, outpatient, and private practice settings.

CCAPP has actively supported residential recovery for over 30 years. We are responsible for credentialing and professional oversight of tens of thousands of addiction treatment and prevention professionals in the most populous state in the Nation. We have also published and disseminated standards for sober living facilities.

At this time, I would like to ask the chairman permission to submit a copy of these standards for the record.

Mr. HARPER. Without objection.

[The information appears at the conclusion of the hearing.]

Mr. NIELSEN. There is, indeed, a nexus between sober living and fraud in the treatment industry. They can easily be approached as two separate issues, yet they merge when treatment centers engage in unsavory marketing practices, prey upon the vulnerable, and offer sober living as a part of the deal.

At some call centers where the process of enrollment for treatment and recovery often begins, workers are paid bonuses for performance based on how many admissions they sign up and marry the high pressure sales tactics on very desperate callers. The sales environment is high pressured and all about getting heads in beds.

As a result, marketers should be properly educated and properly even—or potentially even credentialed. The better trained, better organized, and better coordinated our industry is, the better our services will be. And not only will consumers benefit, but so will all of society.

The first step in ending fraud is to assure that all involved in the industry meet certain standards, both in terms of knowledge and ethics, bad actors using the stigma of addiction against people they claim to care for.

Before anything else, a patient and their caretaker must find the right environment and best suited treatment protocol. This includes proper screening and evaluation. Simply because someone meets the eligibility requirements of the facility, this does not automatically mean the facility is right for them. In a treatment facility, every employee, from the janitor to the manager, the patient and their well-being must be top priority.

Those struggling with addiction are often in need of a stable environment. Cooperative housing offers a bridge to independent living, which is a critical piece of the puzzle. Sober living environments, or SLEs, is a term used to describe a specific type of hous-

ing. Sober living is not, nor has it ever been, intended to be the same as residential inpatient treatment. It is its own entity with its own set of standards and goals.

The difference between residential addiction treatment and sober living is there are typically no clinical services offered in sober living. It is more so about an environment of recovery and cooperation and communal living to support recovery.

In order to ensure that consumers are protected and fraud reduced, CCAPP recommends standards be followed in five categories for SLE in California. We recommend standards for physical environment, for management, for record keeping, for house rules, and for residency requirements. Physical environment standards can include aspects such as design and upkeep. Also, good neighbor policies assure the home and its residents are accepted as part of the community. The person in charge of the facility shall be clearly identified to all residents and on the premises to function properly and achieve management efficiency.

House rules must exist. These rules must be clearly defined: completion of formal alcohol and drug recovery program or documented stability in a self-help group and willingness to abide by house rules.

In California, Assembly Bill 285 was introduced earlier this year. And this bill would offer drug and alcohol-free residents a—and to have proper oversight.

Again, I reiterate to—and thanks to the subcommittee for addressing this critical issue and for inviting me to testify on behalf of CCAPP.

[The prepared statement of Mr. Nielsen follows:]

Testimony of Mr. Peter Nielsen
Chief Executive Officer
California Consortium of Addiction Programs and
Professionals

“Examining Concerns of Patient Brokering and
Addiction Treatment Fraud.”

Before the
Subcommittee on Oversight and Investigations
House Energy and Commerce Committee
December 12, 2017

Good morning Mr. Chairman Harper, and ranking member DeGette, as well as to the entire subcommittee. My name is Pete Nielsen, and I am the Chief Executive Officer of CCAPP, the California Consortium of Addiction Programs and Professionals. CCAPP is California's largest statewide consortium of community-based for profit and nonprofit substance use disorder treatment agencies, and addiction focused professionals, providing services to over 100,000 California residents annually in residential, outpatient, and private practice settings. Our home office in Sacramento is represented by Energy and Commerce Member Doris Matsui, and our entire congressional delegation has been active in the fight against addiction, both before and during the opioid crisis. The Golden state of California is represented on this subcommittee by three distinguished members, Mr. Ruiz, Mr. Peters, and Ms. Walters, whom I thank for their service and their commitment to the people of California.

CCAPP represents the social model approach to recovery and has actively supported residential recovery for over 30 years. We have a long history of excellence in the provision of training, technical assistance and advocacy for programs throughout California. We have published and disseminated standards for sober living facilities, and we are also responsible for the credentialing and professional oversight of tens of thousands of addiction treatment and prevention professionals in the most populous state in the nation. At present, compliance with CCAPP's Sober Living Environment standards is voluntary.

Throughout the entire addiction treatment and recovery process, focus on patient centered care is critical. A patient cannot be treated as a commodity, which is unfortunately what we are seeing in many cases in the current environment. Bad actors are using the stigma of addiction against the people they claim to care for. Vulnerable people and their loved ones must be protected from those who seek to profit, regardless of client need, medical criteria, or human decency. When seeking out the right environment for a loved one, before anything else, the right environment and best suited treatment protocol must be guiding principles, not afterthoughts. There should be no profit motive involved these decisions.

Sadly, addicts who seek treatment are often victimized by being sold to the highest bidder, and in our state this is perfectly legal. People entering treatment are vulnerable physically and mentally. Their loved ones are often so desperate to find safe haven and end the chaos of addictive behavior that they make excellent targets for scam artists and so called "interventionists" who will apply aggressive sales tactics, telling patients and families the addict will die if they do not act upon the referring agent's directive. Add into these scenarios unlicensed, unscrupulous sober living homes that are willing to bill individuals and insurers without shame and you have a perfect storm for abuse, waste of resources, and tragically poor recovery rates.

Sober Living Environments (SLE) is a term generally used to describe a specific type of housing. SLE's offer a housing alternative to individuals who are recovering from alcohol and or drug addiction. Because these homes are residences, not treatment programs, they are not subject to licensing by any State agency and are not subject to any required certification or accreditation. Other terms used to describe such housing are "recovery residences" "cooperative housing for recovering people", "resident-run housing", "sober cooperative living", and "alcohol, drug free living centers." All of these arrangements have something in common in that they are intended for cooperative living of individuals who are recovering from alcoholism or drug addiction. Resident responsibility for the environment sets it apart from formal recovery programs. Sober living is not, nor has it ever been, intended to be the same as residential treatment. It is its own entity, with its own set of standards and goals.

Sober living environments can be found in a variety of settings and can serve a multitude of purposes. It is imperative that we understand this, as they are not "one size fits all." In some cases, they serve as a place to live while a consumer receives outpatient treatment at a separate clinical setting. It is these environments that are the subject of many investigations, especially in Florida and California. In other cases, they can serve as a "recovery residence," where people go to live upon completing residential treatment at a separate facility.

There is a great need for sober living in our communities. Many persons who attend or graduate from organized programs do not have a home to go to, nor can they afford individual housing, which is recovery conducive. Cooperative housing offers a bridge to independent living, which is a critical piece of the sobriety puzzle. Those struggling with addiction are often in need of a stable environment, which sober living facilities seek to provide.

As in any cooperative environment, a sober living house needs rules. Rules may include curfew, smoking rules, chores, payment of rent, and attendance at house meetings, and must include prohibition of any use of alcohol and or drugs for which a prescription is not in existence. A sober living home may or may not have paid staff. The role of the staff must be clearly for management of the housing and not for management of individuals. The environment must be recovery conducive and space should be adequate to accommodate each individual comfortably and with dignity and respect.

Attention should be given to the health and safety of all residents and therefore the home should meet minimum fire and health standards. CCAPP recommends standards be followed in five categories for any SLE in California. This document, "CCAPP Standards for Sober Living Environments," has been submitted for the record. This document includes standards for the, Physical Environment, for Management, for Record Keeping, for House Rules, and for Residency Requirements.

Physical Environment standards can include aspects such as design and upkeep. Design should encourage residents to contact each other incidentally, informally, and without status barriers. Space should be available for all residents to meet for community meetings. Upkeep and appearance: Repair, maintenance, cleanliness, and attractiveness are critical elements in the life of the house. The upkeep and appearance of the house are a metaphor for the lives of the

residents. This includes grounds and driveways surrounding the home. Residents should feel the place is their own. Also, good neighbor policies assure that the home and its residents are accepted as part of the community. This means that residents will be mindful of noise levels of conversations, and designated smoking areas that will not affect the neighbors. There must be fire safety standards in place.

The person in charge of the facility shall be clearly identified to all residents and on the premises. This should be an individual or designated individual within the group. This person shall be responsible for the maintenance and safety of the building. The manager should be the keeper of the “good neighbor” policy and liability insurance and copies should be available and visible in the home. At a minimum, someone must be responsible for the safety of the building, someone must be available to maintain records, to collect rent, and to register and check-out residents, and to maintain rules of the house. The manager in charge of the residency shall maintain formal records. Records fill several important roles: they allow management to track the person served and provide a sense of order. The following record keeping standards are applicable to SLE:

To function properly and achieve maximum efficiency, House Rules must exist. These rules must be clearly defined. Optional rules will depend on the needs of the population to be served, should not be over burdensome, and must be consistent with residency needs. To begin with, no drinking of alcohol or items containing alcohol or using illegal drugs are to be tolerated at any time. Mandatory attendance at a weekly house meeting should also be a universal constant.

Residency Requirements are also critical. The residency requirements must be clearly defined and at a minimum should include: A desire to live a clean and sober life style; Completion of a formal alcohol or drug recovery program, or documented stability in a self-help group; A willingness to abide by all the house rules; and a signed residential agreement on file for each resident.

The substance use disorder treatment and recovery process is highly complex, and as a result, so is the industry that provides these services. The better trained, better organized, and better coordinated our industry is, the better our services will be- and not only will consumers benefit, but so will all of society. Any potential legislation must be crafted to support the industry and its good actors, while at the same time weeding out the bad actors. In the end, the goal is to have an industry that is ethical and strong enough to support itself with minimal oversight.

In California, the bill AB 285 was introduced earlier this year as the Drug and Alcohol-free Residences Act. This bill would define a “drug and alcohol-free residence” as a residential property that is operated as a cooperative living arrangement to provide an alcohol and drug free environment for persons recovering from alcoholism or drug abuse, or both, who seek a living environment that supports personal recovery. It would authorize a drug and alcohol-free residence to demonstrate its commitment to providing a supportive recovery environment by applying and becoming certified by an approved certifying organization that is approved by the State Department of Health Care Services. It provided that a residence housing persons who are

committed to recovering from drug or alcohol addiction is presumed to be a drug and alcohol-free residence if the residence has been certified by an approved certifying organization. The bill would require an approved certifying organization, such as CCAPP, to maintain an affiliation with a national organization recognized by the department, establish procedures to administer the application, certification, renewal, and disciplinary processes for a drug and alcohol-free residence, and investigate and enforce violations by a residence of the organization's code of conduct, as provided. The bill specifies that there would be documentation that an operator who seeks to have a residence certified is required to submit to an approved certifying organization.

A certifying organization would be required to maintain and post on its web site a registry containing specified information of a residence that has been certified pursuant to these provisions, and would require the department to maintain and post on its Internet Web site a registry that contains specified information regarding each residence and operator that has had its certification revoked. The bill would deem the activities of a certified drug and alcohol-free residence a residential use of property under specified circumstances.

This bill would require that a state agency, state-contracted vendor, county agency, or county-contracted vendor that directs substance abuse treatment, or a judge or parole board that sets terms and conditions for the release, parole, or discharge of a person from custody, to only first refer that person to a residence listed as a certified drug and alcohol-free residence on a registry posted by an approved certifying organization, provided there is availability in such a residence.

At some call centers, workers are paid bonuses for "performance," based on how many admissions they sign up, and many use high-pressure sales tactics on very desperate callers. Once a potential client is on the phone, it's up to the call center employee to convince them that they should travel to the treatment center the call center is representing, whether or not going away from home was the person's intention, and whether or not the treatment center provides the right therapies and environment that best suits the consumer.

If the members of this committee can take away just one point from my testimony, please let it be this- all of our standards, our recommendations, our efforts- they all have one primary goal above all else: to protect the consumer. I believe this committee shares our commitment to this pursuit. I believe it is the very reason for this hearing. All of our best practices, and all of our efforts day in and day out, exist so that a vulnerable population with a terrible disease receive all the possible protections at our disposal.

CCAPP is promoting common sense legislation to prohibit patient brokering in our state and to provide voluntary certification for recovery residences that is tied to referrals and funding from public sources. By eliminating the profit motive for referring agents and "starving out" poor sober living by denying them referrals and participation in any public funding streams, we believe we can stop the "Florida model" from transplanting to California and other states. In doing so we are confident we will save more lives, reunite more families that have been torn apart by untreated or poorly treated addiction, and make more communities safer in the process.

Again, I reiterate my thanks to this subcommittee for addressing this critical issue, and for inviting me to testify on behalf of CCAPP.

Mr. HARPER. Thank you very much.

Mr. Aronberg, we now recognize you for 5 minutes for the purposes of an opening statement. Thank you for being here.

TESTIMONY OF DAVE ARONBERG

Mr. ARONBERG. Thank you.

Good morning. My name is Dave Aronberg. I'm a state attorney from Florida's 15th Judicial Circuit, which covers all of Palm Beach County.

As the chief law enforcement officer for a county at the forefront of the national opioid crisis, I want to thank you, Mr. Chairman and all the committee members, for your leadership in confronting this unprecedented epidemic, and also for your advocacy of the much-needed 21st Century Cures Act.

Because of Palm Beach County's tropical climate and long-established drug treatment industry, we've always been a destination for people with substance use disorder. This is the Florida model. In theory, you have someone battling addiction, oftentimes it's heroin. They'll come down to Florida to get inpatient detox and other treatment. Insurance will cover 3 to 7 days of detox and then about 10 days of inpatient treatment. It used to be 28 days, but insurance has cut back. Then they'll go to outpatient care.

Outpatient care is—those acronyms just mean 4 to 6 weeks, paid by insurance, of group counseling and urinalysis. And then to live in a sober home while they're doing that. The sober home, as said previously, there's no treatment there. It's just a group living place, 6, 8, 10 people living together in a drug-free, supportive environment. And then, hopefully, after the insurance runs out, that individual is now sober and can go home. That's in theory.

Together, the Affordable Care Act and the Mental Health Parity Act provide coverage for rehab on a traditional fee-for-service basis, with no yearly or lifetime limits, and with relapse always covered as an essential health benefit.

In recent years, however, we've had a surge of unscrupulous individuals enrich themselves by misusing well-intended Federal laws to prey on opioid addicts who are often willing to participate in patient brokering, illegal kickbacks, and insurance fraud, in exchange for illicit benefits, such as cash, free rent, transportation, and even drugs themselves. This is the Florida shuffle. This is the reality on the ground. Everyone's getting rich.

You have a patient coming down to Florida, sent by a marketer with a free plane ticket, and then going into an inpatient facility that kicks back money to the marketer, then going into an outpatient facility where kickbacks occur, and then living in a sober home, often for free, because the sober home owner will get a kickback from the outpatient care center. And the lab even makes money on kickbacks because urinalyses are very lucrative. And everyone's making money, except there's one area that's not profitable. And that's sobriety. We are incentivizing failure. This is a relapse model, not a recovery model.

What's also important to note, is that when it comes to the sober home area, the Americans With Disabilities Act and the Fair Housing Act together prevent the regulation or inspection of these resi-

dences. And so many are little more than flophouses where drug abuse, human trafficking, and other crimes are prevalent.

It's hard enough to remain sober as it is for someone battling addiction, let alone knowing that their sobriety is going to cost them their free rent, their free gifts, their transportation, their friends, and now they got to move back home, in a chilly climate, and live with their parents and find a job. And this is why 75 percent of all private-pay patients in Florida rehab, come from out of state, and they rarely leave. Too often, they leave in body bags and ambulances.

In July 2016, our office formed a task force to crack down on this fraud and abuse. We have since made 41 arrests. We also impaneled a grand jury and created two additional citizens' task forces to recommend changes to Florida law that led to the passage of an important act that Congresswoman Castor mentioned. But we can't fix this problem alone. We need your help, and that's why we're making the following recommendations.

First, address private insurance abuses by adopting the ACA's outcome-based reimbursement model used in the Medicare program instead of the current fee-for-service reimbursement model. This would reward the best recovery centers while shuttering rogue operators. It could also improve patient outcomes as providers will be incentivized towards a longer term, lower-level continuum of care rather than ineffectual short bursts of intensive forms of treatment with no followup.

Second, address the abuses in the sober home industry by clarifying the ADA and FHA to allow states and local governments to enact reasonable regulations for the health and safety of vulnerable sober home residents. DOJ and HUD attempted to issue such a clarification last year, but their joint statements seem to miss the point that the very Federal laws designed to protect individuals in recovery are instead being used to shield those who do them harm.

Chief assistant Alan Johnson, who heads our Sober Homes Task Force, will provide our other three recommendations.

And I want to thank you, members of the committee, for your time.

[The prepared statement of Mr. Aronberg follows:]

**TESTIMONY OF DAVE ARONBERG, STATE ATTORNEY, 15TH JUDICIAL CIRCUIT,
FLORIDA**

My name is Dave Aronberg. I'm the State Attorney for Florida's 15th Judicial Circuit, which covers all of Palm Beach County. As the Chief Law Enforcement officer for a county at the forefront of the national opioid crisis, I want to thank you, Mr. Chairman, and all of the committee members, for your leadership in confronting this unprecedented epidemic. I also applaud your advocacy of the 21st Century Cures Act, which will speed the discovery and development of new cures and treatments, including alternatives to the addictive prescription painkillers that have led to so many needless deaths.

Because of Palm Beach County's tropical climate and long established drug treatment industry, we have always been a destination for people with substance use disorder. [See PowerPoint Slide #2.] In recent years, however, we have seen an influx of unscrupulous individuals who enrich themselves by exploiting those in recovery. These opportunists are misusing well-intended federal laws to prey on opioid addicts, who are often willing to participate in patient brokering, illegal kickbacks and insurance fraud in exchange for illicit benefits such as cash, free rent, transportation and even drugs themselves.

This is the Florida Shuffle. [See PowerPoint Slide #3.] It starts with deceptive marketing practices, offers or inducements, such as a free one-way plane ticket to a Florida rehab center. Today, 75% of all private-pay patients in Florida drug treatment centers come from out of State, and for too many of them, they leave our community only in ambulances or body bags. Once in Florida, the patient goes through a course of treatment covered by insurance. Together, the Affordable Care Act (ACA) and the Mental Health Parity and Addition Equity Act of 2008 provide coverage for drug rehabilitation on a traditional fee-for-service basis with no yearly or lifetime limits and with relapse always covered as an essential health benefit. During outpatient phases of treatment, the out-of-state patient, in need of a place to live, will be referred to a sober home, which is a group home for individuals in recovery. The Americans with Disabilities Act (ADA) and Fair Housing Amendments Act (FHAA) together prevent the regulation or inspection of these residences, and so many are little more than flophouses where drug abuse, human trafficking and other crimes are prevalent. When insurance benefits are exhausted, outpatient care ends and the individual leaves the sober home. A relapse, however, will trigger a new round of treatment, so rogue providers seek profit through endless failure rather than sobriety.

In July 2016, our office formed a Sober Homes Task Force to crack down on the fraud and abuse in the drug treatment industry. Our Task Force has since made 41 arrests, mostly for illegal patient brokering, which is a third-degree felony in Florida punishable by up to 5 years in prison. We also work with the U.S. Attorney's Office for the Southern District of Florida to

target insurance fraud, which led to the recent federal conviction and 27-and-a-half year sentence for drug treatment and sober home kingpin Kenneth Chatman.

As we succeed in arresting rogue providers and shutter corrupted facilities, we have seen the criminal element leave Palm Beach County for other communities unaware of the Florida shuffle. We have held training sessions for prosecutors and law enforcement officials throughout the State and we're offering our assistance to jurisdictions throughout the country.

On the legislative front, our office empaneled a Grand Jury and created two additional citizens' Task Forces to recommend changes to State law, leading to the 2017 passage of Florida House Bill 807, which tightened enforcement and oversight of the drug recovery industry.

But local and State law enforcement cannot solve this problem alone. We need the federal government to fix federal laws and regulations that exacerbate the national problem and tie our hands at the local level. My Chief Assistant, Alan Johnson, and I offer five recommendations:

First, address private insurance abuses by adopting the Affordable Care Act's outcome-based reimbursement model used in the Medicare program instead of the current fee-for-service reimbursement model for private pay drug rehab. This would reward the best recovery centers while shuttering rogue operators. It could also improve patient outcomes, as providers will be incentivized towards a longer term, lower-level continuum of care rather than ineffectual short bursts of intensive forms of treatment with no follow up. Studies have shown that a more effective and less expensive approach is to provide decelerated care over 12 months instead of an unending series of intensive 7 to 14 day inpatient stays followed by intensive outpatient treatment for 4 to 6 weeks marked by over-testing and overbilling.

Second, address the abuses in the sober home industry by clarifying the Americans with Disabilities Act and Fair Housing Act to allow states and local governments to enact reasonable regulations for the health, safety and welfare of vulnerable sober home residents. The Department of Justice (DOJ) and the Department of Housing and Urban Development (HUD) attempted to issue such a clarification last year, but it was unhelpful. Entitled "State and Local Land Use Laws and Practices and the Application of the Fair Housing Act," the Joint Statement seemed to ignore the realities on the ground that the very federal laws designed to protect individuals in recovery – the ADA and the FHAA -- are instead being used to shield those who do them harm. Chief Assistant Alan Johnson will now offer three additional recommendations.

Mr. HARPER. Thank you for your testimony.

The chair will now recognize Mr. Johnson for 5 minutes for purposes of his opening statement.

TESTIMONY OF ALAN JOHNSON

Mr. JOHNSON. Thank you, Mr. Chair, members. Thank you for the opportunity.

As we succeed in Palm Beach County in arresting and prosecuting rogue providers and shuttering corrupt facilities, we've seen the criminal element leave Palm Beach County for other communities and states that may not be aware of the Florida shuffle. We have held training sessions for prosecutors and law enforcement officers throughout Florida, and we're offering our assistance to other jurisdictions throughout the country.

However, there are a number of roadblocks facing local, state, and Federal prosecutors in effectively combatting these abuses. The following are several concrete steps that can close loopholes in the law, protect the vulnerable patients with substance use disorder from exploitation, and assist prosecutors in their efforts to reign in the corruption that has plagued the treatment industry. In the interest of brevity, I'll highlight these recommendations. My written testimony is more detailed.

Currently, under the Federal Anti-Kickback Statute, which is known as AKS, Federal agents and prosecutors only have jurisdiction to pursue kickbacks related to federally assisted insurance programs, such as Medicare and Medicaid. Patient brokering abuses, regardless of whether the insurance is public or private, hurts patients and increases the cost of healthcare to everyone. In other words, the same public purpose behind the Anti-Kickback Statute applies equally to both federally funded and private treatment. The private industrywide fraud has been estimated in the billions of dollars. I know you know that. The human cost of substandard care motivated by greed is incalculable.

We ask that this committee explore an amendment to the AKS, the Anti-Kickback Statute, that would bring this law enforcement tool to bear on the rampant exploitation occurring in the private-based sector. At a minimum, jurisdiction should be extended to private insurance contracts obtained through the ACA exchanges.

Second, we ask that the bona fide employee safe harbor, BFE it's known as, within the Anti-Kickback Statute be modified. Now, Florida, along with many states, has patient brokering statutes that adopt the Federal safe harbors like bona fide employee.

Currently, rogue actors in the treatment industry are hiring marketers as employees to circumvent the Federal Anti-Kickback and state patient brokering statutes. Employers are paying bonuses and commissions based on the value or the volume of the patients their employees refer. Many of these marketers who are employees have no credentials in traditional marketing, are recovering addicts themselves and, in many cases, own sober homes where they steer the residents to the employer's facilities.

The bona fide employee exception needs to be clarified in two ways. First, an employee should not be permitted to receive bonuses and commissions on the basis of the value of the services or

the volume of the customers they refer. The delivery of healthcare is not the same as selling automobiles or computers.

This can be achieved by applying the safe harbor rules in the Federal statute regulating independent contractors to apply to employees. For example, independent contractors under the Anti-Kickback Statute cannot be paid on the basis of the volume or value of their referrals. This rule should apply to employees as well. By making a marketer an employee should not absolve the employer and the employee from liability for these abuses.

Additionally, the bona fide employee safe harbor exception to the Anti-Kickback Statute allows an employer to pay "any amount to an employee for the employment in the provision of covered items or services." This safe harbor should be clarified to mean that any payment to an employee must be for the performance of services that are actually covered by the applicable Federal program. And this would flow down to the states as well in their patient brokering statutes.

While the current wording of the statute is clear to us, Federal courts continue to disagree as to the meaning of the phrase, and it's hurting our oversight of these abuses.

Third, an increased effort should be made to use appropriate Federal agencies to go after the corrupt marketers and marketing schemes. This is a national problem, and thousands of families throughout the country are affected by false and fraudulent misrepresentations. State and local agencies do not have the resources or jurisdiction to go after large interstate marketing operations.

Lastly, and perhaps most importantly, the rules regulating the application of the ADA and FHA, as they pertain to sober homes, need to be clarified to allow standards to be required for the protection of the residents. There are standards out there. Oxford House is recognized by Congress, as well as the National Alliance of Recovery Residences.

Running out of time, so thank you very much.

[The prepared statement of Mr. Johnson follows:]

**TESTIMONY OF ALAN S. JOHNSON, CHIEF ASSISTANT STATE ATTORNEY, 15TH
JUDICIAL CIRCUIT, FLORIDA**

My name is Alan Johnson. I'm Chief Assistant State Attorney, 15th Judicial Circuit in and for Palm Beach County, Florida. One of my duties is to supervise both the civilian and law enforcement sides of the Palm Beach County Sober Homes Task Force.

As we succeed in arresting and prosecuting rogue providers and shuttering corrupt facilities, we have seen the criminal element leave Palm Beach County for other communities that may not be aware of the Florida Shuffle. We have held training sessions for prosecutors and law enforcement officials throughout Florida and we're offering our assistance to other jurisdictions throughout the country. Our Task Force has also worked with the U.S. Attorney's Office for the Southern District of Florida to target insurance fraud, which led to the recent federal conviction and 27 year prison sentence for drug treatment and sober homes kingpin Kenneth Chapman.

However, there are a number of roadblocks facing local, state and federal prosecutors in effectively combating these abuses. The following are several concrete steps that can close loopholes in the law, protect the vulnerable patients with substance use disorder from exploitation, and assist prosecutors in their efforts to reign in the corruption that has plagued the treatment industry.

EXPAND THE FEDERAL ANTI-KICKBACK STATUTE (AKS) TO INCLUDE PRIVATELY FUNDED TREATMENT:

Federal law prohibits offering or paying, soliciting or receiving, anything of value (i.e., kickbacks) for patient referrals. Currently, the Federal Anti-Kickback Statute only applies to schemes involving federally assisted programs, such as Medicare and Medicaid. Patient brokering abuses, regardless of whether the insurance is public or private, hurts patients and increases the cost of health care to everyone. Kickback schemes can freeze competing suppliers, cause overutilization of services, harm competition and the freedom of choice. Anti-kickback statutes, both state and federal, are designed to prevent (1) corruption of medical judgments, (2) overutilization of services –unnecessary billing, (3) unfair competition, (4) increased costs to the system and (5) patient steering.

In other words, the same public purpose behind the AKS applies equally to both federally funded and private treatment. Currently, federal law enforcement and prosecutors have only limited jurisdiction to investigate and prosecute bad actors defrauding private insurance programs. Federal prosecutors are limited in their ability to prosecute corrupt marketers and patient brokers whose schemes do not involve federally-assisted programs. The private

industry-wide fraud has been estimated in the billions of dollars. The human cost of substandard care motivated by greed is incalculable. We ask that this committee explore an amendment to the AKS that would bring this law enforcement tool to bear on the rampant exploitation occurring in the private pay sector of substance use disorder treatment. At a minimum, jurisdiction should be extended to private insurance contracts obtained through the ACA exchanges.

Local and state law enforcement agencies cannot fight this battle alone, especially against well funded regional and national criminal networks.

MODIFY THE BONA FIDE EMPLOYEE (BFE) SAFE HARBOR WITHIN THE AKS.

There are a number of exceptions to the AKS (adopted by most state patient brokering statutes) that create safe harbors for treatment facilities. One such safe harbor is the Bona Fide Employee exception (BFE). Hiring an employee is often used as a method to disguise kickback schemes. Under the Bona-fide Employee Exception, the AKS does not prohibit, "...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 [.]” 42 USC § 1320a-7b(b)(3)(B).

According to a 1991 OIG opinion, the thinking behind this safe harbor is that the employer-employee relationship is unlikely to be abusive, in part because the employer is generally fully liable for the actions of its employees and is therefore more motivated to supervise and control them. Our experience shows the opposite; many employers are fully invested in the brokering schemes, oftentimes hiring recovering addicts to put “heads in the beds.” We ask that the current BFE be amended to exclude employees from being paid bonuses or commissions based on the value or volume of referrals that they generate.

In addition, we ask that the phrase, “...for employment in the provision of covered items or services” be clarified to mean that any payment to an employee must be for the performance of services that are actually covered by insurance. While the current wording of the statute is clear to us, Federal Courts continue to disagree as to the meaning of this phrase.

Another safe harbor, Personal Services and Management Agreements (PSM), applies to contractual relationships with third party persons or entities. Requirements found in this safe harbor should be made applicable to the BFE exception as well. They include the following:

- 1- The agency agreement is set out in writing and signed by the parties.

- 2- The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.
- 3- The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the ***volume or value of any referrals*** or business otherwise generated between the parties.
- 4- The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.
- 5- The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the service.

42 CFR 1001.952 (emphasis added)

The above requirements for the PSM safe harbor are designed to promote transparency and discourage patient brokering abuses. This reasoning applies equally to employees and may be applied to the BFE safe harbor by simply switching the words “agency” and “agent” to “employment” and “employee.” It should be noted that any treatment provider will be able to hire and maintain employees without adhering to these requirements; however, if that employee violates the AKS or state equivalent patient brokering statute, they may not use the safe harbor as an affirmative defense.

ENHANCE FEDERAL ENFORCEMENT OF CIVIL AND CRIMINAL INTERSTATE MARKETING FRAUD

One of the many contributors to fraud and abuse in the private treatment side of the opioid crisis is false and misleading advertising. Millions of dollars are spent to gain placement, particularly for on-line internet access, to create a funnel from one part of the country to treatment destinations such as Florida, Arizona, Texas and California. In many cases, phone numbers and maps of legitimate providers are hijacked by unscrupulous marketers. On-line positioning in one geographic area can mislead the caller into thinking a facility is local, when the local number is in reality a Trojan horse, answered by a lead generator and sold downstream to the highest bidder. These phone calls are extremely valuable. In some cases, a downstream lead generated call may cost a facility or marketer over \$1,000 or more, once insurance is validated.

Florida recently passed landmark legislation to reign in some of the abusive practices in the marketing of addiction services. HB 807 included new deceptive and fraudulent marketing

practices statutes, recognizing vulnerable consumers and their families are at risk of being victimized by practices that adversely impact the delivery of health care. False or misleading statements or information about a provider or operator's products, goods, services or geographical location marketed on advertising materials, in media or on its website are now violations of state civil and criminal law.

While Florida has prohibited false and misleading advertising, the reality is that many of these fraudulent marketers are operating on a regional or national level. Jurisdiction and investigatory limitations severely hinder effective state action. Lack of resources is also a problem. Local law enforcement is not equipped to investigate large marketing firms operating over state lines. Holding abusive interstate marketers and marketing systems to task, both civilly and criminally, should be made a priority of the appropriate federal agencies.

CLARIFY THE AMERICANS WITH DISABILITIES ACT (ADA) AND THE FAIR HOUSING AMENDMENTS ACT OF 1988 (FHAA) TO PROTECT RESIDENTS OF SOBER HOMES

In 2016, there were 4,661 opioid overdose responses by Fire Rescue in Palm Beach County alone; 552 of them resulting in death. Many, if not most of the calls, were to sober homes.

The Americans with Disabilities Act (ADA) and the Fair Housing Amendments Act (FHAA) limit government oversight of sober homes that house persons recovering from Substance Use Disorder (SUD). When President Reagan signed the FHAA, he added people with disabilities to the classes protected by the nation's Fair Housing Act (FHA). The amendments recognized that many people with disabilities need a community residence in order to live in the community like a family as an alternative to institutionalization. SUD is a recognized disability under the ADA and FHAA. However, unlike other disabilities, a person suffering from SUD is not protected under Federal Law if he or she is actively using controlled substances. In no other instance is a disability conditioned on the actions of the disabled. This is an important distinction when applying protections for persons with SUDs. The nature of the disease creates a circumstance whereby the disabled are vulnerable and easily exploited or manipulated. The need for standards in community housing for this vulnerable class must be considered when applying Federal Law.

Because of a lack of oversight, the majority of sober homes in Palm Beach County are little more than flop houses. Many are owned or operated by convicted felons, are in crime ridden neighborhoods with drug dealers literally next door. Other than voluntary certification with the non-profit organization, Florida Association of Recovery Residences (FARR), there is little or no protection for this vulnerable class. Enforcing criminal laws and municipal code enforcement is reactive and ineffective in protecting sober home residents.

Local and State governments do not have the right to ban or refuse reasonable accommodation in the enforcement of local codes and ordinances. However, there needs to be an acknowledgement that some oversight is necessary for the health and safety of the sober home residents.

There is a type of sober home that is recognized by Congress, called Oxford House. Oxford houses are residences that are chartered by a non-profit, national organization that applies strict rules and conditions attendant upon residence. These rules include, in part, sobriety, collective self governance and good neighbor policies. Oxford House is listed by SAMSHA on the National Registry of Evidenced-based Programs and Practices (NREPP).

In addition, there is a national organization, the National Alliance of Recovery Residences (NARR), that has developed model rules and standards for sober homes that have been adopted by various state non-profit certifying entities. In Florida, the Florida Association of Recovery Residences (FARR) has been authorized by statute and through designation by the appropriate executive department, to certify recovery residences. Certification requires quality standards, including core principals of a recovery based drug free environment, management by a certified recovery residence administrator, a good neighbor policy, ethics and safety standards, resident rights and obligations as well as a displacement policy when a resident materially violates these standards. The Florida legislature has made FARR certification voluntary, in large measure to avoid liability under the ADA and FHAA. Most sober homes remain uncertified.

As previously stated, SUD is a unique disability. Persons with SUD are extremely vulnerable to manipulation and abuse. This is especially true when they have actively used in the recent past. Most sober home residents are currently participating in active intensive out-patient treatment programs. Some have recently completed treatment and are vulnerable to relapse. The lack of standards in housing has strongly contributed to the recycling of SUD patients in and out of treatment. Safe and sober housing is the key to long term sobriety. It should be noted that sober homes are residences only, that is, no treatment is performed in the house.

The proliferation of sub-standard sober homes must be addressed at the federal level. We recommend that states be given the ability to require certification under NARR or similar standards, or other recognized programs such as Oxford House to protect the vulnerable residents living in sober homes. Clarification of the ADA and FHAA can also be achieved through administrative changes to the CFR applicable to group homes housing persons considered disabled due to SUD.

Mr. HARPER. Thank you for your testimony, Mr. Johnson. I look forward to hearing more in response to the questions.

The chair will now recognize Mr. Gold for 5 minutes for the purposes of an opening statement.

TESTIMONY OF ERIC M. GOLD

Mr. GOLD. Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for inviting me to testify this morning on this very important issue.

I'm an assistant attorney general, Chief of the Healthcare Division in the Office of the Massachusetts Attorney General, and I'm privileged to be here today on behalf of Attorney General Healey.

In 2014, Massachusetts became the first state in the country to declare the opioid epidemic to be a public health emergency. Last year, there were 2,190 overdose deaths in our state, and thousands more are in need of treatment for opioid use disorder.

Attorney General Healey has made combating the opioid epidemic her top priority, and dedicated the full resources of our office to address the problem from all sides using criminal and civil law enforcement, and promoting treatment, prevention, and education.

Earlier this year, the office began hearing devastating stories from young men and women from Massachusetts who were lured out of state by paid recruiters who promised them free travel to addiction treatment centers in a warm-weather state.

When the patients arrived, they often discovered that the treatment they were to receive was low quality or even nonexistent. In those cases, they were left thousands of miles from home with no health insurance, no access to the medical care they needed, and no resources to return home. In the most tragic cases, these young people suffered fatal overdoses following their continued use of opioids without treatment.

Following these concerns, our office has opened a criminal investigation into addiction treatment fraud, and issued a consumer advisory alerting patients and their families that they should be wary of unsolicited offers for free out-of-state addiction treatment.

Based on our experience in Massachusetts, I have three recommendations for the subcommittee. First, we need additional resources for Federal, state, and local law enforcement to combat patient brokering and addiction treatment fraud. Every time a recruiter lures a young person from Massachusetts to travel far from home for treatment, that person's life is on the line. While state and local law enforcement are working aggressively on these cases, this is a national problem, and it requires a coordinated national law enforcement solution.

Second, patients need transparency into the quality of addiction treatment providers nationwide. If patients are going to travel out of state for treatment, they need a reliable way to identify the high-quality providers. Right now, families rely on a patchwork of incomplete state directories, providers' own websites, and personal reviews online. Because so many patients are receiving treatment outside of their home state, there is an opportunity for the Federal Government to play a role in getting patients and their families the information they need about treatment providers.

Finally, we need to be sure that any attempts to address patient brokering advance the ultimate goal of ensuring that patients with substance use disorder have access to the treatment that they need. Thanks to changes in Federal and state law, most insured patients now have access to treatment for substance use disorder. And while you could imagine regulatory changes that reduce the risk of patient brokering, in our state, we do not want to change the rules in a way that would reduce access to treatment for many patients living with substance use disorder.

Thank you, again, for the opportunity to share my perspective and that of the residents of Massachusetts with the subcommittee. Thank you to the subcommittee for careful consideration of this important issue, and I look forward to answering any questions that you have.

[The prepared statement of Mr. Gold follows:]

**Written Statement of Eric Gold
Assistant Attorney General
Chief, Health Care Division
Office of Massachusetts Attorney General Maura Healey**

**“Examining Concerns of Patient Brokering and Addiction Treatment Fraud”
Tuesday, December 12, 2017**

**Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

Chairman Harper, Ranking Member Degette, and members of the Subcommittee, thank you for inviting me to testify today on this important issue. I am an Assistant Attorney General and Chief of the Health Care Division in the Office of Massachusetts Attorney General Maura Healey.

I. Summary of Written Testimony

In 2014, Massachusetts became the first state to declare the opioid epidemic to be a public health emergency. Last year, there were 2190 overdose deaths in our state and thousands more are in need of treatment for opioid use disorder. Attorney General Healey has made combatting the opioid epidemic her top priority and dedicated the full resources of the Office to addressing the problem from all sides using criminal and civil law enforcement, and promoting treatment, prevention, and education.

Earlier this year, the Office began hearing devastating stories in which young men and women from Massachusetts were lured out of state by paid recruiters who promised them free travel to an addiction treatment center in a warm-weather state. When the patients discovered that the treatment they were to receive was low quality or nonexistent, they were often left thousands of miles from home with no health insurance, no access to the medical care they needed, and no resources to return home. In the most tragic cases, these young people suffered

fatal overdoses following their continued opioid use without treatment. Following these concerns, the Office has opened a criminal investigation into addiction treatment fraud and issued a Consumer Advisory, alerting patients and their families that they should be wary of unsolicited offers for free out-of-state addiction treatment.

Based on our experience in Massachusetts, I have three recommendations for the Subcommittee. First, we need additional resources for federal, state, and local law enforcement to combat patient brokering and addiction treatment fraud. This is a national problem and it requires a coordinated, national, law enforcement solution. Second, patients need transparency into the quality of addiction treatment providers nationwide. If patients are going to travel out of state for treatment, they need a reliable way to identify the high quality providers. Finally, we need to be sure that any attempts to address patient brokering advance the ultimate goal of ensuring that patients with substance use disorder (SUD) have access to the treatment that they need and do not unintentionally limit that access.

II. Introduction and Background

Massachusetts was the first state in the country to declare the opioid epidemic a public health emergency when it did so in 2014. Our state has been in the throes of the epidemic since then. In a state of 6.8 million residents, opioid overdose deaths more than doubled from 638 state-wide in 2009 to 1364 deaths in 2014, and more than 2100 opioid overdose deaths last year.¹ The toll on our state can be measured not only in the number of deaths, but in the vast number of residents who are in need of treatment.²

¹ Massachusetts Dep't of Public Health, Data Brief: Opioid-Related Overdose Deaths Among Massachusetts Residents at 1 (Nov. 2017), at <https://www.mass.gov/files/documents/2017/11/13/sec1-od%20deaths%20mass%20residents%20Nov-17.pdf>

² See Massachusetts Dep't of Public Health, Data Brief: An Assessment of Opioid-Related Overdoses in Massachusetts 2011-2015 at 2 (Aug. 2017), at <https://www.mass.gov/files/documents/2017/08/31/data-brief-chapter-55-aug-2017.pdf>.

Since taking office in January 2015, Attorney General Healey has made combatting the opioid epidemic her top priority. The office has taken a multi-disciplinary approach to addressing the problem, including criminal and civil law enforcement, and promoting treatment, prevention, and education. This work involves our prosecutors and investigators working side by side with health care experts, other law enforcement personnel, advocates, and public policy experts.

For example, last month more than 30 individuals were arrested in a takedown of a heroin and fentanyl distribution ring in central Massachusetts, which resulted from a joint investigation by our office and local police. In October, the Office announced a civil settlement with an opioid manufacturer, Insys Therapeutics, related to its unlawful marketing and payment of kickbacks to promote the use of the fentanyl spray Subsys. And, in our campaign to prevent opioid addiction, the Office has led a \$2 million public-private collaboration called Project Here that is making substance use prevention education available to every public middle school in Massachusetts.³

III. The Massachusetts Experience

A. Patient Brokering in Massachusetts

Earlier this year, the Office began receiving information about Massachusetts residents with SUD who had been lured to out-of-state addiction treatment providers by paid recruiters. Though the particular circumstances in these cases varied, the trends were similar.

Massachusetts-based recruiters have used web-based marketing, social media, text messaging, and in-person meetings, to aggressively solicit Massachusetts residents with SUD.

The recruiters often have close connections to the recovery community (some may be in

³ More detail about the Office's work combating the opioid epidemic is available at www.mass.gov/ago/opioids. Information about Project Here is available at www.here.world.

recovery themselves) and may be friends or acquaintances of the patients they solicit. These recruiters have even sought to solicit patients at recovery support group meetings. Other recruiters solicit a wider audience on-line or through social media, including on Facebook. Information reported to the Office (and since publicly reported) indicates that Massachusetts recruiters were paid commissions of up to \$2000 for each referral of a commercially insured patient to an out-of-state treatment provider.

In one situation, it was alleged that a recruiter manipulated the phone number associated with the Google search results for a Massachusetts SUD treatment provider. As a result, when patients dialed the phone number displayed next to the name of the treatment provider on Google, patients were connected to a recruiter, not the local treatment provider they had sought.

When recruiters solicit Massachusetts patients, they often communicate that the recruiters will arrange and pay for the patient's travel to and treatment at out-of-state addiction treatment centers in warm-weather states (including Florida, California, or Arizona). In some circumstances where patients do not have commercial insurance that would pay for out-of-state treatment, recruiters will offer to obtain insurance for the patients.

Patients who accept the solicitation and travel out of state have had varied experiences, but some have found the treatment centers to be very low quality with, in some instances, little or no treatment at all. Yet, the patient may find that he cannot move to a different treatment center because his insurance will no longer pay for those services. The patient's insurance coverage may have been terminated for a variety of reasons, including that the premiums were not paid because the insurance carrier learned that the treatment was not legitimate and denied the claims, or that the insurance carrier canceled the coverage all together, believing the policy was procured fraudulently.

Regardless of the reason, once the patient leaves treatment and loses his insurance, he may be stranded far from home, battling a terrible illness, and without access to housing or the treatment he needs. Unfortunately, without access to treatment, some patients have lost their battle with SUD, continuing to use opioids and overdosing thousands of miles from home. These deaths have been all the more devastating to their family and friends who had thought their loved ones were seeking the treatment they needed in a safe and new environment.

B. Response of the Massachusetts Attorney General's Office

Based on the information summarized above, the Office has substantial concerns with patient brokering and addiction treatment fraud in Massachusetts. Most significantly, the Office is concerned that the use of paid recruiters to refer patients to SUD treatment risks patient safety. Recruiters who receive a commission for each patient they refer may act in their own financial interest, rather than the patient's best interest. As a result, patients may be referred to low quality treatment centers that pay the recruiter a commission, rather than a high quality treatment center that does not pay a commission. Even if the treatment center receiving the referral is high quality, where the recruiter has a financial motive, the patient may be referred to a treatment provider that is not the right fit for that particular patient.

These concerns are heightened when patients are referred out of state, for two reasons. First, it is more difficult for patients and their families to assess the quality of the treatment provider when those providers are far from the patient's home. Second, if the patient does not receive adequate treatment at the out-of-state treatment center, the patient may be left far from home in an especially vulnerable situation without family, support, or the means to return home.

Beyond the risk to patient safety, the Office is concerned that patient brokering and addiction treatment fraud cause financial harm to patients, their families, insurance carriers, and

the health care system as a whole, by charging for unnecessary or inappropriate treatment services.

The Office has responded to this problem using both law enforcement and consumer education tools. In Massachusetts, it is illegal to make or accept a payment to induce the referral of a commercially-insured patient for any health care services. *See* Mass. Gen. Laws ch. 175H, § 3. Massachusetts law also prohibits health insurance fraud. *See* Mass. Gen. Laws ch. 266, § 111A. Based on the information we received, the Office has opened a criminal investigation into addiction treatment fraud. The investigation is ongoing.⁴

Separately, the Office issued a Consumer Advisory in April to alert Massachusetts consumers about patient brokering and offer guidance to patients and their families seeking treatment.⁵ The notice provided information about safely accessing SUD treatment services in Massachusetts and also advised patients to:

- Be wary of unsolicited referrals to out-of-state treatment facilities.
 - Anyone seeking to arrange for addiction treatment out of state may be getting paid by the treatment center.
 - In Massachusetts, it is illegal for recruiters to accept kickbacks for referring you to treatment.
 - Anyone paid a referral fee for recommending a particular treatment center does not have your best interests in mind.
- Be wary of anyone offering to pay for your insurance coverage. They can stop paying your premiums at any time, which will result in the cancellation of your insurance.
- If you accept an offer by someone to pay for travel to an out-of-state clinic, make sure you have a plan and the means to pay for a trip back home.
- Be careful about giving your personal information – including your social security number or insurance number – to a recruiter, unless you can confirm that the person is employed by a medical provider or insurance company.

⁴ I cannot disclose further details of the ongoing criminal investigation.

⁵ The Consumer Advisory is available at <http://www.mass.gov/ago/bureaus/hcfc/the-health-care-division/consumer-advisory-scams-addiction-treatment-.html>.

- If someone is offering to arrange travel or cover insurance costs for treatment, call the treatment facility or your insurance company to confirm that the person is an employee.

IV. Recommendations

The practice of paying for referrals for SUD patients has had devastating consequences for some Massachusetts residents. The scope of the epidemic in Massachusetts has caused delays in accessing treatment for some patients, leaving them particularly vulnerable to solicitations to travel out of state for care. Yet, patient brokering is a very complicated problem and there is no simple way to immediately end the practice. Addressing the issue will require continued work from federal, state, and local law enforcement and policy makers to ensure that patients get the treatment they need and unscrupulous brokers cannot take advantage of these vulnerable patients for their financial benefit. Based on our experience in Massachusetts, I have three recommendations to share with the Subcommittee.

First, we need to expand the resources available for federal, state, and local law enforcement to combat patient brokering and addiction treatment fraud. Each time a recruiter successfully lures a young person from Massachusetts to Florida, California, or Arizona for treatment, that person's life is on the line. While state and local law enforcement, including our Office, are working aggressively to investigate and prosecute these cases, this is a national problem and requires coordination among the states and federal law enforcement, as well. The U.S. Department of Justice has successfully prosecuted patient brokering under the Federal Anti-Kickback Act, 42 U.S.C. § 1320a-7b(b), which prohibits payments to induce the referral of patients whose services will be paid for by a federal health care program.⁶ Dedicated additional

⁶ See, e.g., Press Release, Two Defendants Plead Guilty in Multi-Million Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes and Alcohol and Drug Addiction Treatment Centers (S.D. Fla., Mar. 15, 2017), at <https://www.justice.gov/usao-sdfl/pr/two-defendants-plead-guilty-multi-million-dollar-health-care-fraud-and-money-laundering>.

federal resources to investigate and prosecute these cases—especially those that occur across state lines—will ensure that every vulnerable patient is protected from recruiters looking to take advantage of them.

Second, patients need transparency into the quality of addiction treatment providers nationwide. Currently, patients who are referred by family, friends, or a paid recruiter to an addiction treatment provider that is far from home have no reliable way to learn about the treatment provider, including whether it is high or low quality. While some states, including Massachusetts, have on-line directories with information about addiction treatment providers, including whether the providers are licensed and supported by the State, those directories are inconsistent across the states and do not provide detailed information about the providers' quality. As a result, patients are left to rely on treatment providers' websites, calling providers on the phone, and reading personal reviews on various websites. Because many patients are receiving SUD treatment across state lines, there is an opportunity for the federal government to play a role in increasing the transparency that patients have into information about SUD treatment providers.

Finally, we need to be sure that any regulatory or legislative reforms meant to address patient brokering advance the ultimate goal of ensuring that SUD patients have access to the treatment that they need. Following extensive reform over the past decade, including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Patient Protection and Affordable Care Act, and similar laws in Massachusetts⁷ and other states, most insured patients now have coverage for SUD treatment and can access care when and

⁷ Massachusetts law requires that insurance plans cover medically necessary inpatient acute treatment services and clinical stabilization services for fourteen days without prior authorization and with medical necessity determined solely by the treating clinician in consultation with the patient. *See, e.g.*, Mass. Gen. Laws ch. 176G, § 4AA.

where they need it. As policy makers, we want to encourage SUD patients to seek out the treatment they need and health insurance carriers to pay for that needed treatment.

While one could imagine broad regulatory changes that may reduce the risk of patient brokering in Massachusetts (e.g., limiting insurance coverage for out-of-state SUD treatment), those policy changes would substantially reduce access to treatment for the hundreds of thousands of Massachusetts residents living with substance use disorder.

V. Conclusion

Thank you again for the opportunity to share my perspective—and that of the residents of Massachusetts—with the Subcommittee. And thank you to the Subcommittee for your careful consideration of this important issue. Please do not hesitate to contact me for any additional detail, clarity, or with any questions you may have.

Mr. HARPER. Thank you, Mr. Gold.

Before we proceed to member questions, I'd ask for unanimous consent that Mr. Tieman's chart of patient rights and Mr. Aronberg's two charts, The Florida Model in Theory and The Florida Shuffle, be made a part of the record.

Without objection.

[The information appears at the conclusion of the hearing.]

Mr. HARPER. The chair will now recognize himself for 5 minutes to ask questions.

And I want to thank all of you for your testimony. It is troubling to each of you, and certainly to us, that patient brokers, as well as unscrupulous facilities and sober living homes, are treating individuals seeking treatment as a commodity rather than trying to assist them in seeking legitimate treatment and achieve sobriety. Sadly, there have been instances where people have died, and I think it's very important that we flush out and expose these schemes.

My first question will be to Mr. Aronberg and Mr. Johnson. And then, Mr. Tieman, I may have you follow up in response to that after their answers.

From your experience in the Sober Homes Task Force, what consumer information would you provide to families seeking drug abuse treatment for their loved ones to help them distinguish between good actors in the drug treatment industry from the rogue providers or corrupt facilities?

Mr. JOHNSON. Mr. Chair, that hits the heart of the matter. There are no effective means of communicating the Caron organizations from the flophouses and the strip mall providers that may or may not be run by convicted felons. Because everybody gets a license, they get somebody to prepare a license for them, answer all the questions correctly, have a medical director or a clinical director, and they get their license. And, just like everybody else, people can come through the door.

And that would be incredibly helpful to be able to have a registry. How do you do it? That's hard, because how do you pick and choose? But, clearly, accreditation is not the answer. Because there are—a Joint Commission and CARF, they can accredit. And I can tell you that there are some really bad places that we have arrested that were accredited facilities.

So that is an issue that should be explored. There is none. We have no capacity. People call us—we have a hotline—from all over the country worried about their kids that are in Florida, in Palm Beach County. And what do we tell them? We can't recommend a particular place.

There is one thing we can recommend in Florida, and that is the FARR, Florida Association of Recovery Residences' sober homes. Because those residences, the rules that govern those residences, there's a certified recovery administrator that oversees. They're not flophouses. They're actual places that promote sobriety.

And one of the things that we ask is that this committee explore a way to make the states more comfortable with being able to require certification of sober homes for that very reason, to protect the residents within. I can tell you right now the State of Florida will not mandatorily require certification of sober homes in the

Florida Association of Recovery Residences because they are afraid of violating the ADA and the FHA. Thank you.

Mr. HARPER. Thank you for that.

Mr. Aronberg, add to that?

Mr. ARONBERG. Yes. Thank you, Mr. Chairman. It's an excellent question. As Al said, we have a Sober Home Task Force hotline, and we get a lot of tips on rogue operators. But we'll also get calls from families from around the country wanting to know if their child's sober home or drug treatment center is legitimate. And in one case, we had to tell a mother to come down and get your daughter out of this facility right now. And when she tried, the daughter said, no, why would I want to leave? I have everything I need right here. She had free rent, transportation, friends. Why would she want to leave? And so there needs to be a way to separate the good from the bad.

I would recommend—and to build on what Al said—some sort of certification. We have that in Florida, but it's only voluntary. Because the state won't require mandatory certification or registration, even because they're scared of the ADA and the FHA preventing this. So we have FARR, which is a voluntary organization. And the good sober homes are registered with FARR and they're certified. They get inspected. And those are the ones we say, hey, they've got at least a level of accountability and quality. But it would be better if it was mandatory as opposed to just voluntary, because there's only a few homes relative to the population that are certified.

Another way you can improve things, I think, is to adopt an outcome-based reimbursement model. So, right now, the bad guys get more money than the good guys. So Mr. Tieman's facility, they lose patients to the bad guys who are encouraging relapse because that's where the money is. But, under the ACA's Medicare reimbursement model, there's money that's held back, and the good providers for hospitals, they get more money in the end. Good providers get more money. The bad providers get less. I'd love to devise a formula where we can reward the good providers, even if it takes peer reviews to be part of that calculus, and punish the bad providers. If you dry up the money source, you'll see a lot of these guys go away.

Mr. HARPER. Great. And my time has expired. So, Mr. Tieman, hopefully, we will get an opportunity in a little while to respond to any followup that you may have.

At this point, the chair will now recognize the ranking member, Ms. DeGette, for 5 minutes for questions.

Ms. DEGETTE. Thank you, so much, Mr. Chairman.

As I said in my opening remarks, I'm trying to figure out the breadth of this problem. We sent a letter to the Florida Department of Children and Families and asked how many drug treatment facilities and sober living homes have been shut down due to patient brokering. Florida said they've pulled the license of five facilities since December 2016, so in the last year or so.

Mr. Aronberg, I know you've made more arrests and that this problem's probably larger than just a few facilities. Can you tell me how many patient broker arrangements you're aware of that are not legitimate?

Mr. ARONBERG. Thank you for your question, Congresswoman DeGette.

Ms. DEGETTE. And recognizing I've got 5 minutes.

Mr. ARONBERG. Right. OK. Yes, ma'am.

Ms. DEGETTE. Thank you. Sorry.

Mr. ARONBERG. We don't even know how many sober homes there are in Palm Beach County.

Ms. DEGETTE. I see. So you don't have a sense of the extent of it really?

Mr. ARONBERG. Well, what happens is someone opens up a sober home, they do it today.

Ms. DEGETTE. Right.

Mr. ARONBERG. They don't have to get any licensing.

Ms. DEGETTE. Right. There's no regulations. Yes.

Mr. ARONBERG. Right. The only way that—I'm sorry.

Ms. DEGETTE. Well, let me ask you, do you know how many licensed physicians might be taking part in this?

Mr. ARONBERG. Well, licensed physicians aren't affiliated with the sober homes.

Ms. DEGETTE. Right.

Mr. ARONBERG. They're affiliated with the outpatient facilities and the inpatient facilities.

Ms. DEGETTE. Right.

Mr. ARONBERG. As far as how many, I wouldn't know offhand. I would have to defer to Al.

Ms. DEGETTE. Mr. Johnson, do you have any idea?

Mr. JOHNSON. We can't put a number on the abuse because, when we find abuse, we prosecute it.

Ms. DEGETTE. Sure. How many have you prosecuted?

Mr. JOHNSON. We have one physician that we filed felony charges on. And, of course, I can't discuss with you the——

Ms. DEGETTE. Sure.

Mr. JOHNSON [continuing]. The other investigations.

Ms. DEGETTE. I understand. So——

Mr. ARONBERG. We've had 41 arrests so far in the last year.

Ms. DEGETTE. Forty-one arrests. OK. And who are the arrests of?

Mr. ARONBERG. The arrests are individuals who operate sober homes and outpatient drug treatment centers.

Ms. DEGETTE. OK.

Mr. ARONBERG. We even——

Ms. DEGETTE. And how many of these centers are associated with these 41 arrests? Are they 41 different centers or do they all work for one or two centers?

Mr. JOHNSON. If you look at it as a hub and the spokes of a wheel——

Ms. DEGETTE. Yes, yes.

Mr. JOHNSON [continuing]. The hub is the facility that provides treatment——

Ms. DEGETTE. Yes. I understand.

Mr. JOHNSON [continuing]. The spokes are going to be the sober homes.

Ms. DEGETTE. Right. So how many hubs are there?

Mr. JOHNSON. The majority are sober homes.

Ms. DEGETTE. How many?

Mr. JOHNSON. Oh, I would say probably 70 percent, maybe 80 percent, are sober homes.

Ms. DEGETTE. How many facilities are you investigating? I'm trying to figure out how widespread this problem is.

Mr. ARONBERG. Twelve.

Ms. DEGETTE. Twelve.

Mr. ARONBERG. Twelve. In addition to that—

Ms. DEGETTE. OK.

Mr. ARONBERG [continuing]. There have been many others who have packed up and left—

Ms. DEGETTE. OK. Yes.

Mr. ARONBERG [continuing]. Because of our—

Ms. DEGETTE. Yes. Thank you.

Now, in California, Mr. Nielsen, do you have any sense of how many of these rogue actors there are?

Mr. NIELSEN. We do not.

Ms. DEGETTE. OK. Is anybody trying to do any factfinding to figure that out?

Mr. NIELSEN. Yes. But it's hard to be able to boil down what's actually happening. Because it's like Windex—

Ms. DEGETTE. Right.

Mr. NIELSEN [continuing]. A lot of them look like they're good actors, but really they're rotten to the core. So it's peeling away the layers—

Ms. DEGETTE. Yes.

Mr. NIELSEN [continuing]. To get to them.

Ms. DEGETTE. And, as Mr. Aronberg said, since there's no requirement that they meet certain standards, anybody can just open one of these things.

I want to ask you, Mr. Aronberg, one thing I talked about in my opening was this ridiculous billing of laboratories for unnecessary urine tests. And I'm just wondering—maybe some of the rest of you can talk about this too—why would insurance companies pay for these tests? Any of us who've tried to get a prescription for anything know they'll give you like five pills and say you're good. Why would insurance companies pay thousands of dollars for daily urine tests which aren't medically necessary?

Mr. ARONBERG. In my experience in speaking—and I'll defer to others—but in speaking to the insurance company folks, they've said they worry about being sued under Federal law if they don't reimburse. But they have self-corrected in that they used to pay \$3,000 for a urinalysis. Now that's drastically reduced to a few hundred dollars. But it's still very lucrative. But I would defer to the others.

Ms. DEGETTE. Mr. Johnson?

Mr. JOHNSON. The problem is insurance companies are like a battleship and they're slow in maneuvering. And they are finally catching up. Unfortunately, sometimes the pendulum overcorrects.

Ms. DEGETTE. Yes. I know.

Mr. JOHNSON. But you mentioned medical necessity. That's the key.

Ms. DEGETTE. Yes.

Mr. JOHNSON. The insurance companies are battling with providers over what is and is not—

Ms. DEGETTE. Medically necessary.

Mr. JOHNSON [continuing]. Medically necessary, and that includes urine testing.

Ms. DEGETTE. OK. I have one last question for you. And I apologize for romping through these questions. We really do only have 5 minutes.

Florida passed a law, the Practices of Substance Abuse Service Providers Law, in June and which will take full effect in February. This law makes patient brokering a criminal racketeering offense under Florida law, prohibits dishonest treatment provider advertising, and increases penalties for both of these things.

Mr. JOHNSON, do you think this is going to help in enforcement efforts against these rogue actors in Florida?

Mr. JOHNSON. We can't prosecute our way out of this problem, but, yes.

Ms. DEGETTE. OK.

Mr. JOHNSON. The enhanced laws that were passed—actually, they went into effect July 1—are going to be significant. Resources on the state and local level, however—we noticed that other circuits in the state do not have a task force like we do—very difficult. But the laws do help.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

Mr. HARPER. The chair will now recognize the vice chairman of the committee, Mr. Griffith, who has done an exceptional job these last couple of months for our subcommittee. And we now recognize him for 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman. It was an honor to fill in. It will also be a great honor, and I look forward to serving with you and the great work that we're going to do together as a team, along with Ms. DeGette and others, because this subcommittee really does like to try to find answers and solve problems.

So here's a problem I've got. Between Mr. Johnson and Mr. Gold, both of you have touched on the issue. You've identified two sides of the argument. And it's one that has concerned me as we've looked at this issue, and that is you've got some legitimate folks out there that are trying to do drug treatment. In my very rural district, with 29 geopolitical subdivisions, there aren't. And one of the big complaints is we don't have enough drug treatment centers. I know for sure that one of my drug treatment centers pays either based on volume or commission, a couple of people that they send out to interface with the court services units, when they have people who may need their services, they say, OK, here's what we can provide, does that help your person? They also interface with some of the physicians' offices that are dealing with this where they don't have drug treatment themselves, but they identify that a patient has a substance abuse problem.

So between the two of you, how do we resolve the problem that Mr. Gold raised and the problem Mr. Johnson has raised? We've got bad actors, we want to shut them down. But if we eliminate commissions and volume—I get value—but volume referrals for these folks that are out in the field, I fear that, particularly in rural areas like mine, we may be, as Mr. Gold pointed out, limiting access to the substance abuse treatment itself.

So, Mr. Gold, I don't know if you want to go or, Mr. Johnson, if you have some solution to that dilemma that I'm trying to figure out up here. Because we want to stop the bad actors, but we want to make sure people get drug treatment services. Now, the sober homes is completely alien to my knowledge and—before starting to study this issue. And very concerned about those. But for drug treatment.

Mr. GOLD. Sure. Thank you, Congressman. I obviously don't know the specifics in your district. From where we are in Massachusetts, we have a tremendous demand for treatment services, a large number and a limited supply. So from our perspective, if we can cut off the money that's flowing to these commissions, to the brokers that are trying to lure folks out of state, we think that would help in Massachusetts. People would still get access to the treatment that they need, and if they need to go out of state, can do so.

Mr. GRIFFITH. So let me translate, if I might, and make sure I'm hearing it correctly, because I'm going to translate it into my verbiage. So what you're saying is you're worried about the people who are out recruiting people from out of state, but if they were in state, you see where there might be some validity in having somebody out there working with the in-state folks, like the court services units, as opposed to getting on the phone—I never even heard of telemarketers selling these services—but getting on the phone and trying to recruit people. Is that what you're saying?

Mr. GOLD. Yes. I'm concerned about the people being paid commissions in-state too. I think my point was, in Massachusetts, there's not actually a lot of recruiting going on to keep people in the state.

Mr. GRIFFITH. Right.

Mr. GOLD. Because people who are already in this—all the treatment centers in Massachusetts are pretty much full. And so my understanding is they're not out there on the ground doing that. But what I am concerned about is because some people do legitimately need to travel out of state to get treatment, and I want to make sure insurance is still going to be able to cover that and people can go out of state if needed. But they're going to the treatment that they want, not just that the recruiter/broker is getting paid a commission to send them to that treatment.

Mr. GRIFFITH. Right.

Mr. Johnson.

Mr. JOHNSON. I have not yet heard a compelling argument why an employee needs to have commissions or bonuses. If you have a good salesperson—if you're selling automobiles, they're on commission, that's fine. When you're talking about health issues, when you give somebody a commission, you incentivize overutilization. You incentivize the standard of care that's not the appropriate standard of care, because all they're interested in is getting that commission for that person.

You can pay somebody to do the job of going out and talking to doctors and going to court services without giving them a bonus—

Mr. GRIFFITH. So they just have to rearrange their business model.

Mr. JOHNSON. Fair market value.

Mr. GRIFFITH. OK.

Mr. JOHNSON. Fair market value for the product, yes.

Mr. GRIFFITH. Let me go to Mr. Tieman. I only have about a half minute left, but talk about what you all do with drug screening and drug testing. And you all are one of the good players. How do we create rules that make sense?

Mr. TIEMAN. That's a good question. Thank you so much, Vice-Chairman. The whole idea of urine drug screening, particularly in a residential setting, should rarely happen, because you're in a safe environment. We utilize it if someone needs to go home on a home pass. They go home for the weekend. There is a funeral in the family and they need to be gone, we would do a urine drug screen when they come back.

When this whole scam came up about 5 years ago, like all treatment centers, we were inundated with calls. You should do this—and, frankly, it sounded quite attractive. People say, invest a million dollars, you'll have it paid back in 10 months. We said, this doesn't pass the smell test. And, unfortunately, now, the light is on that we have talked to insurance companies. And as I think Mr. Johnson pointed out, insurers are now saying—they were slow to react to it, but they see it, and now that has been slowed down dramatically and will continue to do so, which has now put other pressures on the charlatans because they've got to find other ways to make that money. But it should be used when medically necessary, clinically appropriate.

Mr. GRIFFITH. I thank you, and yield back.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlelady from Florida, Ms. Castor, for 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman.

Mr. Aronberg and Mr. Johnson, thank you very much for your very direct and concise recommendations to the committee. It's very helpful. I think your first one relating to changing the ACA health insurance plans to the Medicare reimbursement approach is—that's very helpful. The one that's a little more difficult involves the ADA and the Fair Housing Act.

You write in your testimony, Federal law prevents the regulation or inspection of these residences, and many are little more than flophouses or drug abuse, human trafficking, and other crimes are prevalent. And you recommend to the committee that we address these abuses by clarifying the ADA and Fair Housing Amendments Act to allow states and local governments to enact reasonable regulations for the health, safety, and welfare.

How do you recommend that be done, while we maintain the important protections of the ADA and Fair Housing?

Mr. ARONBERG. Thank you, Congresswoman Castor. I realize also the challenge of opening up the ADA for amendment, so that's why we're suggesting clarification. This was requested for some time to HUD and DOJ because the Fair Housing Act and the ADA, they're the ones who had issued the clarification, and they did last year, but the clarification they issued was not helpful. It was a joint statement, and it seemed to ignore the realities on the ground.

They were talking about senior housing and all these other issues, but they did not give any good guidance.

The only thing they did help us with was that the clarification did say that a local government can prevent the clustering of sober homes in one small area. That that's not conducive to recovery. But we wanted to know, well, can we require mandatory certification or inspection of these facilities? They didn't answer that.

And so we're left now where local governments are starting to require these things, but they're doing so out on their own, waiting to get sued. The City of Boca Raton tried to zone sober homes into an industrial area a few years ago. They got sued and they paid out and lost, and they had to pay out \$3 million.

So local governments are scared to challenge the ADA and FHA without some guidance. So I don't think you need to amend it; you just need to maybe give a better clarification that acknowledges the realities on the ground. The ADA and the FHA were designed to protect these individuals. And in reality, it's being used a shield to protect people who are harming these folks.

Ms. CASTOR. Good. And, hopefully, that's something the committee can work on.

I'm being advised by a father back home in the Tampa area who has struggled with his son's addiction for many years, probably not unlike many of the members on this committee dealing with folks back home. He says—and he wrote in advance of the hearing just what you had said and showed that—that our current system incentivizes the cycle of addiction and relapse. And he wrote: The current system is designed to maintain a perpetual healthcare crisis. There is no incentive to help addicts as their illness creates wealth, profits shielded by the illusion of healthcare. They are left to those that will pretend to help and provide some initial safety net, so long as they profit from the disease.

He says: The mechanism for getting healthy does not exist right now, given the paradox between the insurance companies and the providers of healthcare. Insurance carriers put downward pressure on cost and addiction care, providers put upward pressure on creating recurrence.

And he is advocating for an entire paradigm shift, a separate system, because of the waste in the system, because of the huge amount of dollars lost in productivity all across the country. He says our entire system must be revamped. He suggests maybe a VA-style system or something new.

Mr. Tieman, clearly, we have to change the paradigm here. This is not working, and it's costing the Federal Government and the folks we represent a whole lot of money. What do you think about a revamped system that really directly provides care?

Mr. TIEMAN. Thank you so much for that question, Congresswoman Castor. As I enter the last chapter or last lap of my career, one I began 35 years ago, and at the time, it was a bunch of dogooders that cared desperately about families that were suffering from substance use disorder. And seeing the abuses of today and the kind of comments I hear really reflect what you have stated.

I had one guy say to me, we want to treat people so well that when they relapse, and we surely expect they will, that they want to come back, which is that whole idea of almost having an annuity

when someone comes to treatment. So we've adopted the practice and, in fact, are slow in his recovery for life. But we want you to get well. We'd love you to come back for an alumni reunion. We'd love you to come back as a sponsor. We'd love for you to come back and share your story, but we really don't want you to come back as a patient. And you're absolutely right.

And I think Mr. Aronberg mentioned the whole idea of incenting quality, incenting outcome. We're currently working with Independence Blue Cross trying to develop that exact model, where people who get substance use treatment costs Independence Blue Cross less money for other kinds of healthcare. They save money in the jail system, the court system, emergency room system. That's where we need to get to, which is an outcome-based system, as opposed to just continuing to look at this as an acute episode.

Substance use disorder is a chronic illness. You have it for the rest of your life. We need to put it in remission. Unfortunately, not everyone gets there. Just like other chronic illnesses, not everybody goes into remission from cancer or diabetes, but this is very successfully treated when we do it for the long haul. And the savings to society are enormous and the savings of pain is beyond comprehension.

Ms. CASTOR. Thank you very much.

Mr. HARPER. The chair now recognizes Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Again, thanks to our witnesses. This has been a fascinating discussion and clearly a problem that needs our attention.

I've got a number of questions that I will submit for the record as written questions, but our discussion has actually—I'd like to ask for some clarification on some of the points that have already been raised.

And, Mr. Aronberg, in your written testimony, you talked a little bit about this, in response to the last questions—address private insurance abuses by adopting the Affordable Care Act's outcome-based reimbursement model used in the Medicare program. I just need to add here that that is a process in evolution. Payment reform in Medicare actually predated the ACA by some time, and again, it is still a work in progress. It is far from settled.

But so many of the nongovernment insurances, the private insurances, so many of them, as the ranking member suggested, it's hard to get reimbursement. I was in private practice in medicine for 25 years. It's hard to get money out of insurance companies. They don't part with it willingly. How is it that they're giving it so freely in this instance?

Mr. ARONBERG. Thank you, Dr. Burgess. It's the big question we've been trying to answer, is why do the insurance companies continue to pay out these large amounts. And as Al Johnson said, it's like a battleship where, at first, they were caught by surprise by this, and they're worried about being sued, so we're paying out \$3,000 per urinalysis, which is egregious. And now, they have cut back dramatically. Mr. Tieman could probably tell you what they get reimbursed now on it.

But in talking to the executives, they have said they were concerned about being sued. And then there was another issue, which

I'm not an expert on, but, apparently, the 80/20 rule within the Affordable Care Act exists. And so, I guess, for some insurance companies, if you pay out more on the 80 percent, you can keep more, the 20 percent, the pie is expanded. So the 80/20 rule may have created incentives to pay out as much as possible. You just get reimbursed by the taxpayers, and now you get to keep that 20 percent which you get to keep for profits is now expanded. So it's something to pursue, but we are seeing a correction.

Mr. BURGESS. You're referring to the medical loss ratio. You expand the pie and your 20 percent is a larger piece of pie.

Mr. ARONBERG. Correct.

Mr. BURGESS. Actually, I had not considered that, and I thank you for bringing that point up.

The other aspect is we're all familiar with hearing from our constituents, the difficulties with the out-of-pocket expenses within the Affordable Care Act and the high deductibles. And I can't tell you this is happening, but what it looks to me, one of the things that may be happening is, let's get through that deductible as fast as we can, and then everything else is a covered benefit, and the checks will continue to come in. Again, I have no proof that that is actually happening, but from what I've heard discussed here this morning, it's something certainly worthy of our investigation.

On the whole issue of the urine tests, a urine test has to be ordered by a physician. You can't just go down to a lab and say, I want you to test my urine for drugs today, and get your reimbursement check. That doesn't happen in the real world. So how is that happening?

Mr. ARONBERG. Congressman, we've seen physicians just leave pads for prescriptions for urinalyses and just walk away. The corrupted physicians who are part of this—

Mr. BURGESS. So that has to be a violation of your state law. There's probably a False Claims Act violation in there somewhere. Does any of this ever get prosecuted?

Mr. ARONBERG. Yes. It is harder to prosecute a physician, just like it's harder to prosecute a lab, but we're going after labs, and we have gone after physicians. But it's tougher. To determine a violation of standard of care—and maybe Al can speak to that a little more, but we have gone after physicians and labs.

Mr. BURGESS. Well, Mr. Gold, before I run out of time, let me just ask you, because the compelling testimony that you provided, and you've lost constituents who have gone places for treatment and ended up not surviving. Is that correct?

Mr. GOLD. That's right.

Mr. BURGESS. So has any family ever brought an action against one of these locations? I'm not one to think that medical liability cases are ones that should be brought, but it begs the question, if an avoidable death has happened, generally, there's some questions asked and some liability assigned.

Mr. GOLD. That's a good question. I'm not aware of any medical malpractice cases that have been brought on this issue that I'm aware.

Mr. BURGESS. You're not aware of any medical malpractice cases?

Mr. GOLD. No.

Mr. BURGESS. And how many deaths in your state, in Massachusetts?

Mr. GOLD. I don't have any statistics. I'm aware of public reports of at a least a handful of them. But, again, many of these cases, the healthcare treatment was provided out of state. It's not even clear that the families are aware of the particular healthcare providers that were providing that treatment. So I don't know that there have been any of those cases brought.

Mr. BURGESS. Well, OK. Again, I thank all of you for your testimony. I do have some questions that I'll submit for the record.

Thank you, Mr. Chairman. I yield back.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentleman from New York, Mr. Tonko, for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair. And congratulations on your appointment.

Mr. HARPER. Thank you, sir.

Mr. TONKO. These schemes we have heard about today are very upsetting, and that's all the more reason why we need to encourage and support access to evidence-based addiction treatment as we address the opioid crisis.

I would like to ask our panelists today what good treatment looks like, and what people in need and their families should look for when seeking treatment.

Mr. Nielsen, your organization offers credentialing in California for agencies and professionals in substance use disorder treatment. What are the hallmarks of effective evidence-based treatment?

Mr. NIELSEN. So it's important not only for the facility to be competent, but the professionals that they employ to be competent as well. Everybody has to be brought in the process that this is about the person and not about the profits. And for a facility to really be outstanding, and they have to go above and beyond to make sure that the clients' rights are protected and that they give quality care, meaning that the individual is the driver of the care, not the facility. And that there is a way for them to have a say in the process. They need to be a part of the process and they need to be stakeholders. And it's very important that they not only are given input, but their family is also given input as well, and that this is a whole team approach and not just the facility driving the bus for profits.

I also think that it's very important that there's credentials for the executives, which do not exist, for the telemarketers, and admission specialists, and sober living specialists, that there should be credentialing. That there's a legal aspect and there's also an ethical aspect as well. And I really think at the heart of this, it's an ethical aspect of them putting the profits and treating the individuals as a commodity versus as an individual that needs care.

Mr. TONKO. Thank you.

And, Mr. Tieman, a similar question. How can a patient know if a particular treatment facility offers evidence-based treatment?

Mr. TIEMAN. Thank you so much for that question, Congressman. We were so concerned about that 2 years ago that, along with a Hazelden Betty Ford center, we actually authored a paper on how to select a treatment center. It's something that we would really

love to see a part of the SAMHSA website so that people can look at it.

One of the things that we encourage folks to do is to look at whether or not it is being promoted as healthcare. If you look at the Caron website, you would see the credentials of all of our healthcare providers, the doctors, the psychiatrists, the psychologists. You would see outcomes, something that we've been doing for the last 15 years with the University of Pennsylvania, and it talks about what you can expect at Caron, as far as the likelihood of being sober at the end of the year. We would talk about our academic affiliations, where we provide training and where our staff have teaching credentials of places like Penn state Hershey and University of Pennsylvania and Drexel and Temple.

When a patient looks at that, this looks like healthcare. When they look at another website that talks about yoga, that talks about thread count, that talks about meals, that talks about free things that you get, that's not healthcare. So these are the types of things that we encourage people to look at. Because if it looks and feels like healthcare, you're certainly a long ways toward that.

One other thing I'd like to just mention, National Association of Addiction Treatment Providers is trying to put together the kind of list that you heard Mr. Aronberg talk about. That's what we need. Who are the good guys? And it's something that we're looking at. Because licensure and accreditation is a bar, it's a low bar, but we also need, who does provide evidence-based practices. And while CARF and Joint Commission looks at things, they don't look at the ethics behind it. So it's something that between the National Association of Addiction Treatment Providers and the American Society of Addiction Medicine, we're trying to put that together so that the state, the Federal Government, and insurers can have the list of who should we be paying for to go to what kind of treatment.

Mr. TONKO. Beyond examining those websites, are there any particular questions that patients or their families should be asking before enrolling in a treatment facility?

Mr. TIEMAN. Yes. I think good ones to ask are: Are your medical, psychiatry, and psychology, are they on your staff or are they outside consultants? That's a great start. If they're on your staff, that is a terrific start. What is the staff to patient ratio? Are you gender separate? Are you age separate? An 18-year-old with a 48-year-old is not good treatment. Do you have a family program that's more than just an educational program? Do you do follow-up studies? Do you have outcomes?

And any program that does followup and has outcomes is committed to some level of quality. Can you tell me what those are? And, like I say, on a website like Caron's, we put them out there and we talk about the process that we go through, so it's completely transparent.

Mr. TONKO. Thank you very much for the insight.

I yield back.

Ms. DEGETTE. Mr. Chairman, could we ask Mr. Tieman for a copy of those standards that he wants to give to SAMHSA so that we can put them in the record of this hearing? And I'd ask unanimous consent they be included.

Mr. HARPER. Yes. Yes. Without objection.

[The information appears at the conclusion of the hearing.]

Mr. TIEMAN. Absolutely. Thank you.

Mr. HARPER. The chair will now recognize Mr. Barton for 5 minutes for questions.

Mr. BARTON. Well, thank you, Mr. Chairman. And, again, as I'm sure everybody has, congratulations on your chairmanship. You follow me, Fred Upton, Gregg Walden, and when we were in the minority, John Dingell, Bart Stupak. So this is kind of a mini committee of the full committee. The Oversight Subcommittee looks at everything the full committee does. So I'm sure you'll do an excellent job, and I think on both sides of the aisle we'll do our best to make you a successful chairman.

Mr. HARPER. Thank you.

Mr. BARTON. So congratulations.

I want to ask Mr. Aronberg and Mr. Gold some basic questions. Is so-called patient brokering illegal under any state law currently?

Mr. ARONBERG. Yes, Congressman. In Florida, it's a third-degree felony, punishable by up to 5 years in prison, but because of sentencing guidelines, it's rare that anyone would get that. So our recent legislation we passed got tough on it, and now it's easier to get a tougher sentence, but still it's rare to get the full 5 years.

Mr. BARTON. Mr. Gold.

Mr. GOLD. So Massachusetts does not have a specific law related to patient brokering for substance use treatment, but we do have a general anti-kickback statute that applies to commercial insurance as well. So paying for referrals for any commercial health insurance is illegal in Massachusetts.

Mr. BARTON. Are there any other states that would have a state law that patient brokering is illegal? No?

Mr. GOLD. I'm not aware of others.

Mr. BARTON. OK. Does any—

Mr. ARONBERG. Congressman, we believe there are. I'm sorry, off the top of our heads, we don't know how many.

Mr. BARTON. That's OK.

Mr. ARONBERG. But we can get that information.

Mr. BARTON. Just if you can get it, if there are.

Does anybody on the panel think that we should pass a Federal law criminalizing patient brokering? Anybody?

Mr. BARTON. I see some nods. You have to say something.

Mr. JOHNSON. There is a Federal anti-kickback statute, which is a patient brokering—you can't pay for the volume or value of referrals into treatment. And there are states that have fashioned patient brokering. I know there are, if not a majority, a minority of states have some sort of patient brokering.

Mr. BARTON. I think Mr. Nielsen had a comment.

Mr. NIELSEN. Chairman, my understanding of the Federal law, I believe it's the Stark Law. And my understanding of that is that it's for medical services, and within Medicaid, but not non-Medicaid. So some of the facilities fall under nonmedical facilities, and it wouldn't apply to them. That's our issue in California.

Mr. BARTON. OK.

Mr. TIEMAN. I'd like to just comment, we looked at the Stark Laws and the anti-kickback laws, and not being a lawyer, it seems like most of the things that we're seeing, at least to us, feels illegal,

and kind of like if it looks like a duck and walks like a duck, it is probably a duck. But not being a lawyer, it's really a concern.

I actually just talked to Governor Wolf this last week about some of those issues, and there really gets to be a question about what's state and what's Federal. So the kind of point about this is it's providing a lot of loopholes right now for folks to call it like speeding in North Dakota, I mean, there's no speed traps, so you can go as fast as you want to go, and if you do happen to get caught once in awhile, it's kind of the price of driving fast. And that's what we're seeing from a lot of these charlatans is we're not going to get caught, and if we do, there's probably an escape hatch there.

Mr. BARTON. What percent of the claims that are paid under the current system are private pay or family out-of-pocket versus Medicaid/Medicare? Anybody know that?

Mr. TIEMAN. Yes. Of the \$36 billion that will—the rough estimate on what will be paid for substance use disorder treatment this year, about 70 percent of that will be public fund.

Mr. BARTON. Public?

Mr. TIEMAN. Public fund. About 30 percent of that will be a combination of insurance, along with private pay—

Mr. BARTON. So Medicaid—

Mr. TIEMAN. Medicaid and Medicare is a large part of that 70 percent. I can't remember the exact number.

Mr. BARTON. I would have thought it would be reversed.

Mr. TIEMAN. No, it's not. The government is far and away the largest payor of substance use treatment disorder in the United states today.

Mr. BARTON. Since the Federal Government, based on what you just said, is paying the majority of these claims, should we require at the Federal level a certain cure rate for treatment per facility or per company?

Mr. TIEMAN. Again, with any chronic illness that is progressive, there is no cure. Diseases can be put into remission. I think there are certain standards that—

Mr. BARTON. I guess an outcome—a positive outcome.

Mr. TIEMAN. Right. I think definitely demanding some level of outcome based—I think Mr. Aronberg talked about that as well—there should be some level of outcome for any kind of healthcare that's provided today.

Mr. BARTON. We'll let Mr. Aronberg, and then my time's expired.

Mr. ARONBERG. Thank you, Congressman. Most of the fraud we see, the Florida shuffle is being fueled by private insurance payments, not government insurance payments. The Florida shuffle really is being fueled by the overpayments and the payments from private insurance companies, not a Medicare—

Mr. HARPER. Thank you for clearing that up.

The gentleman yields back.

The chair will now recognize the gentleman from California, Mr. Ruiz, for 5 minutes.

Mr. RUIZ. Thank you very much.

This is such an important conversation. I'm going to start big idea, then go into the granular. I think it's very important that we do get a grasp on the severity and the intensity and the frequency of these type of illnesses, because we need to prioritize how we're

going to address the mental health/addiction opioid crises that we have in the United States of America. And the bigger picture here is that we are woefully short in providing the resources, in providing more providers, and in being able to improve healthcare access to mental health services. And instead of taking away health insurance or coverage for mental health services, that we will take care of our patients.

So having said that, this is an important issue. I think that this is an issue that we can all focus on bringing justice towards. But let's not forget the big picture here and how we are going to address the overall mental health crisis and get patients the adequate care.

I have heard of stories where these recruiters will go into my local parks, from constituents of mine, and offer them free room and board. And they would sign them up in a homeless—it can be either hot in the desert or it can be really cold in the winter at night. They'll take room and board, they'll get reimbursed, they'll get sent out, and they'll do it again over and over and over again. And the homeless just want a place to stay. And some of them may be addicted, some may not, but they'll go through whatever is necessary to get the care that—or a shelter and a warm plate of food to eat.

So I know that Congresswoman Chu has been working on legislation that would direct SAMHSA to publish best practices for operating recovering housing. And I know that you've said that you want a certification. Perhaps SAMHSA could develop these kind of best practices, and those that can meet them can get this kind of certification for consumer marketing purposes.

Mr. Tieman, what do you think about this idea?

Mr. TIEMAN. I love it. Great question and great observation. And it's really the thing that we're trying to work through with some of our associations to establish standards, and then work with SAMHSA so that there is a bona fide list. We think that, you know, it should be easy for people to find at the Federal level, we think people should be able to find it at the state level, we think the insurer should know it as well, as to where are those facilities that are providing ethical evidence-based treatment with legitimate results.

Mr. RUIZ. Yes, I think that's a very simple solution whose time has come. And I think that by working with all the different agencies that are out there, with your best standards, I think that SAMHSA could provide something like this. And I know it can gain bipartisan support here in this committee as well.

Now, getting a little more to the granular. In terms of the excessive urine drug tests, my understanding is that the insurance companies have the ability to apply very good data analytics to claim submissions—for claim submissions to detect potential abusive or fraudulent practices. So a single patient responsible for multiple billings for urine tests, each of which may be many thousands of dollars, I would think that this would be something that could be looked at more closely through insured data analytic tools.

So, Mr. Johnson and Mr. Aronberg, have any insurers reached out to you to discuss this issue?

Mr. ARONBERG. I have spoken to Blue Cross Blue Shield and been working with them. But our Sober Homes Task Force—we have two different groups that meet once a month—we’ve had trouble bringing the insurance companies to the table. We would love a way to discuss these issues with them.

Mr. RUIZ. OK. And why do you think it’s so hard for the insurance companies to get their arms around what appears to be one of the primary drivers of this problem? And why is it difficult for them to discuss this with you?

Mr. JOHNSON. That’s an excellent question. And if you look at this behavioral health, and it’s a parity now with physical health, if you have a heart condition or if you have diabetes, there are protocols that are involved. There are preauthorizations that—and everybody has had that issue with getting an MRI or something of that nature. The preauthorization situation for behavioral health, because you have these doctors saying, I need urine confirmation with 50 panels, which is going to cost \$1,500, there’s no preauthorization for that. The insurance companies haven’t caught up yet in terms of standards for the behavioral health, especially substance use disorder.

So we’ve spoken to investigators for insurance companies, and they say, look, there’s no preauthorization. They do it, and then it’s a matter of grappling with, after the fact, whether we will pay or we won’t pay.

Mr. RUIZ. Yes. I mean, most of these drug urine tests, they’re very complicated and they take awhile to get the results to begin with. So having daily checks is medically even unnecessary.

Thank you very much.

Mr. HARPER. The gentleman yields back.

The chair will recognize the gentlelady from California, Mrs. Walters, for 5 minutes.

Mrs. WALTERS. Thank you, Mr. Chairman.

Sadly, like so many other communities, Orange County, which is where I live, has been ravaged by the opioid epidemic. In August, the Orange County Healthcare Agency issued its 2017 Opioid Overdose and Death in Orange County Report. I have it right here.

And, Mr. Chairman, I would like to submit this article for the record.

Mr. HARPER. Without objection.

[The information appears at the conclusion of the hearing.]

Mrs. WALTERS. This report found that the rate of opioid-related emergency room visits increased by over 140 percent since 2005. Drug overdose deaths in 2015 have increased by 88 percent, and nearly half of those deaths were due to accidental prescription drug overdose.

Orange County officials and health providers are working hard to combat this epidemic, but sadly, some bad actors are doing far more harm than good. And I want to be clear that not all rehab centers are taking advantage of patients. It’s the bad actors in this space that require us to hold this hearing.

A four-part series published in May 2017 by the Orange County Register exposed the practice of patient brokering and insurance fraud.

And, Mr. Chairman, I'd also like to submit this article for the record, please.

Mr. HARPER. Without objection.

[The information can be found at: <https://docs.house.gov/meetings/IF/IF02/20171212/106716/HHRG-115-IF02-20171212-SD007.pdf>]

Mrs. WALTERS. It found that a lack of oversight of rehab centers contributed to these practices. One issue is that there are nearly 2,000 rehab centers throughout the state, yet only 16 inspectors are employed to monitor the centers. According to state regulators, between 2013 and 2016, consumer complaints about licensed rehab centers nearly doubled to 509 complaints per year.

Bad actors in the rehab center business are exploiting this epidemic through deceptive advertising and third-party recruiters to persuade addicts from around the country to travel to southern California for treatment. In fact, some rehab centers will pay for an individual to travel to California and then sign them up for insurance. Some recruiters will seek out those suffering from the addiction at AA or NA meetings or drug courts to find people to send to rehab centers who will then pay the recruiters a kickback. These bad actors run up medical bills for patients, yet do little to provide effective treatment and recovery services.

Court documents and state records found that some centers, including sober living homes, provide street drugs to patients to restart the fraudulent process. I'm incredibly troubled by these practices, particularly given how rampant it is throughout my district and state.

Mr. Nielsen, my questions are for you. It is our understanding that, in California, the Department of Healthcare Services licenses residential or inpatient treatment facilities, but does not license outpatient treatment facilities. Do you know why that is?

Mr. NIELSEN. That's a great question, Congresswoman Walters, and I ask myself the same question as well. It should be. They should license or certify outpatient facilities; they do not. And I think it's just something that's been passed through time, that originally it was voluntary to have an outpatient facility. And we don't even have a licensure for drug and alcohol counselors to do private practice. So, actually, anybody can hang up a shingle and do private practice in California.

So I think that there needs to be licensure for drug and alcohol counselors and private practice, as well as the outpatient facilities need to be either licensed or certified and make it mandatory.

Mrs. WALTERS. Do you know if there are outpatient facilities licensed or overseen by any other body to ensure that these facilities meet standards to ensure safe and effective treatments?

Mr. NIELSEN. So part of our network, we have a provider network, and there are many of them that do adhere to our standards and are a part of it, but they usually are not the ones that are part of the problem. Also, one of the issues is that the out-of-network providers versus in-network providers. We're finding in California that it's the out-of-network insurance providers that are the largest issue and not so much the in-network providers.

Mrs. WALTERS. OK. Interesting.

OK. You state that sober living homes serve as a bridge to independent living. This stage of the recovery process is obviously distinct from inpatient treatment, yet clearly, the patient is not prepared to resume complete independence. Should these sober living homes be subject to state licensing?

Mr. NIELSEN. I think they should be certified. And I think that Riverside County is a really good model to what it should look like statewide. They actually protect the ADA, and also make sure that there's actually proper oversight of those facilities. And there also has to be a mandatory complaint line for neighbors and individuals to complain, and somebody needs to be able to investigate those. And I think they don't necessarily need to be a part of the state, but it could be independent oversight by a nonprofit that would take on that responsibility.

Mrs. WALTERS. OK. Thank you. And I'm out of time.

Mr. NIELSEN. Thank you.

Mrs. WALTERS. Thank you very much.

Mr. HARPER. The gentlelady yields back.

The chair will now recognize the gentlemen from Pennsylvania, Mr. Costello, for 5 minutes.

Mr. COSTELLO. Mr. Tieman, my first question maybe can be the one that you end on, and that is, if you just think about any testimony that's been provided that you may want to add to, as well as when we look through your written testimony, in terms of defining the problem and the various problems and the largely unregulated sector, I think you mentioned, if there's anything that you would like to add that you think that we need to be looking at or where you think Federal legislation may be required. You conclude to suggest that it might be a combination of state and/or Federal laws that we may need to bring about in order to address some of these problems.

What I'd like to focus on for a minute is the role of call centers and call aggregators. We have discussed them a little bit this morning. You also speak about how Caron was—the name of Caron was manipulated there.

Do the call centers provide any value? Number one. Do call aggregators provide any value to a legitimate treatment provider?

Mr. TIEMAN. Thank you so much, Congressman. Call aggregators and call centers, by and large in our industry, have really become marketing opportunities to put heads on beds. There's a lot of common schemes that are used. One of the real common one is, go to to a city some time and just type in "top ten treatment centers." If you're in Kansas City, St. Louis, wherever. And you will probably always see Hazelden Betty Ford, very legitimate, high quality. You'll probably see Caron Treatment Centers. You might see one other good one locally. And then there will probably be seven that are owned by whoever the call center is.

Now, here's the catch. All of the phone numbers are going to go to the place, even if what you think is calling Hazelden Betty Ford, calling Caron, calling another reputable place, you're going to end up at the place that owns the call center. So call centers have become synonymous with a way for a marketing firm to be able to either sell that person to the highest bidder, wherever their insurance will pay them the most money, or if it's owned by a treatment

center, it puts them in one of their facilities, the telemarketer is instructing you. Yes, you may be wanting to go to Minnesota, but let me tell you why our place in Florida is far better this time of the year. So that tends to be the ploy.

For example, we have a call center at Caron, but when you call——

Mr. COSTELLO. But it's identified as your call center.

Mr. TIEMAN. You are calling Caron. You are calling Caron Treatment Center. Hazelden has a call center. You are calling Hazelden. You know that you're calling them. But when you're calling one of these obscure ones, you just think you're calling something like the American Cancer Society. I'm trying to get information about cancer. So most of these are set up. I'm trying to get information about addiction treatment, but you're actually calling a place that's going to funnel you to a specific treatment center. And we think that is morally wrong.

Mr. COSTELLO. Well, that strikes me that way too. I guess the question is, at what point in time does it become a deceptive business practice? And is there just too much room for interpretation or ambiguity to allow what would otherwise be a deceptive business practice to continue to persist?

Mr. TIEMAN. And that's where we think the whole idea of laws regarding accuracy and transparency. If somebody calls a call center, they should know who is the treatment center that they've called.

Mr. COSTELLO. I think the answer is no. But working at a call center, does it require any sort of training or certification that makes them qualified to advise people on drug treatment options?

Mr. TIEMAN. No, you could do it today.

Mr. COSTELLO. Do you think that I should be allowed to do it today?

Mr. TIEMAN. No.

Mr. COSTELLO. Good. I don't either.

Do you believe there should be some level of accreditation in that respect?

Mr. TIEMAN. We definitely think there should be credentialing around anybody that is dealing and directing people to patient care.

Mr. COSTELLO. Speak a little bit more, I saw you nodding your head when, I believe, Mr. Aronberg was speaking on the role of accreditation. You said that that was the lowest common denominator there.

Mr. TIEMAN. Yes.

Mr. COSTELLO. What if we wanted to up that? What if we wanted to add to it? Let's enhance the accreditation process. What would that look like? Do you think that that would be of value? Would that help to Mr. Barton's question on the issue of public? Two-thirds of the money being spent here is government dollars. What do you think that we should be doing?

Mr. TIEMAN. Well, I definitely think the accreditors, right now, we are working with CARF and JCAHO to try to deal with them from an ethical perspective. They basically look at the standards, but we just think there needs to be more. And so having this high-

er level, this gold or platinum level is something that we think would be very important.

The thing that's kind of interesting, as it relates to the public and private piece, is more money, is insurance per case, which to Mr. Aronberg's reason, why the Florida shuffle has primarily gone after private insurance, as opposed to public. But with the public paying between Medicare, Medicaid, and state grants, which is a big portion of this, there's a lot of money there, and I'm sure we will find abuses in that as well.

Mr. COSTELLO. I have more questions, but I'm out of time. I will yield back.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlelady from Indiana, Mrs. Brooks, for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman. And congratulations. We look forward to your leadership on this committee.

I am a former U.S. attorney, and so I'm very curious—I was very involved in a lot of different fraud task forces as a U.S. attorney between 2001 and 2007, but I have to admit, a sober living task fraud force is not something that came across my plate during that time period. And I'm curious, are there other sober living task forces, that you're aware of, in the country, Mr. Aronberg and Mr. Johnson?

Mr. ARONBERG. Thank you, Congresswoman. Not that I'm aware of. And, also, I think we're the first jurisdiction that empaneled a grand jury to look into fraud and abuse in this area.

Mrs. BROOKS. And I saw that—and because of the grand jury recommendations, then went to your state legislature to try to increase penalties and really raise the level of awareness of this problem?

Mr. ARONBERG. Yes. Congresswoman, we successfully were able to pass House Bill 807, which did tighten oversight and penalties in this area. And we're going back to the legislature this coming session to ask for additional reforms.

Mrs. BROOKS. And I saw that you had 41 arrests. And I realize it might be early in the process, just out of curiosity, any convictions yet?

Mr. ARONBERG. Yes. I think 10 convictions already. We started the task force about a year ago, so it's happening pretty quickly, but—

Mrs. BROOKS. That's in one county?

Mr. ARONBERG. Oh, yes. Yes.

Mrs. BROOKS. OK. So this is one county in Florida where you've got 41 people arrested. And just out of curiosity, on the 41 arrests, how many of those are actually county residents? Do you know? Or is this a national network, just out of curiosity, if you know?

Mr. ARONBERG. They're all residents. The 41 are all residents. I think there were a few who may not be citizens, but they are all county residents.

Mrs. BROOKS. OK. And can you share with me maybe, Mr. Johnson, what has been the involvement of the U.S. Attorney's Office? And what have been some of the impediments that maybe you've seen in working with the U.S. Attorney's offices as to challenges they might have in these types of cases?

Mr. JOHNSON. Thank you, Congresswoman, for asking. We've had a great relationship with the Federal prosecutors and the FBI. As a matter of fact, we frequently meet to make sure we don't conflict with each other. We don't want to be tripping over each other in our investigations. We've been involved and shared intelligence with them. They've made a very significant arrest and conviction on a fellow by the name of Kenneth Chatman. He got 27 years prison, and his abuses were about the worst of the worst. And we—

Mrs. BROOKS. And was this violation of which statute, if you recall?

Mr. JOHNSON. The problem is it had to be conspiracy to commit insurance fraud, because they don't have the ability under either the Stark Act or the Anti-Kickback Statute, to do patient brokering. So they had to go obliquely, and it was mainly fraud, human trafficking as well, because one of the abuses is the patients are made to be prostitutes or labor pool workers, et cetera.

Mrs. BROOKS. Did that individual plead guilty or go to trial?

Mr. JOHNSON. He pled guilty.

Mrs. BROOKS. And I assume the 27 years was because of the amount of money that had been defrauded?

Mr. JOHNSON. Amount of money and the egregious factual basis.

Mrs. BROOKS. And I'm curious, in your cases, are patients or the participant—the residents of the sober living homes, rather than patients, but residents. Are you using residents as witnesses in your cases, Mr. Aronberg or Mr. Johnson?

Mr. JOHNSON. Yes, we are.

Mrs. BROOKS. OK.

Mr. JOHNSON. Yes, we are. And we cannot prosecute the patients, nor would we want to, but that's one of the unique things about this fraud, is that one of the members of the conspiracy is a willing participant but also a victim at the same time.

Mrs. BROOKS. And so it's very, very difficult to figure out who the bad actors are, who's in charge.

Mr. JOHNSON. And they're transient, so it's very difficult—in one case we had 1,500 potential witnesses, and I think we're at a 2 percent rate of being able to find them and have them cooperate.

Mrs. BROOKS. Because I was not aware of these websites that have been discussed, on one particular website run out of a group out of California, it indicates that Indiana has 310 sober living facilities, which I find fascinating that—now, some I recognize, some of these service providers, but I have to admit, they don't direct you directly to phone numbers, from what I can tell. And then they also are putting up a time where a person has the last 10 phone numbers requested.

Mr. TIEMAN, why would they be putting up these by the minute?

Mr. TIEMAN. I'm not sure I understand the question.

Mrs. BROOKS. So the question is, oddly, on this website it says, last 10 phone numbers requested: 12/12, 10:55, and they direct to a provider. Then 12/12, 10:55, to a southern California provider. This is on the Indiana website.

Mr. TIEMAN. Wow, I don't know how to answer that question. There's so much that happens through the internet. That is fascinating. I don't know the answer.

Mrs. BROOKS. OK. Thank you.

Mr. TIEMAN. Sorry.

Mrs. BROOKS. My time is up. I yield back.

Mr. HARPER. The gentlelady yields back.

The chair will now recognize the gentleman from Georgia, Mr. Carter, for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman. And thank all of you for being here today. This is certainly an important subject.

Mr. Chairman, I would certainly be remiss if I didn't join in congratulating you on your new position, and let you know how much I look forward to working with you.

Gentlemen, as a practicing pharmacist and currently the only pharmacist serving in Congress, this is a big problem that I have worked with closely over the years. And I can assure you that no two people are the same, you all know that, that people react differently. And some people can rehab through little therapy, some people it's going to take a lifetime of therapy, and we all understand that.

The opioid problem, in particular, if we're going to get more specific about a problem, the opioid problem, to me, is a twofold problem. One problem is prevention. How do we prevent it? And we've certainly talked about that on this committee, and certainly it's one of our concerns. But the second part of the twofold problem is just what we're talking about, and that's those people who are addicted now. We can talk about prevention, how we prevent it. But what about those people who are already there? What do we do with them? And that's what we're talking about here.

Just like every profession, there are bad actors in this area. We all understand that. And that's why we're here today. We want to know how we can help in the Federal Government to do away with these bad actors. We know that there's patient brokering. We understand that and we know that that's a big problem. And I guess the question I have for you, and it's a very general question, is just, what can we do from a Federal perspective to give you, Mr. Aronberg, at the state level, the resources you need and the ability that you need to get rid of these bad actors?

Mr. ARONBERG. Thank you, Congressman. I think more than providing money, it's to help us by closing loopholes in Federal law that—

Mr. CARTER. And that's what I'm talking about. Please understand, I'm not interested in throwing money at this problem. I want to know specifically what we can do to help you legislatively.

Mr. ARONBERG. Thank you, Congressman. Yes. And that's why we're not coming here to ask for money. We're just asking for help in the form of reforming the Federal laws that have enabled and exacerbated this problem. You can't attack the opioid epidemic without going after the increased number of deaths from fraud and abuse in the drug treatment industry that—and those deaths are preventable. These are people who are looking for help and, instead, get caught up in the Florida shuffle until they leave Florida in an ambulance or a body bag. And there's stuff that can be done.

As we mentioned earlier, clarifying the ADA to allow reasonable regulations at the local level for the sober homes. To change the fee for service model of the ACA to an outcome-based reimburse-

ment model. And then Mr. Johnson also had some areas we're dealing with a kickback statute.

Mr. JOHNSON. Reforming the Anti-Kickback Statute and the Stark Laws. So that these safe harbors, you can drive a truck through them right now—

Mr. CARTER. Right. Right.

Mr. JOHNSON [continuing]. With boots on the ground.

Mr. CARTER. And that's exactly what I'm looking for. What do we need to put in code that's going to help you, that's going to give you the ability to get rid of these bad actors?

All of you, I suspect, are familiar with drug courts. We certainly use them in the State of Georgia. They've been very successful. We've been very pleased with the results that we've gotten there.

Just wondering, how do you and your states employ who you're going to use in those drug treatments? If it's a pretrial motion to get someone to go through drug therapy, how do you go about in selecting the company that you'll be using there? Are there any kind of qualifications?

Mr. JOHNSON. Most of the court-referred cases are Medicare, Medicaid, or other federally assisted programs. Very few are private, but when there is a private one, the Court doesn't get involved in picking and choosing where somebody will go for treatment.

Mr. CARTER. They just say you've got to go to one.

Mr. JOHNSON. Now, we had a judge, he's just been reassigned, who administered drug court, and would only recommend or send people to certified sober homes. Again, no treatment at the sober homes, but the sober homes themselves had to be certified.

Mr. CARTER. So sober living facilities have to be certified?

Mr. JOHNSON. No, not under state law. It's voluntary only, which is a problem.

Mr. CARTER. Is that something we can handle through Federal law? Should we require it?

Mr. JOHNSON. Yes. By clarifying the ADA and FHA, to give some comfort to the states, that they indeed can have some requirement of certification of the sober homes, where right now they're afraid to do that. They're afraid that that is in violation of the FHA.

Mr. CARTER. And I too am hesitant to get more Federal involvement in these things. However, I want to give you the tools you need. And it's just a dilemma, and I understand it firsthand, I've seen it firsthand.

Mr. JOHNSON. Nobody's asking you to open up the FHA or ADA, that's not the ask. The ask is to get DOJ and HUD to do a real clarification applying the fact that if a resident needs protection that—

Mr. CARTER. I understand. Well, please hear the message: We want to help. This is a serious, serious problem.

And, thank you, Mr. Chairman, and I yield back.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentleman from Florida, Mr. Bilirakis, for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Congratulations again. I know you're going to do a great job running this committee.

And I also want to welcome Mr. Aronberg. We served in the legislature together. And thanks for coming up and advocating on behalf of our great State of Florida.

I have a couple questions. Mr. Nielsen and Mr. Tieman, is there currently an industrywide uniform code of ethics that bans patient brokering?

Mr. NIELSEN. There's not an industrywide. There is some. There should be an industrywide that's agreed upon. I know that there are—

Mr. BILIRAKIS. Why don't we have an industrywide code? I mean, my goodness, you would think we'd have something like that.

Mr. NIELSEN. Because it affects both for-profit and nonprofit, and it seems that they run in separate circles, and that there needs to be a unified ethical code because fraud happens both in for-profit and nonprofit organizations. And so there should be. Just as there's a patient bill of rights, there should be ethical standards for treatment facilities, just as there are for social workers, for drug and alcohol professionals.

Mr. TIEMAN. Congressman, that's a great question. And there should be, and it's one of the real high priorities of the National Association of Addiction Treatment Providers, as we've just initiated something called Quality Control Initiative, which actually outlined, for the first time, what is ethical and what is nonethical. There needs to be standards.

One of the things that amazed me was, for the last 3 years, some of the most unethical practitioners would hold conferences on what is ethical. And what I found out was that ethics was defined by every individual. I actually had treatment providers tell me about the urine drug screening. It's OK to do that because the end justifies the means. The insurance company doesn't pay for this, so you know what, they will pay for urine drug screens, so we'll have them pay for that. And the net result is the person gets treatment. That was ethical in their minds.

So one of the things we've taken upon our national association is, you know what, someone's got to put the line in the sand and determine what is ethical. So we've now done that. And in 2018, we're going to be, with all of our association members, saying, ignorance is no longer a defense, your own interpretation isn't a defense. We're going to tell you what's ethical and nonethical, and we'll determine whether or not it is. But you're absolutely right, that needs to be done.

Mr. BILIRAKIS. Very good. We need to make progress in that area.

Mr. NIELSEN. I have a followup.

Mr. BILIRAKIS. Yes. Go ahead, please.

Mr. NIELSEN. If you don't mind. It's not just the treatment centers, but the executives should be held accountable as well. Part of the problem is it's at the top. And so I think that they should have a code of ethics that they should follow, and they should be credentialed. That these executives that run these treatment facilities should—and then you would have a list of the individuals that are unethical because they would lose their credential around that.

The International Certification and Reciprocity Consortium is an organization that credentials counselors. We need something like

that for executives, and even for marketers and admissions specialists.

Mr. TIEMAN. And really to that, that's what we're looking at with this ethical certification. It's just like a CEO, I have to sign off on our audit. I have to sign off on our 990. I would have to sign off and saying that Caron Treatment Centers has—we have provided the training, and I verify that we are adhering to ethical standards. Mr. Nielsen's absolutely correct that you start at the top.

Mr. BILIRAKIS. Absolutely. Let's get it done.

A question for Mr. Aronberg. As you're well aware, patient brokering continues to be an issue in the State of Florida. Upon learning that various mental health and substance abuse facilities were making payments to individuals for the referral of patients identified in Alcoholics Anonymous meetings, homeless shelters, and other similar environments, Florida's legislature recently passed a Patient Brokering Act to prevent it by making the perverse practice a third-degree felony, punishable by 5 years in prison. However, monitoring and enforcing continue to challenge our state.

What are other states doing? And then whoever wants to speak on the—please give us if you have anything to contribute. What are other states doing to monitor and enforce patient brokering laws?

Mr. ARONBERG. Congressman, thank you. And thank you for your service to Florida and Pinellas County in particular. We're seeing that a lot of our sober homes are moving to your coast because of our crackdown, and so we're all in this together.

I can't speak to what other states are doing, but we do know that other states do have patient brokering laws on the books. And we were discussing earlier whether the Federal Government should have a more effective anti-patient brokering law. They do have an anti-kickback law.

But this is something that you're going to see a lot of the scam—the Florida shuffle move to other communities that are not as aware of this problem and don't have effective laws on the books. And that's why we're offering ourselves as a resource for any community that would like to see what we're doing. We've trained prosecutors and law enforcement from throughout the state, and we'd be happy to help folks from across the country so they will be aware and ready to stop the Florida shuffle when it comes to them.

Mr. BILIRAKIS. Very good. Thank you. Great work.

Mr. ARONBERG. Thank you.

Mr. BILIRAKIS. I yield back, Mr. Chairman.

Mr. HARPER. The gentleman yields back.

In conclusion, I want to thank our witnesses and members for participating in today's hearing. I remind members that they have 10 business days to submit questions for the record. And if so submitted, I would ask that the witnesses agree to respond promptly to those questions.

With that, the subcommittee is adjourned.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Mr. Chairman, for holding this hearing. Congratulations again for taking over this esteemed Subcommittee.

Today's hearing subject is classic oversight and investigations territory: fraudsters and knaves who exploit the vulnerable for profit. This particular outrage involves unscrupulous people trying to make a buck off of the nation's opioid epidemic with unethical practices such as patient brokering, identity theft, kickbacks, and insurance fraud.

How do these abuses happen? One such story was reported in STAT News. A 30-year old man in Massachusetts suffering from heroin addiction was approached by a prominent figure in the Boston-area drug recovery community with an offer too good to be true. The patient could get treatment in South Florida, with all expenses paid, including airfare. This young man took the deal and two months later he was dead. He was treated as a paycheck by a middle man, a "patient broker" who recruits and arranges transportation and insurance coverage for vulnerable patients seeking treatment for their addiction.

These patient brokers can earn up to tens of thousands of dollars a year from finder's fees of \$500 to \$1,000 per person by steering patients to out-of-state treatment centers that often provide few services and sometimes are run by shady operators with no training or expertise in drug treatment. Worse, people are getting paid to relapse so that treatment facilities can collect more insurance money.

A Palm Beach Post investigation of the county's \$1 billion drug treatment industry found that testing the urine in the substance use disorder treatment industry is so lucrative that treatment centers are paying sober living homes for patients. A basic urine drug screening test in cup can detect ten types of drugs or more, costs less than \$10, and can display the results within minutes. Yet we've heard of instances where individuals are tested daily and the treatment facility or sober living home sends the samples for more expensive confirmatory tests that can cost thousands of dollars.

Another nefarious problem is "black hat marketing" where some providers overstate their treatment capabilities and use established treatment program names to market and attract patients, a form of identity theft. The fraudsters also use misleading websites or call centers to recruit out-of-state patients who were looking for a legitimate treatment provider in their local area.

These abuses have consequences. It threatens patients, communities, taxpayers, and insurance policyholders. It undermines the ethical and legitimate treatment facilities that provide life-saving treatment to patients.

The Committee's investigation has revealed that while many of these schemes involve steering patients to warm-climate destinations such as California, Florida, and Arizona, it is increasingly emerging as a nationwide problem.

Today's hearing will help bring needed attention to this issue, highlight some effective actions taken, and start a thoughtful discussion on the best solutions to combatting these corrupt practices while protecting good and legitimate treatment programs and those that are seeking treatment.

I welcome our witnesses and look forward to their testimony.



California Consortium of
Addiction Programs and
Professionals

Inspiring Excellence, Promoting Change

STANDARDS

FOR SOBER LIVING ENVIRONMENTS

JANUARY 19, 1993
OCTOBER 12, 1993
MAY 26, 1996
JANUARY 18, 1999
OCTOBER 30, 2003
FEBRUARY 16, 2012

STANDARDS
FOR
SOBER LIVING ENVIRONMENTS

Sober Living Environments (SLE) is a term generally used to describe a specific type of housing. SLE's offer a housing alternative to individuals who are recovering from alcohol and or drug addiction. These environments are not subject to licensing by any State agency and are not subject to certification or accreditation. Other terms used to describe such housing are "recovery residences" "cooperative housing for recovering people", "resident-run housing", "sober cooperative living", "alcohol, drug free living centers", etc. All of these arrangements have something in common in that they are intended for cooperative living of individuals who are recovering from alcoholism or drug addiction. Resident responsibility for the environment sets it apart from formal recovery programs.

There is a great need for sober housing in our communities. Experience has shown that persons who have completed a residential program of recovery or have stabilized in Alcoholics Anonymous need to live in a sober environment in order to maintain sobriety and recovery. Many persons who leave organized programs do not have a home to go to, nor can they afford individual housing, which is recovery conducive. Cooperative housing offers a bridge to independent living.

Sober Living Environments come in all sizes and configurations - from freestanding homes to apartment buildings. If more than six people who are not related to each other (not a "family") live together they may need to have some sort of a use permit from the governing district in which they live. Some local jurisdictions require health clearance and there may be a need for review by the local fire marshal.

SLE's must not require residents to attend programs or counseling sessions, however certain rules may be set as provisions of residency. House rules may include curfew, smoking, chores, payment of rent, and attendance at house meetings, and A.A. /N.A. meetings, and must include prohibition of any use of alcohol and or drugs.

A sober living home may or may not have paid staff. The role of the staff must be clearly for management of the housing and not for management of individuals.

The environment must be recovery conducive and space should be adequate to accommodate each individual comfortably and with dignity and respect.

Attention should be given to the health and safety of all residents and therefore the home should meet minimum fire and health standards.

STANDARDS

Article 1:	Physical Environment	2100
Article 2:	Management	2200
Article 3:	Record Keeping	2300
Article 4:	House Rules	2400
Article 5:	Residency Requirements	2500

2100

Article 1. Physical Environment

2101 ARCHITECTURAL ASPECTS OF RECOVERY-CONDUCTIVE HOUSING

Architectural aspects of design should be similar to those for regular residences with a few important differences.

- (a) Sociopetality: Design should encourage residents to contact each other incidentally, informally, and without status barriers. Mundane contacts with each other during the course of the day are the medium for recovery in a well-designed setting.
- (b) Communality: Space should be available for all residents to meet for community meetings, and to attend community events (parties, meals, holidays, celebrations).
- (c) Security: Entrance and exit must be controlled. This means that informal perimeter security and monitoring of the front door are necessary. Human security (people circulating through the facility) is far preferable to electronic security.
- (d) Durability and quality of furnishings: Only the highest quality fixtures, materials, appliances and furniture should be used. The extra investment in the beginning repays itself many times over.
- (e) (f) (g) Upkeep and appearance: Repair, maintenance, cleanliness, and attractiveness are critical elements in the life of the house. The upkeep and appearance of the house are a metaphor for the lives of the residents. This includes grounds and driveways surrounding the home.
- (h) (i) Personalization and comfort: Residents should feel the place is their own. This means allowing room for personal possessions, decorating one's own area, etc.

(Reprinted with permission, "The architecture of recovery: Prospects for the Nineties for housing low-income people with alcohol and drug problems", Friedner D. Wittman, Clew Associates, presented April 10, 1992, at a Conference on Recovery-Conducive Affordable Housing Strategies, University of California, San Diego.)

- (j) Respect for neighbors: Good neighbor policies assure that the home and its residents are accepted as part of the community. This means that residents will be mindful of noise levels of conversations, designated smoking areas that will not affect the neighbors, and walking on sidewalks and paths to destinations.

2102 SPACE

- (a) Space should be adequate to accommodate each individual comfortably and with dignity and respect.

- (b) Each home shall have a living room area with adequate space for participants to assemble for social or other group activities.
- (c) Each home shall have a dining area suitably furnished for group or individual meal service.
- (d) Sleeping rooms shall be adequate to provide a bed and private space for each resident. These areas shall not be used for any other purposes.
- (e) Bathrooms shall be conveniently located and sufficient to provide adequate facilities for health, hygiene and privacy for each resident.
- (f) Kitchen facilities shall provide cooking and storage space to meet the needs of the home and its residents.
- (g) Personal storage should be provided for each resident.

2103 FIRE SAFETY

The following minimum fire prevention requirements shall be followed:

- (a) There shall be no smoking in bedrooms;
- (b) Smoking is allowed outside only and smoking materials shall be disposed of safely;
- (c) There shall be no accumulation of clothing, newspapers, or cartons in the living/sleeping areas;
- (d) Stoves and cooking areas shall be kept clean of grease accumulation;
- (e) Furniture and drapes are treated with fire retardant materials
- (f) Smoke detectors fire extinguishers, and CO2 detectors shall be installed;
- (g) Exit doors shall be clearly marked and readily available;
- (h) Fire drills from sleeping areas should be encouraged;
- (i) Buildings with 2nd floor shall have emergency fire ladders clearly marked.

2104 HEALTH STANDARDS

The following minimum health maintenance measures shall be followed:

- (a) There shall be adequate space for food storage;
- (b) All food shall be stored in covered containers, or properly wrapped;
- (c) Perishable items shall be refrigerated and adequate refrigeration in good repair shall be available;
- (d) All dishes and cooking implements shall be washed upon use;
- (e) There shall be adequate hot water for dish washing;
- (f) Bathroom space shall be adequate for number of residents;

- (g) Bathrooms shall be kept clean on a daily basis;
- (h) Bathrooms shall provide personal privacy;
- (i) There is a policy for drug testing.

2200

Article 2. Management

2202 MANAGERS RESPONSIBILITY

The person in charge of the facility shall be clearly identified to all residents and on the premises (a). This should be an individual or designated individual within the group. This person shall be responsible for the maintenance and safety of the building. (b) If the person is designated, the lines of authority must be clearly defined. (c) The manager should be the keeper of the "good neighbor" policy and liability insurance and copies should be available and visible in the home.

2203 STAFFING

(a) – (f) Staffing may or may not be necessary depending on the nature of the housing. At a minimum, someone must be responsible for the safety of the building, someone must be available to maintain records, to collect rent, and to register and check-out residents, and to maintain rules of the house. The resident group may choose to have other staff available such as cooks, grounds keepers, etc. Staff shall not provide any direction to the residents but shall be available for appropriate management of the physical plant.

2300

Article 3. Record Keeping

2301 RESIDENT RECORDS

- (a) The manager in charge of the residency shall maintain formal records. Records fill several important roles: they allow management to track the person served and provide a sense of order. The following record keeping standards are applicable to SLE:
- (b) Personal Data Form: Biographical personal data that provides an identification profile and emergency contact. Personal data requirements should be consistent with the organization's record and profile data requirements. Length of sobriety, prior recovery experience, and source of referral are appropriate.
- (c) Resident Log: This is a continuing record of residents as they enter and exit residency. The log includes referral into the home and circumstances of exit. Management thus has available a quick review of residents registered in a given

year, along with the number of people moving out and why.

- (d) Resident Fee Payment Record: This record indicates the amount of resident fee due, and the date and amount of actual payment.
- (e) Sign-in, Sign-out Sheets: For the safety of the residents and in case of emergency, the designated person must know the location of each resident. Sign-in and Sign-out sheets are available and in a prominent place in the home.

2400

Article 4. House Rules

- (a) The rules of the house must be clearly defined. Optional rules will depend on the needs of the population to be served, should not be over burdensome, and must be consistent with residency needs.
- (b) No drinking of alcohol or items containing alcohol or using illegal drugs at any time.
- (c) No alcohol, items containing alcohol or illegal drugs shall be brought onto the premises at any time.
- (d) Rent must be paid on time.
- (e) Mandatory attendance at a weekly house meeting.
- (f) A policy on drug testing is available and equally applies to all residents and staff if utilized.

2500

Article 5. Residency Requirements

- (a) The residency requirements must be clearly defined and at a minimum should include:
- (b) A desire to live a clean and sober life style.
- (c) Completion of a formal alcohol or drug recovery program, or documented stability in a self-help group.
- (d) A willingness to abide by all the house rules;

(e) A signed residential agreement on file for each resident.

For questions concerning these standards, or the registration process:

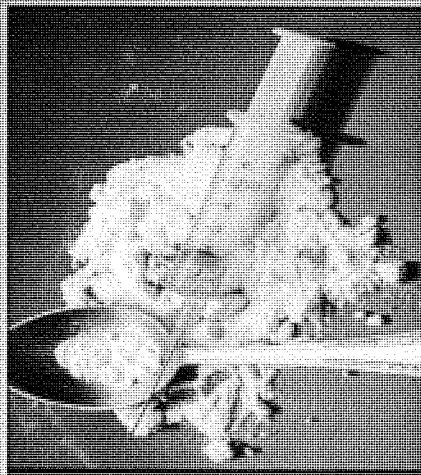
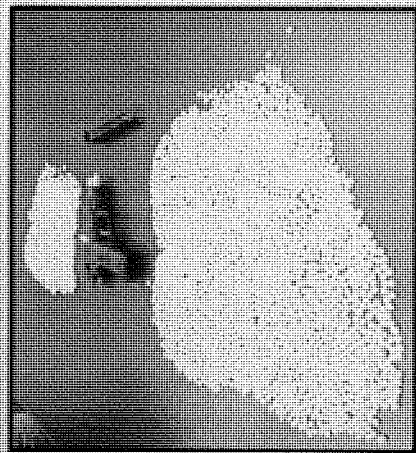
Craig Koury
916-338-9460 ext 123
craig@ccapp.us

Patients have the right to:

- 1. Be treated for the life-threatening, chronic disease of addiction with honesty, respect and dignity.**
- 2. Know what to expect from treatment, and the likelihood of success.**
- 3. Be treated by licensed and certified professionals.**
- 4. Evidence-based treatment.**
- 5. Be treated for co-occurring behavioral health conditions simultaneously.**
- 6. An individualized, outcomes-driven treatment plan.**
- 7. Remain in treatment as long as necessary.**
- 8. Treatment for their families and loved ones.**
- 9. A treatment setting that is safe and ethical.**

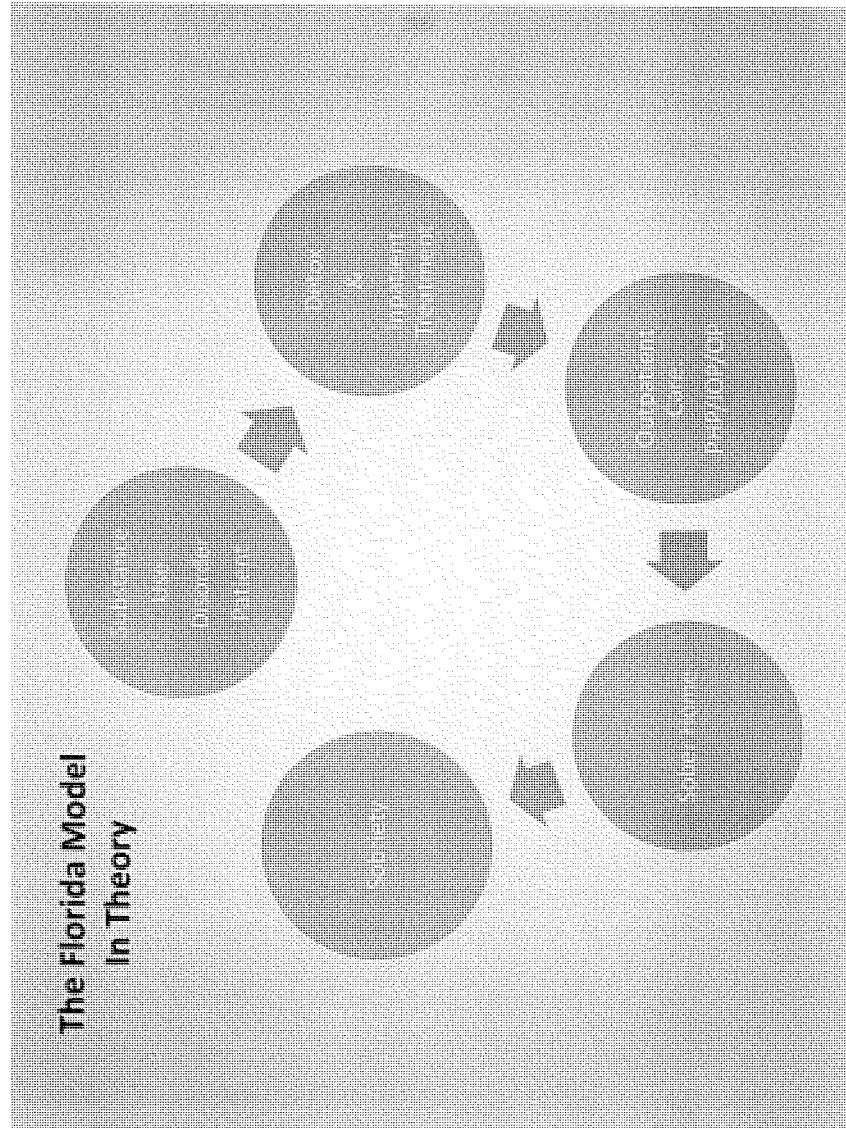


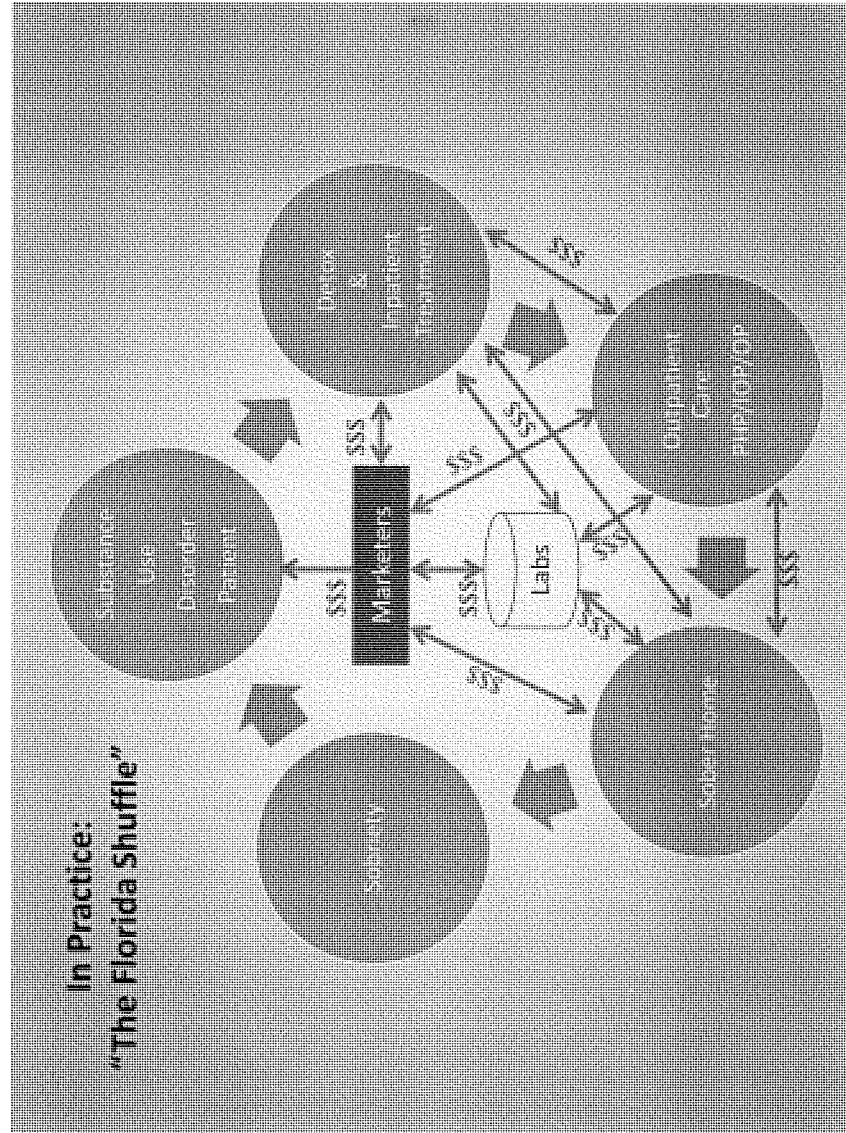
**EXAMINING CONCERNS OF PATIENT BROKERING AND
ADDICTION TREATMENT FRAUD**



Dave Aronberg
State Attorney, 15th Judicial Circuit

Alan Johnson
Chief Assistant State Attorney







Caron Treatment Centers and Hazelden Betty Ford Foundation | February 2016

Defining a Center of Excellence: An Addiction Treatment Model

Introduction

From a medical model perspective, a Center of Excellence (COE) is defined as an organization that demonstrates leadership and the highest clinical quality in a field of specialized treatment. This definition by nature includes not only leadership but also demonstrated best practices, progressive treatment modalities, a solid infrastructure, utilization of a personalized team approach that includes both the patient and family, staff development, and academic research that generates outcomes guiding not only best treatment practices but also measures quality. Increasing the quality of addiction treatment is now more critical than ever. At present, the addiction treatment industry is fragmented with

no consistent operating principles or regulatory requirements. Some states require no regulation, which leaves treatment centers unaccountable for the services they provide. In addition, the industry is seeing an upswing in for-profit centers that offer exclusive, spa-like environments that "guarantee" success, but offer little in the way of evidence-based treatment or demonstrated outcomes.

Two leading non-profit organizations, Caron Treatment Centers and the Hazelden Betty Ford Foundation, co-authored this article to outline criteria necessary for an addiction treatment provider to qualify as a Center of Excellence. We hope this begins a national dialogue around this important issue and leads to further action in establishing a clearinghouse to identify the industry's centers of excellence.

of Rehabilitation Facilities (CARF). It is also important to maintain a state license and meet the expectations at the highest standard of care. Hazelden Betty Ford and Caron are accredited and licensed facilities. Surprisingly, many addiction treatment providers throughout the United States have not received accreditation, and there is no mandate in the field requiring providers to have accreditation in order to operate. Because accrediting agencies are vital in establishing rigorous standards for quality of care, organizational performance, and evaluating whether providers meet these standards, accreditation should be a "minimum requirement" of any organization offering addiction treatment.

Qualified Clinicians

Well-trained and credentialed clinicians are critical to providing quality care. COEs hire and retain clinicians with the appropriate degrees and licenses, such as addiction medicine physicians, doctoral-level psychologists, and licensed or certified addiction counselors. As the field of addictions counseling has increased in complexity and sophistication over the past decades, so too have the licensing and certification requirements across the United States. At present, few states will license counselors at the associate's level. COEs hire addictions counselors that have, at a minimum, a baccalaureate degree from an accredited institution with a preference for those prepared at the master's level. COEs also implement clinical training programs that keep clinicians up to date in their fields and continuously advance their clinical skills.

Key Attributes of a COE in Addiction Treatment

Determining the characteristics of a COE requires identification of the minimum standards necessary to deliver outstanding quality of care. In other words, an obvious starting point is to define the characteristics and practices that are minimally required in order for a provider to demonstrate it is delivering adequate services. This section of the paper will list and describe each of these criteria.

Accreditation

The first essential characteristic is receiving and maintaining accreditation from external regulatory organizations, such as the Joint Commission (JCAHO) or the Commission on Accreditation





Technology and Data Systems

COEs use state-of-the-art tools for conducting all aspects of business, including clinical operations. These include a well-designed, integrated electronic health record that allows information to be shared across all stakeholders, including direct providers of care. Organizations should have solid Information Technology (IT) platforms, case management systems and other data systems that facilitate care and allow quick and seamless communication among staff and stakeholders. It is also important for these platforms to provide accurate and reliable data that can be used for benchmarking and quality performance assessment. Advances in technology have led to its use during treatment. Both Caron and Hazelden Betty Ford utilize technology as part of their treatment. At Caron, the IT team worked with the clinical team to develop a program called Passport. This program is electronic and allows the patients to interface with their patient-centered treatment plan, track progress, keep their treatment homework, work on their treatment work digitally, interface with their addictions counselor when not in group or individual sessions, and be part of a peer community. At Hazelden Betty Ford, the My Ongoing Recovery Experience (MORE) web-based program helps discharged patients track their recovery process, interact with recovery coaches, and participate in a peer community of support.

Evidence-Based Treatment

Clinical services offered to patients should be "evidence-based," serve as "practice-based evidence" and/or be rooted in research and aimed at establishing new innovations in practice. In addition, the treatment provider should have a hard-wired process for routinely reviewing the ongoing research literature and exploring ways to incorporate new practices and methods as the evidence base for these develops. Hazelden Betty Ford and Caron both have robust training programs and affiliations with leading universities to ensure employees are knowledgeable and trained in current trends in the industry, age and gender specific treatment issues, along with recognized evidenced-based practices such as Motivational Interviewing and Dialectical Behavioral Therapy.

Care for Co-Occurring Disorders

It is well known that the majority of individuals with a substance use disorder also have a co-occurring mental health condition or other co-existing addiction. An addiction treatment provider should therefore offer formal treatment for these co-occurring disorders (in addition to treatment for the substance addiction) and do so using evidence-based practices. To ensure proper treatment of co-occurring disorders, addiction treatment providers should have medical or psychiatric staff available to treat the presenting co-occurring disorder and clinical staff trained in the treatment of these disorders. An integrated approach to treatment is the best practice. At Caron and Hazelden Betty Ford, there is a comprehensive behavioral health team bolstered by full-time medical, psychiatry and psychology staff.

Performance Measurement Systems

Another area vital to a COE is performance measurement. Increasingly, substance use treatment centers are being called to task to provide measurable outcomes demonstrating the success of their

programs. At the industry level, addiction treatment centers are facing a rapidly expanding competitive environment and increasing pressure from government and health care insurance industries to show demonstrated success. Individuals seeking treatment are also becoming progressively savvy in their search for a treatment center that will give them the best possible outcome. A COE should have formalized, proven methods for measuring several aspects of organizational performance, including patient outcomes.

While there appears to be field-wide acknowledgement that such measurement is important, addiction practitioners and scholars have yet to agree on the precise metrics that should be collected and reported within the addiction treatment field. If outcomes are collected at all, most treatment centers rely solely on patient self-reporting without methods and structures in place to reduce bias and demand characteristics. Centers of Excellence have robust measures, which include reports from families, information from other professionals and science-based, physical measures, such as urine drug screens in addition to self-reports. This is an area where both organizations have been pioneers. For decades, Hazelden Betty Ford and Caron have collected patient self report, but recognized the limitations of distal-outcomes measurement and designed programs to manage and monitor patients during treatment and after discharge for a year or more. It is not uncommon to find providers with little to no evidence of measuring patient outcomes or



organizational performance as it relates to the quality of services provided. Centers of excellence pave the way toward standard outcome measures for the addiction treatment field, so that one day all programs can be compared based on the same measures – a development strongly urged and supported by both Caron and the Hazelden Betty Ford Foundation.

Commitment to Quality and Process Improvement

A first-class treatment provider must engage in quality and process improvement, and have reliable, valid measurement systems to track improvement efforts and demonstrate quality of care. After much-needed industry-wide consensus around measurement has been reached, a COE would lead this effort and encourage peers to adopt and share metrics results. In this way, national benchmarking can occur, which is currently lacking in addiction treatment but vital in terms of demonstrating accountability for care quality. A few examples of benchmarking criteria include satisfaction rates, average length of treatment, successful treatment completion, abstinence rates, re-engagement rates, and integration of family into treatment.



At a minimum, a COE needs to participate in national benchmarking efforts and help drive adoption and compliance with such activities

throughout the field. Both Caron and Hazelden Betty Ford participate in a national benchmarking group where they are measured against other treatment centers. Both have also agreed to participate in a first of its kind pilot study through NAATP (National Association of Addiction Treatment Programs) which has the goal of setting the standard of practice for collecting outcomes.

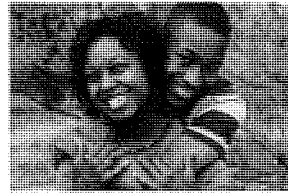
There should also be transparency in sharing information regarding the quality of care and outcomes, and educating the consumer about services and expected results. It is important for this information to be valid, so the use of outside agencies to evaluate the data is essential. Both Hazelden Betty Ford and Caron collaborate with leading university-based researchers in the field to create measurement systems, analyze data, and publish them in peer-reviewed research journals. Data should be displayed in a forthright, appropriate way so they are not misinterpreted.

Full Continuum of Care

Regarding service offerings, a COE must offer a full continuum of care that provides a complete range of services that offer the patient an array of treatment opportunities based on acuity level and need. These services span a

wide range of areas, including prevention and education, formal treatment and management of addiction issues, and post-treatment services, tools and resources that support ongoing recovery. Caron and Hazelden Betty Ford believe that not all of these levels of care need to be offered by a single addiction treatment provider. Rather, some services can be offered through strategic

affiliations with other providers that are transparent with their clinical outcomes and business practices, operate ethically, and are committed to providing quality



care.

Treatment is only one component of a continuum of care. A COE should have services offered to the patient and family prior to admission to treatment. Examples include education, intervention, and supports for families in the community and in the schools. COEs have extensive programming for families, which includes education, support and referrals to professionals for their own treatment when warranted. The continuum of care should continue post treatment. Both patients and families require additional support as they navigate early recovery. Transitional recovery care programs based on physician monitoring programs have been shown to be highly successful. Both Hazelden Betty Ford and Caron offer ongoing monitoring of patients post discharge for 1 year or longer. Caron's program, My First Year of Recovery, and Hazelden Betty Ford's program, Connection, focus on recovery transitions, overall wellness, monitoring through random urine drug screens, and assisting families with their own transition issues when their loved one returns home. The goal is not only promoting continuous abstinence, but swiftly re-engaging the individual back on the recovery path if a relapse occurs.

Student Assistance Programs, whether delivered in schools or in the treatment setting, provide resources to children impacted by a parent's or sibling's addiction. School-based programs can also be a great support when an adolescent patient returns to school after the completion of treatment.

Education and Scholarship

An addiction treatment provider that aims to be a COE should also engage in

ongoing education and scholarship through collaboration with local academic centers and universities and the delivery of educational programs, fellowships, internships and opportunities for further professional development (such as continuing medical education offerings). Scholarship and research are both important and can be accomplished through collaboration with other institutions. A COE should also conduct primary, prospective research on the topic of addiction and publish findings in peer reviewed scientific journals.

Advocacy. To the extent possible, a COE in addiction treatment should engage in advocacy efforts and be a leading voice in the field. Some of this activity can be accomplished through membership with national trade associations. A first-class provider can educate people in local communities by hosting and sponsoring events and conducting interviews with the media.

Sound and Ethical Business Practices

Though it may sound obvious, Hazelden Betty Ford and Caron believe the core business practices of a provider should be sound and ethical. Marketing, advertising and promotional activities should be ethical, truthful and legal. Paying organizations for patient leads is highly inappropriate, as is presenting misleading data or results. Regarding financials, a world-class provider should also be well-capitalized.



A Broad Reach.

Lastly, the reach of services should be extensive in order for a provider to qualify as a COE. Compared to acute care providers, the addiction treatment industry has been slow to serve underprivileged individuals who do not have economic resources. To the extent possible, services should be available to people of all socioeconomic backgrounds. COEs like Hazelden Betty Ford and Caron offer extensive scholarships and patient aid programs to ensure access for all. A first-class treatment center also practices diversity and inclusion, including having culturally appropriate symbols and employing staff who are diverse and bilingual.

Staff Development

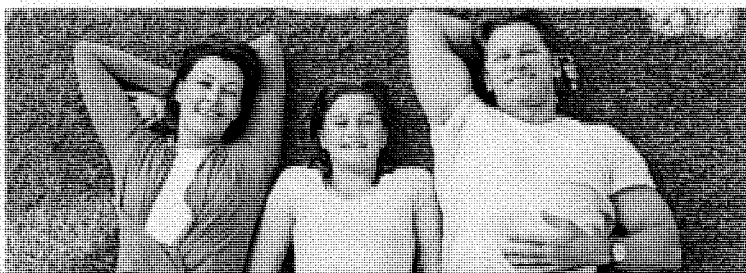
A COE should also be invested in the development of staff, which creates a pipeline for growth within the organization. Growing staff from within is not only cost effective for the organization, but allows individuals to expand their leadership skills, creating a

staff better equipped to meet the needs of an ever-changing and complex healthcare system. It also creates a loyalty to the organizational mission.

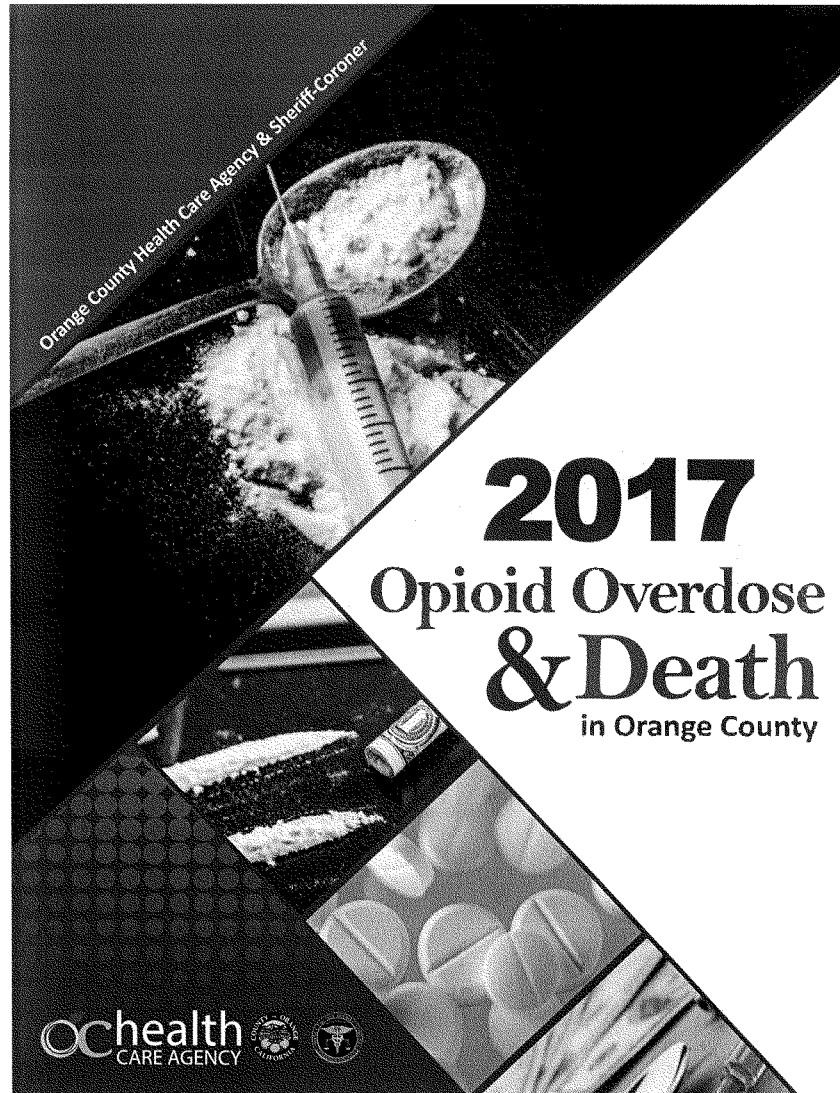
Conclusion

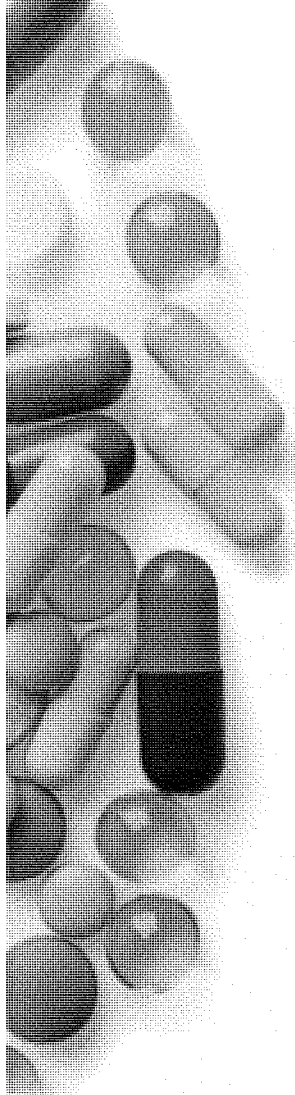
These characteristics represent, at a minimum, what is needed for an addiction treatment organization to consider itself a Center of Excellence. With the ever-changing landscape of the American healthcare system, providers are challenged to meet evolving expectations, which will continually increase over time. As an industry, addiction treatment centers are in a position to set the highest standard of care for clients. This is accomplished with accreditation, performance management, and evidence-based care with the capacity to treat co-occurring illnesses, an investment in education and research, transparent and ethical practices and marketing, availability to all individuals, and advocacy in the field.

It is time for accountability in the addiction field. It is time to set standards that all treatment organizations should strive to meet. While Caron and Hazelden Betty Ford uphold the highest standards required to be a Center of Excellence, both organizations call upon others to adopt similar standards which promote overall quality of care.



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Suggested Citation

"Opioid Overdose and Death in Orange County.
OC Health Care Agency and Orange County Sheriff-Coroner
Department. Santa Ana, California, August, 2017."

This report, a story map, and a variety of additional resources
about outreach and prevention efforts are available online at
www.ochealthinfo.com/opioids.

EXECUTIVE SUMMARY

Drug overdose (poisoning) is now the leading cause of unintentional injury death in the United States, causing more deaths than motor vehicle crashes. Opioids – both prescription painkillers and heroin – are responsible for most of those deaths. The number of Californians affected by prescription and non-prescription opioid misuse and overdose is substantial, with rates varying significantly across counties, and even within counties. In Orange County, there were **7,457** opioid overdose/abuse cases treated in emergency departments (ED) between 2011 and 2015. Importantly, seven of every 10 overdose deaths investigated by the Orange County Sheriff-Coroner during this five-year period involved opioids.

While Orange County has lower opioid mortality rates compared to some other states and the nation, notable disparities and risk factors were identified for some of our residents. For example, males were nearly two times more likely than females to overdose and/or die from an opioid-related incident. Geographically, cities along the coastal and southern regions of Orange County tended to have higher rates of ED visits and death than other cities.

Some key findings of the report include:

- ◆ The rate of opioid-related overdose deaths has remained relatively level between 2011 and 2015, but the rate of opioid-related ED visits has more than doubled since 2005.
- ◆ The majority of overdose deaths were to Non-Hispanic Whites (61%), followed by Hispanics.
- ◆ Residents between the ages of 45 to 54 had the highest overdose death rates, and nearly half of all deaths occurred for those between the ages of 45 to 54.
- ◆ Higher ED visit rates were found in coastal and southern cities (e.g., Dana Point, Costa Mesa, San Clemente, Laguna Beach, and Laguna Woods).

The Orange County Health Care Agency offers several different public education, prevention, outreach and treatment services aimed at reducing the misuse and abuse of drugs and alcohol among Orange County residents. Current efforts to address these findings include increasing available treatment, the hosting of town halls and community meetings to raise awareness for parents,

support National Take Back Day to encourage the proper disposal of prescription medication, and target educational outreach and services in communities with higher prevalence among high school age youth. The County continues to look for opportunities to expand these services.

On July 11, 2017, the Orange County Board of Supervisors accepted a grant for 6,218 doses of Naloxone. Naloxone, also known as Narcan, is an opiate antagonist and is used to reverse the effects of an opiate overdose. The purpose of the grant is to distribute the naloxone locally and save lives from opioid overdose. Efforts will be made to link those who are using opioids, including those who overdose, to the services available throughout the county.

Additionally, the Orange County Alcohol and Drug Advisory Board is working on an Opioid Strategic Plan that will identify individual and community needs in Orange County and effective strategies to address these needs. The plan will focus on integration of evidence-based practices related to education and prevention, early intervention, treatment and recovery.

For more information on these and additional resources, please refer to page 16 of the report.

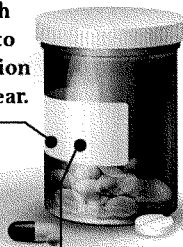
INTRODUCTION

According to the National Survey on Drug Use and Health (NSDUH, 2015), 27.1 million people in the United States used illicit drugs or misused prescription drugs in the last month (Center for Behavioral Health Statistics and Quality, 2016). Additionally, the rate of drug-induced overdose deaths in the U.S. has significantly increased in the past decade with an estimated 47,055 drug overdose deaths occurring in 2014 and over 60% of such deaths are due to opioids, including heroin and prescription drugs (Rudd et al., 2016). The Centers for Disease Control and Prevention (CDC) also found the lethal combination of benzodiazepines and opioids was a leading cause of overdose in the nation (CDC, 2014; Chen et al., 2014). Researchers have speculated that concurrent use of multiple substances may be related to the surge in hospitalizations and overdose deaths (CDC, 2013a; Paulozzi et al., 2011).

Substance use disorders also have serious economic consequences resulting in lost productivity, criminal justice involvement, and health care expenses accumulating upwards of \$400 billion annually in the U.S. (Sacks et al., 2015; National Drug Intelligence Center, 2011). In Orange County alone, substance-related hospitalization charges between 2011 and 2012 were estimated to be more than \$269 million (OSHDP-ED & OSHDP-PD, 2011-12) and increased to over \$425 million between 2013 to 2015 (OSHDP-ED & OSHDP-PD, 2013-15). The development of prevention programs not only have the potential to reduce substance-related hospitalizations and/or deaths, but also provide cost-effective interventions. The benefit-per-dollar cost ratios can range from small returns to more than \$64 for every dollar invested in prevention programs (U.S. Department of Health and Human Services, 2016).

Similar to nationwide trends, Orange County has seen an increase in drug-related overdose deaths within the last 15 years. In a recent report, drug overdose deaths increased by 88% between 2000 and 2015 (HPRC, 2017), and nearly half

The average prescription in OC was filled for 72 pills, which corresponds to over 122 million pills in one year.



of all deaths were due to accidental prescription drug overdoses. Moreover, a total of 1,711,809 prescriptions for opioids (e.g., hydrocodone, oxycodone) were dispensed to OC residents in 2015 according to the Controlled Substance Utilization Review and Evaluation System (CURES; data provided by California Department of Justice). Additionally, opioids have become the most prescribed class of medications in the U.S. with more than 289 million prescriptions written each year (Levy et al., 2015; Volkow et al., 2011). This highlights the importance of focusing prevention efforts to address the rising opioid consumption among residents.

This report serves as a follow-up to Orange County Health Care Agency's (HCA) Drug & Alcohol Overdose Hospitalization & Death report published in 2017, wherein we further examine in more detail, opioid-related emergency department (ED) visits, hospitalizations, and deaths that occurred between 2011 and 2015. It presents demographic differences (e.g., gender, age, race/ethnicity, and geography) of Orange County residents who overdosed and/or died as a result of using opioids, as well as examines factors that contributed to an overdose (e.g., intent and type of substance used). These findings and profiles are intended to help guide local

substance use education, prevention, and treatment efforts.

ED visit and hospitalization cases (2011-2015) were collected from the State of California Office of Statewide Health

Top 5 Prescribed Opioids in OC:

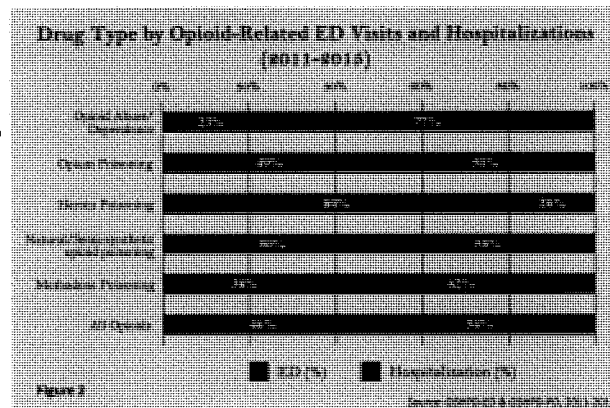
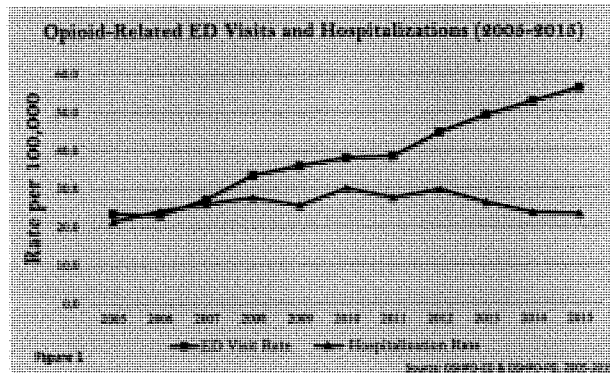
1. Hydrocodone (62%)
2. Oxycodone (16%)
3. Morphine (7%)
4. Methadone (2%)
5. Hydromorphone (2%)

Planning and Development – Emergency Department (OSHDP-ED) and Patient Discharge (OSHDP-PD) and were categorized according to the International Classification of Disease 9th (ICD-9) and 10th (ICD-10) Revisions. Information regarding overdose deaths (2011-2015) were analyzed from death certificates, which was found in the state master death file for the county and matched to data from the Orange County Sheriff's Department, Coroner Division.

OPIOID-RELATED ED VISITS AND HOSPITALIZATIONS

As part of an indepth investigation into the substance use habits of Orange County residents, this report examines cases where opioids were the primary drug resulting in a visit to the Emergency Department (ED) or subsequent hospitalization. Over the last ten years (2005-2015), the rate of opioid-related ED visits has steadily increased, while the rate of hospitalizations has remained relatively level. The overall rate of ED visits has increased by 141%, from 23.3 per 100,000 in 2005 to 56.0 in 2015 (Figure 1). The rate of hospitalizations as a result of an opioid-related overdose also increased by 9% over this ten year period (21.1 vs. 23.1 per 100,000). Overall, this increase can largely be attributed to the rise of opioid abuse or opioid dependence cases, as well as poisoning by heroin.

The type of opioid substance used prior to overdose also influenced whether or not



patients were admitted to the hospital after being treated in the ED. Opioid-related cases were classified based on the principal diagnosis (ICD-9 or ICD-10) in to one of five categories (Figure 2). Overall, 54% of opioid cases (n = 4,012 of 7,457) were admitted to the hospital for additional treatment. Patients who were classified as opioid abuse or dependent, as well as those poisoned by prescription opioids (i.e., opium, semi-synthetic, or methadone) were more likely to be admitted to the hospital. Conversely, only 20% of cases involving heroin poisoning were admitted to the hospital for additional treatment.

Frequency of Opioid-Induced Emergency Department Visits (2011-2015)

During this time period, 7,457 residents visited an ED for opioid-related issue (**Table 1**) – the majority of which were for opioid abuse or dependence (39%), followed by heroin poisoning (24%), and natural/semi-synthetic opioid poisoning (21%).

Table 1		2011	2012	2013	2014	2015	Total	
							n	%
	Opioid Abuse/Dependence	398	514	545	623	846	2,926	39%
	Heroin Poisoning	241	312	394	419	484	1,850	24%
	Semi-Synthetic Opioid Poisoning (Prescription)	314	319	345	317	274	1,569	21%
	Opium Poisoning	150	148	176	230	160	864	11%
	Methadone Poisoning	62	64	57	80	45	268	4%
	Total	1,165	1,357	1,517	1,669	1,769	7,457	100%

Source: OSHPD-ED, 2011-2015

DEMOGRAPHIC PROFILES

On average, 1,500 residents are treated in the ED each year for an opioid-related overdose or dependence. Roughly six out of ten (61%) cases were among males (n = 4,532), while 39% (n = 2,924) were female (**Table 2**). Additionally, males were treated in the ED at an average rate of 59.1 per 100,000, whereas females had a rate of 37.4 per 100,000. Between 2011-2015, the number of opioid-related ED visits increased for both males (54%) and females (48%).

The majority of opioid-related ED visits was among Non-Hispanic White residents (78%), followed by Hispanics (15%), Other / Unknown (4%), Asian / Pacific Islanders (2%), and African-Americans (1%). Non-Hispanic Whites also had the highest number and rate of ED visits for opioid-related issues at 87.2 (per 100,000). African-Americans had the second highest rate at 41.8 albeit a very small number of cases,¹ followed by Hispanics at 21.5. With the exception of African-Americans, the number of opioid-induced ED visits increased for all racial/ethnic groups between 2011-2015 (**Table 2**).

Adults between the ages of 18 to 34 accounted for more than half of those who were treated for opioid abuse (53%). The highest number and rate of visits were for people between 18 to 24 years old at 133.8 (per 100,000), followed by 25 to 34 year olds at 82.7. Adults ages 45 to 54 and 55 to 64 had the next highest rates (45.2 and 45.9 per 100,000; respectively). Teenagers (<18 years) and seniors (>65 years) had much lower rates. Importantly, the number of opioid-related ED visits increased for all age groups between 2011-2015, except for adolescents ages 10 to 17 (**Table 2**).

¹ The rate of African-American ED visits should be interpreted with caution due to the small population size.

1,157
Non-Hispanic
Whites on
average per year

230
Hispanics on
average per year

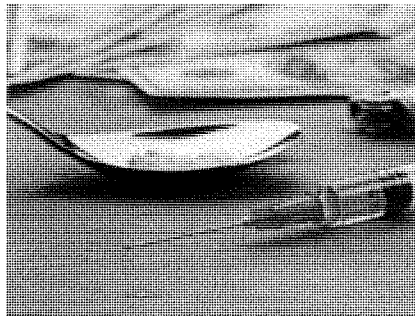
27
Asian/Pacific
Islanders on
average per year

19
African-
Americans on
average per year

Source: OSHPD-ED, 2011-2015

Demographic Characteristics of Opioid Overdose Emergency Department Visits
(2011-2015)

Table 2	2011	2012	2013	2014	2015	5-yr Total No.	5-yr Avg. Rate per 100,000
Gender							
Male	696	841	849	972	1,074	4,532	39.1
Female	469	536	568	667	684	2,924	37.4
Race/Ethnicity							
Non-Hispanic White	910	1,071	1,192	1,272	1,341	5,786	87.2
Hispanic	183	198	214	255	298	1,148	31.5
Asian / Pacific Islander	21	29	14	27	43	134	4.4
African-American	20	24	13	19	17	95	41.8
Other / Unknown	31	45	82	66	70	294	73.2
Age							
0-9	10	5	5	7	14	46	2.3
10-17	38	57	35	57	26	193	11.6
18-24	522	434	462	444	464	2,126	133.8
25-34	220	292	341	375	532	1,760	82.7
35-44	135	142	166	213	198	854	40.1
45-54	204	183	195	224	217	1,023	45.2
55-64	114	150	160	199	183	805	45.9
65+	102	104	150	141	135	631	31.7
Total	1,165	1,367	1,517	1,639	1,769	7,457	48.1



GEOGRAPHY

The geographic distribution for opioid-related ED visits between 2011 and 2015 is presented in **Table 3** and **Map 1** on page 7 and 8. Importantly, those ZIP codes and cities with the highest rates were primarily located in the southern and coastal cities of Orange County. Examining the regional prevalence of ED visits for opioid overdose or poisoning revealed a 59% increase in the number of cases in the southern region of Orange County (50.6 per 100,000). Between 2011-2015, there was also a 58% increase in the number of opioid cases reported in the central portion of the county (50.7 per 100,000).

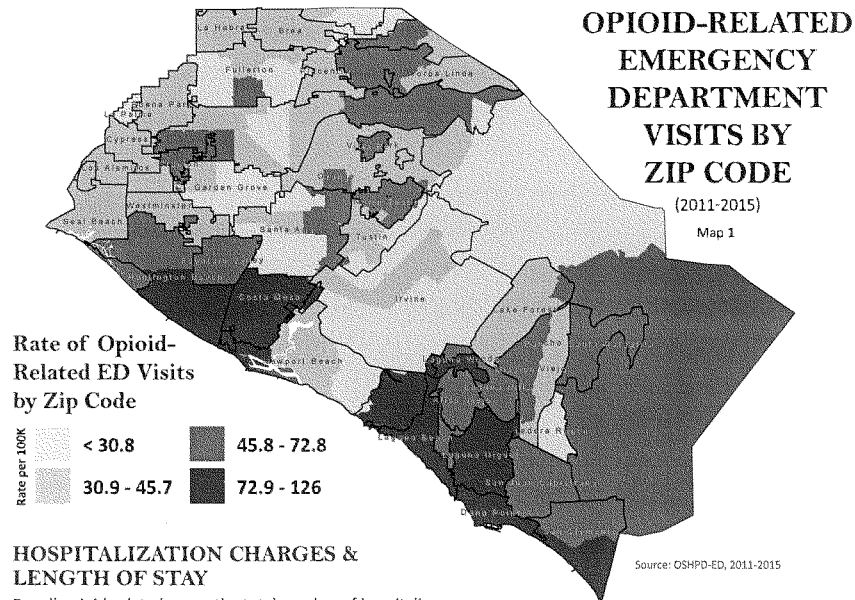
Opioid Emergency Department Visit Numbers and Rates by Geographic Region and City (2011-2015)

City of Residence ¹	2011	2012	2013	2014	2015	Total	5-Yr Avg Rate/Year	5-Yr Avg Rate	95% Confidence Interval
Southern Cities: 55% increase in the number of cases (52.6 per 100,000; CI [46.1, 55.5])									
Corona Point	27	29	42	37	70	205	43	130.2	86.2 169.0
San Clemente	50	60	67	52	71	301	60	92.4	70.2 118.5
Laguna Beach	13	22	25	24	26	105	21	90.0	55.7 137.6
Laguna Woods	12	9	15	15	17	72	14	87.5	46.6 143.0
Laguna Hills	43	40	60	46	30	219	48	73.9	54.0 97.5
San Juan Capistrano	18	21	28	32	32	131	26	72.8	47.2 105.6
Laguna Hills	10	22	29	29	20	101	20	65.2	29.4 99.7
Mission Viejo	37	53	53	56	64	268	54	55.5	41.6 72.4
Aliso Viejo	26	22	19	26	24	117	23	46.5	29.1 69.8
Rancho Santa Margarita	14	27	22	23	28	114	23	46.1	28.8 68.0
Lake Forest	26	31	42	29	31	159	32	40.0	27.0 56.1
Irvine	47	50	45	78	74	323	65	27.2	21.0 34.7
Unincorporated	17	14	24	30	35	140	28	24.4	16.2 35.3
Central Cities: 58% increase in the number of cases (52.7 per 100,000; CI [46.5, 54.8])									
Costa Mesa	74	72	100	125	174	559	112	39.4	31.6 115.4
Huntington Beach	113	174	123	144	152	726	145	73.3	61.8 86.1
Fountain Valley	21	19	26	38	44	158	32	55.5	27.7 78.4
Newport Beach	45	44	44	52	38	223	45	51.5	37.3 68.3
Seal Beach	7	8	17	4	13	49	10	39.7	18.1 71.9
Westminster	25	16	43	47	38	179	36	38.9	26.9 53.5
Tustin	30	22	30	38	42	152	30	38.7	25.8 54.5
Santa Ana	103	101	119	143	160	631	126	37.5	31.2 64.7
Garden Grove	48	51	54	55	54	252	52	29.3	22.2 38.0
Northern Cities: 37% increase in the number of cases (42.3 per 100,000; CI [38.8, 45.3])									
Villa Park	8	5	0	1	2	16	3	53.5	10.8 145.9
Yorba Linda	34	25	43	20	27	162	32	48.3	32.6 67.2
Orange	44	56	57	80	81	324	65	46.2	35.4 58.7
Anaheim	119	147	177	180	179	782	156	45.2	38.3 52.8
Stanton	13	17	8	18	29	85	17	49.9	25.6 70.1
Los Alamitos / Rosemead	13	8	11	5	7	47	9	42.4	18.6 77.0
Placentia	22	19	21	19	29	120	22	42.0	26.3 62.6
Brea	16	15	22	16	17	86	17	41.8	24.1 66.2
Cypress	21	14	26	17	20	98	20	39.3	24.0 61.5
Buena Park	28	24	29	48	31	139	32	38.3	25.8 53.6
La Habra	16	21	20	27	28	112	24	38.2	24.2 56.8
Fullerton	34	53	44	57	51	239	48	34.3	25.1 45.3
La Palma	1	2	7	1	6	17	3	21.3	2.9 55.0
Orange County	1,165	1,367	1,517	1,639	1,765	7,457	1,493	47.6	45.4 50.3

Cities with 10 or fewer cases can lead to unreliable rates and thus should be interpreted with caution.


Source: OHRPO-EB, 2011-2015

¹Geographic regions are based on the Behavioral Health Services' Service Planning Area breakdowns.



HOSPITALIZATION CHARGES & LENGTH OF STAY

For all opioid-related cases, the total number of hospitalizations between 2011 and 2015 ($N = 4,012$) resulted in over 20,000 hospital days, with the average length of stay being 5.1 days (Table 4). During this five-year period, the total amount of charges accumulated to more than \$133 million. On average, each hospitalization stay resulted in over \$33,000 in charges. Nearly four in ten patients were insured through a private insurance company (41%), followed by those who self-paid (i.e., uninsured) or were covered through Medi-Cal insurance (37%).

 Hospitalization charges averaged **\$33,000** per admission

Opioid-Related Hospitalization Charges and Length of Stay (2011-2015)

Table 4	
Total Number of Hospitalizations	4,012
Total Number of Bed Days	20,535
Average Length of Stay (in days)	5.1
Total Charges	\$113,880,543
Average Charge per Admission	\$13,370

姓名	性别	年龄	职业	住址	联系电话	电子邮箱	备注
张三	男	35	教师	北京市海淀区中关村大街100号	13800138000	zhangsan@163.com	
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王五	男	45	工程师	上海市浦东新区世纪大道100号	13600136000	wangwu@163.com	
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王十八	女	34	产品经理	广东省广州市天河区珠江新城100号	12300123000	wang18@163.com	
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徐二十八	女	32	数据分析师	江苏省南京市鼓楼区长江路100号	11300113000	xu28@163.com	
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朱三十	女	38	产品经理	广东省深圳市南山区科技园100号	11100111000	zhu30@163.com	

PATIENT DISPOSITION

The majority of patients admitted to the hospital for opioid-related problems had a routine discharge (75%). Nearly one in ten left the hospital against medical advice (9%), while a smaller percentage of patients transferred to a skilled nursing facility/rehab or home health care/hospice (6%). Fewer were discharged to another acute or psychiatric hospital (4%), and even less died or went to jail after being admitted to the hospital (2%).

CORONER-INVESTIGATED OPIOID-RELATED DEATHS

Data from the Orange County Sheriff's Department's (OCSD) Coroner Division was used to identify opioid-related drug overdose deaths. The data contained demographic information of the decedent, as well as information regarding the specific drugs used, categorized specific opioid types, and contributing causes of death. To better understand the latest trends in opioid-related overdose deaths, data was analyzed from the Coroner's database for deaths that occurred between 2011 and 2015. Residents who died out of the county were not investigated by the Coroner and, therefore, not included in the following analysis. Also excluded from this analysis were deaths of non-Orange County residents.

DEMOGRAPHIC PROFILES

Fully 70% of all overdose deaths investigated by the coroner during this five-year period involved opioids, either illicit and/or prescription (n=1,207). Approximately 62% of opioid-related deaths were among males (n = 744), who also had a higher 5-year average rate compared to females (9.7 vs 5.9 per 100,000, respectively; Table 5). Between 2011 and 2015, the 5-year average rate of opioid-related deaths was 7.8 per 100,000, and remained relatively stable throughout this time period.

Demographic Characteristics of Opioid-related Overdose Deaths (2011-2015)

Table 5	2011	2012	2013	2014	2015	5-yr Total No.	5-yr Avg. Rate per 100,000
Gender							
Male	149	134	142	152	167	744	9.7
Female	85	90	95	98	95	463	5.9
Race/Ethnicity							
Non-Hispanic White	181	175	201	202	222	981	14.8
Hispanic	38	31	30	37	32	168	3.2
Asian/Pacific Islander	8	9	3	5	7	32	1.1
African-American	2	2	3	6	1	14	6.2
Age							
10-17	5	0	1	2	1	9	0.5
18-24	26	29	31	19	25	130	8.2
25-34	45	44	40	53	63	245	11.5
35-44	45	31	41	45	40	202	9.5
45-54	72	69	67	56	48	312	13.8
55-64	32	37	45	56	62	232	12.9
65+	9	14	12	19	23	77	3.9
Total	234	224	237	250	262	1,207	7.8
Rate (per 100,000)	7.7	7.3	7.7	8.0	8.3	Source: OC Coroner, 2011-2015	

One exception was found in 2012, which demonstrated a very slight drop in the number and rate compared to adjacent years (7.3 per 100,000).

The majority of deaths were among Non-Hispanic White residents (81%), followed by Hispanic (14%), Asian/Pacific Islander (3%), and African-American (1%). Non-Hispanic Whites also had the highest rate with 14.8 per 100,000, which was much higher than other racial/ethnic groups.³ Nearly half of all opioid-involved deaths were between the ages of 45 and 64 (45%). Adults aged 45-54 had the highest rate with 13.8 per 100,000.

³ The rate of African-American deaths should be interpreted with caution due to the small population size.

OPIOID SUB-TYPES

Information regarding the specific opioid(s) used were also provided by the Coroner. When examining opioid-related overdose deaths by sub-types, at least one form of natural and/or semi-synthetic opioid was found in 66% of deaths, or 801 cases, followed by heroin (n = 239; 20%), methadone (n = 177; 15%) and synthetic opioids other than methadone (n = 139; 12%; **Table 6**). From 2011 to 2015, deaths involving natural/semi-synthetic opioids and methadone decreased; however, there was an increase in heroin and synthetic opioids other than methadone (e.g., Fentanyl). See the **Appendix** for a classification of opioid types. The growing trend among heroin and synthetic opioids are consistent with other recent reports highlighting this nationwide pattern (Rudd et al., 2016).

Opioid Sub-types in Overdose Deaths (2011-2015)⁴

Table 6	2011	2012	2013	2014	2015	5-yr Total
Natural/Semi-Synthetic Opioids	191	149	145	156	160	801
Heroin	4	37	30	67	81	239
Methadone	46	44	32	33	22	177
Synthetic Opioids other than Methadone	22	24	31	33	29	139

⁴ Drug cause of death may indicate more than one type of opioid found prior to overdose.

Source: OC Coroner, 2011-2015

TYPE & INTENT OF DRUG USE

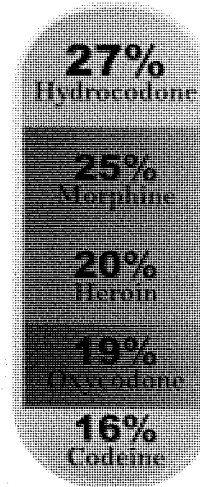
Examining opioid type (e.g., prescription versus illicit opioids) and the intent of use (e.g., intentional or accidental overdoses) can provide evidence for how opioid substances were obtained and how the user planned to use these types of drugs. In general, 81% of all overdoses were accidental, while 16% identified as intentional or suicide. Over half of opioid-involved deaths were categorized as due to prescription opioid medication overdoses (55%), followed by poly-drug use or the mixing of opioids with alcohol (26%; **Table 7**). Deaths caused by illicit opioids such as heroin accounted for 19% of cases. Additionally, accidental overdoses accounted for the majority of illicit, mixture, and prescription opioid overdose death (93%, 88% and 74%, respectively).

Opioid-type and Intention of Opioid-related Overdose Deaths (2011-2015)

Source: OC Coroner, 2011-2015

Table 7	2011	2012	2013	2014	2015	Total	%
Prescription	134	117	135	128	131	606	55%
Accident	93	108	100	93	96	490	74%
Suicide	30	23	32	32	31	148	22%
Undetermined	11	6	3	4	4	28	4%
Mixture	48	62	57	70	76	313	26%
Accident	40	54	50	64	63	271	83%
Suicide	5	6	7	5	3	26	8%
Undetermined	3	2	0	1	0	6	2%
Illicit (e.g., heroin)	92	73	49	51	94	339	19%
Accident	51	24	39	48	51	213	93%
Suicide	1	1	4	1	4	11	6%
Undetermined	0	0	2	2	0	4	1%
Total	234	278	237	250	262	1,261	100%

% OF OPIOID OD DEATHS



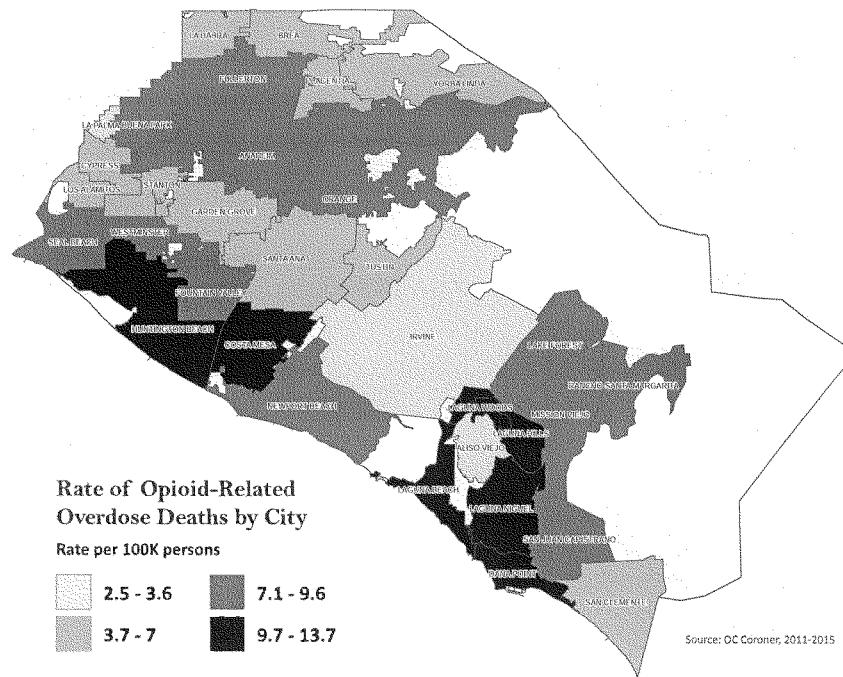
GEOGRAPHY

The geographic distribution for opioid-related overdose deaths between 2011 and 2015 are presented in Map 2 and Table 8 on pages 11 and 12. The highest rates were among coastal and south county cities including Laguna Beach, Laguna Woods, Dana Point, Costa Mesa, Laguna Hills, Huntington Beach, and Laguna Hills. Moreover, the southern region of Orange County experienced the highest increase in number of deaths (211%) during this time period.

OPIOID-RELATED OVERDOSE DEATHS BY CITY

(2011-2015)

Map 2



Opioid Overdose Death Numbers and Rates by Geographic Region and City (2011-2015)

City of Residence ^a	2011	2012	2013	2014	2015	Total	5-Yr Avg No.	5-Yr Avg Rate	95% Confidence Interval
Southern Cities: 21% increase in the number of deaths (6.3 per 100,000; CI [4.8, 8.2])									
Laguna Beach	3	2	3	3	5	16	3	13.7	2.7
Laguna Woods	3	1	1	5	0	10	2	12.2	1.5
Dana Point	3	3	2	8	4	20	4	11.7	3.2
Laguna Niguel	7	2	10	10	7	36	7	11.1	4.3
Laguna Hills	1	4	5	5	1	16	3	10.3	2.0
Mission Viejo	8	11	5	5	12	41	8	8.5	3.6
Lake Forest	4	4	8	10	6	32	6	8.0	2.8
Rancho Santa Margarita	3	2	5	3	6	19	4	7.7	1.7
San Juan Capistrano	3	3	5	1	1	13	3	7.2	1.2
San Clemente	3	8	3	1	6	21	4	6.4	1.7
Aliso Viejo	0	0	6	1	2	9	2	3.6	0.2
Unincorporated	3	6	5	3	2	19	4	3.3	0.7
Irvine	6	7	5	10	5	33	7	2.8	1.1
Central Cities: 20% increase in the number of deaths (7.8 per 100,000; CI [6.2, 9.5])									
Costa Mesa	9	12	13	16	15	65	13	11.6	6.2
Huntington Beach	20	22	19	16	29	106	21	10.7	6.6
Westminster	12	9	6	7	10	44	9	9.6	4.1
Newport Beach	6	6	11	8	10	41	8	9.4	4.0
Seal Beach	5	1	2	0	3	11	2	8.9	1.0
Fountain Valley	2	4	7	2	5	20	4	7.0	1.9
Garden Grove	6	12	9	12	15	54	11	6.2	2.9
Santa Ana	22	17	20	16	16	91	18	5.4	3.2
Tustin	7	6	1	2	4	20	4	5.1	1.4
Northern Cities: 18% decrease in the number of deaths (6.7 per 100,000; CI [5.3, 8.5])									
Orange	11	10	18	9	8	56	11	8.0	3.9
Buena Park	3	9	8	9	4	33	7	7.9	3.0
Fullerton	10	10	5	16	10	51	10	7.3	3.4
Anaheim	32	24	21	26	20	123	25	7.1	4.6
Placentia	4	4	2	3	4	17	3	6.5	1.2
Brea	3	0	3	3	4	13	3	6.3	1.0
Yorba Linda	6	2	2	6	4	20	4	6.0	1.6
Los Alamitos / Rossmore	1	0	2	2	1	6	1	5.4	0.1
Cypress	0	4	3	4	2	13	3	5.3	0.8
Stanton	4	1	3	0	2	10	2	5.2	0.6
La Habra	4	1	2	3	4	14	3	4.5	0.7
La Palma	0	0	1	0	1	2	0	2.5	N/A
Villa Park	0	0	0	0	0	0	0	N/A	N/A
No Fixed Abode: 70% increase in the number of deaths									
Homeless	20	17	16	25	34	112	22	N/A	N/A
Orange County	234	224	237	250	262	1,207	241	7.8	6.1

^aGeographic regions are based on the Behavioral Health Services' Service Planning Areas. Cities with 20 or fewer cases can lead to unstable rate estimates and thus should be interpreted with caution.

Source: OC Coroner, 2011-2015

SUMMARY

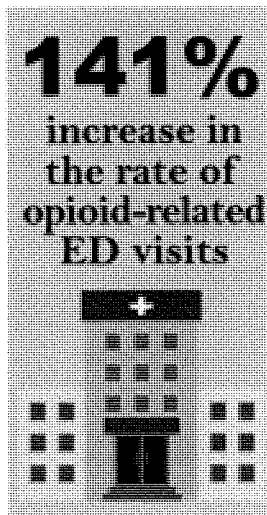
Between 2011 and 2015, there were **7,457** opioid overdose/abuse cases treated in the ED, which averaged to approximately 1,491 ED visits each year. Importantly, 7 of every 10 overdose deaths investigated by the Coroner during this five-year period involved opioids (n=1,207 opioid-related overdose deaths), for an average of 241 opioid-related overdose deaths each year.

OPIOID-RELATED ED VISITS AND HOSPITALIZATIONS

- ❖ The rate of opioid-related ED visits has more than doubled since 2005, increasing to **1,769** cases in 2015.
- ❖ Orange County residents were more likely to be admitted to the hospital for opioid abuse/dependence (77%) or methadone poisonings (62%). Conversely, cases involving heroin poisoning were less likely to be admitted to the hospital (20%).
- ❖ While males had a higher rate of opioid overdoses compared to females (59.1 vs 37.4 per 100,000), the rate increased for both males (54%) and females (48%) over the last five years.
- ❖ Majority of hospitalizations were Non-Hispanic Whites (78%) with a rate of 87.2 per 100,000, followed by Hispanics (15%; 21.5 per 100,000).
- ❖ Residents between the ages of 18 to 24 and 25 to 34 were most likely to visit the ED for an opioid-related issue (53%) and demonstrated the highest rates

(133.8 and 82.7 per 100,000, respectively).

- ❖ Higher ED visit rates were found in coastal and southern cities (e.g., Dana Point, Costa Mesa, San Clemente, Laguna Beach, and Laguna Woods).
- ❖ There were nearly 21,000 hospital bed-days with an average stay length of 5.1 days – resulting in approximately \$133 million in total charges.



OPIOID-RELATED DEATHS

- ❖ Between 2011 and 2015, the 5-year average rate of opioid-related overdose deaths was 7.8 per 100,000 persons and has remained relatively level over this time period.
- ❖ Males had a higher rate of overdose deaths when compared to females (9.7 vs 5.9 per 100,000).
- ❖ The majority of overdose deaths were to Non-Hispanic Whites (81%) with a rate of 14.8 per 100,000, followed by Hispanics (14%; 3.2 per 100,000).
- ❖ Residents between the ages of 45 to 54 had the highest overdose death rates of 13.8 per 100,000 with 45% of all deaths in the age range of 45 to 64.
- ❖ Natural or semi-synthetic opioids were present in 66% of overdose deaths (n = 801).
- ❖ Coastal and southern cities demonstrated the highest rates of opioid-related mortality relative to the rest of the county (e.g., Laguna Beach, Laguna Woods, Dana Point,

Costa Mesa, Laguna Niguel, Huntington Beach, and Laguna Hills).

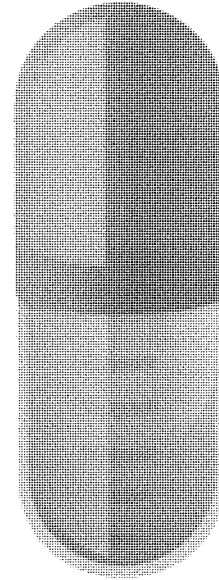
- ❖ There was an increase in the number of deaths that occurred in southern and central regions of the county between 2011 to 2015 (21% and 20%, respectively), while northern cities had an 18% decrease.

The Orange County Health Care Agency (HCA) offers several public education, treatment, and counseling services aimed at reducing the misuse of drugs and alcohol. To support these educational initiatives, the Agency and our partners often host events to provide a safe and responsible way for residents to dispose of unused prescription medication (<http://ochealthinfo.com/eh/waste/medwaste/medwaste>).

Emergency medical personnel and paramedics have administered over 1,500 doses of naloxone in each of the last two years. Additionally, Orange County Emergency Medical Services (OCEMS) developed a public safety, first responder standing order to support the Orange County Sheriff's Department (OCSD) and other jurisdiction's implementation of an Overdose Prevention Program. For example, OCEMS staff partnered with OCSD to train more than 150 OCSD Deputies to administer prepackaged naloxone to unconscious, unrespon-

81%
of overdose
deaths were
accidental

55%
due to
prescription
opioids



sive victims of a suspected opioid overdose (after ensuring that 9-1-1 EMS responders are en route) to help reverse effects of these narcotics.

Our efforts focus on providing consumers and professionals in the behavioral health field with accurate information regarding the potential risk factors associated with drug and alcohol abuse. For more information on HCA's Behavioral Health Services, please call the information and referral line at 855-OC-Links (625-4657) or visit <http://www.ochealthinfo.com/oclinks/>.

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APPENDIX: CLASSIFICATION OF OPIOID SUB-TYPES

Semi-synthetic opioids are derived from the naturally occurring opiates and opium alkaloids (e.g., morphine). Fully-synthetic opioids such as methadone and fentanyl are synthesized from other chemicals and molecules that do not come from alkaloids found in opium.

Natural/Semi-Synthetic Opioids
Codaine
Morphine
Hydrocodone
Oxycodone
Hydromorphone
Oxymorphone
Buprenorphine
Dihydrocodeine
Naloxophen
Naraxycodone
Orbital
Methadone
Fentanyl
Synthetic Opioids other than Methadone
Meperidine
Fentanyl
Tramadol
Tapentadol
Propoxyphene
Norpropoxyphene
Norcodeine
Miltarginin

MENTAL HEALTH & SUBSTANCE ABUSE PREVENTION RESOURCES

NAMI WarmLine

877-910-WARM (877-910-9276)

The NAMI WarmLine provides telephone-based, non-crisis support for anyone struggling with mental health and/or substance abuse issues. Services are available in English, Spanish, Vietnamese, Farsi and interpretation for other languages is made available upon request.

24 Hour Suicide Prevention Line

877-7-CRISIS (877-727-4747)

The Suicide Prevention Line provides 24-hour, immediate, confidential over-the-phone suicide prevention services to anyone who is in crisis or experiencing suicidal thoughts. The service is provided in English, Spanish, and Vietnamese, while interpretation for other languages is made available upon request.

Medication Disposal

<http://www.ochealthinfo.com/phs/about/promo/adept>

There are many drop box location sites throughout Orange County. Drop boxes offer a safe location where people can dispose of unused medications, which can help prevent people from using medications that were not prescribed to them. In addition, medications can be safely destroyed at home.

Opioid Strategic Plan

The Orange County Alcohol and Drug Advisory Board is working on an Opioid Strategic Plan that will identify individual and community needs in Orange County and effective strategies to address these needs. In addition, the Orange County Board of Supervisors accepted a grant for 6,218 doses of Naloxone in July 2017. Naloxone, also known as Narcan, is an opiate antagonist used to reverse the effects of an opiate overdose. The purpose of the grant is to distribute the naloxone locally and potentially save lives from opioid overdose. For more information on these resources, please visit:

<http://www.ochealthinfo.com/bhs/about/adab>.

SAFER OC

Orange County Collaborative
on Prescription Drug Abuse

<http://www.saferxoc.org/>

Working together to save lives. Misuse and abuse of prescription drugs is Orange County's fastest growing drug problem, with overdose deaths increasing at alarming rates — most of them accidental. The harm of substance abuse is rippling through our families, schools and workplaces. To stem this epidemic, we have launched SafeRx OC, an initiative led by a team of community members and experts.

OC Links

855 OC-LINKS (855-625-4657)

www.ochealthinfo.com/oclinks

OC Links is an information and referral phone and on-line chat service to help navigate the Behavioral Health Services (BHS) system within the Health Care Agency for the County of Orange. Callers are connected to clinical Navigators who are knowledgeable in every program within the BHS system. This includes children and adult mental health, alcohol and drug inpatient and outpatient programs, crisis services, and prevention/early intervention programs. Once a program is identified, the Navigator will make every effort to link the caller directly to that program while still on the call or engaged in a chat.



Behavioral Health Information & Referrals

855-OC-Links
(625-4657)

www.ochealthinfo.com/OCLinks

This information is also available on our website at www.ochealthinfo.com/opioids.

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January 23, 2018

Mr. Douglas Tieman
President and CEO
Caron Treatment Centers
P.O. Box 150
Wernersville, PA 19565

Dear Mr. Tieman:

Thank you for appearing before the Subcommittee on Oversight and Investigations on December 12, 2017, to testify at the hearing entitled "Examining Concerns of Patient Brokering and Addiction Treatment Fraud."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Tuesday, February 6, 2018. Your responses should be mailed to Ali Fulling, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Ali.Fulling@mail.house.gov.

**US House Energy Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
December 12, 2017 Hearing Entitled:
Examining Concerns of Patient Brokering and Addiction Treatment Fraud**

**Questions for the Record Responses and Member Requests for the Record
Submitted on Behalf of Doug Tieman, President and CEO of Caron Treatment Centers**

Attachment I—Additional Questions for the Record

The Honorable Michael C. Burgess

1. The issue of abusive billing, particularly relating to urine drug tests in the context of this hearing, is especially concerning given the costly nature of the issue. In one case in Florida, an insurance company was billed \$600,000, primarily for drug tests, over the course of just seven months. How can we work to limit abusive billing and incentivize insurance companies to get involved?

Caron is greatly concerned about abusive billing practices. These practices undermine the trust between providers and payers, and make it more difficult to help patients access the treatment modalities and clinically-based practices often required to establish ongoing recovery from addiction. Additionally, urine drug screen (UDS) billing may serve as an indication of a shift in focus from providing quality addiction treatment to increasing profits at patient and insurance payer expense.

Caron's primary concern is for the patients and the quality of care provided to those who are subjected to unnecessary urine drug screens (UDS) to such a dramatic extent. While there is a place for UDS in substance use disorder (SUD) treatment, excessive testing that is not clinically necessary must end. Not only is this an unethical practice, it adds to the barriers to treatment by casting an exploitative shadow over the addiction treatment sector of health care as a whole.

Here are a few federal and industry guidelines related to UDS testing and billing that may help mitigate abusive billing practices:

- The Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) – Provider Compliance Tips for Laboratory Testing¹ and Controlled Substance Monitoring and Drugs of Abuse Testing²
- The American Society for Addiction Medicine (ASAM) – the Appropriate Use of Drug Testing in Clinical Addiction Medicine³

¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforLabTests-Other-ICN909412.pdf>

² [https://www.cms.gov/medicare-coverage-database/shared/handlers/highwire.aspx?url=https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?@@@LCDId=\\$36029***ContrId=\\$5238***ver=\\$511***ContrVer=\\$552***CtrctrSelected=\\$5238*2***Ctrctr=\\$5238***name=\\$SCGS+Administrators,+LLC+\(15202,+MAC:+Part+8\)***DocType=\\$55Active***s=\\$542***bc=\\$55AggAAQAAAAAAS\\$555***&session=vekze4vu1q31z645ae130wub&kq=1201395334](https://www.cms.gov/medicare-coverage-database/shared/handlers/highwire.aspx?url=https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?@@@LCDId=$36029***ContrId=$5238***ver=$511***ContrVer=$552***CtrctrSelected=$5238*2***Ctrctr=$5238***name=$SCGS+Administrators,+LLC+(15202,+MAC:+Part+8)***DocType=$55Active***s=$542***bc=$55AggAAQAAAAAAS$555***&session=vekze4vu1q31z645ae130wub&kq=1201395334)

³ https://journals.lww.com/journaladdictionmedicine/Fulltext/2017/06000/Appropriate_Use_of_Drug_Testing_in_Clinical.1.aspx

1 | Examining Concerns of Patient Brokering and Addiction Treatment Fraud Questions for the Record Response, Douglas Tieman, President & CEO, Caron Treatment Centers

- Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) – Treatment Improvement Protocol (TIP) Substance Abuse: Clinical Issues in Intensive Outpatient Treatment, Appendix B. Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use.⁴

It is Caron's belief that key points from the above-referenced guidelines could serve as components of a quality care standards certification for both substance use disorder treatment and recovery residence providers. In addition, Caron supports provider education based on the recommendations in the resources listed above for UDS testing as a standard of quality treatment and care to limit abusive billing. Key points to highlight include:^{5,6}

1. For people in addiction treatment, frequency of testing should be dictated by patient acuity and level of care.
2. Urine drug screening must be ordered by the physician or other eligible professionals who are treating the patient.
3. Drug testing should be scheduled more frequently at the beginning of treatment; test frequency should be decreased as recovery progresses.
4. When a patient is stable in treatment, drug testing should be done at least monthly. Individual consideration may be given for less frequent testing if a patient is in stable recovery. When possible, testing should occur on a random schedule.
5. Weekly random drug testing is appropriate in a recovery residence. (Any patient expelled from a recovery residence should be able to continue an ongoing therapeutic relationship with his or her outpatient addiction treatment provider.)
6. Drug testing during and after tapering from methadone or buprenorphine continues to be an important way to support a patient's recovery; providers may want to consider increasing drug testing frequency during tapering and in the period after tapering.
7. The physician or other eligible professionals who ordered the test must maintain documentation of medical necessity in the beneficiary's medical record.
8. Providers should seek to work with a laboratory that has expertise in drug testing in addiction treatment settings and should be aware of the costs of different test methods.
9. When selecting a laboratory, providers should investigate whether state law requires a specific certification.
10. It is important to work with a laboratory qualified to perform accurate tests and assist in the interpretation of results.
11. Because drug testing should be individualized, laboratories should allow providers to order specific tests for each patient.
12. Entities submitting a claim must maintain documentation received from the ordering physician or non-physician practitioner.

⁴ <https://www.ncbi.nlm.nih.gov/books/NBK64092/>

⁵ Jarvis, Margaret MD, DFASAM; Williams, Jessica MPH; Hurford, Matthew MD; Lindsay, Dawn PhD; Lincoln, Piper MS; Giles, Leila BS; Luongo, Peter PhD; Safarian, Tareen BA. (May/June 2017). *Appropriate Use of Drug Testing in Clinical Addiction Medicine*. Retrieved from https://journals.lww.com/journaladdictionmedicine/Fulltext/2017/06000/Appropriate_Use_of_Drug_Testing_in_Clinical_1.aspx

⁶ Department of Health and Human Services, Centers for Medicare & Medicaid Services. (n.d.). Provider Compliance Tips for Laboratory Tests – Other – Urine Drug Screening. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforLabTests-Other-ICN909412.pdf>

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Caron believes that most insurance companies are engaged on this issue and are looking for ways to reduce abusive billing practices. As noted above, guidelines are available in relation to appropriate clinical use of UDS in addiction treatment. As substance use disorders and treatment become more widely acknowledged and accepted as a sector of health care, further defining the medical necessity guidelines of UDS may facilitate further insurer engagement.

The Honorable Michael C. Burgess

2. Insurance companies are at the forefront of abusive billing practices. Would a practice such as requiring consent from a patient or a referral for out-of-network services be effective in preventing beneficiaries from enrolling in ineffective treatment programs or schemes?

Ideally, a patient would obtain a referral for substance use disorder (SUD) treatment from a primary care provider to a board-certified addiction medicine physician, like any other illness requiring specialized care. However, most health care providers lack the information and training to adequately identify, assess, or refer a patient in need of SUD treatment. The fact that individuals and families turn to the internet as the primary source of information and access to treatment indicates a lack of adequate training for health care professionals, as well as the overwhelming stigma associated with this disease. Another obstacle for those seeking treatment is a lack of knowledge and understanding about insurance coverage for SUD treatment. From our conversations with Independence Blue Cross (IBC) and Cigna, we have learned that driving policyholders to their websites for addiction treatment information is a challenge. As part of the solution to this dilemma, an insurer may consider utilizing predictive modeling to send information about policy SUD coverage and in-network providers to some policyholders.

Since the window of opportunity when an individual or family is ready to access treatment is quite brief, the additional step of obtaining a referral can create delays and barriers to obtaining care. Unfortunately, due to the nature of SUD, a delay in accessing treatment can be deadly.

Due to the interstate nature of insurance fraud and patient brokering, determining the appropriate federal response, coordination, and responsibility is imperative. Caron recommends:

- Immediate action by examining internet search provider marketing practices to prevent beneficiaries from enrolling in ineffective treatment programs or schemes.
- Prioritizing anti-kickback legislation, similar to what is in place for publicly funded health care, to protect commercial insurance companies.
- The issue of patient brokering/human trafficking must also be addressed and supported by heavy financial penalties for violators.
- Long-term engagement with the Department of Education to fund and mandate evidence-based addiction prevention education for all children K-12 as part of the health curriculum.
- Additionally, SUD identification and referral to treatment should be an educational requirement for all health care professionals to obtain licensure and certification.

3 | *Examining Concerns of Patient Brokering and Addiction Treatment Fraud Questions for the Record Response, Douglas Tiemon, President & CEO, Caron Treatment Centers*

The Honorable Michael C. Burgess

- a. What role do you think insurers can play in preventing or avoiding fraudulent billing practices while protecting their beneficiaries?

IBC and other insurers often have robust data-driven warning flags in place to track claims submissions trends. Insurers are also refocusing fraud investigations to address suspicious billing from SUD : treatment providers. Caron is aware of at least one other insurer that is reaching out to large employers to provide education on this issue as a method to prevent policyholders from falling victim to unethical schemes.

Caron recommends insurers partner with in- and out-of-network treatment providers to strategize and bridge solutions. Providers and payers must have a level of agreement regarding ethical, evidence-based treatment.

The Honorable Michael C. Burgess

3. You outlined in your testimony that "we must certify evidence-based treatment standard practices and outcomes, and treatment providers to safeguard that individuals and families seeking substance use disorder care are receiving the medical attention needed to manage recovery of this chronic disease." When there are so many bad actors present online and in person, how can we ensure that patients are obtaining reliable information and that insurance companies are effectively collecting billing data to detect fraud and abuse occurring?

Sy Syms used to say, "An educated consumer is our best customer." Individuals and families looking for reliable addiction treatment information often fall prey to unethical marketers and treatment providers because they lack a good understanding about the chronic disease of addiction and are uninformed about what to look for when seeking treatment. In short, they don't know what to look for and they don't know how to find it.

Although some progress has been made with internet search providers, the measures to address predatory advertising are limited in scope and offer little protection from unethical marketers. The most significant change has been ensuring the [National Helpline](https://www.samhsa.gov/find-helo/national-helpline)⁷ from the Substance Abuse and Mental Health Services Administration (SAMHSA) appears at or near the top of the results page when performing a search for "rehab near me." The National Institutes of Health (NIH) also offers concise information for [finding and evaluating online resources](https://ncch.nih.gov/health/webresources#key), including questions to ask when evaluating a health-related web site.⁸ However, to date, a vetted, reliable, and current list of ethical treatment providers does not exist.

The addiction treatment sector of health care is in the midst of significant growing pains. As a sector, the National Association of Addiction Treatment Providers (NAATP) is a strong example of an organization that defines quality treatment and ethical standards in addition to requiring members to attest that they have read, understand, and agree to adhere to the [NAATP Code of Ethics](https://www.naatp.org/resources/ethics/code-ethics).⁹ Licensing

⁷ <https://www.samhsa.gov/find-helo/national-helpline>

⁸ <https://ncch.nih.gov/health/webresources#key>

⁹ <https://www.naatp.org/resources/ethics/code-ethics>

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and certification regulations vary from state to state. Caron supports the development and implementation of something akin to the Centers for Medicare & Medicaid Services' (CMS's) Five-Star Quality Rating System¹⁰ for addiction treatment providers. Additionally, Caron recommends the passage of necessary state and/or federal regulations making it illegal to provide false or misleading information about substance use treatment providers intended to lure or misdirect individuals or family members seeking care.

Caron supports the long-term solution of early intervention via routine screening for those at risk of developing SUDs. Incorporating screening and early intervention into routine health care practice and into health services offered through schools is an effective approach to reduce risky substance use and the development of addiction.¹¹ Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Caron believes that education is key to resolving the addiction crisis. Currently, most health care professionals typically receive fewer than 10 hours in addiction-specific training. At Caron, we believe that this paradigm needs to shift to ensure that health care professionals are armed with the information they need to proactively prevent the onset of addiction wherever possible and to facilitate access to treatment when appropriate.

Caron recommends:

1. National implementation of universal school-based SBIRT for all 9th graders.
2. Educate health care professionals and the American public:
 - a. To recognize the risk factors and warning signs of SUDs
 - b. To understand that addiction is a chronic disease, not a moral failing
 - c. Where to find accurate information if you or someone you know has a problem and may need help
 - d. To know patients' rights in SUD care
 - e. To know what good treatment is and what to look for in a treatment center.

The Honorable Michael C. Burgess

4. **You have argued that non-profits and for-profits should work together in order to ensure transparency and outcomes for patients and their families. I think that this is a noble cause. How many other providers have you worked with to create these standards and how do you expect they will affect the industry as a whole?**

Caron is very active with the National Association of Addiction Treatment Providers (NAATP), serving on its Board of Directors and engaging in the development of NAATP's Quality Assurance Initiative.¹²

¹⁰ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS.html>

¹¹ Guide for Policymakers: Prevention, Early Intervention and Treatment of Risky Substance Use and Addiction. (December 2015). Retrieved from <https://www.centeronaddiction.org/addiction-research/reports/guide-policymakers-prevention-early-intervention-and-treatment-risky>

¹² <https://www.naatp.org/resources/news/naatp-launches-new-year-ethics-code-20/jan-8-2018>

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NAATP is supported by hundreds of addiction treatment provider members.¹³ Caron also serves on the Boards of the Drug & Alcohol Service Providers Organization of Pennsylvania (DASPOP) and the Florida Alliance for Recovery. Plus, Caron and Hazelden Betty Ford Foundation collaborate quite often.

In addition to the provider organizations above, Caron collaborates and supports the efforts of a number of other advocacy groups and federal agencies including: Addiction Policy Forum (APF), American Society of Addiction Medicine (ASAM), Collaborative for Effective Prescription Opioid Policies (CEPOP), Faces & Voices of Recovery (FAVOR), Facing Addiction with NCADD; Institute for Behavior & Health (IBH), National Council for Behavioral Health (The Council), and Shatterproof to name some of them; plus, National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse & Alcoholism (NIAAA).

Through Caron's work with other providers, advocacy groups, and Federal agencies, it is our hope to improve transparency for both patients and insurance companies to ensure that what is promised on websites is, in fact, what is delivered and with no surprises related to billing. Ultimately, we are working in partnership to create a transparent sector of health care.

The Honorable Frank Pallone, Jr.

1. What kind of treatment are patients pulled into patient brokering schemes receiving at these facilities, and how do these schemes cause roadblocks in their recovery process?

Treatment for patients pulled into patient brokering schemes vary by provider. From Caron's perspective as a treatment provider, there are three levels of providers who participate in unethical practices:

1. Ignorance – providers who truly are simply unaware of what business and treatment practices are considered unethical or use outside firms for marketing and are unaware that patient brokers are working on their behalf
2. Ends justify the means – providers who deliver quality care, but need to fill beds to be financially solvent, or who may “color outside the lines” when it comes to insurance billing to help a patient remain in treatment longer to stabilize their recovery.
3. Disregard – providers who know and understand ethical business and treatment standards, but overlook what is in the best interest of the patients or best practices, or refuse to adopt industry proposed quality measures for financial reasons.

In some cases, potential patients are considered “leads”. Since patient brokers and lead generators are paid by the lead, patients are referred to the highest bidder. When individuals in crisis are essentially sold as products, they may be sent to a treatment center that does not meet their clinical needs. Imagine if this were the case with any other chronic disease, for example individuals seeking treatment for heart disease, asthma, diabetes, or even cancer.

¹³ <https://www.naatp.org/resources/addiction-industry-directory>

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The most widely abused treatment scheme that Caron is aware of consists of a recovery residence engaged in an undisclosed financial arrangement with a substance use disorder treatment provider. These types of arrangements have been highlighted in the press as the most frequent source of anti-kickback and insurance billing fraud violations.

Patients who do not receive adequate treatment:

- Are more likely to suffer a relapse
- Become disenchanted by treatment, and less likely to seek further treatment
- Are drained of financial resources and insurance coverage for treatment
- Are more likely to die from complications of SUD or overdose because addiction is a chronic and progressive disease.

The Honorable Frank Pallone, Jr.

2. I understand that Caron Treatment Centers' online profile was hijacked by a third party in an apparent attempt to redirect patients. How prevalent do you believe these tactics are in patient broker schemes?

Based on Caron's experience and through anecdotal evidence, Caron believes these tactics are widespread. Unfortunately, concrete numbers are difficult to determine since there is currently no way to track how many individuals and families have been diverted or misdirected. Unless addiction treatment providers search their own names daily, or several times a day, the only other way to know if a phone number or facility name has been hijacked or pirated is if we are informed by individuals, families, or referring providers. Caron conducts these searches on a regular basis.

An advisory memo from the Pennsylvania Department of Drug & Alcohol Programs about this issue is attached at the end of this document for your reference. Although this is dated from 2016, it indicates the scope of the problem. Caron is currently not aware of any further steps taken by the Commonwealth of Pennsylvania to address the marketing element of these schemes. The interstate nature of internet marketing, patient brokering, and insurance fraud is likely contributing to the delay in a comprehensive response.

Caron does recognize that the issue is prevalent enough that the internet search engine Google has had to revisit its practices around paid searches utilizing certain key words twice within less than one year.

The Honorable Frank Pallone, Jr.

3. What do you believe can be done to address the issue of frequent and excessive urine drug testing, which appears to be a key component of patient broker schemes?

Please see Caron's response to The Honorable Michael C. Burgess' question #1.

The Honorable Kathy Castor

- 1. What treatments have you seen that have had the most success for individuals in recovery and how can we ensure that patients have access to the treatment that will work for them?**

There is no single SUD treatment that works best for all individuals. Treatment of SUD must address the chronic nature of the disease and be individualized for each patient's needs. Treatment needs to incorporate the psychological, social, behavioral and physical aspects of the disease to be managed successfully. Because SUD is a chronic disease, it is a disease of remission and relapse. Therefore, relapse, which has traditionally been viewed as a failure of treatment, is now understood to be a part of the disease that can be successfully managed.

According to the National Center on Addiction and Substance Abuse (CASA), in Addiction Medicine: Closing the Gap Between Science and Practice, of those who do receive treatment, few receive anything that approximates evidence-based care. This compares with 70% to 80% of people with such diseases as high blood pressure and diabetes who do receive treatment. This report exposes the fact that most medical professionals are not sufficiently trained to diagnose or treat the disease, and most of those providing addiction care are not medical professionals and are not equipped with the knowledge, skills or credentials necessary to provide the full range of effective treatments. Misunderstandings about the nature of addiction and the best ways to address it, as well as the disconnection of addiction medicine from mainstream medical practice, have undermined effective addiction treatment.¹⁴

It is Caron's belief that until substance use disorders and addiction treatment are truly incorporated into the medical profession and health care industry, ensuring that patients have access to the treatment that will work for them will continue to be a challenge. With full incorporation as a sector of health care, patients will have access to necessary the assessments and evaluations to determine the most appropriate level of care.

The Honorable Kathy Castor

- 2. It seems some providers seek to profit on failure of a treatment rather than on long term recovery. What can we do to break the cycle? In other words, how can we incorporate incentives that provides for positive results?**

The simplest answer is a model that adequately reimburses treatment providers for patients to achieve and maintain a level of successful chronic disease management. This type of model would provide coverage and reimbursements to incentivize all levels of care, from identification and assessment through recovery supports.

¹⁴ <https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice>

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Attachment 2—Member Requests for the Record**The Honorable Gregg Harper**

1. Throughout the hearing, there were several questions regarding which states have patient broker laws and the specifics of those laws. Please provide the committee with a list and short description of all current state laws or proposed legislation in Pennsylvania that address patient brokering.

To the best of Caron's knowledge, through outreach and dialog with others, Pennsylvania has not passed a law, nor proposed legislation, specifically to address patient brokering. However, PA Act 59 of 2017 includes regulations that may deter patient brokering, stating:

(4) A policy that no drug and alcohol recovery house owner, employee, house officer or individual related to a drug and alcohol recovery house owner, employee or house officer shall directly or indirectly solicit or accept a commission, fee or anything of monetary or material value from residents, other related individuals, third party entities or referral sources, beyond specified rent established in writing at the time of residency.¹⁵

For more information, Caron recommends contacting DASPOP for more information at (717) 652-9128 or dasdbeck@hotmail.com.

The Honorable Gregg Harper

2. During the hearing, gaps in the federal anti-kickback statute as it applies to non-Medicaid facilities were discussed. Please provide a list of all current state laws or proposed legislation in Pennsylvania addressing anti-kickback statutes applying to commercial insurers and nonmedical facilities.

Pennsylvania's current anti-kickback statutes under 18 Pa. Cons. Stat. Ann. § 4117(b)(2) state:

(2) With respect to an insurance benefit or claim covered by this section, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient; except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense provided for by this paragraph, the prosecutor shall certify such conviction to the appropriate licensing board in the Department of State which shall suspend or revoke the health care provider's license.

(3) A lawyer or health care provider may not compensate or give anything of value to a person for providing names, addresses, telephone numbers or other identifying information of individuals seeking or receiving medical or rehabilitative care for accident, sickness or disease, except to the extent a referral and receipt of compensation is permitted under applicable professional rules of conduct. A person may not knowingly transmit such referral information

¹⁵ <http://www.legis.state.pa.us/cfdocs/legis/lj/uconsCheck.cfm?vyr=2017&sessind=0&act=59>

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to a lawyer or health care professional for the purpose of receiving compensation or anything of value. Attempts to circumvent this paragraph through use of any other person, including, but not limited to, employees, agents or servants, shall also be prohibited.

(4) A person may not knowingly and with intent to defraud any insurance company, self-insured or other person file an application for insurance containing any false information or conceal for the purpose of misleading information concerning any fact material thereto.¹⁶

To the best of Caron's knowledge, there is no proposed legislation in Pennsylvania relating to anti-kickback statutes for the current legislative session to date. For more information, Caron recommends contacting DASPOP for more information at (717) 652-9128 or dasdbeck@hotmail.com.

¹⁶ <http://www.legis.state.pa.us/cfdocs/legis/lj/consCheck.cfm?txtType=HTM&ttl=18&div=0&chpt=41&sctn=17&subscn=0#>

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IMPORTANT: Incorrect Routing of Calls for Treatment Placement

Smith, Jennifer S (DDAP)

Wed 11/9/2016 1:14 P.M.

Reply

Good afternoon,

DDAP would like to make SCAs and treatment providers aware of an issue that has been occurring more frequently over the past few days. Individuals from the general public have been using Google to locate treatment providers and/or SCAs and the phone number Google shows for the facility is **NOT** that of the SCA/provider. In fact, in all of the instances brought to DDAP's attention, the phone number is answered by an entity referring to themselves as "Treatment & Addiction Helpline" where a recorded voice asks the caller to select 1 or 2 based on whether the caller has "government insurance" or private insurance. If the caller selects the option for "government insurance" the call is rerouted to an agency referring to themselves as the "recovery helpline" and the caller is again asked to select whether they have private insurance or government insurance.

When selecting government insurance, the recording says "I'm sorry. We can't help you with inpatient treatment" or "I'm sorry. We only accept private insurance." At that point the recording directs the caller to contact 800-662-HELP, which is SAMHSA's number that is currently answered by DDAP for PA callers but will be answered by our hotline, PA Get Help Now, as of tomorrow 11/10/16. When the caller gets to DDAP, they believe they've reached the SCA/provider they initially googled. DDAP gives the caller the correct number for the SCA/provider.

When an individual selects "private insurance" the call is picked up by someone from an agency that calls itself "National Treatment Program" or "National Treatment Referral Network". Callers' experience has been the individual that is taking the call is often abrupt and tells the caller if he/she wants inpatient treatment he/she will need to go to Florida. Callers who have questioned the individual from "National Treatment Program" or "National Treatment Referral Network" have had their calls terminated and/or met with a rude response.

As DDAP became aware of this issue, staff were attempting to alert the SCA/provider; however, the number of callers who have been misdirected has increased significantly today, so it has become impossible for DDAP to reach out to each impacted SCA/provider individually. It appears there is an option on Google where the SCA/provider can suggest an edit to the incorrect information and by doing so, you can select scam/scammer as the reason for the change. Again, as DDAP receives calls, we are giving the caller the correct contact information for the SCA/provider and when the calls transfer to PA Get Help Now tomorrow, staff will also have access to the correct phone numbers for the SCAs and providers, but your agency may want to attempt to take correct the information on the web search engines whenever possible.

Thank you for your attention to this matter.

Jennifer S. Smith | Deputy Secretary
 Department of Drug and Alcohol Programs
 02 Kline Village | Harrisburg, PA 17104
 Phone: 717.736.7513 | Fax: 717.787.6285
www.ddap.pa.gov

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January 23, 2018

Mr. Pete Nielsen
Executive Director
California Consortium of Addiction Programs and Professionals
2400 Marconi Avenue, Suite C
Sacramento, CA 95821

Dear Mr. Nielsen:

Thank you for appearing before the Subcommittee on Oversight and Investigations on December 12, 2017, to testify at the hearing entitled "Examining Concerns of Patient Brokering and Addiction Treatment Fraud."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Tuesday, February 6, 2018. Your responses should be mailed to Ali Fulling, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Ali.Fulling@mail.house.gov.

Attachment I—Additional Questions for the Record**The Honorable Michael C. Burgess**

1. **The issue of abusive billing, particularly relating to urine drug tests in the context of this hearing, is especially concerning given the costly nature of the issue. In one case in Florida, an insurance company was billed \$600,000, primarily for drug tests, over the course of just seven months. How can we work to limit abusive billing and incentivize insurance companies to get involved?**

Urine testing should abide by best practice parameters, with justification, should there be an increased need for frequency of testing. Urine testing is a necessary tool to assist in the individual's recovery, but should be done correctly. This can be accomplished by having insurance companies adopt recommended testing frequency guidelines published by the American Society of Addiction Medicine (ASAM) and cap all reimbursements for testing to Medicare rates.

2. **Insurance companies are at the forefront of abusive billing practices. Would a practice such as requiring consent from a patient or a referral for out-of-network services be effective in preventing beneficiaries from enrolling in ineffective treatment programs or schemes?**

This is a double edged sword because, on one hand we have treatment facilities taking advantage of insurance companies with abusive billing practices, and on the other, we have insurance companies denying reimbursement to treatment facilities for medically necessary and physician recommended courses of treatment for this life threatening disease. Many times insurance companies will dispute medical necessity after three days of treatment, forcing the beneficiary, who may have benefits at a lower (and less expensive) level of care. Unfortunately, insurance companies often do not have qualified care managers making medical necessity and appeal decisions. A tremendous improvement to the insurance payment system would be to require that individuals making coverage decisions for care have competency in addiction. One way to accomplish this would be to require physicians with ASAM certification be required to oversee treatment decisions, particularly where there are disputes between clients and insurance companies.

Optum Care Medical Group now requires consent from the patient in order to verify benefits and to seek authorization for out of network admissions. This practice is beneficial to the patient for privacy reasons, and to keep the patient informed of who will be billing for treatment services. Its application to preventing beneficiaries from enrolling in ineffective treatment programs or schemes would not be a likely deterrent because being an out of network provider has little to do with whether a program is effective or ineffective.

Our organization is considering an initiative that would create an "exchange" for addiction providers where placement criteria aligned to ASAM, would be required for providers to participate. In order for insurers to participate they would need to accept treatment protocol approved by ASAM certified physicians. Additionally, providers would be required to complete ethical treatment standards coursework and could be

removed from the exchange when unethical behavior, including inappropriate treatment referrals, is found to have occurred.

3. What role do you think insurers can play in preventing or avoiding fraudulent billing practices while protecting their beneficiaries?

Insurance companies need to do a better job understanding the types of addiction treatment in the continuum of care. This will entail a better working relationship between insurers and treatment professionals. One example of how the lack of knowledge leads to abusive billing is billing for services via two concurrent modalities of care. When patients have been admitted to “all-inclusive” levels of care, providers should not be concurrently billing for claims for professional services that should be included as “all inclusive.” For example, claims for patients in Residential Treatment Center (RTC) and Partial Hospitalization Program (PHP) levels of care should never bill for individual professional services (by providers associated with that RTC or PHP program) that should be included in the RTC and PHP per diem rates. This should not prevent patients from continuing to see their outpatient provider while in treatment, but rather prevent a facility from double billing for RTC/PHP and having a therapist/psychologist associated with the program also bill. Again, having qualified professionals with a competency in addiction treatment overseeing the care (e.g. ASAM physician, licensed addiction counselor, addiction psychologist/psychiatrist) would reduce these billing abuses.

4. Mr. Nielsen, in your testimony, you explained that sober homes do play a role in substance abuse treatment, but that they need to have rules. You later stated that it is important that the industry be able to support itself with minimal oversight. What kind of legislative approach might allow us to drive out bad actors while allowing for the development of safe and effective sober homes in a minimally burdensome environment?

Legislation that encourages recovery residence certification by a certifying organization that uses National Alliance for Recovery Residence (NARR) standards is certainly a step in the right direction. Recovery residences that are not associated with any type of treatment program should be treated exactly as any other congregate living (roommate) situation. Imposing complex rules or health care licensing parameters on recovery residences that are not associated with, or receive funding from, any healthcare provider will drive up operating costs and reduce access to supportive recovery housing that is essential to long term recovery. Stand-alone sober living homes provide a much needed service and are absolutely not part of the problem.

Federal law regarding employment protection for persons with addiction is very clear. When a person claiming protection is no longer maintaining sobriety, employers are no longer required to provide protection required by statute. Recovery residences should be held to the same standard. A home that maintains certification has a positive defense that should be protected by statute. Problem homes, who cannot abide by certification standards, should lose their protection. Homes that are not shown to be “bad actors” should be left alone. Essentially, if an individual claims protection, there are rules to maintain this protection. There is no parallel for residences. Any group of people can claim the protection and there is no way to remove it.

The Honorable Frank Pallone, Jr.

1. Because some bad actors are taking advantage of the sober home model, how can good actor sober homes differentiate themselves from the bad ones?

Most “good” sober living homes go unnoticed in neighborhoods. As the need for recovery residences increases consumers have very little in the way of resources to identify safe homes for loved ones. Private or public certification that is voluntary allows homes that wish to be distinguished by a “seal of approval” to come forward and identify themselves for consumers. Certification requires quality and safety measures, including a good neighbor policy, maintenance of a recovery environment, and a safe and healthy physical environment. These homes are an asset to the community. “Bad actors” are often times be associated with a treatment center. The recovery residences that are influenced by greed will always be associated with, or receive money from, a treatment center. Stand-alone recovery residences are not structured to make substantial short term gains. Recovery residences have existed as long as people with addiction have been excluded from their homes due to the consequences of addictive behavior. They will always exist because they provide a much needed service; one that will be in demand again after the bad actor treatment centers go away.

2. How can voluntary certification help patients seeking treatment for substance use disorders distinguish legitimate facilities from bad actors?

In California recovery residences do not provide treatment. They are strictly residences. Recovery residences that choose to list availability of housing can choose to agree to being displayed on a public website. The certifying organization’s website typically displays only certified recovery residences in good standing. Certification also allows consumers to lodge complaints so that “bad” sober living homes can be identified and either trained to correct deficiencies or revoked, which would be displayed on the public website to discourage potential residents from selecting it. The certifying organization typically requires that all homes certified post a complaint phone number that goes directly to the certifying organization. This number is also published and posted at locations in the community so that members of the community could report to certifying organization any complaints or concerns. The certifying organization also performs scheduled, unscheduled, and complaint driven inspections. If a home is found to be in violation of the certifying organization’s standards it could be suspended or revoked. This information is then displayed on the certifying organization’s web site to inform the public of the home’s status.

3. What can be done to improve the voluntary certification process? Are better standards needed?

The most effective way to encourage participation in a voluntary certification program is to provide preferential referrals to certified residences, for example, requiring that all licensed programs refer only to certified residences.

As for evolving standards, NARR continuously assesses its standards, on a periodic basis, to ensure that they are implementable, provide safe environments, and encourage participation. The third version of NAAR standards will be introduced by year’s end.

4. What else can be done to bring more accountability to sober homes?

A stigma reduction campaign to assist communities in becoming more “recovery friendly” would greatly aid in improving accountability in sober living. If the public could help to distinguish bad homes from good, resources could be focused on problem homes rather than all homes. When community members associate all homes with bad homes, code enforcement resources are wasted on harassing and stigmatizing residences that should come to be a natural part of any neighborhood. If communities and local government could learn what “good” sober living looks like, they could lodge legitimate complaints about homes that harm people and impact communities.

5. What resources would help your Consortium's members to distinguish themselves as legitimate treatment providers and recovery residences?

Funding that would incentivize volunteer certification would help strengthen recovery residences. Funding for technical assistance for our members to improve quality of care and stay current with changes in the industry would also be a benefit.

The Honorable Kathy Castor

1. What treatments have you seen that have had the most success for individuals in recovery and how can we ensure that patients have access to the treatment that will work for them?

People achieve sobriety and remain in long term recovery through a wide variety of means. Some have accomplished this in religious based programs; via 12 step recovery meetings and step work with sponsors; through social model residential and outpatient treatment programs; or through medical model treatment programs including clinics that conduct medically assisted treatment (MAT). Since recovery is a highly individualized process, there is not one single path to achieve sobriety and maintain recovery. All healthy approaches to recovery should be embraced. Since the words “treatment” and “recovery” were both used in the question, it is important to distinguish the two. Recovery is the overall healing process by which people move from a state of being unwell toward wellness. Formal treatment may or may not be a part of the recovery process. When we are talking about formalized treatment (medical model or medical model mixed with aspects of social model that receive public funds), a full continuum of care founded on evidence based practices for addiction, case management, recovery services, the availability of recovery residences, and connection to other ancillary services equips clients with the greatest chance for recovery success (see section B of question 2 for further explanation). For reference please refer to John Herdman’s book, *12 Core Functions* for descriptions of counseling and treatment, and refer to the *American Society of Addiction Medicine (ASAM) Patient Placement Criteria* for appropriate level of care protocol for individuals needing treatment.

2. It seems some providers seek to profit on failure of a treatment rather than on long term recovery. What can we do to break the cycle? In other words, how can we incorporate incentives that provide for positive results?

The key is to have a treatment program that puts people before profits. These programs have staff who genuinely care about client success; client success allows them to attract dedicated and talented professionals to their programs and maintain a solid community reputation, which creates long term viability for a program.

The reason that SUD treatment often appears to be a revolving door with low success rates is two-fold:

- a) **Misunderstanding of the Disease of Addiction** - Public ignorance about the chronic, relapsing nature of the disease of addiction, or outright refusal to recognize addiction as a chronic disease of the brain that often involves relapse like other common chronic diseases such as diabetes, high blood pressure, and asthma, plays a large role in the perception that treatment is either ineffective or is designed to fail in order to financially benefit those who profit from its treatment. Rarely would a physician treating diabetes be accused of profiting due to failure of his or her patients.

When the chronic and relapsing nature of the disease of addiction is not understood or acknowledged a false paradigm, namely, that SUD treatment programs can inoculate individuals against relapse, essentially “curing” the disease is propagated. No other treatment of a chronic, relapsing medical problem is tethered to such an expectation. This expectation is stigma, plain and simple. Even more unrealistic is the notion that if the treatment programs use evidence based treatments and provide clients with all the support and tools they need, the client will be 100% successful after the first attempt at treatment. Treatment cannot be completely formulized into a “cookie cutter” model that works for all clients because clients have diverse psychological, social, and medical needs which require individualized treatment plans for both short term and long term recovery.

While treatment does work and can be improved to be made more effective through research and improved scientific treatment models and evidenced based practices, the nature of the disease of addiction, unfortunately, often (not always) requires multiple treatment episodes and a lifetime of recovery maintenance once stabilization is achieved. Healing, as with other diseases often involves multiple attempts and requires client cooperation. Relapsing after a period of sobriety following treatment is not a treatment failure in that the client has not lost the tools he or she obtained during the course of treatment. The common nature of relapse and return to treatment may give the false impression that programs want clients to return to pad their pocketbook, rather than relapse being a part of the disease and a component of the learning process in recovery for many. While treatment providers bear the responsibility of ensuring quality care and improving care as treatment methodologies are discovered to be effective, realistic expectations need to be embraced in light of the chronic relapsing nature of the disease.

- b) **Lack of a Nationally Standardized and Comprehensive System for SUD Treatment and Service Delivery** – Since people come from different backgrounds, enter treatment at different stages of life, use different substances or combinations of substances, suffer from a wide variety of functional impairments caused by their

substance abuse, and come into treatment with various degrees of recovery capital, treatment must be tailored to each individual seeking treatment. This requires that a full continuum of SUD care exists from the lowest level, outpatient care, to the highest level, residential treatment and medically assisted treatment (MAT).

Entry into treatment at any level and transition to higher or lower levels of care through periodic re-assessment of client progress must be according to medical necessity as determined by a medical doctor or a licensed practitioner of the healing arts utilizing the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5). It also requires that a wide range of withdrawal management exists from the lowest level of outpatient withdrawal management to medically managed withdrawal management so that clients can be accommodated during withdrawal at all stages of treatment. In addition to a full continuum of SUD treatment and withdrawal management levels, case management services must be utilized throughout the continuum at every level of care to ensure that transition from one level of care to another is seamless and client barriers are addressed by connecting clients to community resources/ancillary services (e.g., medical services, mental health services, recovery residences) in order to resolve issues that may pose as barriers to sustained recovery.

Once a client discharges from any level of treatment, recovery support in the form of recovery services must be available for as long as it is deemed medically necessary so that clients can remain engaged in activities and with people that promote sustained recovery. The comprehensive framework for this continuum and as described above exists in the *American Society of Addiction Medicine (ASAM) Continuum of Care* and is the current framework for the Organized Delivery System (ODS-Drug Medical Waiver) in California and in many other states, yet it has not been adopted as a national standard.

The DSM 5 and the ASAM Continuum should also be the standard for private sector treatment programs and the insurance companies that fund SUD treatment. This ensures that private sector programs are admitting clients utilizing a medically and clinically accepted admission standard based on medical necessity. Requiring the use of the DSM 5 and ASAM Continuum through legislation would force insurers, who attempt to deny legitimate claims to justify a service denial, to use a common industry standard. This would protect consumers and promote public health by ensuring treatment in both the public and private sector are standardized.

In addition to the creation of a full continuum of SUD care and a national standard for admission to treatment within the continuum, there also needs to be a national standard for SUD counselor practice and a standard code of conduct. This standard can be found in the International Certification and Reciprocity Consortium's *12 Core Functions* (www.internationalcredentialing.org).

The *12 Core Functions* for addiction counseling and a nationally adopted SUD counselor code of conduct should be required for all programs that receive public funding so that SUD counselors understand what their role and work is while conducting services in the greater framework of a standardized SUD continuum of

care, which includes both Medicaid and Medicare funding (for addiction treatment for older adults).

Finally, SUD treatment that is conducted in the public and private sector must be based on sound, evidence based practice for substance use disorders (e.g., motivational interviewing, cognitive behavioral therapy, trauma informed care, relapse prevention, psycho-education). While 12 step recovery models have served as the primary mode of treatment in social model programs for decades and continues to be indispensable for many during treatment process and in sustained recovery, newer evidence based models have shown to be effective in helping individuals obtain and maintain long term recovery. Evidence based models should constitute the bulk of clinical practice while still utilizing 12 step models throughout the recovery process for those it is effective for.

Embracing national standards for SUD treatment and clinical practice would require public and/or private oversight in the form of program accreditation and licensure, counselor certification/licensure, and both annual and random, on sight compliance audits. Unifying SUD treatment under a standardized continuum and clinical practice standards, coupled with regular fiscal and clinical oversight, would improve access to treatment, improve treatment outcomes, and help eliminate abusive and incompetent counselors and owners/operators.

3. **Mr. Nielsen, you stated in your testimony that cooperative housing offers a bridge to independent living, which is a critical piece of the sobriety puzzle. Those struggling with addiction are often in need of a stable environment, which in theory, sober living facilities seek to provide. Do you know on average what the percentage of success is for patients who have lived in cooperative housing and for how long?**

Although there are not a lot of studies concerning long term recovery rates and sober living, *What Did We Learn from Our Study on Sober Living Houses and Where Do We Go from Here?* (Polcin) and others do provide some data on the issue. Research continues to document the important role of social factors in recovery outcome (Polcin, Korcha, Bond, Galloway & Lapp, in press). For example, in a study of problem and dependent drinkers Beattie and Longabaugh (1999) found that social support was associated with drinking outcome. Not surprising, the best outcomes were predicted by *alcohol-specific* social support that discouraged drinking. Similarly, Zywiak, Longabaugh and Wirtz (2002) found that clients who had social networks with a higher number of abstainers and recovering alcoholics had better outcome 3 years after treatment completion. Moos and Moos (2006) studied a large sample of 461 treated and untreated individuals with alcohol use disorders over a 16 year period to examine factors associated with relapse. They found that social support for recovery was important in establishing sustained abstinence. Finally, Bond, Kaskutas and Weisner (2003) reached a similar conclusion in a 3-year follow up study on 655 alcohol dependent individuals who were seeking treatment. Abstinence from alcohol was associated with social support for sobriety and involvement in Alcoholics Anonymous.

A critically important aspect of one's social network is their living environment. Recognition of the importance of one's living environment led to a proliferation of inpatient and residential treatment programs during the 1960' and 70's (White, 1998). The idea was to remove clients from destructive living environments that encouraged

substance use and create new social support systems in treatment. Some programs created halfway houses where clients could reside after they completed residential treatment or while they attended outpatient treatment. A variety of studies showed that halfway houses improved treatment outcome (Braucht, Reichardt, Geissler, & Bormann, 1995; Hitchcock, Stainback, & Roque, 1995; Milby, Schumacher, Wallace, Freedman & Vuchinich, 2005; Schinka, Francis, Hughes, LaLone, & Flynn, 1998).

4. **In your testimony you say that "as in any cooperative environment, a sober living house needs rules. Rules may include curfew, smoking, chores, payment of rent, and attendance at house meetings, and must include prohibition of any use of alcohol and or drugs. The space should be adequate to accommodate each individual comfortably and with dignity and respect." How can we incentivize sober living homes that are safe spaces for patients to recover from addiction? Also, what recommendations do you have to ensure qualified, well-trained individuals are working at sober homes?**

Voluntary certification of recovery residences is a fair and economically feasible way to encourage higher levels of quality. The certification process is a means of teaching operators and residents about how to maintain effective and safe homes. It allows outside entities that have extensive experience in recovery residence programming to assist residents in developing high quality, supportive environments. It also allows for the dissemination of information about new trends in recovery residence management to occur. Most importantly it sets a baseline for safety within a residence, which should be guaranteed to all who reside in them.

Recovery residences are residences. There should be no "staffing" at a recovery residence because clinical services are not provided in them. There are typically "house managers" or "chairs" who perform duties beyond those of the rest of the residents. These individuals generally have seniority in the home and typically have longer sobriety times than other members of the house. They may be paid directly or "in-kind" via rent reduction or payment of utilities. Although not 24-hour employees, their leadership in the home should be fostered via continuing education and mentoring. This could be achieved through certification requirements that include continuing education specific to recovery residence programming.

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Gregg Harper

1. **Throughout the hearing, there were several questions regarding which states have patient broker laws and the specifics of those laws. Please provide the committee with a list and short description of all current state laws or proposed legislation in California that address patient brokering.**
2. **During the hearing, gaps in the federal anti-kickback statute as it applies to non-Medicaid facilities were discussed. Please provide a list of all current state laws or**

proposed legislation in California addressing anti-kickback statutes applying to commercial insurers and nonmedical facilities.

CA Penal code 549 was used by the Riverside District Attorney in June 2017 to arrest and prosecute an individual that served as a “patient broker” or “referent” to a treatment center. This individual was paid \$2,000 per each admission.

The code reads:

Any firm, corporation, partnership, or association, or any person acting in his or her individual capacity, or in his or her capacity as a public or private employee, who solicits, accepts, or refers any business to or from any individual or entity with the knowledge that, or with reckless disregard for whether, the individual or entity for or from whom the solicitation or referral is made, or the individual or entity who is solicited or referred, intends to violate Section 550 of this code or Section 1871.4 of the Insurance Code is guilty of a crime, punishable upon a first conviction by imprisonment in the county jail for not more than one year or by imprisonment pursuant to subdivision (h) of Section 1170 for 16 months, two years, or three years, or by a fine not exceeding fifty thousand dollars (\$50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 or by that imprisonment and a fine of fifty thousand dollars (\$50,000). Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.

CA Penal code 550 was used by the Riverside District Attorney in June 2017, and again in June 2018 to arrest and prosecute a treatment provider who was procuring insurance policies for patients, and engaging in fraudulent billing practices. These fraudulent billing practices yield revenue that fund patient brokering practices and perpetuate fraud overall.

The code reads:

(a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

...

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

(10) For purposes of paragraphs (6) to (9), inclusive, a claim or a claim for payment of a health care benefit also means a claim or claim for payment submitted by or on the behalf of a provider of any workers' compensation health benefits under the Labor Code.

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

...

(c) (1) Every person who violates paragraph (1), (2), (3), (4), or (5) of subdivision (a) is guilty of a felony punishable by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or five years, and by a fine not exceeding fifty thousand dollars (\$50,000), or double the amount of the fraud, whichever is greater.

(2) Every person who violates paragraph (6), (7), (8), or (9) of subdivision (a) is guilty of a public offense.

(A) When the claim or amount at issue exceeds nine hundred fifty dollars (\$950), the offense is punishable by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or five years, or by a fine not exceeding fifty thousand dollars (\$50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail not to exceed one year, by a fine of not more than ten thousand dollars (\$10,000), or by both that imprisonment and fine.

(B) When the claim or amount at issue is nine hundred fifty dollars (\$950) or less, the offense is punishable by imprisonment in a county jail not to exceed six months, or by a fine of not more than one thousand dollars (\$1,000), or by both that imprisonment and fine, unless the aggregate amount of the claims or amount at issue exceeds nine hundred fifty dollars (\$950) in any 12-consecutive-month period, in which case the claims or amounts may be charged as in subparagraph (A).

(3) Every person who violates paragraph (1), (2), (3), or (4) of subdivision (b) shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or five years, or by a fine not exceeding fifty thousand dollars (\$50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by

imprisonment in a county jail not to exceed one year, or by a fine of not more than ten thousand dollars (\$10,000), or by both that imprisonment and fine.

(4) Restitution shall be ordered for a person convicted of violating this section, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.

(d) Notwithstanding any other provision of law, probation shall not be granted to, nor shall the execution or imposition of a sentence be suspended for, any adult person convicted of felony violations of this section who previously has been convicted of felony violations of this section or Section 548, or of Section 1871.4 of the Insurance Code, or former Section 556 of the Insurance Code, or former Section 1871.1 of the Insurance Code as an adult under charges separately brought and tried two or more times. The existence of any fact that would make a person ineligible for probation under this subdivision shall be alleged in the information or indictment, and either admitted by the defendant in an open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

Except when the existence of the fact was not admitted or found to be true or the court finds that a prior felony conviction was invalid, the court shall not strike or dismiss any prior felony convictions alleged in the information or indictment.

This subdivision does not prohibit the adjournment of criminal proceedings pursuant to Division 3 (commencing with Section 3000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code.

(e) Except as otherwise provided in subdivision (f), any person who violates subdivision (a) or (b) and who has a prior felony conviction of an offense set forth in either subdivision (a) or (b), in Section 548, in Section 1871.4 of the Insurance Code, in former Section 556 of the Insurance Code, or in former Section 1871.1 of the Insurance Code shall receive a two-year enhancement for each prior felony conviction in addition to the sentence provided in subdivision (c). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury. Any person who violates this section shall be subject to appropriate orders of restitution pursuant to Section 13967 of the Government Code.

(f) Any person who violates paragraph (3) of subdivision (a) and who has two prior felony convictions for a violation of paragraph (3) of subdivision (a) shall receive a five-year enhancement in addition to the sentence provided in subdivision (c). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

...

(h) This section shall not be construed to preclude the applicability of any other provision of criminal law or equitable remedy that applies or may apply to any act committed or alleged to have been committed by a person.

In the for-profit sector, close to 100% have had to modify their payer matrix to include commercial payers...either directly or through courtesy billing. These providers DO NOT accept federal healthcare funding (Medicare, etc.), and are often not owned or operated by licensed physicians or any other licensed individual that is subject to the same restrictions imposed by CMS, and OIG. **CA Penal Codes 549 and 550 have the ability to hold anyone, licensed or not, accountable for patient brokering and/or fraudulent billing practices.**

SB 1228 was recently signed by the Governor, and while the fine imposed as punishment is less than that of California Penal Codes listed above, it does allow for the revocation of the facility license and/or professional credentials. This will play a major role in hindering patient brokering. The text of the new law is as follows:

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1.

The Legislature finds and declares all of the following:

- (a) The opioid epidemic is a nationwide scourge that claimed approximately 1,925 lives in California in 2016, and drug and opioid overdoses are currently in the top 20 causes of death statewide.
- (b) The need for quality recovery services has grown, driven by the opioid crisis and changes in federal law that requires insurance coverage of substance use disorders. Yet, only one in five people who need treatment for opioid use disorders currently receives treatment, according to the United States Surgeon General.
- (c) Desperation is fueling a surge in patient brokering or patient trafficking, where unscrupulous services refer people with substance use disorders to programs that are inappropriate for their needs in order to gain access to insurance payments.
- (d) All people in recovery from substance use disorders are entitled to safety and security throughout their recovery.
- (e) California has an interest in ending patient brokering and trafficking and increasing the availability of quality recovery services to encourage recovery and stability for all patients.

SEC. 2.

Section 11831.6 is added to the Health and Safety Code, to read:

11831.6.

- (a) The following persons, programs, or entities shall not give or receive remuneration or anything of value for the referral of a person who is seeking alcoholism or drug abuse recovery and treatment services:
 - (1) An alcoholism or drug abuse recovery and treatment facility licensed under this part.
 - (2) An owner, partner, officer, or director, or shareholder who holds an interest of at least 10 percent in an alcoholism or drug abuse recovery and treatment facility licensed under this part.

(3) A person employed by, or working for, an alcoholism or drug abuse recovery and treatment facility licensed under this part, including, but not limited to, registered and certified counselors and licensed professionals providing counseling services.

(4) An alcohol or other drug program certified by the department in accordance with the alcohol or other drug certification standards established pursuant to Section 11830.1.

(5) An owner, partner, officer, or director, or shareholder who holds an interest of at least 10 percent in an alcohol or other drug program certified by the department in accordance with the alcohol or other drug certification standards established pursuant to Section 11830.1.

(6) A person employed by, or working for, an alcohol or other drug program certified by the department in accordance with the alcohol or other drug certification standards established pursuant to Section 11830.1, including, but not limited to, registered and certified counselors and licensed professionals providing counseling services.

(b) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may, if it deems appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

SEC. 3.

Section 11831.7 is added to the Health and Safety Code, to read:

11831.7.

(a) The department may investigate allegations of violations of Section 11831.6. The department may, upon finding a violation of Section 11831.6 or any regulation adopted pursuant to that section, do any of the following:

(1) Assess a penalty upon an alcoholism or drug abuse recovery and treatment facility licensed under this part.

(2) Suspend or revoke the license of an alcoholism or drug abuse recovery and treatment facility licensed under Chapter 7.5 (commencing with Section 11834.01), or deny an application for licensure, extension of the licensing period, or modification to a license. Article 4 (commencing with Section 11834.35) of Chapter 7.5 shall apply to any action taken pursuant to this paragraph.

(3) Assess a penalty upon an alcohol or other drug program certified by the department in accordance with the alcohol or other drug certification standards established pursuant to Section 11830.1.

(4) Suspend or revoke the certification of an alcohol or other drug program certified by the department in accordance with the alcohol or other drug certification standards established pursuant to Section 11830.1.

(5) Suspend or revoke the registration or certification of a counselor for a violation of Section 11831.6.

(b) The department may investigate allegations against a licensed professional providing counseling services at an alcoholism or drug abuse recovery and treatment program licensed, certified, or funded under this part, and recommend disciplinary actions, including, but not limited to, termination of employment at a program and suspension and revocation of licensure by the respective licensing board.

(c) Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may, if it deems appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

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January 23, 2018

Mr. Dave Aronberg
State Attorney
15th Judicial Circuit
401 North Dixie Highway
West Palm Beach, FL 33401

Dear Mr. Aronberg:

Thank you for appearing before the Subcommittee on Oversight and Investigations on December 12, 2017, to testify at the hearing entitled "Examining Concerns of Patient Brokering and Addiction Treatment Fraud."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Tuesday, February 6, 2018. Your responses should be mailed to Ali Fulling, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Ali.Fulling@mail.house.gov.

The Honorable Michael C. Burgess

1. **The issue of abusive billing, particularly relating to urine drug tests in the context of this hearing, is especially concerning given the costly nature of the issue. In one case in Florida, an insurance company was billed \$600,000, primarily for drug tests, over the course of just seven months. How can we work to limit abusive billing and incentivize insurance companies to get involved?**

Insurance companies generally are not investing significant resources in identifying and investigating provider fraud. In addition, carriers are not required to report suspected fraud, have been slow to respond to requests from law enforcement for information, and when fraudulent schemes are suspected, refuse to pay claims or “claw back” payments that have already been made to treatment providers.

Our law enforcement task force recently contacted an insurance carrier investigator to obtain information regarding a physician who was under criminal investigation. As it turned out, this physician had billed the carrier \$7 million dollars in the previous nine months. This activity was neither flagged nor audited by the carrier and when the insurance investigator reviewed a sample of 240 claims, he discovered that 30% contained the exact same diagnosis (allergies), symptoms, environmental circumstances (black mold) and contained the same date of service and recorded vital signs for all the patients. In short, the doctor had “cut and pasted” his notes on over 70 claims. The insurance investigator had no idea that this ongoing fraud was occurring.

The market appears to be self-correcting with regard to excessive confirmatory urinalysis (U/A) lab tests, however, this correction is localized by state network and in many cases is only applied to insurance networks where the fraud has been identified as a significant issue. For example, in Florida, carriers have drastically cut the allowable number and percentage of reimbursable confirmatory U/A tests, while the same carrier in another state network still reimburses unlimited testing at inflated rates. Another example; while carriers have put limits on treatment providers, rural hospitals have been reimbursed without question, and at inflated rates. Bad actors will follow the money.

Government must intervene and encourage insurance carriers to work with law enforcement. When they uncover fraud, they should be required to report the fraud. Federal privacy laws should not stand in the way of sharing information, especially when the victims of exploitation are the patients.

2. **Insurance companies are at the forefront of abusive billing practices. Would a practice such as requiring consent from a patient or a referral for out-of-network services be effective in preventing beneficiaries from enrolling in ineffective treatment programs or schemes?**

Patients are being marketed to out-of-network providers by the thousands; however, while in many instances the marketing is deceptive or outright fraudulent, the patient is oftentimes a willing participant. Consent is not an issue. Unscrupulous marketers prey on desperate addicts or their family members. Education and outreach are important. If the consumer had a list of questions and red flags available in layman's terms, the risk of falling prey to marketing abuse would be reduced. The Palm Beach County Sober Homes Task Force is working to create such a list. The American Society of Addiction Medicine (ASAM) and the National Association of Addiction Treatment Providers (NAATP) have lists of recommended questions, albeit somewhat technical in nature. The general population must have easy access to this information.

Requiring a local in-network referral for out-of-network drug and alcohol treatment would go a long way in ending the fraud and abuse created by deceptive marketing. A medical doctor, either a Psychiatrist or Physician with training and certification in addiction medicine would be able to properly assess a patient and appropriately make a referral to an in or out-of-network provider that fits with the patient's diagnosis. In the current system, patients who are marketed out of state, in most instances, are not properly assessed (if at all) until they arrive at a facility. Certainly not by the bad actors in the industry. In a perfect world, if a clinical assessment made upon the patient's arrival determines that the receiving facility does not offer the appropriate level of care, the provider would not accept the patient but would refer to an appropriate facility. While this would be ethically and medically appropriate, referring a patient would not be in the economic interest of the provider. Unfortunately, we do not live in a perfect world.

Lastly, if insurance providers were required to make drug and alcohol treatment programs start as in-network programs, rather than out-of-network, ethical treatment providers, insurance companies and consumers would all benefit. In-network systems will provide more access for patients; allow for direct contracting between provider and insurance company (rather than assignments of benefits); allow treatment providers to be able to determine with a level of certainty that they will be paid and how much; will eliminate the high deductibles and co-pays inherent in out-of-network arrangements; and create sufficient numbers of patients at programs so that data can be gathered on what is and is not working. Unfortunately, in behavioral health, the current system does not produce sufficient in-network provider contracts as such contracts are very difficult to obtain. Maintaining our current system that favors out-of-network services only churns the unethical marketing practices that have become prevalent in the industry and incentivizes unethical behavior as out-of-network payouts are not limited by contract and are therefore much larger.

a. What role do you think insurers can play in preventing or avoiding fraudulent billing practices while protecting their beneficiaries?

Insurance carriers have a duty to ensure that their beneficiaries obtain the best medical care within their plans. The current model for addiction treatment is fee for service. While this may be appropriate in other areas of healthcare, it is a failed system for a chronic disease like opioid use disorder (OUD). Treatment is covered in the short term, with a continuum of care that in

most cases lasts for days (detox/in-patient) followed by weeks (intensive out-patient) and then discharge. Medical science has long since identified opioid addiction as a disease of the brain. Chronic use of opioids will physically alter the brain and requires at least a year of abstinence for the brain to repair the damage. The best practice is a longer, lower level continuum of care. The care continuum as it now stands is one of failure. Worse, the economic model favors relapse. Once a round of treatment is finished and insurance is exhausted, the patient is discharged. Relapse is a pre-existing condition. Relapse is covered as an acute episode, therefore insurance kicks in anew and coverage resumes. Too often provider decisions are being made based on self-interest rather than cost, quality of care or necessity of service. This recycle model is economically beneficial to the bad actors and is being grossly exploited; however, as the insurance companies move to correct the market, they wind up hurting those patients who are being treated by legitimate providers, by cutting services, days in treatment and denying medically necessary treatment.

Insurance carriers need to be part of the solution. Changing their reimbursement model from fee for service to an outcome based model that rewards effective treatment programs would significantly increase positive outcomes, and decrease fraud and overutilization of the health care system. Positive outcome models already exist. For example, Medicare reimbursement under the Affordable Care Act (ACA) uses an outcome based model that rewards good treatment. A hospital that does a poor job is not rewarded with additional payments for readmission.

3. **In your fall 2016 Presentment of the Palm Beach County Grand Jury, you mention that substance use treatment licenses should be treated as other health care licenses – as a privilege, not a right. While fraud and abuse of the system is something that needs to be addressed, do you have any concern that with increased regulation we would see a decline in substance abuse treatment facilities such that supply would not meet demand?**

No. We are in the middle of an opioid addiction health crisis. Supply will meet demand. Effective long term treatment, incorporating best practices and rewarding positive outcomes will result in a decrease in demand over time, as the crisis abates. The current system of fee for service, and the attendant overutilization of care, combined with low regulation and minimal oversight, has contributed to the explosion in demand over the past decade. In short, ineffective or fraudulent treatment may be more damaging than no commercial treatment at all.

The Honorable Frank Pallone, Jr.

1. **In your estimation, how many patients seeking treatment for substance use disorders have been pulled into these schemes?**

There is no way to numerically measure the extent of the systemic failure due to fraud or ineffective treatment coupled with overutilization of services. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 11.8 million U.S. citizens over 12 had misused opioids in 2016. From 2002 through 2016 there had been a 135% increase in the number of heroin users and a 533% increase in the number of deaths attributable to heroin. During 2016, slightly less than 7% of those aged 12 or older with a substance use disorder (SUD) received treatment at a specialty treatment facility. In 2016, Palm Beach County, Florida (PBC), Fire Rescue responded to 4,661 opioid overdose calls, including transport to area hospitals. This does not include scores of overdose victims otherwise brought to area hospitals. 589 overdose victims died in Palm Beach County alone 2016. In 2017, the PBC Medical Examiner has reported 642 opioid related deaths. This scenario is repeated nationwide, with over 42,000 opioid overdose deaths reported by the CDC for 2016. In August, 2018, the CDC released provisional numbers for overdose deaths in 2017. Through December 17, 2017, over 49,000 opioid overdose deaths were reported.

A review of insurance statements show a pattern of recycle in and out of treatment for persons with SUD, and in Palm Beach County, with over 200 treatment facilities, the number of patients has been estimated in the tens of thousands. Anecdotally, one facility in PBC purchased over 3000 airline tickets for patients in 2016.

Based on the confidentiality and unavailability of patient records, there is no way to accurately estimate the number of patients that have been drawn into these marketing schemes. The "Florida shuffle" actually refers to the recycling of addiction treatment. Therefore, it is entirely possible that many patients originally attend a good facility and are subsequently either "poached" (enticed) away during a course of treatment, or are approached by "body brokers" after discharge and encouraged to relapse and begin a new cycle of treatment with facilities paying kickbacks to the broker. As indicated earlier, the fee for service model favoring short treatment programs, feeds this cycle of relapse.

2. Are there any typical patterns regarding patients seeking treatment for substance use disorder, such as their socioeconomic status or where they reside before they come to Florida for treatment?

In PBC, the typical demographic for an SUD private-pay patient is; young adult, 18-27 years old, male. Many come here under their parent's insurance policies and their socioeconomic status is middle to upper middle class. There are a number of similar destinations marketed by out-of-network programs in places including; Orange County, CA, Prescott, AZ, Austin, TX.

3. How is Florida's Patient Brokering Act designed to address the patient brokering issue?

Modelled after the Federal Anti-Kickback statute (AKA), the Florida Patient Brokering Act (PBA) seeks to eliminate bribes, kickbacks, commissions, split fee arrangements and other benefits used to induce patients or patronage to utilize a particular health care provider or compensate a third party for the referral of patients or patronage for health care services. Marketing

addiction treatment is not the same as selling cars or appliances. Incentivizing a referral for medical treatment leads to decisions that are based on self-interest rather than cost, quality of care or necessity of services. The patient's best interest becomes secondary to the monetary interest of the broker.

The PBA does not seek to eliminate advertising or marketing, so long as it is done in a manner that does not incentivize the placement of a patient for economic, and not appropriate medical reasons.

4. How has Florida's Patient Brokering Act been working so far? What successes has Florida had in using the law to disrupt patient brokering schemes and bring prosecutions?

Patient Brokering is a "white collar" crime. It is also a form of human trafficking. It requires significant forensic investigation, akin to insurance, health care and other types of fraud. In addition, unlike most fraud cases, the victim who is being trafficked is generally unreliable, uncooperative, and in many cases, a willing participant in the fraud. In most brokering cases, the patient is induced with free rent, gym memberships, gift cards, cigarettes and other "stuff" so long as they attend a particular treatment facility. As such, the patient is aiding and abetting the brokering, and in some instances, self-brokers to a facility in return for cash and other benefits.

In Palm Beach County, we have established a Law Enforcement Task Force (TF), with investigators from a number of local and state agencies, along with assigned prosecutors. To date, the TF has arrested and prosecuted 46 individuals, mostly under the state Patient Brokering Act (PBA). Twenty two defendants have pled guilty. Our TF is also closely cooperating with a similar Federal Task Force and have participated in numerous joint investigations resulting in additional federal arrests and convictions. Palm Beach County remains a premier location for SUD treatment, however, it has seen a significant reduction in sober homes and facilities. Ethical treatment providers have been supportive of our efforts.

In many ways, state law enforcement and prosecutors face resource issues within the context of the opioid crisis. Numerous jurisdictions have become destinations for unscrupulous actors who prey on this vulnerable population. Areas of Florida, Arizona, California and Texas have become destinations for addiction treatment. As we have cracked down on patient brokering, these schemes have become more sophisticated, or bad actors have fled into other jurisdictions where law enforcement is not as aggressive and state regulation is lax. Many have relocated in states that do not have patient brokering laws that apply to behavioral health. We have seen a trend with providers relocating to the Northeast and Mid-Atlantic states. There has also been an increase in activity in other local jurisdictions within Florida that do not have a multi-agency approach to the problem. With resources stretched, most prosecutor offices and law enforcement agencies focus on violent crimes and crimes against persons. For example, I am unaware of any patient brokering cases having been brought in the other 19 Florida Circuits (other than Federal AKA cases) in the past 2 years. We have been encouraging other Florida

State Attorneys to form multi-agency task forces to go after patient brokers, especially sober home owners who funnel residents into sub-standard programs in exchange for kickbacks from the facilities. This effort needs encouragement and resources. As our model has shown, with a coordinated effort, we can achieve significant results.

5. How does Florida's Patient Brokering Act seek to crack down on deceptive advertising practices used as part of these schemes, and how successful has it been thus far?

The Florida PBA does not address deceptive advertising or marketing practices. In 2017, Florida enacted into law two deceptive marketing statutes, one civil and one criminal. In essence, F.S. 397.55 and F.S. 0345 prohibit a marketer from providing false or misleading information about the location, services or identity of a facility being marketed. Willful, material violations are punishable as a 3rd degree felony. The Florida Attorney General has dedicated an attorney to investigate and prosecute civil violations. However, it is difficult for a local prosecutor to investigate and criminally prosecute a marketing company located in another state, or operating on a national level. We have been in touch with attorneys for the Federal Trade Commission and have sent them information on actors who we believe are using deceptive marketing practices.

6. Do you feel that law enforcement has sufficient resources to investigate and go after bad actors in your state? If not, what additional resources would help you do so?

As discussed above, local law enforcement agencies and prosecutors do not have the resources to effectively combat these fraudulent practices. This is true in Florida as well as elsewhere. As indicated, these are complex, sophisticated activities. Privacy laws including HIPAA and Title 42 protections prevent law enforcement from obtaining patient information without prior court approval. An investigation cannot even begin without this prior approval.

Specific grants, earmarked to hot spots (sober home and treatment facility saturation) to assist local jurisdictions in undertaking these investigations through multi-agency task forces, would dramatically change the paradigm, encouraging an active and productive response to this fraudulent activity.

7. Have insurers reached out to you to discuss issues with frequent and excessive urine drug tests as part of these patient broker schemes? If so, what challenges do you believe insurers face in addressing this issue?

Unfortunately, insurance companies have remained uninvolved with both the civilian and law enforcement sections of our Task Force. In most cases, insurance companies were unaware of the problem, slow to react, and reluctant to cooperate with law enforcement in the investigation of this fraud. They are not legally required to pass potential criminal information on to law enforcement and when insurance investigators uncover unnecessary or excessive charges, they either withhold payment, or "claw back" these payments from providers after the fact. According to the Florida Department of Financial Regulation investigators attached to the

Task Force, they receive very few referrals or complaints from insurance providers. Our multi-agency task force has not received a provider referral in the two years since its inception.

Of greater concern, most insurance providers have been unhelpful with ongoing criminal investigations; slow to respond, unwilling to provide employee witnesses to verify fraudulent payments or release investigative files pursuant to subpoena or court order. Notwithstanding the fact that the insurance company is the victim of these fraudulent schemes, in too many instances, their actions delay and diminish the ability of local prosecutors to timely and efficiently prosecute these fraud cases.

The Honorable Kathy Castor

1. What treatments have you seen that have had the most success for individuals in recovery and how can we ensure that patients have access to the treatment that will work for them?

As previously stated, Opioid Use Disorder (OUD) is a disease of the brain. There is a common consensus in the medical and scientific community that the physical effects of this disease take time to reverse. Despite the scientific evidence that best practices include a long term plan for recovery, our system of care favors short term, limited care continuums; days in detox or inpatient care followed by weeks of intensive out-patient treatment and then discharge. Insufficient long-term recovery then feeds the syndrome of relapse rather than recovery, known as the “Florida Shuffle.” Numerous studies have shown that the longer a patient remains in treatment, the better the outcome. Common success rates through short term treatment are very low, around 10% in some studies. However, a patient who remains in a continuum of care for more than a year is far more likely to succeed, even if they have experienced relapses along the way. No one would argue that a diabetic, asthmatic or heart patient receive short term care and then be discharged without continual follow-up care.

Medication Assisted Treatment (MAT) is one best practice that focuses on harm reduction. If an addict can be stabilized through low dose opioid maintenance (Buprenorphine/Methodone) or opioid free medication (Vivitrol/naltrexone), along with clinical treatment, outcomes can be significantly improved. In addition, this form of treatment can be very effective at the point of contact with an active user as it is less painful than abstinence detoxification. Acute withdrawal can be reduced and the patient will not only be less likely to use, but is more likely to initially engage. The use of medication is generally seen as a short or moderate term transition to abstinence, to reduce the likelihood of relapse while the patient is receiving clinical care and the brain has a chance to repair. Common sense would dictate that the MAT of choice would be Vivitrol, as an anti-agonist, that is, a non-addictive replacement for opioids. While at least one study by the National Institute on Drug Abuse (NIDA) found that the use of Vivitrol is just as effective as Buprenorphine, the findings applied only to those patients who already went through detoxification (no longer craving opioids). In reality, harm reduction must apply to those persons most at risk, who are active users. Both agonists (Buprenorphine), and anti-

agonists (Vivitrol) are effective evidence based treatments. One of the dangers inherent in the use of low-dose opioid agonists is the chance that this medication will become the next pill-mill, exploited by corrupt physicians who prescribe for profit and do not adhere to the best practice that requires a robust clinical component be a part of the treatment. Buprenorphine has a black market value and our Task Force has already prosecuted a physician who was inappropriately prescribing the drug.

2. Though some states have prosecuted corrupt facilities and rogue providers, how can we crack down on facilities not providing the level of care needed to aid patients?

First, we cannot arrest our way out of the corruption, including the criminal malfeasance and systemic misfeasance, inherent in substance use disorder treatment. However, there are some industries that so affect the health and safety of our society that significant government oversight is necessary and appropriate. Public utilities is one. Substance abuse treatment should be looked at in a similar fashion. Most states require very little oversight of this industry. While strides have been made on the federal level to bring parity to both physical and behavioral health, many states have not enforced parity, or have treated behavioral health as a quasi-medical entity. For example, Florida has significant oversight of the medical profession through its Department of Health (DOH) and Agency for Health Care Administration (AHCA). Mental health and substance abuse oversight is regulated by the Department of Children and Families (DCF). DCF operates with a fraction of the budget provided to DOH and AHCA and its administrative powers are also significantly reduced. There is no way to police the industry, when there is no effective police force available. A recent effort to transfer oversight authority of behavioral health to AHCA gained no traction in the Florida legislature. Parity in the provision of medical services must include parity of oversight.

Second, the policing of the medical profession is largely left to the profession itself. Unless the subject of a criminal probe, complaints to medical regulating agencies are generally reviewed by physicians, or boards of physicians. Historically these review boards are very reluctant to act against a doctor's license.

To truly crack down on those facilities that provide sub-standard care to those suffering from SUD, government must do a better job of requiring and enforcing best practices.

The Honorable Gregg Harper


- 1. Throughout the hearing, there were several questions regarding which states have patient broker laws and the specifics of those laws. Please provide the committee with a list and short description of all current state laws or proposed legislation in Florida that address patient brokering.**

There is no proposed legislation currently pending before the Florida Legislature. Most states have some form of patient brokering (PBA) or anti-kickback statutes (AKS). However, the enforcement and application of these laws vary significantly. For example, California has an anti-kickback statute that does not apply to drug treatment facilities, although there is a current bill before the legislature that mirrors the Florida PBA. The new California legislation contains no penalties, civil or criminal, for its violation.

States With Anti-Kickback/Fee-Splitting Statutes



At the outset it's important to note that there are two main groups of laws that deal with healthcare referrals: (1) Stark laws, and (2) Anti-Kickback/Fee-Splitting laws. Stark Laws focus on physicians that refer patients to a business that the physician has an interest in. Anti-Kickback/Fee-Splitting laws apply more generally to the wide world of payment for patient referrals. These two groups can sometimes overlap in certain areas, especially when dealing with complex business arrangements so it's important not to get caught up in semantics. While I've made note of the Stark laws in each state, this memo, in response to the Committee's questions, addresses Anti-Kickback/Fee-Splitting laws.

46 states have at least some kind of Anti-Kickback/Fee-Splitting law. Of those states, only 12 have a general criminal statute that applies to both public and private healthcare (like Florida's Patient Brokering Act). And 8 of those 12 states adopt at least one or more of the federal AKS safe harbors or have their own exceptions that closely resemble the federal AKS safe harbors. Below is a more in-depth outline of what I've found.


 = only applies to publicly-funded treatment

 = applies to public AND private treatment

1. Alabama

- a.  Ala.Code 1975 § 22-1-11
 - i. adopts AKS and all safe harbors
- b.  Ala. Code § 22-21-354
 - i. (financial arrangement between hospital authority and non-hospital-based physician for the furnishing of office space may take into account the probability or possibility that such person will refer patients or others to [a health care facility] owned or operate by the authority)

2. Alaska

- a.  Alaska Stat. § 11.46.660
 - i. (crime of commercial bribe, receiving; applies to physicians; class C felony)
 - ii. Very obscure.

3. Arizona

- a.  A.R.S. § 32-1979.02

- i. Very obscure, only applies to fluoride varnish!
- ii. No safe harbors
- b. A.R.S. § 13-3713
 - i. Similar to AKS
 - ii. Appears to adopt all safe harbors
- c. Ariz. Rev. Stat. Ann. § 32-1401
 - i. (noncriminal)
- d. A.R.S. § 32-1696 (2mm only)
 - i. 3. Give, pay or receive, or offer to give, pay or receive, directly or indirectly, any gift, premium, discount, rebate or remuneration to or from any physician or optometrist in return for the referral of patients or customers.

4. Arkansas

- a. A.C.A. § 20-77-902
 - i. Adopts some of the AKS safe harbors

5. California

- a. West's Ann.Cal.Welf. & Inst.Code § 14107.2
 - i. Similar to AKS
 - ii. Adopts most safe harbors
- b. West's Ann.Cal.Bus. & Prof.Code § 650
 - i. Very broad
 - ii. Adopts some safe harbors and ADDS some unique exceptions of its own
- c. West's Ann.Cal.Bus. & Prof.Code § 654.1
 - i. LAB SPECIFIC!
 - ii. Has some unique exceptions but does not adopt any safe harbors
- d. West's Ann.Cal.Bus. & Prof.Code § 654.2
 - i. California's version of Stark Law

6. Colorado

- a. C.R.S.A. § 12-36-125
 - i. General prohibition against fee splitting or payment for patient referrals
 - ii. Adopts no safe harbors but is RENDERED COMPLETELY USELESS BY EXCEPTION!
 - 1. (b) Notwithstanding the provisions of paragraph (a) of subsection (1) of this section, a licensee may pay an independent advertising or marketing agent compensation for the advertising or marketing services rendered on the licensee's behalf by such agent, including compensation which is paid for the results or performance of such services on a per patient basis.

7. Connecticut

- a. C.G.S.A. § 19a-30
 - i. LAB SPECIFIC but noncriminal
 - ii. (e) A license issued under this section may be revoked or suspended in accordance with chapter 54 or subject to any other disciplinary action specified in section 19a-17 if such laboratory has engaged in fraudulent practices, fee-splitting inducements or bribes . . .

- iii. (f) No representative or agent of a clinical laboratory shall solicit referral of specimens to his or any other clinical laboratory in a manner which offers or implies an offer of fee-splitting inducements to persons submitting or referring specimens, including inducements through rebates, fee schedules, billing methods, personal solicitation or payment to the practitioner for consultation or assistance or for scientific, clerical or janitorial services.

b. Conn. Gen. Stat. Ann. § 20-7a

i. LAB SPECIFIC STARK LAW

c. C.G.S.A. § 53a-161c

- i. VERY BROAD, APPLIES TO ANY SERVICES NOT JUST TREATMENT!
- ii. Adopts all safe harbors
- iii. (2) knowingly solicits, accepts or agrees to accept any benefit, in cash or in kind, from another person upon an agreement or understanding that such benefit will influence such person's conduct in relation to referring an individual or arranging for the referral of an individual for the furnishing of any goods, facilities or services to such other person under contract to provide goods, facilities or services to a local, state or federal agency

8. Delaware

a. 31 Del.C. § 1005

- i. Identical to AKS
- ii. Only adopts a few of the safe harbors!

9. District of Columbia

a. DC ST § 4-802

- i. Similar to AKS
- ii. No safe harbors

10. Florida

a. FSA 817.505

- i. Similar to AKS
- ii. Adopts all safe harbors

b. FSA 456.054

- i. Extremely broad
- ii. Excludes substance abuse treatment
- iii. Adopts all safe harbors via 817.505

c. FSA 395.0185

- i. VERY BROAD
- ii. Only applies to hospitals
- iii. No safe harbors
- iv. Noncriminal

d. FSA 465.053 (Patient Self-Referral Act of 1992)

- i. Florida's Stark Law

e. FSA 409.920

- i. Medicaid only

f. FSA 400.17 and 400.176

- i. Nursing homes only

g. FSA 483.245

- i. Lab kickbacks
- ii. Non-criminal
- iii. No safe harbors

h. FSA 465.105

- i. Pharmacy kickbacks
- ii. Non-criminal
- iii. No safe harbors

i. FSA 429.195

- i. ALF kickbacks
- ii. Adopts all safe harbors via 817.505

j. FSA 458.331(f)

- i. Non-criminal for medical practice in general
- ii. No safe harbors

k. FSA 459.013 and 459.105

- i. Osteopathic only
- ii. Has Stark provision
- iii. Has broad AKS provision
- iv. Some exceptions but no safe harbors

l. FSA 466.0235

- i. Dental charting
- ii. Adopts all federal and state AKS laws and safe harbors

m. FSA 462.14

- i. Naturopathy
- ii. Non-criminal
- iii. No safe harbors

n. FSA 390.025

- i. Abortions
- ii. Very broad
- iii. No safe harbors

11. Georgia

a. Ga. Code Ann. § 43-18-4

- i. Georgia's Stark Law

12. Hawaii

a. HRS § 458-13

- i. Only Applies to Opticians
- ii. No safe harbors

b. HRS § 481-7

- i. Broad, but civil only, unfair trade regulation on referral kickbacks
- ii. No safe harbors

c. HRS § 431-10C-308.7

- i. Broad but non-criminal
- ii. no safe harbors

13. Idaho**a. I.C. § 54-1814**

- i. Noncriminal
- ii. General prohibition against fee splitting for referrals

b. I.C. § 54-1525

- i. Only applies to Optometrists
- ii. No safe harbors

14. Illinois**a. 305 ILCS 5/8A-3**

- i. General public assistance fraud
- ii. Some exceptions but no adopted safe harbors

15. Indiana**a. IC 12-15-24-2 and IC 12-17.6-6-12**

- i. Medicaid only
- ii. VERY BROAD
- iii. NO SAFE HARBORS
- iv. Only a Class A misdemeanor though

b. IC 25-14-4-2

- i. Stark law notice to patient requirement
- ii. Dentists only

16. Iowa**a. ICA 153.32**

- i. Uniquely worded anti-kickback provisions for dentists
- ii. Non-criminal
- iii. No safe harbors

b. I.C.A. § 149E.6

- i. Uniquely worded anti-kickback provisions for acupuncturists
- ii. Non-criminal
- iii. No safe harbors

c. ICA 154A.24(1)

- i. Same as above but for Hearing AIDS
- ii. Non-criminal
- iii. No safe harbors
- iv. i. Directly or indirectly giving or offering to give, or permitting or causing to be given, money or anything of value to a person who advises another in a professional capacity, as an inducement to influence the person or cause the person to influence others to purchase or contract to purchase products sold or offered for sale by a hearing aid specialist, or to influence others to refrain from dealing in the products of competitors.

17. Kansas**a. K.S.A. 65-2837**

- i. Non-criminal
- ii. No safe harbors

- iii. (29) Referring a patient to a health care entity for services if the licensee has a significant investment interest in the health care entity, unless the licensee informs the patient in writing of such significant investment interest and that the patient may obtain such services elsewhere

b. KSA 21-5928

- i. Medicaid only
- ii. Identical to AKS
- iii. No safe harbors

18. Kentucky

a. KRS § 311.820

- i. Abortion
- ii. Very broad
- iii. No safe harbors

b. KRS § 216.2950

- i. Medicaid and medicare kickbacks
- ii. Very broad
- iii. Adopts all safe harbors

c. KRS 205.8461

- i. Social Security Act funded kickbacks
- ii. Very broad
- iii. Adopts all safe harbors

19. Louisiana

a. LSA-R.S. 46:438.2 and LSA-R.S. 14:70.5

- i. Similar to AKS
- ii. Adopts all safe harbors

b. LSA-R.S. 37:1745

- i. Non-criminal prohibition

20. Maine

a. 10-144 CMR Ch. 101, Ch. I, § 1

- i. Adopts AKS but only as non-criminal regulation

21. Maryland

a. MD Code, Criminal Law, § 8-511..... Formerly cited as MD CODE Art. 27, § 230D

- i. Extremely broad language
- ii. No safe harbors

b. MD Code, Criminal Law, § 8-512..... Formerly cited as MD CODE Art. 27, § 230D

- i. Extremely broad language
- ii. No safe harbors

c. See also MD Code, Health Occupations, § 1-301 (Definitions)

d. And § 1-302: Certain referrals prohibited

- i. Mostly Stark Law and includes some exceptions

e. § 19-356: Discounts and split fees

- i. Relating to hospitals and split-fee arrangements with referral services
- ii. No safe harbors

f. § 19-357. Rebates from pharmacy or other providers of drugs prohibited

- i. Very broad (for pharmacies)
- ii. No safe harbors

22. Massachusetts

a. M.G.L.A. 118E § 41

- i. Broad language
- ii. Only includes a few exceptions similar to main safe harbors

b. M.G.L.A. 111D § 8

- i. Lab specific
- ii. Civil only
- iii. Very broad
- iv. No safe harbors
- v. See also M.G.L.A. 111D § 13 (interesting language)
 - 1. (c) A person or company that solicits, offers or enters into a referral arrangement or scheme with a clinical laboratory which the person or company knows or should know has a principal purpose of assuring referrals by the person or company to a particular clinical laboratory which, if the person or company directly made referrals to such clinical laboratory, would be in violation of clause (17) of section 8 or section 8A, shall be liable to the commonwealth for a civil penalty of not more than \$100,000 for each referral arrangement or scheme plus 3 times the amount of damages sustained, including consequential damages. No action shall be brought under this section more than 6 years after it accrues. The commissioner shall transmit to the attorney general such evidence of an offense as the department may have in its possession

c. M.G.L.A. 175H § 3

- i. Criminal AND Civil penalties
- ii. Broad yet contains some exceptions similar to popular safe harbors
- d. Mass also has some Stark Laws for specified physicians

23. Michigan

a. M.C.L.A. 400.604

- i. Very broad
- ii. No safe harbors!

b. M.C.L.A. 752.1004

- i. Very broad
- ii. No safe harbors
- iii. Aiding and abetting receipt of rebate or referral fee in violation of Medicaid False Claims Act (MFCA) and Health Care False Claims Act (HCFA) are general intent, not corrupt intent, crimes and, thus, to convict defendants as aiders and abettors, prosecution must prove that they intended that another receive rebate or referral fee. People v. Motor City Hosp. and Surgical Supply, Inc. (1997) 575 N.W.2d 95, 227 Mich.App. 209, appeal denied 590 N.W.2d 66, 459 Mich. 946

c. M.C.L.A. 445.162

1. Blanket prohibition against physicians receiving kickbacks from labs!
2. No safe harbors!
3. Only a misdemeanor though

d. Non-criminal Disciplinary measures for specified physicians

- i. See also Mich. Comp. Laws Ann. § 14.15(16221)(licensed health professional subject to discipline for engaging in fee-splitting or illegal remuneration activity in connections with patient referrals or medical or surgical services, appliances, or medications); Mich. Comp. Laws Ann. § 333.16221(d)(iii)(licensed health professionals subject to discipline for, among other things, unethical business practices, which includes [d]ividing fees for referral of patients or accepting kickbacks on medical or surgical services, appliances, or medications purchased by or on behalf of patients); id. § 333.20525(clinical laboratory (or owner or director) subject to discipline for solicit[ing] specimens . . . by offering or implying, directly or indirectly, discounts, rebates, or other benefits or considerations to persons referring patients or work); id. § 333.21792(nursing home cannot accept or pay illegal remuneration for referrals or for purchase of items or services for a patient); id. § 339.1910(specifies penalties for nursing home administrator who receives or pays (or offers or solicit or implies a willingness to pay or receive) illegal remuneration); id. § 400.604 (person who solicits, offers, receives, or pays a kickback or bribe in connection with services or items to be paid by Medicaid program is guilty of felony); id. § 550.1211a (corporation providing services in connection with non-insured benefit plan cannot induce a person to contract or to continue to contract for services through payment of something of value or through discount or rebate not reflected in contract or service certificate); id. § 550.1402(2)(c) (same)

24. Minnesota

- a. Only regulatory and civil
- b. And adopts all safe harbors
 - i. Minn. Stat. Ann. § 62J.23 (West 2006) (explaining that the rules in this section must be “compatible with, and no less restrictive than, the federal [anti-kickback statute] and regulations adopted under it.”)
 - ii. M.S.A. § 256R.04
 - i. Nursing homes specific
 - ii. Civil only

25. Mississippi

- a. Miss. Code Ann. § 43-13-207
 - i. Medicaid only
 - ii. Extremely broad
 - iii. No safe harbors

26. Missouri

- a. V.A.M.S. 191.905
 - i. Similar to AKS
 - ii. Adopts all safe harbors

b. V.A.M.S. 198.145 and V.A.M.S. 198.148

- i. Medicaid only
- ii. Broad
- iii. No safe harbors
- iv. But exception for pharm rebates for chronic illnesses (V.A.M.S. 376.823)
- v. Not sure of criminal penalty???

c. V.A.M.S. 334.253

- i. Stark Law
- ii. With some exceptions

27. Montana**a. MCA 45-6-313**

- i. Medicaid only
- ii. Similar to AKS
- iii. Adopts all safe harbors

b. Mont. Code Ann § 39-71-1108. Physician self-referral prohibition

- i. Stark law
- ii. See also Mont. Code Ann. § 37-2-102 (medical practitioner may not have legal or beneficial interest in drug company and may not accept illegal remuneration from same); id. § 37-2-103 (same with respect to medical practitioner and pharmacy); id. § 37-3-322 (unprofessional conduct by physician includes fee-splitting)

28. Nebraska**a. Regulations and admin. Sanctions only!!!**

- i. Neb. Admin. R. & Regs. Tit. 172, Ch. 128
- ii. Neb. Admin. R. & Regs. Tit. 471, Ch. 12-000, § 12-011
- iii. Neb. Admin. R. & Regs. Tit. 471, Ch. 2-000, § 2-002

29. Nevada**a. N.R.S. 422.560**

- i. Medicaid only
- ii. Very strange language
- iii. No safe harbors but some weird exceptions

b. Other disciplinary actions for specified physicians

- i. Civil and admin sanctions only

30. New Hampshire**a. N.H. Rev. Stat. § 167:61-a**

- i. Medicaid only
- ii. No safe harbors
- iii. (i) Knowingly solicit or receive any remuneration, including any bribe or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or ordering of any good, service, accommodation or facility for which payment may be made in whole or in part under RSA 161 or RSA 167, or knowingly offer or pay any remuneration, including any bribe or rebate, directly

or indirectly, overtly or covertly, in cash or in kind, to induce a person to purchase, lease, order, or arrange for or recommend the purchase, lease, or ordering of any good, service, accommodation or facility for which payment may be made in whole or in part under RSA 161 or RSA 167; or

- iv. (j) Knowingly charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under RSA 161 or RSA 167, any gift, money, donation, or other consideration either as a precondition of admitting or expediting the admission of a patient to a hospital, skilled nursing facility, or intermediate care facility, when the cost of the services provided in such facility to the patient is paid for in whole or in part under RSA 161 or RSA 167.
- v. II. (a) Any natural person who violates any provision of this section shall be guilty of a class B felony.
- vi. (b) Any other person who violates any provision of this section shall be guilty of a felony.

- b. RSA 125:25-a, 125:25-b
 - i. State Self-Referral Law (Stark)

31. New Jersey

a. N.J.S.A. 45:9-37.21

- i. Only applies to physicians fee-splitting
- ii. One exception but no other safe harbors

b. N.J.S.A. 45:9-42.42

- i. Only applies to Lab kickbacks and fee-splitting
- ii. No safe harbors
- iii. NON-CRIMINAL!!!!

c. N.J.S.A. 30:4D-17

- i. Medicaid only
- ii. BFE and a couple other exceptions
 - 1. c) Any provider, or any person, firm, partnership, corporation, or entity who solicits, offers, or receives any kickback, rebate, or bribe in connection with: (1) The furnishing of items or services for which payment is or may be made in whole or in part under P.L.1968, c. 413; or (2) The furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments under P.L.1968, c. 413; or (3) The receipt of any benefit or payment under this act, is guilty of a crime of the third degree, provided, however, that the presumption of nonimprisonment set forth in subsection e. of N.J.S.2C:44-1 for persons who have not previously been convicted of an offense shall not apply to a person who is convicted under the provisions of this subsection.
 - 2. This subsection shall not apply to (A) a discount or other reduction in price under P.L.1968, c. 413 if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made under P.L.1968, c. 413; and (B) 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.

32. New Mexico

- a. N. M. S. A. 1978, § 30-41-1 (solicit or receive)
- b. N. M. S. A. 1978, § 30-41-2 (offer or pay)
- c. N. M. S. A. 1978, § 30-41-3 (only safe harbors are disclosed discount and BFE)
- d. N. M. S. A. 1978, § 30-44-7 (A)(1)
 - i. Broader than AKS and has NO SAFE HARBORS

33. New York

- a. McKinney's Public Health Law § 587
 - i. Labs
 - ii. No safe harbors
 - iii. Only a misdemeanor though
 - iv. Interesting minimum fine scheme
- b. McKinney's Public Health Law § 2811
 - i. ABSOLUTE PROHIBITION ON FEE-SPLITTING WITH MEDICAL REFERRAL SERVICES
 - ii. NO SAFE HARBORS
 - iii. No idea what the penalty is????
- c. McKinney's Public Health Law § 238-a
 - i. Stark Law
 - ii. Lots of exceptions
- d. McKinney's Social Services Law § 366-d
 - i. Extremely broad!
 - ii. No safe harbors!
 - 1. 1. Definitions. As used in this section, "medical assistance provider" means any person, firm, partnership, group, association, fiduciary, employer or representative thereof or other entity who is furnishing care, services or supplies under title eleven of article five of this chapter.
 - 2. 2. No medical assistance provider shall: (a) solicit, receive, accept or agree to receive or accept any payment or other consideration in any form from another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under title eleven of article five of this chapter; or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under title eleven of article five of this chapter; or (b) offer, agree to give or give any payment or other consideration in any form to another person to the extent such payment or other consideration is given: (i) for the referral of services for which payment is made under title eleven of article five of this chapter; or (ii) to purchase, lease or order any good, facility, service or item for which payment is made under title eleven of article five of this chapter;

34. North Carolina

- a. N.C.G.S.A. § 108A-63
 - i. Identical to AKS,
 - ii. Adopts all safe harbors

35. North Dakota

- a. NOTHING!!!!

36. Ohio

- a. R.C. § 2913.40
 - i. Medicaid only
 - ii. Has a few strange exceptions but does not adopt any AKS safe harbors

37. Oklahoma

- a. 63 Okl.St. Ann. § 1-742
 - i. Adopts all AKS safe harbors

38. Oregon

- a. Only admin and reg
 - i. See Ore. Rev. Stat. § 677.190 (physician subject to discipline for [e]mploying any person to solicit patients for the licensee)

39. Pennsylvania

- a. 62 P.S. § 1407
 - i. (expressing that any person who solicits, receives, offers or pays any illegal remuneration shall be guilty of a felony)
 - ii. No safe harbors!
- b. ...stat 1457

40. Rhode Island

- a. Gen. Laws 1956, § 40-8.2-3
 - i. Medicaid only
 - ii. Adopts a few safe harbors

41. South Carolina

- a. 40-45-10(A)(1)
 - i. Only regulatory and admin.
- b. 44-113-60
 - i. Very broad
 - ii. No safe harbors
 - iii. Only a misdemeanor

42. South Dakota

- a. SDCL § 36-2-19
 - i. Stark law only regulatory

43. Tennessee

- a. T. C. A. § 63-31-109
 - i. Regulatory sanctions only
 - ii. No safe harbors

- iii. (19) Paying or agreeing to pay any sum or providing any form of remuneration or material benefit to any person for bringing or referring a patient, or accepting or agreeing to accept any form of remuneration or material benefit from a person for bringing or referring a patient
- b. T. C. A. § 63-6-602
 - i. Stark law with exceptions

44. Texas

a. V.T.C.A., Occupations Code § 102.001

- i. (a) A person commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency.
- ii. (b) Except as provided by Subsection (c), an offense under this section is a Class A misdemeanor.
- iii. (c) An offense under this section is a felony of the third degree if it is shown on the trial of the offense that the person: (1) has previously been convicted of an offense under this section; or (2) was employed by a federal, state, or local government at the time of the offense
- iv. **No safe harbors, but interesting exception!**
 - 1. V.T.C.A., Occupations Code § 102.004
 - a. Section 102.001 does not prohibit advertising, unless the advertising is: (1) false, misleading, or deceptive; or (2) not readily subject to verification, if the advertising claims professional superiority or the performance of a professional service in a superior manner

45. Utah

a. U.C.A. 1953 § 26-20-4

- i. Broad
- ii. No safe harbors

46. Vermont

a. NOTHING!

47. Virginia

a. VA Code Ann. § 32.1-315

- i. Adopts all AKS safe harbors

b. VA Code Ann. § 54.1-2962.1

- i. Only regulatory and admin.
- ii. Adopts all AKS safe harbors

c. VA Code Ann. § 54.1-2962

- i. Separate statute for physician fee splitting in exchange for patient referrals
- ii. Adopts some safe harbors

d. VA Code Ann. § 37.2-420

- i. SPECIFIC TO BEHAVIORAL HEALTH

- ii. Narrowly worded-though
- iii. Adopts all AKS safe harbors
- iv. Only a misdemeanor

48. Washington

a. West's RCWA 19.68.010

- i. Strangely-worded
- ii. Similar to AKS and Stark
- iii. No safe harbors
- iv. Only a misdemeanor

b. West's RCWA 74.09.240

- i. Same as AKS and Stark
- ii. Adopts some of the main safe harbors

49. West Virginia

a. W. Va. Code, § 9-7-5

- i. Similar to AKS
- ii. No safe harbors

50. Wisconsin

a. WSA 448.08

- i. Narrowly prohibits fee-splitting for referrals
- ii. No safe harbors

51. Wyoming

- a. NOTHING!

2. During the hearing, gaps in the federal anti-kickback statute as it applies to non-Medicaid facilities were discussed. Please provide a list of all current state laws or proposed legislation in Florida addressing anti-kickback statutes applying to commercial insurers and nonmedical facilities.

Federal anti-kickback statutes apply to both medical and behavioral facilities, however, the current law only gives jurisdiction to the Department of Justice to prosecute kickback schemes involving federal programs such as Medicaid and Medicare. This limitation ties the hands of federal prosecutors from going after corrupt facilities involved in foreign or interstate commerce who defraud private insurance providers. This multi-billion dollar scam, at least insofar as it involves private pay patient brokering, is not being prosecuted by the federal government. There has been legislation proposed in the U.S. Senate (Eliminating Kickbacks in Recovery Act of 2018, S. 3254) by Senators Rubio and Kobach that will extend the jurisdiction of federal prosecutors to those bad actors scamming commercial insurers through interstate marketing and brokering of patients.

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (201) 225-2927
Minority (202) 225-3841
January 23, 2018

Mr. Alan S. Johnson
Chief Assistant State Attorney
15th Judicial Circuit
401 North Dixie Highway
West Palm Beach, FL 33401

Dear Mr. Johnson:

Thank you for appearing before the Subcommittee on Oversight and Investigations on December 12, 2017, to testify at the hearing entitled "Examining Concerns of Patient Brokering and Addiction Treatment Fraud."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Tuesday, February 6, 2018. Your responses should be mailed to Ali Fulling, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Ali.Fulling@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Gregg Harper
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Attachment—Additional Questions for the Record**The Honorable Michael C. Burgess**

1. The issue of abusive billing, particularly relating to urine drug tests in the context of this hearing, is especially concerning given the costly nature of the issue. In one case in Florida, an insurance company was billed \$600,000, primarily for drug tests, over the course of just seven months. How can we work to limit abusive billing and incentivize insurance companies to get involved?
2. Insurance companies are at the forefront of abusive billing practices. Would a practice such as requiring consent from a patient or a referral for out-of-network services be effective in preventing beneficiaries from enrolling in ineffective treatment programs or schemes?
 - a. What role do you think insurers can play in preventing or avoiding fraudulent billing practices while protecting their beneficiaries?
3. In your fall 2016 Presentment of the Palm Beach County Grand Jury, you mention that substance use treatment licenses should be treated as other health care licenses -- as a privilege, not a right. While the fraud and abuse of the system is something that needs to be addressed, do you have any concern that with increased regulation we would see a decline in substance abuse treatment facilities such that the supply would not meet demand?

The Honorable Gus Bilirakis

1. Mr. Johnson - The Sober Homes Task Force in Palm Beach County represents a unique, forward-thinking local approach to addressing patient brokering.
 - a. Who comprises the makeup of this task force?
 - b. To date, what work has been undertaken by the task force to address the issue of patient brokering?
 - c. It's my understanding that many of the task force's findings and recommendations were used in crafting Florida's newly implemented law aimed at addressing fraud and abuse the sober home industry. Which recommendations from the task force are still outstanding?

The Honorable Frank Pallone, Jr.

1. In your estimation, how many patients seeking treatment for substance use disorders have been pulled into these schemes?
2. Are there any typical patterns regarding patients seeking treatment for substance use disorder, such as their socioeconomic status or where they reside before they come to Florida for treatment?

3. How is Florida's Patient Brokering Act designed to address the patient brokering issue?
4. How has Florida's Patient Brokering Act been working so far? What successes has Florida had in using the law to disrupt patient brokering schemes and bring prosecutions?
5. How does Florida's Patient Brokering Act seek to crack down on deceptive advertising practices used as part of these schemes, and how successful has it been thus far?
6. Do you feel that law enforcement has sufficient resources to investigate and go after bad actors in your state? If not, what additional resources would help you do so?
7. Have insurers reached out to you to discuss issues with frequent and excessive urine drug tests as part of these patient broker schemes? If so, what challenges do you believe insurers face in addressing this issue?

The Honorable Kathy Castor

1. What treatments have you seen that have had the most success for individuals in recovery and how can we ensure that patients have access to the treatment that will work for them?
2. Though some states have prosecuted corrupt facilities and rogue providers, how can we crack down on facilities not providing the level of care needed to aid patients?

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

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2125 RAYBURN HOUSE OFFICE BUILDING
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Minority (201) 225-3641

January 23, 2018

Mr. Eric M. Gold
Assistant Attorney General
Chief, Health Care Division
Office of the Massachusetts Attorney General
One Ashburton Place
Boston, MA 02108

Dear Mr. Gold:

Thank you for appearing before the Subcommittee on Oversight and Investigations on December 12, 2017, to testify at the hearing entitled "Examining Concerns of Patient Brokering and Addiction Treatment Fraud."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Tuesday, February 6, 2018. Your responses should be mailed to Ali Fulling, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Ali.Fulling@mail.house.gov.



MAURA HEALEY
ATTORNEY GENERAL

THE COMMONWEALTH OF MASSACHUSETTS
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(617) 727-2200
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February 13, 2018

*By Electronic Mail (Ali.Fulling@mail.house.gov)
And U.S. Mail*

Ali Fulling
Legislative Clerk
Committee on Energy and Commerce
Rayburn House Office Building
Washington, D.C. 20515

Dear Ms. Fulling:

It was a pleasure to testify before the Committee on Energy and Commerce, Subcommittee on Oversight and Investigations at the December 12, 2017 hearing entitled, "Examining Concerns of Patient Brokering and Addiction Treatment Fraud." As requested, enclosed are my responses to additional questions for the record.

Please let me know if you have any further questions.

Very truly yours,

A handwritten signature in black ink, appearing to read "Eric M. Gold".

Eric M. Gold
Assistant Attorney General
Chief, Health Care Division
(617) 963-2663

Eric Gold
Assistant Attorney General
Chief, Health Care Division
Office of Massachusetts Attorney General Maura Healey

“Examining Concerns of Patient Brokering and Addiction Treatment Fraud”
Tuesday, December 12, 2017

Before the United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Responses to Additional Questions for the Record

The Honorable Michael C. Burgess

1. The issue of abusive billing, particularly relating to urine drug tests in the context of this hearing, is especially concerning given the costly nature of the issue. In one case in Florida, an insurance company was billed \$600,000, primarily for drug tests, over the course of just seven months. How can we work to limit abusive billing and incentivize insurance companies to get involved?

As suggested by the example in the question, insurance carriers have substantial financial incentive to detect, investigate, and prevent health care fraud, including bills for unnecessary urine drug screens and can be helpful partners, working with law enforcement and policy makers. In Massachusetts, both public and private payers have engaged in extensive activities to root out urine drug screen fraud in billing. For example, in 2012, our Office, working in collaboration with the Massachusetts Medicaid Program, obtained a \$20 million settlement from Calloway labs to resolve allegations of an elaborate kickback scheme that cost Massachusetts millions of dollars for unnecessary urine drug screens.¹ Similarly, the largest commercial health

¹ Press Release, Office of Massachusetts Attorney General, Calloway Laboratories Pays \$20 Million to Resolve Allegations of Kickbacks and Fraud on State Medicaid Program (Mar. 30,

insurers in Massachusetts, Blue Cross Blue Shield of Massachusetts,² Harvard Pilgrim Health Care,³ and Tufts Health Plan⁴, expend substantial resources to detect and prevent this type of health care fraud.

2. Insurance companies are at the forefront of abusive billing practices. Would a practice such as requiring consent from a patient or a referral for out-of-network services be effective in preventing beneficiaries from enrolling in ineffective treatment programs or schemes?

Many health insurance plans currently require that patients receive referrals for out of network services. Some health insurance plans have also imposed prior authorization requirements on certain treatments for substance use disorder (“SUD”). Massachusetts law, however, now requires that insurance carriers provide coverage for medically necessary acute treatment services and clinical stabilization services for treatment of SUD for up to a total of fourteen days without requiring preauthorization. See Mass Gen. Laws ch. 176A, § 47GG. As I noted in my written testimony, policy makers need to be sure that any attempts to address patient brokering advance the ultimate goal of ensuring that patients with SUD have access to the treatment that they need and do not unintentionally limit that access.

3. What role do you think insurers can play in preventing or avoiding fraudulent billing practices while protecting their beneficiaries?

2012), at <http://www.mass.gov/ago/news-and-updates/press-releases/2012/2012-03-30-calloway-settlement.html>

² <http://www.bluecrossma.com/healthy-times/did-you-know/health-care-fraud.html>

³ https://www.harvardpilgrim.org/pls/portal/docs/PAGE/PROVIDERS/MANUALS/PAYMENT%20POLICIES/H-2%20FRAUD-WASTE-ABUSE%20POLICY_112917.PDF

⁴ <https://tuftshealthplan.com/member/our-plans/tufts-health-together/documents-and-resources/fraud-and-abuse>

Insurers have an important role to play and must balance detecting and preventing health care fraud with giving patients access to the health care treatment that they need. As noted above, public and private health care payers in Massachusetts have invested substantial resources in rooting out fraudulent billing practices, including fraudulent practices related to SUD treatment.

The Honorable Frank Pallone, Jr.

1. What tools does the Massachusetts Attorney General's office have to investigate and prosecute patient brokers?

Our office has both civil and criminal law enforcement tools. On the civil side, the Office enforces the Massachusetts Consumer Protection Act, Mass. Gen. Laws ch. 93A, and Massachusetts False Claims Act, Mass. Gen. Laws ch. 12, §§ 5A-5O, both of which give the Attorney General pre-suit investigatory authority and allow for robust remedies, including civil penalties, against those who violate the law. Criminally, the Office has authority to enforce various criminal statutes that may relate to patient brokering, including but not limited to, Mass. Gen. Laws ch. 175H, § 2 (false statements on insurance applications and claims), ch. 175H, § 3 (anti-kickback), ch. 266, § 30 (larceny), and ch. 266, § 111A (fraudulent insurance claims).

2. What barriers, if any, are preventing Massachusetts officials from being able to do more to assist families whose loved ones have been pulled into patient broker schemes?

In instances where Massachusetts residents have been lured out of state for treatment by patient brokers, there are substantial obstacles to our Office directly assisting those patients and their families. Most practically, those patients are often far from home and, in many cases, the families who have contacted our office in Massachusetts do not know exactly where their loved

ones are located, only that they are being treated in a particular state. Even in situations where the families know where their loved ones are, the patients (who may be still suffering from addiction) may not be in contact with their families, may not want our Office to intervene, or may not want to return home, despite the risks of receiving sub-par treatment far from home.

Despite these barriers, our Office does offer support and guidance for SUD patients and their families who have run into difficulties seeking the treatment they need.

3. What challenges inherent to these patient broker schemes make it difficult for the Massachusetts Attorney General's office to investigate and prosecute cases?

There are a number of challenges to our Office investigating and prosecuting patient brokering schemes. I note three of those challenges here. First, patient brokering schemes are often devised and run from out-of-state, especially states far from Massachusetts like Florida, Arizona, or California. Although our Office can effectively prosecute certain interstate cases, those investigations pose substantial logistical and other challenges. Second, the victims of patient brokering schemes are often suffering from severe substance use disorder. The victims may, therefore, be unable or unwilling to work with our Office because of ongoing treatment or other complications, which poses challenges to the investigation. Finally, the patient brokers themselves may be closely integrated into the recovery community or in recovery themselves. The victims, victims' families, and others working to assist those in recovery may, therefore, have close relationships with those who have engaged in the unlawful patient brokering, making investigations and prosecutions more challenging.

4. What more can be done to educate the public about patient broker schemes?

Our Office has issued a consumer advisory and, through our Community Engagement Division, worked to spread the word among SUD patients and their families about patient

brokering schemes. Similarly, other government agencies, including federal, state, and local health departments, may educate the public through broad public education campaigns (like our Office's consumer advisory) and direct interactions with patients and their families.

We have also found that the media can be helpful in raising awareness with the public about the issue. A number of Massachusetts families have reported becoming aware of the issue through reports in the newspaper and on local television news. Other professionals who work with SUD patients, including doctors, nurses, and insurance carriers, can remind patients of the risks of accepting referrals to unknown treatment centers.

5. What types of deceptive marketing tactics have been employed by patient brokers in Massachusetts, and how prevalent do you believe the use of these tactics is?

We are aware of various allegations of deceptive marketing tactics that patient brokers have employed to lure Massachusetts residents to out-of-state treatment. As noted in my written testimony, in one situation, it was alleged that a recruiter manipulated the phone number associated with the Google search results for a Massachusetts SUD treatment provider, so that when the patient called the number, he was routed to a patient broker. More generally, we are aware of allegations that patient brokers have misled prospective patients about various aspects of the treatment that the patient was to receive. It is unclear how prevalent these tactics are.

6. What can be done to prevent call aggregators from preying on patients seeking treatment for substance use disorders?

The most immediate thing that can be done is to educate patients and their families about patient brokering schemes and the role that call aggregators and other referral services play. Our Office has issued a consumer advisory reminding consumers to be aware of unsolicited referrals for addiction treatment. Over the long term, law enforcement should also continue efforts to

investigate and prosecute, either civilly or criminally, those engaged in fraudulent marketing through call aggregators or otherwise.

7. Do you feel that law enforcement has sufficient resources to investigate and go after bad actors in your state? If not, what additional resources would help you to do so?

Our Office has and continues to dedicate substantial resources to combatting all aspects of the opioid epidemic, including investigating and prosecuting patient brokering schemes. Still, many patient brokering schemes involve individuals and entities operating across the country and it is challenging for our Office to address all components of a particular scheme through our investigations and prosecutions. As I recommended in my written testimony, dedicating additional federal resources—whether in the form of additional federal investigative teams or grants for state and local investigators—to investigate and prosecute these interstate cases will ensure that every vulnerable patient is protected from recruiters looking to take advantage of them.

The Honorable Kathy Castor

1. What treatments have you seen that have had the most success for individuals in recovery and how can we ensure that patients have access to the treatment that will work for them?

Although I am not a health care professional, I understand that for many patients the most effective treatment for substance use disorder (especially opioid use disorder) is a combination of medication-assisted treatment (i.e., buprenorphine, methadone, or naltrexone) and psychosocial

therapy. See American Society for Addiction Medicine, *The National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use*, at 39 (2015).⁵

Massachusetts has taken a number of steps to ensure that patients have access to treatment they need. First, our state requires that insurers cover up to fourteen days of medically necessary acute treatment services (detoxification treatment) and clinical stabilization services and that patients receive outpatient SUD treatment without prior authorization. Further, since 2015, Massachusetts has added more than 1100 treatment beds in the state, and our Medicaid program has committed to investing up to \$30 million to expand residential recovery services and increase access to medication-assisted treatment, among other types of treatment.

We can also work to expand the number of health care providers that are available to treat substance use disorder by incentivizing doctors, nurses, counselors and others to go into the field and providing training to current health care providers about how to treat SUD.

Member Requests for the Record

The Honorable Gregg Harper

1. Throughout the hearing, there were several questions regarding which states have patient broker laws and the specifics of those laws. Please provide the committee with a list and short description of all current state laws or proposed legislation in Massachusetts that address patient brokering.

I am not aware of any Massachusetts laws or proposed legislation that specifically address patient brokering. The following are examples of Massachusetts statutes that prohibit conduct that may be present in patient brokering schemes:

Mass. Gen. Laws ch. 12, §§ 5A-5O (false claims act)

⁵ <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>

Mass. Gen. Laws. ch. 93A, § 2 (consumer protection law)

Mass. Gen. Laws ch. 175H, § 2 (false statements on insurance applications and claims)

Mass. Gen. Laws ch. 175H, § 3 (commercial anti-kickback law).

Mass. Gen. Laws ch. 266, § 30 (larceny)

Mass. Gen. Laws ch. 266, § 111A (fraudulent insurance claims)

2. During the hearing, gaps in the federal anti-kickback statute as it applies to non-Medicaid facilities were discussed. Please provide a list of all current state laws or proposed legislation in Massachusetts addressing anti-kickback statutes applying to commercial insurers and nonmedical facilities.

Mass. Gen. Laws ch. 175H, § 3 (commercial anti-kickback law).