EXAMINING ADVERTISING AND MARKETING PRACTICES WITHIN THE SUBSTANCE USE TREATMENT INDUSTRY

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 ADVERTISING AND MARKETING PRACTICES WITHIN THE SUBSTANCE USE TREATMENT INDUSTRY

TUESDAY, JULY 24, 2018

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

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123, Rayburn House Office Building, Hon. Gregg Harper (chairman of the subcommittee) presiding.

Present: Representatives Harper, Griffith, Burgess, Brooks, Collins, Walberg, Walters, Costello, Carter, Walden (ex officio), DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, and Pallone (ex officio).

Also Present: Representative Bilirakis.

Staff Present: Jennifer Barbla, Chief Counsel, Oversight and Investigations; Adam Fromm, Director of Outreach and Coalitions; Ali Fulling, Legislative Clerk, Oversight and Investigations, Digital Commerce and Consumer Protection; Brighton Haslett, Counsel, Oversight and Investigations; Brittany Havens, Professional Staff, Oversight and Investigations; Ed Kim, Policy Coordinator, Health; Andrea Noble, Fellow, Oversight and Investigations; Jennifer Sherman, Press Secretary; Austin Stonebraker, Press Assistant; Hamlin Wade, Special Advisor, External Affairs; Everett Winnick, Director of Information Technology; Julie Babayan, Minority Counsel; Jeff Carroll, Minority Staff Director; Waverly Gordon, Minority Health Counsel; Zach Kahan, Minority Outreach and Member Services Coordinator; Chris Knauer, Minority Oversight Staff Director; Jourdan Lewis, Minority Staff Assistant; Miles Lichtman, Minority Policy Analyst; Perry Lusk, Minority Government Accountability Office Detailee; Kevin McAloon, Minority Professional Staff Member; and C.J. Young, Minority Press Secretary.

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

Mr. HARPER. The subcommittee will come to order.

Today, the subcommittee holds a hearing entitled examining, advertising, and marketing practices within the substance abuse treatment industry. This hearing builds on the subcommittee's extensive work over the past 4 years examining the causes and scope

of the opioid epidemic including ways to effectively treat individuals with a substance use disorder.

The opioid epidemic continues to ravish our nation. According to the Centers for Disease Control approximately, 2.1 million Americans over the age of 12 suffer from an opioid use disorder. Meanwhile, the number of Americans dying from opioid overdoses has increased in recent years to 115 deaths per day.

As the opioid epidemic continues to take its toll, the demand for treatment has dramatically increased. According to the Substance Abuse and Mental Health Services Administration, the number of treatment facility admissions for opiate use increased 58 percent from 2005 through 2015. With rising demand, the number of treatment facilities has also grown. However, the increased demand for treatment and attendant proliferation of treatment facilities has raised a number of concerns about practices within the industry.

Our December hearing examined "patient brokering," the practice of recruiting individuals with a substance use disorder and luring them to treatment facilities and sober living homes, often in other States, in return for financial kickbacks. We also heard testimony about the problems stemming from the dramatic surge and substance use disorder treatment facilities including practices employed by businesses known generally as "call aggregators." These practices incentivize profit over the recovery and well-being of the individual seeking treatment.

The information we learned at the hearing in December, along with additional reports and research that the Committee conducted, led us to dig deeper into these marketing and advertising practices within the drug treatment industry.

If you compare how one seeks care for a substance use disorder to how one would seek care for any other illness or disease, the differences are staggering. For example, if you aren't feeling well, most people would go to their primary care physician, or if it's an emergency, the ER, and that doctor is likely to refer you to another doctor or specialist, depending upon what's wrong. Here, individual seeking treatment for themselves or loved one often turn to the Internet to find resources to guide them in choosing a treatment center. One study found that 61 percent of people who went to rehab used the Internet to find treatment. Such online searches can prove overwhelming. Patients are often at the mercy of what they find online with little or no guidance from a medical professional.

Many treatment-focused websites advertise hotlines that purport to direct individuals to a trained professional that can help the individual assess what treatment facilities will best meet their needs. These call centers may appear to be unaffiliated third-party referral services, but they are often either owned and operated by treatment facilities or are paid by facilities to refer calls. While some centers disclose their relationship with treatment facilities, others may engage in deceptive marketing tactics to hide them. Moreover, these call centers are often staffed by sales representatives rather than medical professionals. In some cases, the individual staffing the company's call center receive a bonus each month based on the number of callers that are successfully admitted into one company's facilities.

In some of the worst cases, call aggregators, or call centers, may refer patients to facilities that don't meet their needs based on a financial arrangement. And once patients enter treatment, they may be vulnerable to exploitation by unscrupulous business owners.

Concerns raised about deceptive advertising and marketing practice have already led to action. For example, several States have passed legislation, the National Association For Addiction Treatment Providers updated its code of ethics, and Google placed a temporary restriction of online advertising by treatment providers due to misleading experiences among rehabilitation treatment centers.

As the opioid epidemic continues to claim lives, it is vital that we ensure individuals seeking treatment for themselves or loved ones are able to find treatment that best meets their needs without being misled by those who would prioritize financial gain over saving lives.

We thank our panel of witnesses for joining us this morning. I hope that today's hearing will shed light on how we can combat deceptive marketing practices while protecting legitimate treatment centers and the individuals desperately seeking their care.

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

At this time, the chair will recognizes the ranking member of this subcommittee Ms. DeGette for 5 minutes 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 the Subcommittee holds a hearing entitled "Examining Advertising and Marketing Practices within the Substance Use Treatment Industry." This hearing builds on the Subcommittee's extensive work over the past four years examining the causes and scope of the opioid epidemic, including ways to effectively treat individuals with a substance use disorder.

The opioid epidemic continues to ravage our nation. According to the Centers for Disease Control, approximately 2.1 million Americans over the age of 12 suffer from an opioid use disorder. Meanwhile, the number of Americans dying from opioid overdoses has increased in recent years to 115 deaths each day.

As the opioid epidemic continues to take its toll, the demand for treatment has dramatically increased. According to the Substance Abuse and Mental Health Services Administration, the number of treatment facility admissions for opiate use increased 58 percent between 2005 and 2015. With rising demand, the number of treatment facilities has also grown. However, the increased demand for treatment and attendant proliferation of treatment facilities have raised a number of concerns about practices within the industry.

Our December hearing examined "patient brokering," the practice of recruiting individuals with a substance use disorder and luring them to treatment facilities and sober living homes, often in other states, in return for financial kickbacks. We also heard testimony about the problems stemming from the dramatic surge in substance use disorder treatment facilities, including practices employed by businesses known generally as "call aggregators." These practices incentivize profit over the recovery and well-being of the individual seeking treatment.

The information we learned at the hearing in December, along with additional reports and research that the Committee conducted, led us to dig deeper into these marketing and advertising practices within the drug treatment industry.

If you compare how one seeks care for a substance use disorder to how one would seek care for any other illness or disease, the difference is staggering. For example, if you aren't feeling well most people would go to their primary care doctor or if it's an emergency, the ER, and that doctor is likely to refer you to another doctor or specialist depending on what's wrong. Here, individuals seeking treatment for themselves or a loved one often turn to the internet to find resources to guide them in

choosing a treatment center—one study found that 61 percent of people who went to rehab used the internet to find treatment. Such online searches can prove overwhelming, patients are often at the mercy of what they find online with little or no guidance from a medical professional.

Many treatment-focused websites advertise hotlines that purport to direct individuals to a trained professional that can help the individual assess what treatment facility will best meet their needs. These call centers may appear to be unaffiliated third-party referral services, but they are often either owned and operated by treatment facilities or are paid by facilities to refer calls. While some centers disclose their relationship with treatment facilities, others may engage in deceptive marketing tactics to hide them. Moreover, these call centers are often staffed by sales representatives rather than medical professionals. In some cases, the individuals staffing the company's call center receive a bonus each month based on the number of callers that are successfully admitted into one of the company's facilities.

In some of the worst cases, call aggregators or call centers may refer patients to facilities that don't meet their needs based on a financial arrangement and once patients enter treatment they may be vulnerable to exploitation by unscrupulous business owners.

Concerns raised about deceptive advertising and marketing practices have already led to action. For example, several states have passed legislation, the National Association for Addiction Treatment Providers updated its code of ethics, and Google placed a temporary restriction of online advertising by treatment providers due to "misleading experiences among rehabilitation treatment centers."

As the opioid epidemic continues to claim lives, it is vital that we ensure individuals seeking treatment for themselves or loved ones are able to find treatment that best meets their needs without being misled by those who would prioritize financial gain over saving lives.

We thank our panel of witnesses for joining us this morning. I hope that today's hearing will shed light on how we can combat deceptive marketing practices while protecting legitimate treatment centers and the individuals desperately seeking their care.

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.

Mr. Chairman, throughout the several years that we have been holding a series of hearings in this subcommittee and other subcommittees of the Energy and Commerce Committee, one of the themes that has emerged is that families need good information about the types of treatments that are available. And also we've heard from the medical experts that evidence-based treatment, including medication-assisted treatment is the most effective means for overcoming opioid use disorders.

But this is echoing what your concern is. Not all facilities provide that treatment. Some facilities make only vague promises about the effectiveness of various treatment models they offer. And in addition, when you're finding your facility online, most patients will have no idea if the facilities that they're identifying would have the types of treatment that would actually work in dealing with this opioid crisis.

We've been seeing through this committee's investigation that we've got nefarious or unqualified actors out there who are taking advantage of those who are suffering in order to capitalize on this condition.

Last year, this subcommittee had a hearing where we heard about individuals known as "patient brokers" who profit from re-

cruiting patients with opioid addiction and then send them to dubious treatment centers in other States.

We have heard that the operators of many of these centers sometimes have no training or expertise in drug treatment and once the patients arrive, they may receive substandard or no care at all. And then in December, the subcommittee heard from law enforcement officials in States that were affected by these schemes.

They testified about the wide variation and the quality of care provided at some of the facilities and how we lack sufficient national standards.

Now, today, we're looking at another feature of the opioid epidemic that shows the challenges patients with opioid use disorder currently face. And that is, how the treatment providers advertise, market, or locate prospective patients seeking treatment and guide them to appropriate treatment.

In other words, are patients prioritized when it comes to finding and directing those seeking care for opioid use disorders and for those patients who are the target of aggressive marketing practices, how should they evaluate a possible treatment facility for its effectiveness?

As you noted, Mr. Chairman, this committee has seen reports of call centers that sell customer referrals to treatment providers. Some also hide the fact that they're making referrals for a fee or that the call centers actually owned by the same company that owns the treatment center.

We've also seen aggressive advertising and marketing strategies by treatment facilities such as websites and 1–800 numbers that do not clearly disclose who a patient is contacting or where they're being referred. And some facilities try to lure in patients with promises of luxurious treatment such as daily yoga sessions and free housing. And I think that the experts who are here today will tell you that things like daily yoga sessions, while they might be great for a spa, are not going to cure opioid addiction.

So how pervasive are these problems in the industry, and how many of these practices, like having multiple websites or purchasing calls in bulk, actually provide the treatment that helps people recover?

So for today's discussion, here is what I'm looking to hear from the witnesses: What are good practices when it comes to marketing treatment services and what are dubious practices?

We need to hear whether there are certain quality indicators patients should look for when seeking a treatment and just as important, are there certain red flags that indicate questionable services?

In other words, Mr. Chairman, opioid use disorder and its treatment is complicated enough for any prospective patient to navigate.

We need to make sure that existing practices are not making it more difficult for people seeking treatment by obscuring what's really being provided and what they need to treat their addiction.

And so we need to find out how treatment providers find patients, educate them, and then guide them into appropriate treatment.

I look forward to hearing from all of the witnesses about these issues, and I yield back.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

Thank you, Mr. Chairman.

We have all heard the statistics about the opioid crisis: the thousands who die each year, and millions more who are suffering from addiction.

But through this committee's investigation, we have seen another side of this crisis: some nefarious or unqualified actors are taking advantage of those who are suffering, out of the desire to capitalize on their condition.

As the Committee learned last year, some individuals known as "patient brokers" profit from recruiting patients with opioid addiction, and then send them to dubious treatment centers in other states. We heard that the operators of many of these centers sometimes have no training or expertise in drug treatment, and once the patients arrive, they may receive sub-standard or no care at all.

This past December, the subcommittee heard from law enforcement officials in States affected by these schemes. They testified about the wide variation in the quality of care provided at some facilities, and how we lack consistent standards.

Today we are examining another feature of the opioid epidemic that again shows some of the challenges patients with opioid use disorder currently face. And that is how treatment providers advertise, market, or locate prospective patients seeking treatment and guide them to appropriate treatment.

In other words, are patients prioritized when it comes to finding and directing those seeking care for opioid use disorders? And for those patients who are the target of aggressive marketing practices, how should they evaluate a possible treatment facility for its effectiveness?

This Committee has seen reports of call centers, for example, that sell customer referrals to treatment providers. Some also hide the fact that they are making referrals for a fee, or that the call center is owned by the same company that owns the treatment center.

We have also seen aggressive advertising and marketing strategies by treatment facilities, such as websites and 1–800 numbers that do not clearly disclose who a patient is contacting or where they're being referred. Some facilities also try to lure in patients with promises of luxurious treatment, such as daily yoga sessions and free housing.

How pervasive are these problems in the industry, and how do many of these practices—such as having multiple websites or purchasing calls in bulk—actually help individuals recover?

For today's discussion, the witnesses need to articulate what they regard as good practices when it comes to marketing treatment services, and what they regard as dubious practices. Also, are there certain quality indicators that patients should look for when seeking a treatment option? As importantly, are there certain red flags that indicate questionable services?

In other words, Mr. Chairman, opioid use disorder and its treatment is complicated enough for any prospective patient to navigate. We must make sure that existing practices are not making it harder for those seeking treatment by obscuring what's really being provided and what they need to treat their addiction.

So today we have questions regarding how treatment providers find patients, educate them, and then guide them into appropriate treatment.

The witnesses today can articulate how they do these things before referring or accepting a patient. And hopefully, they will also describe how pervasive certain questionable tactics are regarding treatment offerings.

Mr. Chairman, one of the themes that has emerged in our years-long examination of the opioid crisis is that families need much better information about the types of treatment available.

This Committee has long heard from the medical experts that evidence-based treatment- including medication-assisted treatment-is the most effective method for overcoming opioid use disorder. But not all facilities provide that treatment, and some make vague promises about the effectiveness of the various treatment models they offer.

Our witnesses today can provide a benchmark of what they regard as quality treatment, and how that compares to some of the questionable treatment facilities we have seen reports about. This is critical because if patients don't know what to look for when they are seeking care, it is even easier for bad actors to take advantage of them.

Mr. Chairman, the effects of the opioid crisis will be with us for decades. It is going to take a monumental effort by the medical community, public health agencies, Congress, and this Committee to climb out. That will be challenging enough. But in the process, we cannot let bad or ineffective actors make the problem even worse.

I hope this Committee can shed some light on these problems and provide the tools and resources for people to get the treatment they need.
I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the chairman of the full committee, Greg Walden for the purposes of his opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Thank you very much, Mr. Chairman. I appreciate you holding this hearing.

I want to thank our witnesses for being here today to inform our work.

Today's hearing follows up on our year-long bipartisan investigation to patient brokering and the fraud and abuse within the substance use disorder treatment industry.

Beginning in April of 2014, this subcommittee commenced a comprehensive examination into the causes of the opioid epidemic, the impact it's had on Americans and explored possible solutions to enable greater access to effective evidence-based treatment for substance use disorders.

The House, as you know, recently passed H.R. 6. This is the Support For Patients and Communities Act, which includes 70 provisions, largely from this committee, that seek to address a number of issues within the opioid epidemic. But our work here is not done. The committee continues to conduct its proper oversight, because our Nation is far from seeing the end of the opioid epidemic and its tragic and deadly effects.

In December, the subcommittee held a hearing examining the patient brokering and addiction treatment fraud where concerns were raised about deceptive and sometimes predatory advertising and marketing practices within the treatment industry.

In addition, we've read news reports, spoken to treatment facilities, doctors, associations and stakeholders within the industry, but most importantly, we've heard from individuals, their loved ones, who have faced some of these aggressive and deceptive advertising practices. In fact, in my own district out in Oregon, a father named Mike told me about the troubling experience he had when his son was seeking treatment for addiction. The recovery center that his son went to was located in another State. And he said it seemed more interested in cashing the check than actually caring for his son.

As the committee dove deeper into the advertising and marketing practices within this industry, we found a Pandora's box of online advertisement, websites, phone numbers, lead generators, call centers, and television commercials. In some cases an individual or company may own dozens and dozens of websites, and some of these websites contain different 1–800 numbers, despite all being owned by the same person were all leading to the same treatment company.

Some websites and television commercials used pretty forceful language, such as, "Call now, don't wait any longer," "Get the help you need," "Talk to someone who cares," "End your addiction now," or "For immediate treatment help." One individual the committee

spoke with shared that the person on the other end of the phone went on to say, "if you don't get your kid here now, your kid will die."

Further, some of the websites and advertisements purport to offer the "best" treatment in the country or claim high success rates to lure patients to their facilities. This all sounds great. We don't know what those statements are based upon. For example, does that mean someone successfully enrolled in the treatment, completed treatment, that they are still maintaining their sobriety one year later? What does success mean, and how do you measure it? These are the types of questions that individuals and their loved ones should be able to find answers for when they search their treatment that best meets their needs.

These advertising practices lead to reputable and quality treatment. That's great. That's what we hope for. But deceptive practices can have consequences, whether it's online advertisements, websites, 1–800 numbers, or television commercials, individuals and their loved ones should be able to expect transparency, know who answers the phone or responds to an inquiry when they reach out for help. Individuals who call treatment hotlines are often in times of crisis and they had need help fast and from someone that can be trusted. They have a right to know what facilities they're calling and the type of treatment that facility offers so they can decide whether it's the right treatment for them or their loved one.

So today's hearing will help bring much-needed attention to this issue, help us understand the scope of advertising and marketing practices within the treatment issue. Our hope is a thoughtful discussion will help us establish a baseline for best practices, help inform individuals or loved ones about how to seek treatment that best meets their needs.

And I would yield the balance of the time to the chairman of the Subcommittee of Health, Dr. Burgess.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Mr. Chairman, for holding this hearing. Today's hearing follows up on a year-long bipartisan investigation into patient brokering and the fraud and abuse within the substance use disorder treatment industry.

Beginning in April 2014, this subcommittee commenced a comprehensive examination into the causes of the opioid epidemic, the impact it's had on Americans, and explored possible solutions to enable greater access to effective, evidence-based treatment for substance use disorders.

The House recently passed H.R. 6, the SUPPORT for Patients and Communities Act, which includes 70 provisions—largely from this committee—that seek to address a number of issues within the opioid crisis. But our work here is not done and the committee continues to conduct oversight because our country is far from seeing the end of the opioid epidemic and its tragic effects.

In December, this subcommittee held a hearing examining patient brokering and addiction treatment fraud where concerns were raised about deceptive and sometimes predatory advertising and marketing practices within the treatment industry.

In addition, we've read news reports, spoken to treatment facilities, doctors, associations, and stakeholders within the industry, but most importantly, we've heard from individuals and their loved ones who have faced some of these aggressive and deceptive advertising practices. In my district in Oregon, a father named Mike told me about the troubling experience he had when his son was seeking treatment for addiction. The recovery center was located in another stated and seemed more interested in cashing a check rather than caring for his son.

As the committee dove deeper into the advertising and marketing practices within this industry we found a Pandora's box of online advertisements, websites, phone numbers, lead generators, call centers, and television commercials. In some cases, an individual or company may own dozens and dozens of websites, and some of these websites contain different 1–800 numbers, despite all being owned by the same person or all leading to the same treatment company.

Some websites and television commercials use forceful language, such as: "Call now," "don't wait any longer," "get the help you need," "talk to someone who cares," "end your addiction now," or "for immediate treatment help." One individual the committee spoke with shared that the person on the other end of the phone went as far to say, "if you don't get your kid here now, your kid will die."

Further, some of the websites and advertisements purport to offer the "best" treatment in the country or claim high success rates to lure patients to their facilities. This all sounds great, but we don't know what those statements are based on. For example, does that mean someone successfully enrolled in treatment, completed treatment, that they are still maintaining their sobriety one year later? What does success mean and how do you measure it? These are the types of questions that individuals and their loved ones should be able to find answers for when they search for treatment that best meets their needs.

If these advertising practices lead to reputable and quality treatment, that's great. But, these deceptive practices can have consequences. Whether it's online advertisements, websites, 1–800 numbers, or television commercials—individuals and their loved ones should be able to expect transparency and know who answers the phone or responds to an inquiry when they reach out for help. Individuals who call treatment hotlines are often in a time of crisis and they need help fast and from someone they can trust. They have a right to know what facility they are calling and the type of treatment that facility offers so they can decide whether it is the right treatment for them or their loved one.

Today's hearing will help bring much needed attention to this issue and help us understand the scope of advertising and marketing practices within the treatment industry. Our hope is that a thoughtful discussion will help us establish a baseline for best practices and help inform individuals and their loved ones about how to seek treatment that best meets their needs.

I welcome our witnesses and look forward to their testimony.

Mr. BURGESS. I thank the chairman for yielding. And the chairman makes an important point. H.R. 6 did pass through this committee and, indeed, on the floor of the House. And we do call on the Senate, the other body, to take that up.

This is not the first hearing we've had on this subject. Last December, we did have a hearing, and we heard from the assistant attorney general from the Massachusetts attorney general's office, Eric Gold, was his name. And he provided for us three recommendations on the evaluation and solution for the problems that are existing at sober homes.

He said we need additional resources for Federal, State and local law enforcement. OK, that's covered in H.R. 6. Second, patients need transparency into the quality of addiction treatment of the providers nationwide. I agree with that. I'm not sure we're there. And the third thing: We need to ensure that patients with substance use disorder have access to the treatment they need and we do not unintentionally limit access. And that is an important point as well.

Additionally, we heard from a panel of family members who had been affected by family members who had problems with opioid addiction. And one of the statements of one of the witnesses really stands out.

She said, "the intent, of course, was not to kill Jaime, but to keep him in the system and continue to abuse his insurance."

Those are pretty apocryphal words, and I hope we get to explore some more of that. Mr. Chairman, thank you for the indulgence, and I yield back Mr. Walden's time.

Mr. HARPER. The gentleman yields back. The chair will now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

The opioid epidemic continues to devastate families and communities around the Nation. We still have a long way to go to climb out of this crisis. Opiates killed more than 115 Americans a day in 2016, and millions more continue to suffer. That's bad enough, but to see people taking advantage of this crisis by preying on victims to make money is unconscionable.

The Affordable Care Act expanded access to substance abuse treatment for millions of Americans. It also required insurance companies to cover this treatment just as they would cover any other chronic disease. Thanks to the ACA and Medicaid expansion, Americans who could not get access to this treatment before, now can. Unfortunately, people with substance use disorder still face barriers to accessing treatment. According to SAMHSA, of the 19 million adults who had a substance use disorder in 2016, 17 million did not receive treatment.

We need to do everything we can to help more Americans access this treatment. Unfortunately, there are companies preying on individuals in desperate need of treatment services. Some of the companies this committee has been examining claim they are merely filling a market need, but anyone advertising treatment services must put the needs of the patient first, and they must employ well qualified staff that can provide quality treat or ensure that they are only referring patients to quality treatment providers.

This committee's investigation into patient brokering revealed shocking examples of companies that claim to offer treatment and special perks to individuals suffering from opioid addiction. Families that were desperate to help their loved ones put their trust and hope in many of these treatment facilities. But as our investigation has found, many of those entities are a scam, and do not offer actual treatment. In some instances, these facilities are actually putting people's lives at risk.

Now the Committee has broadened its focus to look at treatment call centers and marketing tactics. And unfortunately, we've discovered that some companies have looked at this devastating epidemic as an opportunity solely to make money.

For instance, reports indicate that some of these call centers or "call aggregators" advertise opioid treatment to get people to call looking for help, and then sell those calls to various facilities. And it is unclear how this helps the patient.

Other companies actually appear to offer treatment for opioid use disorder, but they also engage in aggressive marketing tactics. For example, some facilities operate multiple websites with different names and phone numbers, with the goal of maximizing the number of beds filled.

And this raises questions about how transparent these companies are about the services they offer and how they help patients find the treatment that's right for them. It also raises questions about how a prospective patient is supposed to navigate the countless number of treatment offerings and find quality care against the backdrop of the array of services being advertised.

So I'm hopeful our witnesses can shed some light on the types of marketing and treatment practices that are best designed to put the patient first and help them find quality care.

And unless someone else wants my time, I yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

The opioid epidemic continues to devastate families and communities around the nation. We still have a long way to go to climb out of this crisis. Opioids killed more than 115 Americans a day in 2016, and millions more continue to suffer. That is bad enough—but to see people taking advantage of this crisis by preying on victims to make money is unconscionable.

The Affordable Care Act expanded access to substance abuse treatment for millions of Americans, and it also required insurance companies to cover this treatment just as they would cover any other chronic disease. Thanks to the ACA and Medicaid Expansion, Americans who could not get access to this treatment before now can. Unfortunately, people with substance use disorder still face barriers to accessing treatment. According to SAMHSA, of the 19 million adults who had a substance use disorder in 2016, 17 million did not receive treatment.

We need to do everything we can to help more Americans access this treatment. Unfortunately, there are companies preying on individuals in desperate need of treatment services. Some of the companies this Committee has been examining claim they are merely filling a market need. But anyone advertising treatment services must put the needs of the patient first, and they must employ well-qualified staff that can provide quality treatment or ensure that they are only referring patients to quality treatment providers.

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I am hopeful our witnesses can shed some light on the types of marketing and treatment practices that are best designed to put the patient first and help them find quality care.

For example, Dr. Kenneth Stoller from the Johns Hopkins Hospital Broadway Center for Addiction can tell us about how they conduct outreach to individuals who may be in need of substance use disorder services and enroll patients seeking care. He can also tell us about how treatment providers should clinically assess the needs of each patient to determine the best course of treatment, and the role of medication-assisted treatment (or MAT) for opioid addiction.

I also look forward to hearing from some of the other treatment providers on their marketing and treatment practices to understand if they are designed to always put the patient first and guide them to the care most appropriate for their condition.

This is important considering that not all families seeking help have access to objective information or even know what to look for in evaluating treatment options.

And this problem is especially complicated when families stumble upon misleading or confusing websites, designed not to educate people about the best forms of treatment available. So we need to hear from the panel about what they regard as quality care, and what a family in crisis should look for in a treatment program as they struggle to find help with their addiction.

I support efforts that get more people into quality treatment. Marketing and advertising can be important tools in educating people about the different treatment options available to meet their needs, but if these companies want to be in the treatment business, they simply must put the patient first. And this Committee must continue to work to ensure that any American suffering from this terrible disorder gets the treatment they need.

Thank you, I yield back.

Mr. HARPER. The gentleman yields back.

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

Without objection, so ordered.

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

Without objection, so ordered.

I would now like to introduce our witnesses for today's hearing.

Today, we have Dr.Marvin Ventrell, who is the Executive Director of the National Association of Addiction Treatment Providers. Next, is Mr. Mark Mishek, President and CEO of the Hazelden Betty Ford Foundation. Third, is Mr. Michael Cartwright, who is the Chairman and CEO of American Addiction Centers. Mr. Robert Niznik, who is the CEO of Addiction Recovery Now and Niznik Behavorial Health. Then we have Mr. Jason Brian, Founder of Redwood Recovery Solutions and TreatmentCalls.com. And finally, Dr.Kenneth Stoller, who serves as the Director of John Hopkins Hospital Broadway Center For Addiction.

We welcome each of you here.

You are all aware that the Committee is holding an investigative hearing. And when doing so, we have had the practice of taking testimony under oath.

Do any of you have any objection to testifying under oath?

Every witness has replied no.

The chairman then advises you that under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel.

Do you desire to be accompanied by counsel during your testimony today?

Let the record reflect that all the witnesses have replied no.

In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses Sworn.]

You may be seated.

All the witnesses responded affirmatively. And you are now under oath and subject to the penalties set forth in Title 18 Section 1001 of United States Code. And you may now give a 5-minute summary of your written statement.

There should be a light system that will tell you when that time is come, so you'll have 5 minutes. It should go yellow at 1 minute, at red when your time is up.

And I will now start with Mr. Ventrell. You may begin. Make sure your mic is up close and you turn your button on when you testify.

TESTIMONY OF MARVIN VENTRELL, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS; MARK MISHEK, PRESIDENT AND CEO, HAZELDEN BETTY FORD FOUNDATION; MICHAEL CARTWRIGHT, CHAIRMAN AND CEO, AMERICAN ADDICTION CENTERS; ROBERT NIZNIK, CEO, ADDICTION RECOVERY NOW AND NIZNIK BEHAVIORAL HEALTH; JASON BRIAN, FOUNDER, REDWOOD RECOVERY SOLUTIONS AND TREATMENTCALLS.COM; AND DR. KENNETH STOLLER, DIRECTOR, JOHNS HOPKINS HOSPITAL BROADWAY CENTER FOR ADDICTION

TESTIMONY OF MARVIN VENTRELL

Mr. VENTRELL. Thank you, Chairman Harper. Thank you, Ranking Member DeGette. I also recognize the comments of Ranking Member Pallone and the comments made by the committee at large chair, Mr. Walden.

Thank you for the opportunity to be here today to present this testimony. I represent the National Association of Addiction Treatment Providers. I am the Executive Director of the National Association, also known from time to time as NAATP. Our folks will say NAATP. That all refers to us.

It is an honor to be here. I'm excited to give this testimony because our association is fully supportive of the work of this subcommittee. This has in fact been the focus of the National Association for the past several years.

We are horrified by the behaviors that have occurred in this field. They are not us. It is not unusual for a trade association such as ours to perhaps object or resist certain regulation. We do not do so in this instance. In fact, we have been at the forefront of asking for this sort of regulation for some time. That is why, among other things, we developed our new code of ethics and are in the process of writing a resource guidebook for the ethical and proper operation of addiction treatment centers.

So thank you again for this opportunity. We wholeheartedly support what you are doing. We want to be part of that. We want to provide as much information as we possibly can for you. And I look forward to giving this testimony today and answering your questions.

Ranking Member DeGette specifically asked in her opening comments for recommendations for choosing treatment centers and for red flags in understanding what is not an appropriate center. We have worked diligently on these very things. Much of that resource is attached to my written testimony as a supplement, and it should be ultimately in the record. And I look forward, again, to articulating any of those principles.

Our association is grateful for this opportunity. On behalf of our members and the thousands of patients that they serve, and we

support this committee's efforts to clean up the practices that are harming us all.

This matter, ethical operation, professional operation, and legal operation of addiction treatment is at the forefront of our work. What has happened in our industry is among the greatest threats to the success of our work as an addiction treatment field that we have ever seen.

Historically, the practice of addiction treatment has been marginalized. It has been stigmatized. And we have functioned on the outskirts of healthcare. We are poised to make a change in this regard now. We are poised with all of the developments that have occurred in terms of science, social science, and opportunity for funding and treatment. We are poised to do the best work we have ever been able to do. That is what we wish to do, and we are being delayed, and we are being impeded from that by bad actors.

These bad actors that are the source of comments that the committee made are a minority. They are a small minority, but they are an effective and very damaging minority. They are not our members. I wish to say that they are not we.

The National Association of Addiction Treatment Providers is comprised of approximately 850 treatment campuses around the country. These are good centers doing good work. The source of the problem is not the national association. It is not common, as I indicated, for a trade association to resist regulation. Once again, we do not, in fact, we are promulgating much of that within our practices now.

The primary issues have been accurately identified. I applaud the subcommittee's staff memorandum. It is accurate, and I adopt all of it. The problems we are facing are primarily these.

Patient brokering, billing and insurance abuses, credential misrepresentation, predatory web practices and foremost, in predatory web practices is the matter of deceptive, unbranded or inadequately branded websites.

While a trade association is not typically in the business of policing, we have undertaken that role as it concerns our members, and we have adopted an initiative called of the quality assurance initiative, which has 11 components.

I would like to explain all of them to you. Of course, I don't have time do that, but hopefully, you will ask me questions about those.

In each of these 11 initiatives, many of which are focused specifically on deceptive advertising matters are addressed in the quality assurance initiative which will be fully articulated in the guidebook that will be published later this year.

I see that my time is up, and I thank you for the opportunity.

[The prepared statement of Mr. Ventrell follows:]

NATIONAL ASSOCIATION
OF
ADDICTION TREATMENT PROVIDERS

Voice. Vision. Leadership.

Written Testimony of Marvin Ventrell
Executive Director
National Association of Addiction Treatment Providers (NAATP)

Submitted: July 22, 2018

Supplemental Material:
1. *NAATP Code of Ethics*
2. *NAATP Article: Time to Raise the Floor*
3. *NAATP Guide to Locating Addiction Treatment*

Congress of the United States
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearing:
"Examining Advertising and Marketing Practices within the Substance Use Treatment Industry"

Thank you for the opportunity to provide testimony regarding this critically important matter. I serve as Executive Director of the National Association of Addiction Treatment Providers (NAATP). In this capacity, I am charged with directing the NAATP mission to provide leadership, advocacy, training, and member support services to ensure the availability and highest quality of addiction treatment. NAATP, founded in 1978, is a not-for-profit professional membership association of addiction treatment providers. NAATP functions as a trade association for addiction treatment providers. NAATP is comprised of approximately 850 member-facilities that provide varying addiction treatment services along the continuum of care. The core membership of NAATP is the residential addiction treatment center that provides comprehensive integrated addiction treatment.

Substance Use Disorder (SUD), also known as addiction, alcoholism, drug addiction, or chemical dependency, is a serious health care condition that effects in excess of 20 million Americans (SAMHSA). SUD is a chronic brain disease with biological, psychological, social, and spiritual

manifestations. While chronic and potentially fatal, SUD is treatable. If provided with proper care, patients can recover to lead healthy, happy, productive and useful lives. In excess of an additional 20 Million Americans identify themselves as such persons in long-term recovery from addiction (SAMHSA). Addiction treatment, when provided along a comprehensive continuum of care that addresses all of the above referenced disease manifestations (bio-psycho-social-spiritual), also known as integrated care, is effective. Problematically, SUD treatment delivery is hampered by several factors that result in the lack of service to the majority of patients suffering. We estimate that only approximately 10% of those suffering from the disease get the care they need (SAMHSA). Disease stigmatization, unavailability of services, and a serious lack of payment resources (including no health care coverage and difficulty accessing existing insurance payments) are at the root of the problem.

In recent years, excellent progress has been made toward narrowing this treatment gap through professional and societal acceptance of addiction as a disease, parity law, and more recently bipartisan congressional funding of addiction services through legislation (CURES Act and increased appropriations). As an industry, we have become increasingly better positioned to treat this disease.

However, the problem became more complicated over the past decade with the advent of the Opioid Epidemic, wherein it is estimated 2 million individuals suffer from dangerous opioid addiction (ASAM) and as many as 115 individuals die from opioid overdoses each day (CDC). While alcohol (Alcohol Use Disorder or AUD) continues to be the substance within SUD that causes the most harm (84%), opioid addiction impacts approximately 9% of the SUD population (SAMHSA) and has the capacity to kill faster than alcohol and other SUD substances.

It is at this stage of our work that the specific subject matter of this hearing entered the picture. Whereas many competent and ethical treatment providers have been delivering addiction care since as early as the 1940s (Alcoholics Anonymous was founded in 1939), a new population of addiction treatment providers (and some longer-standing providers) entered the addiction service business

market and began marketing their services in an unprofessional, unethical, and sometimes illegal fashion. Addiction treatment began to be perceived as a highly profitable industry. Whereas consumers in the American business market may vary in vulnerability to marketing tactics, the population seeking treatment is particularly and highly vulnerable to manipulation because the disease of addiction is misunderstood and the patient and family seeking help are in serious and desperate distress.

From the perspective of the National Association of Addiction Treatment Providers, the harmful actions took the following forms:

1. Patient Brokering
2. Billing and Insurance Abuses
3. License and Credential Misrepresentation
4. Predatory and Deceptive Web Practices
    a. Unbranded Marketing Pages
    b. Web and Call Directory Deception
    c. Consumer Identity Aggregation
    d. Google Platform Deception
        i. AdWords
        ii. Maps
        ii. Search Engine Optimization (SEO)

Over the past several years NAATP became increasingly aware of these advertising and marketing tactics as they became more and more prevalent. The behavior caused serious harm to the consumer patient, the patient's family, insurer, and the addiction treatment industry at large. While we believed and continue to believe that these harmful practices are limited to a minority of providers generally and an even smaller minority within our own association membership, the harm caused was and is too great for us, as the industry trade association, to not act. It is important to note that the

action we have taken is extraordinary in the typical operation of a trade association. Like many trade associations, NAATP is a voluntary membership society wherein members, in our case treatment programs, come together for education, training, resources, convening, networking, and collegiality. We are not a licensing, accrediting/certifying, or policing body. We have no authority to control addiction providers' business or clinical practices beyond our membership conditions. We believe, however, that by setting high values-based professional and ethical membership standards, we can achieve and maintain an association that is comprised of treatment providers on which the public and payer/insurer can safely rely. We also believe that we can, by these actions, lead the entire field by example and influence best practices across the industry through public policy.

Therefore, in the summer of 2017, NAATP adopted its Quality Assurance Initiative (The QAI) designed to:

- Promote best business practice
- Deter problematic business practice
- Inform law and policy makers
- Protect and assist the consumer
- Train the provider

The QAI is comprised of the following 11 Programs:

- NAATP Code of Ethics (Ethics 2.0)
- Ethics Code Enforcement Provider Conduct Review Process
- Adoption of Accreditation as an NAATP Provider Requirement
- Addiction Industry Directory (The AID)
- Quality Assurance Guidebook
- Google LegitScript Advertising Advisement
- Outcomes Measurement Toolkit

- Insurance Industry Collaboration
- Cross Agency Collaboration
- Annual National Conference Training Program
- NAATP Provider Webinar Series

The subject matter and time limits of this hearing do not allow for an expansive description of each of these programs. NAATP will be pleased to provide this Committee with comprehensive information as to all programs upon request. The following testimony will be focused on the first six of the foregoing programs:

NAATP Code of Ethics (Ethics 2.0)

The foundation of the NAATP QAI is the NAATP Ethics Code (Ethics 2.0) provided herein as supplemental material. It was adopted by the association in December 2017 and became effective January 1, 2018. It was preceded by our code that, while similar in terms of philosophy and intent, did not adequately articulate the prohibited conduct that became problematic. Ethics 2.0 was implemented so that our members knew the rules and knew they were required to follow them as a condition of membership. Our membership embraced this move. Ethics 2.0 is comprised of these parts:

Preamble / Philosophy / Adherence Required

1. Treatment Ethics
2. Management Ethics
3. Facilities Ethics
4. Marketing Ethics
    a. Financial Rewards
    b. Deceptive Advertising / Marketing
    c. Client Identities

Each of the harmful practices described in this testimony is articulated and specifically prohibited by the Code (Patient Brokering, Billing and Insurance Abuses, License and Credential Misrepresentation, Predatory and Deceptive Web Practices). Most applicable to the subject matter of this hearing is Marketing Ethics. Within the provisions of Section IV, parts A, B, and C, the code describes and specifically prohibits the deceptive, misleading, and non-transparent marketing of treatment services.

Ethics Code Enforcement Provider Conduct Review Process

Prior to launching Ethics Code 2.0, NAATP worked with legal counsel to develop a comprehensive process whereby addiction treatment provider members of NAATP who are suspected of ethics code violations would be reviewed for code compliance. Fellow members, non-member providers, and the public may file a complaint against an NAATP member based on ethics code violations. Thereafter, the alleged conduct is reviewed by NAATP and notice and opportunity to respond is given to the provider. If a violation is found to exist, the NAATP member may incur the following penalties: notice and opportunity to cure the violation or expulsion from membership. Our goal is to encourage compliance rather than punish. As part of code enforcement, NAATP also began, as of January 1, 2018, a process whereby members' code compliance can be internally assessed when the member's annual membership is expiring. This process allows NAATP to determine whether the member that is expiring should be invited back based on code compliance.

Since implementation of the code and process, NAATP has removed from our member roles 99 addiction treatment campus locations operated by 24 parent companies. This has resulted in the forfeiture of $111,150 in dues revenue. This has significant negative economic impact for our association. Nonetheless we believe the action must be taken and continue to be taken in order to serve the objectives of the QAI and ensure our association integrity. Our objective is to distinguish the NAATP member as a reliable ethical treatment provider. We believe that we diminish our own value

and do a disservice to the good provider by associating with providers who do not function as professional, values-based ethical programs. The primary reasons for removal of these members from our roles are unbranded websites and the buying or selling of leads. Members were also deleted based on licensing misrepresentation and billing abuses.

Adoption of Accreditation as an NAATP Provider Requirement

At the 2018 Annual Meeting of the NAATP Board of Directors in May of 2018, our leadership voted to adopt a new membership requirement whereby an addiction treatment provider must obtain accreditation as an addiction treatment provider to qualify for membership. This month, July 2018, the NAATP membership at large approved this measure, effective January 1, 2019. The measure is consistent with our QAI objective to ensure competence and reliability of NAATP members. While accreditation alone is not dispositive of high quality care, it is strong indicia of such. Addiction treatment accreditors, primarily CARF and The Joint Commission, typically work to ensure patient treatment quality and safety. Combined with the NAATP QAI efforts to ensure ethical business practice, we all take a significant step forward toward protecting the consumer and improving care.

Addiction Industry Directory (The AID)

Consumers, payers, and treatment professionals must have a reliable source to locate addiction treatment. For-profit call centers, treatment center operated directories, and similar web directories do not reliably fulfill this function and frequently mislead the consumer. The NAATP Addiction Industry Director is a comprehensive and transparent listing of all members without rank or recommendation, just data on service, location, staffing, programs, and credentials. Combined with the NAATP Guide to Selecting Addiction Treatment, the AID serves the QAI objectives and helps protect the consumer as well.

Quality Assurance Guidebook

The Quality Assurance Guidebook is a major effort that will result in the publication this year of a comprehensive resource for addiction treatment provider operations. It will serve as a kind of rulebook for the field. No such resource currently exists. The Guidebook will detail the competencies for operations in the following form: Guideline, Commentary, and Implementation Resource. The list of Guidelines is as follows:

A. **Operations**
- *Guideline A-1: Treatment Philosophy*
- *Guideline A-2: Licensing*
- *Guideline A-3: Accreditation*
- *Guideline A-4: Governance*
- *Guideline A-5: Policies and Procedures*
- *Guideline A-6: Strategic Planning*
- *Guideline A-7: Leadership Practices*
- *Guideline A-8: Facilities*
- *Guideline A-9: Management*

B. **Admissions / Patient Screening**
- *Guideline B-1: Admission Process*
- *Guideline B-2: Screening / Assessment*

C. **Training and Credentialing**
- *Guideline C-1: Staff Training*
- *Guideline C-2: Professional Staff Credentials*

D. **Billing**
- *Guideline D-1: Calculating Cost of Service*
- *Guideline D-2: Usual and Customary Rates*
- *Guideline D-3: Balance Billing and Receiving*
- *Guideline D-4: Toxicology*

E. **Discharge & Continuing Care**
- *Guideline E-1: Continuum of Care*
- *Guideline E-2: Discharge Planning*
- *Guideline E-3: Atypical Discharges*

F. **Outcomes Measures**
- *Guideline F-1: Tracking Patient Outcomes*

G. **Community Engagement, Public Relations, and Public Policy**
- *Guideline G-1: Participation in the Community*
- *Guideline G-2: Public Relations Strategy*
- *Guideline G-3: Public Policy Position*

H. **Marketing, Advertising, and Visibility**
Guideline H-1: Transparency
Guideline H-2: Treatment
Guideline H-3: Management
Guideline H-4: Facilities
Guideline H-5: Marketing
a. Policy
b. Finance
c. Deception
d. Client Identities

Google LegitScript Advertising Advisement

The internet serves as the primary source for consumer location of addiction treatment. This is not the case for most health care and NAATP encourages consumers to approach addiction treatment search as one would any other health care matter. Consumers should seek professional referral and speak to one's medical and mental health provider for example.

Nonetheless, the internet is used in this fashion and has been manipulated by unscrupulous providers to deceive consumers. The majority of internet searches are performed on the Google platform. Deceptive practices on Google by unscrupulous providers include AdWords misuse, search engine optimization (SEO) misuse and dominance, and Google Map deception. While Google was, at one time, unresponsive to our requests to control this behavior, they became responsive in 2017 and took the significant are largely unprecedented step of suspending the purchase of AdWords associated with addiction treatment. NAATP and industry colleagues met with Google staff in the fall of 2017 to begin a dialogue on the matter. Since that time, NAATP has become an advisor and advisory board member to Google and the company LegitScript. LegitScript is the entity that now reviews a treatment provider's qualifications to purchase AdWords. Without the LegitScript authorization based on treatment operation criteria, Google will not approve the entity for AdWords purchase. This month, LegitScript approved the first batch of 31 authorized providers through a beta process. Going forward, LegitScript will approve providers on a rolling basis.

In addition to the AdWords issue, NAATP is scheduled to meet later this year with Google staff to discuss a regulatory process for managing the concerns regarding SEO and Maps.

Summary of Key Testimony Points

1. **The Role of the National Association of Addiction Treatment Providers (NAATP).** As the long-standing addiction industry trade association, NAATP provides resources, education, and training to the professional community and sets a standard of reliable, high-quality, ethical addiction treatment program operation. NAATP also provides guidance to the consumer, insurer, and policy maker.

2. **The Context of Addiction Treatment in the United States.** Addiction is a chronic brain disease with biological, psychological, social, and spiritual components effecting over 20 million Americans. While treatable, most individuals suffering do not get adequate care. Significant progress has been made in terms of treatment knowledge and service delivery, but the problem became exacerbated by the Opioid Crisis and bad actors coming into the work who are more focused on profit than good care.

3. **The Problem of the Unscrupulous Provider.** The unscrupulous provider harms the highly vulnerable consumer and the entire treatment system through unprofessional, unethical, and even illegal practices. Harmful actions include patient brokering, billing abuses, license and credential misrepresentation, and predatory and deceptive web practices. The web practices fall primarily in the areas of unbranded web pages, web and call directory deception, consumer identity aggregation, and Google platform deception.

4. **The NAATP Quality Assurance Initiative (QAI) Response**. The Quality Assurance Initiative (QAI) responds to the problem through a series of measures that promote best business practice, deter problematic business practice, inform law and policy makers, protect and assist the consumer, and train the provider. NAATP Ethics Code 2.0 is the foundation of the program. Enforcement of Ethics 2.0 NAATP has resulted in NAAP removing 99 addiction treatment campus locations resulting, in the forfeiture of $111,150 in association dues revenue. The QAI components that address the concerns of this committee hearing are: NAATP Code of Ethics (Ethics 2.0), Ethics Code Enforcement Provider Conduct Review, Adoption of Accreditation as an NAATP Provider Requirement, Addiction Industry Directory (The AID), Quality Assurance Guidebook, and the Google LegitScript Advertising program.

Mr. HARPER. Thank you, Mr. Ventrell.

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

TESTIMONY OF MARK MISHEK

Mr. MISHEK. Thank you, Chairman Harper, Ranking Member DeGette, and members of the subcommittee for inviting me. It is an honor.

I am grateful for your leadership in addressing the opioid crisis and addiction, and for the opportunity to testify today about business practices and quality standards in the addiction treatment industry.

My name is Mark Mishek, and I am the President and CEO of the Hazelden Betty Ford Foundation, a non-profit addiction treatment provider with 17 sites in 9 States. We treat over 21,000 people annually and are also engaged in prevention, education, publishing, research and advocacy related to the disease of addiction.

On behalf of the millions of vulnerable people and families suffering from substance use disorders, thank you again, for your bipartisan look into patient brokering and related issues.

Growing market demand for addiction treatment, driven by the opioid crisis and expanded insurance coverage has attracted unprecedented investment and an influx of new providers all operating in a field that is under-regulated and lacks consistent quality standards. It is in this environment that our industry has seen the rise of unprofessional, unethical, and sometimes illegal practices such as deceptive marketing and patient brokering—not to mention excessive consumer billing and insurance fraud. In too many cases, people who need help are instead being harmed.

Most in our field do great work. But to ensure ethical, quality care for all who seek help for addiction, we believe it is time to establish quality standards and a consistent, enforceable regulatory framework for the addiction treatment industry. The stakes—patient safety and public confidence in addiction treatment—are high.

Now, patient referrals, of course, are not bad, per se. The problem is when referrals are made with little or no regard to what is clinically appropriate for the patient when there is a lack of transparency in the process and especially when financial kickbacks are involved. That's when referrals become patient brokering. Many brokering schemes begin with deceptive marketing.

Now, at Hazelden Betty Ford, all of our treatment marketing leads to one website, one consumer website, HazeldenBettyFord.org. That is not the case for others who use multiple sites and multiple brands to acquire patients.

Often, it is not clear who is behind ads for addiction treatment or who consumers will get when they reach out for help. Some providers obscure their affiliations to other organizations or misrepresent the services they provide, the conditions they treat, the credentials of their staff, or the insurance that they actually accept. And some use online bait-and-switch techniques to get calls from people intending to call a different treatment center. Something, unfortunately, we see frequently with our name.

All of this can lead to bad treatment for consumers. The lack of transparency on top of minimal quality standards in the industry

puts patients at risk. These kinds of practices certainly would not be tolerated in any other area of healthcare. And in light of them and because of the life saving work that we do, it is more imperative than ever for the addiction treatment field to hold itself to the highest ethical, legal, and quality standards.

Ultimately, we think reforms are needed to bolster State licensure requirements, accreditation standards, clinician education qualifications and access to comprehensive evidence-based care.

Beyond State initiatives, Federal oversight through the Federal Trade Commission, for example, is essential. Fraudulent advertising and patient brokering obviously cross State lines. Finally, we think a Federal law explicitly outlawing patient brokering is critical.

Without such accountability, our field will continue to evolve into a sector where success is predicated not on whether patients get well or families heal, but on the size of your advertising budget, your website analytics, your search engine optimization, and your call center tactics.

Now is the time to restore faith and accountability in the addiction treatment field, and it's time to establish quality standards in that enforceable regulatory framework.

Thank you for the opportunity to share my testimony. And I look forward to answering your questions.

[The prepared statement of Mr. Mishek follows:]

Testimony of Mark Mishek, President and CEO, Hazelden Betty Ford Foundation
Before the House Energy & Commerce Committee
Subcommittee on Oversight and Investigations
July 24, 2018

Summary: Chairman Harper, Ranking Member DeGette, and Members of the Committee, thank you for inviting me to participate in this important hearing. I am grateful for your leadership in addressing the nation's opioid overdose epidemic and the addiction crisis that underlies it. I appreciate the opportunity to testify today about advertising and marketing practices in the addiction treatment industry and to contribute to the subcommittee's bipartisan investigation into patient brokering.

My name is Mark Mishek, and I am the President and CEO of the Hazelden Betty Ford Foundation. Our nonprofit organization provides addiction treatment as well as education, prevention and recovery services. We were founded in 1949 in Minnesota, where we remain headquartered. We now have 17 sites in nine states, including the Betty Ford Center, founded in 1982 by the former First Lady. At our clinical sites, we treat more than 20,000 people annually. Our nonprofit also includes an accredited graduate school of addiction studies; a publishing house; a research center; an education arm for medical professionals; a program for young children affected by addiction in the family; and an advocacy function focused on public education, policy and stigma reduction.

On behalf of the millions of vulnerable people and families suffering from substance use disorder, thank you again for your interest in this devastating public health issue.

Growing market demand for addiction treatment—driven by the opioid crisis and expanded insurance coverage—has attracted unprecedented private investment and an influx of new providers, all operating in a field that is under-regulated and lacks consistent quality standards. It is in this environment that our industry has seen the rise of unprofessional, unethical and sometimes illegal practices such as deceptive marketing and patient brokering—not to mention excessive consumer billing and insurance fraud. In too many cases, people who need help are instead being harmed.

Most in our field do great work. But to ensure ethical, quality care for all who seek help for addiction, we believe it is time to establish quality standards and a consistent, enforceable regulatory framework for the addiction treatment industry. The stakes—patient safety and public confidence in addiction treatment—are high.

Testimony (Cont.): As this subcommittee discovered in its earlier hearing on patient brokering, laws prohibiting commissions and kickbacks for patient referrals are not strong, or even existent, everywhere. As a result, some treatment providers pay a third-party "lead-generation" service for calls, turning patients into commodities. We've also heard of patient brokers monitoring Twelve Step meetings, drug courts and the streets to find people they can send to treatment centers willing to provide a kickback, regardless of the clinical appropriateness.

In addition, some brokers are wooing addicted patients into treatment centers and sober homes with promises of free travel and healthcare, spa-like accommodations, free rent, gift cards, trips to casinos, cash and drugs. Some brokers are actually encouraging relapse just to churn people through the system and generate claims and kickbacks as many times as possible. We have read these reports in the news, just like many of you. But we also hear them from our patients, staff and peers in the field.

While some patient brokering practices are blatantly inappropriate, others are more subtly so—and may even seem well-intended. Referrals, of course, are not bad per se. The problem is when referrals are made with little or no regard to what is clinically appropriate for the patient, when there is a lack of transparency in the process, and especially when financial kickbacks are involved.

Deceptive marketing is enabling some of these patient brokering practices. Often, it is not clear who is behind TV and online ads for addiction treatment, or who callers will get when they reach out for help. Some treatment providers also deny or obscure their affiliations to other organizations, or misrepresent the services they provide, the conditions they treat, the credentials of their staff, or the insurance plans they accept. And some use online bait-and-switch techniques to get calls from people who actually are intending to call a different treatment center.

Deceptive marketing and patient brokering can lead to bad treatment for consumers. The lack of transparency, on top of minimal quality standards in the industry, puts patients at risk. These kinds of practices certainly would not be tolerated in any other area of healthcare.

The specialty addiction treatment field has long been marginalized and a step removed from mainstream healthcare—not integrated, not taught in medical school and not even recognized as a specialty until recently. Stigma has kept it separated, which is one reason it has been able to exist under a looser regulatory framework. Congress needs to assist in tightening the regulatory framework.

It is also more imperative than ever for the field to hold itself to the highest ethical, legal and quality standards in the health care industry, commensurate with the lifesaving work of helping people overcome the disease of addiction. We are among members of the National Association of Addiction Treatment Providers (NAATP) committed to a robust new code of ethics, which prohibits, among other things:

- Patient brokering or any kind of financial rewards for patient referrals or leads;
- The offering of non-clinical amenities to induce prospective patients;
- And false, deceptive or misleading statements, advertising or marketing practices of any kind.

I want to also address some of the same questions you posed in your recent letters to companies involved in aggregating calls from prospective patients.

First, we do have our own call center that accepts calls made directly to us. In 2017, we received 1,200 calls a week. This year, we are averaging 1,400 calls a week—on track for 72,000 calls total. Our call center employees are trained only on our own programs and services, and that's because our call center policy is to NOT refer callers to other treatment providers unless they are deemed inappropriate for our services.

We screen all callers and involve medical and mental health staff if there is a question about appropriateness for our services. If something outside the scope of our services—such as a primary eating disorder, gambling disorder or severe mental illness, for example—is a factor, we refer callers to their insurance company and to the treatment directory operated by the Substance Abuse and Mental Health Services Administration (SAMHSA). If we know of options in the caller's area, we may occasionally mention those, too, but not as a formal referral and certainly not with any financial incentive. Because we don't route our calls to other providers and list our number only alongside the name of our organization, our callers clearly know they have reached the Hazelden Betty Ford Foundation.

The referrals we do make are to support the continuing care of our patients. For example, someone may travel to access our treatment and then need to return home. We may refer such people to a provider that we trust to continue their care in their home area—in the same way that a primary care doctor might refer to a specialist or pharmacist. This is standard practice in the healthcare industry, and kickbacks are never involved. We are also stepping up our efforts to more thoroughly vet and collaborate with other providers. We recently launched a Patient Care Network (PCN)—unique to our field but common elsewhere in healthcare—to foster collaboration with quality, like-minded providers and to help extend the continuum of care for our patients. Our PCN members each complete a robust application, host us for a site visit and are researched thoroughly. Our aim is to collaborate with licensed, accredited, evidence-based programs that provide effective, accessible, patient-centered, equitable and safe services and resources across a continuum.

We have three websites with phone numbers that ring to our main treatment call center, all clearly and consistently branded: Hazelden.org, HazeldenBettyFord.org and HBFFoundation.org. We also own

nine other websites—one for our prevention arm, for example—but they do not ring to our call center because they are not treatment sites.

We do pay search engines and social media platforms for ads to help drive traffic to our HazeldenBettyFord.org website. Specifically, we have paid Google for ads, as well as Bing and Facebook. We appreciate that Google is now vetting ads and ad buyers more rigorously, and support that process. In fact, just this past week—after a thorough application process—we were certified by LegitScript to resume ads on Google.

To discourage deceptive and unethical practices—and also ensure quality—efforts must be undertaken to improve the nation's regulatory framework for addiction treatment. Reforms ought to bolster state licensure requirements; accreditation standards; clinician education qualifications; and access to comprehensive, evidence-based care and support that is coordinated and integrated with the rest of the healthcare system. To help inform such efforts, the Hazelden Betty Ford Foundation has identified quality standards in collaboration with another nonprofit provider and NAATP member, Caron Treatment Centers. I will touch on 12 of the standards we identified, all of which reflect our views on the key attributes of a quality provider.

1. **Accreditation and Licensure.** The first essential characteristic of a quality addiction treatment provider is ongoing accreditation from external regulatory organizations, such as the Joint Commission (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). It is also important to maintain a state license. 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. Accreditation and licensure should be "minimum requirements" of any organization offering addiction treatment.

2. **Qualified Clinicians.** Well-trained and credentialed clinicians are critical to providing quality care. Quality providers employ addiction medicine physicians, doctoral-level psychologists, and licensed or certified addiction counselors who have, at a minimum, a bachelor's degree from an accredited institution with a preference for those prepared at the master's level; they also implement clinical training programs that keep clinicians up to date in their fields and continuously advance their clinical skills. In addition, they develop staff from within to both improve performance and enable continuity of quality through periods of growth and changes in the ever-evolving and complex healthcare system.

3. **Technology and Data Systems.** Quality care providers use state-of-the-art tools for conducting all aspects of business, including clinical operations. Such tools include a well-designed, integrated electronic health record that allows information to be shared across all and 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. Quality care providers also use technology to deliver care and ongoing support for patients.

4. **Evidence-Based Treatment.** In this environment of under-regulation, the market has seen an influx of for-profit centers that offer exclusive, spa-like environments guaranteeing success, but little in the way of evidence-based treatment or demonstrated outcomes. Clinical services 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, quality providers 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.

5. **Care for Co-Occurring Disorders.** Most individuals with a substance use disorder also have a co-occurring mental health condition or other co-existing addiction. A quality addiction treatment provider should have a comprehensive behavioral health team capable of providing integrated treatment for these co-occurring disorders.

6. **Performance Measurement.** Quality care providers should have formalized, proven methods for measuring several aspects of organizational performance, including patient outcomes. Patient outcome measures should include reports from patients themselves, reports from families, information from other professionals, and science-based, physical measures such as urine drug screens. Practitioners and scholars have yet to agree on the precise metrics that should be collected and reported throughout the addiction treatment field. As such, we urge the development of standard outcome measures so that all programs can be compared based on the same measures.

7. **Commitment to Quality and Process Improvement.** A quality provider with a valid performance measurement system also engages in quality and process improvement, and participates in national benchmarking efforts to demonstrate accountability. Benchmarking criteria should include (but not be limited to) satisfaction rates, average length of treatment, successful treatment completion, abstinence rates, re-engagement rates and integration of family into treatment. Quality providers are transparent in sharing information regarding the quality of care and outcomes, and educating the consumer about services and expected results. Using outside agencies and university-based researchers to evaluate the data is essential. Data should be displayed in a forthright, appropriate way so they are not misinterpreted.

8. **Full Continuum of Care**. Quality care providers offer a full continuum of care that provides a complete range of services to meet patients' unique needs, based on the acuity of their condition and their social and environmental situation. Available services should be explained and offered at the outset, prior to admission. They should span a wide range of areas, including prevention and education, intervention, treatment and post-treatment recovery support. Quality providers also provide extensive services for families, including children affected by a loved one's addiction.

9. **Education and Scholarship.** The best addiction treatment providers collaborate with academic centers and universities to help advance addiction education and scholarship through programs, fellowships, internships and professional development opportunities, as well as by conducting or participating in research for publication in peer-reviewed scientific journals.

10. **Advocacy.** Quality providers engage their stakeholders in activities to educate the public about the problems of addiction and the promise of recovery; advance helpful public policy changes and reduce the stigma associated with addiction. This can be accomplished through membership with national trade associations, hosting and sponsoring events, and conducting interviews with the media, among other strategies.

11. **A Broad Reach.** Compared to the rest of healthcare, the addiction treatment industry has been slow to serve underprivileged individuals with limited financial means. To the extent possible, services should be available to people of all socioeconomic backgrounds through insurance utilization, scholarships and patient aid programs. Quality care providers also emphasize diversity and inclusion; this includes having culturally appropriate symbols and employing staff who are diverse and bilingual.

12. **Sound and Ethical Business Practices.** As outlined earlier, marketing and billing 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 provider should also be well-capitalized to ensure stability for patients, alumni and employees. We believe all addiction treatment providers should adhere to the previously mentioned NAATP code of ethics.

These characteristics represent, in our view, the minimum standards of a Center of Excellence in addiction treatment. While the federal government does not have regulatory authority over ethical and quality issues involving addiction treatment, it can develop and disseminate standards for states to consider, provide training and technical assistance, and work with organizations like NAATP and agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) to disseminate standards and best practice guidance. Therefore, our Hazelden Betty Ford Institute for Recovery Advocacy—which has made industry reform a top priority—advocates for the following:

- Directing the Secretary of Health and Human Services to publish and disseminate a report assessing the adequateness and uniformity of licensure, accreditation and clinician education requirements for substance use disorder treatment providers nationwide.
- Directing SAMHSA to develop, publish and disseminate best practices for operating recovery housing that promotes a safe environment for sustained recovery from substance use disorder.
- Empowering the Federal Trade Commission to investigate and prosecute deceptive marketing practices by addiction treatment providers and call aggregators, in response to complaints from consumers and businesses.
- Directing SAMHSA to develop, publish and disseminate best practices, and practices to avoid, for "interventionists" who help families and individuals access addiction treatment.

- Directing the Department of Justice to define "patient brokering" in consultation with SAMHSA, with an eye toward outlawing such practices.
- Directing the Secretary of Health and Human Services to assess the adequateness and uniformity of addiction treatment education and training in medical schools.

We also support an assortment of legislation to improve addiction treatment quality by:

- Expanding and elevating the addiction treatment workforce.
- Encouraging greater integration of specialty addiction care with primary care and all of mainstream medicine.
- Encouraging greater linkages to community-based recovery support and throughout the continuum of care.
- Incenting evidence-based practices and quality-based outcome measures and standards.

It is time to restore faith and accountability in the addiction treatment field. It is time to establish quality standards and an enforceable regulatory framework to guide all treatment organizations. It is time to ensure ethical, quality care for all people who seek help for addiction.

Thanks again for the opportunity to share my views. I look forward to answering your questions.

Mr. HARPER. Thank you, Mr. Mishek. The chair will now recognize Mr. Cartwright for 5 minutes for the purposes of his opening statement.

TESTIMONY OF MICHAEL CARTWRIGHT

Mr. CARTWRIGHT. Thank you, Chairman Harper and Ranking Member DeGette. Thank you for having me here.

My name is Michael Cartwright I'm the Chairman and CEO of American Addiction Centers.

Thank you Chairman Harper and Ranking Member DeGette. Thank you for having me here.

My name is Michael Cartwright I'm the Chairman and CEO of American Addiction Centers. We operate in 9 States. We offer 39 treatment centers.

I've been a treatment counselor and executive for 23 years. For 12 of those years, I operated a not-for-profit organization. I've also run both publicly traded, as well as privately funded drug and alcohol treatment centers. I have actually advised the U.S. Senate Health Subcommittee on Substance Abuse and Mental Health Services back in the early 2000s when we were looking at co-occurring disorders in this country and how we could better implement that.

I also serve on the board of directors of the National Association for Behavorial Healthcare, which for 85 years has advocated nationally for mental healthcare and substance abuse. Its members include American Addiction Centers and other publicly traded healthcare companies like HCA and Acadia UHS, among others.

I've been in recovery for 26 years. As a young man, I struggled with addiction. I know the pain of untreated addiction. AACs mission is to help with those who are struggling like I did, find the right treatment for psychiatric and community support. I'm glad that Congress is looking into treatment marketing practices. Treatment providers and government officials should work together not just to keep bad actors out, but to let potential patients and their loved ones know who they can trust.

I'm glad that Congress is continuing to look at marketing practices and treatment providers and government officials. AAC's recovery brands business operates online treatment directories, including Recovery.org and Rehabs.com. These directories provide information about treatment centers across the country. Centers that are also approved and listed by the Federal Government Substance Abuse and Mental Health Services Administration on SAMHSA.gov.

In fact, about 300 treatment providers, who are members of the National Association of Addiction Treatment Providers or NAATP, Marvin's association, either list or advertise on our websites. A lot of treatment centers don't have large online presences in their own right. Addicts who need help reach these treatment centers through our website.

We don't engage in unethical market practicing like hijacking phone numbers. We are not a call center aggregator. We don't take calls for other treatment centers, just for our own. We don't sell information gathered on calls, AAC opposes this kind of lead generation.

We make sure that our website visitors know who they are contacting. Under our transparency guidelines, we work with treatment centers across the country to make sure their listings are up-to-date and accurate. We make clear that users know which treatment centers are going to answer the numbers they call. We make clear that AAC's toll-free numbers go to AAC's call center. And when they pick up, AAC's call center reps identify themselves as an AAC employee.

Not all treatment centers market honestly, but they should. AAC supports legislation that criminalizes fraudulent advertising, outlaws tactics like hijacking of treatment center phone numbers, requires disclosures about who owns and operates call centers, and bans kickbacks and bribes. AAC has supported this kind of legislation in its home State of Tennessee and elsewhere.

I have the following recommendations. Congress should ask the National Association of Insurance Commissioners or the National Alliance For Model Drug Laws to draft a model law banning deceptive marketing. Number two, existing or proposed laws in Tennessee, Florida, and California should be considered as models for reform. Number three, SAMHSA should update its treatment center locator regularly, and should include sober homes in its listings. SAMHSA should prioritize sober homes that are members of the National Association of Recovery Residences. Number four, existing FTC Truth in Advertising Guidelines should be used to stop misleading addiction treatment marketing.

While there is rightfully a lot of attention being paid to bad marketing practices, I hope we don't lose sight of all the great work that treatment centers do. Treatment does work. I've been clean and sober now for 26 years. And throughout this country we have great treatment centers, just like Hazelden Betty Ford.

We need help. We have tens of thousands, almost 100,000 people a year dying from this disease.

We definitely need to look into this as a matter of a marketing practice, but we also need to be looking at what are some of the solutions to solve this epidemic.

Thank you very much for having me here today.

[The prepared statement of Mr. Cartwright follows:]

American Addiction Centers
People Who Care. An Approach That Works.

200 Powell Place
Brentwood, TN 37027
AmericanAddictionCenters.org

STATEMENT OF MICHAEL CARTWRIGHT, CHAIRMAN & CEO
OF
AMERICAN ADDICTION CENTERS, INC.

BEFORE THE U.S. HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING TO EXAMINE ADVERTISING AND MARKETING PRACTICES WITHIN THE SUBSTANCE USE TREATMENT INDUSTRY

JULY 24, 2018

My name is Michael Cartwright. I'm Chairman and CEO of American Addiction Centers, which operates 39 treatment locations in 9 states. I've been a treatment counselor and executive for 23 years. For 12 of those years I ran a non-profit treatment organization. I've run both publicly and privately funded treatment centers. I've advised the U.S. Senate Health Subcommittee on Substance Abuse and Mental Health Services.

I also serve on the board of trustees of the National Association for Behavioral Healthcare, which for 85 years has advocated nationally for mental healthcare, including addiction treatment. Its members include AAC and other publicly traded healthcare companies, among them Hospital Corporation of America and Acadia Healthcare.

I've been in recovery for 26 years. As a young man, I struggled with addiction. I know the pain of untreated addiction and mental illness. AAC's mission is to help those who are struggling like I did, find the right psychiatric care and community support.

I'm glad that Congress is looking into treatment marketing practices. Treatment providers and government officials should work together not just to stop bad actors, but to let potential patients and their loved ones know who to trust.

AAC's Recovery Brands business operates online treatment directories, including recovery.org and rehabs.com. These directories provide information about treatment centers across the country, centers that are also approved and listed by the federal government's Substance Abuse and Mental Health Services Administration, on samhsa.gov.

In fact, about 300 treatment providers who are members of the National Association of Addiction Treatment Providers, or NAATP, either list or advertise on our websites. A lot of treatment centers don't have a large online presence of their own. Addicts who need help reach these treatment centers through our websites.

We don't engage in unethical marketing practices, like hi-jacking phone numbers. We're not a call center aggregator. We don't take calls for other treatment centers, just for our own. We don't sell information gathered on calls. AAC opposes this kind of lead generation.

We make sure that our website visitors know who they are contacting. I've included with this statement a presentation that illustrates our transparency guidelines. Under these guidelines:

- ***We work with treatment centers across the country to make sure their listings are up-to-date and accurate.***
- ***We make clear that users know which treatment centers are going to answer the numbers they call.***
- ***We make clear that AAC's toll-free number goes to AAC's call center and when they pick up, AAC call center reps identify themselves as AAC employees.***

Not all treatment centers market honestly. But they should. AAC supports legislation that:

- ***Criminalizes fraudulent advertising,***
- ***Outlaws tactics like the hijacking of treatment center phone numbers,***
- ***Requires disclosure about who owns and operates call centers, and***
- ***Bans kickbacks and bribes.***

AAC has supported this kind of legislation in its home state of Tennessee and elsewhere.

I have the following recommendations:

1. ***Congress should ask the National Association of Insurance Commissioners, or the National Alliance for Model State Drug Laws, to draft a model law banning deceptive marketing.***
2. ***Existing or proposed laws in Tennessee, Florida and California should be considered as models for reform.***
3. ***SAMHSA should update its treatment center locator regularly and should include sober homes in its listings. SAMHSA should prioritize sober homes that are members of the National Association of Recovery Residences.***
4. ***Existing FTC truth-in-advertising guidelines should be used to stop misleading addiction treatment marketing.***

AAC also supports online advertiser vetting processes such as those currently being put into place by Google and its certifying agency, LegitScript LLC. AAC has offered to share its

viewpoints on industry advertising and marketing practices to LegitScript. AAC is glad that LegitScript is seeking the perspectives of participants across the industry, which we hope would include those of both for-profit and non-profit treatment operators, as well as members of the National Association for Behavioral Healthcare.

While there is rightfully a lot of attention being paid to bad marketing practices, I hope we don't lose sight of all the great work most treatment centers do. Treatment works. Research shows that those who follow sound treatment plans stay clean and sober. But those seeking help from addiction shouldn't have to worry about false advertising.

Thank you for the opportunity to testify. I am happy to answer your questions.

Mr. HARPER. Thank you, Mr. Cartwright.

The chair will now recognize Mr. Niznik for 5 minutes for his opening statement.

TESTIMONY OF ROBERT NIZNIK

Mr. NIZNIK. Chairman Harper, Ranking Member DeGette, and members of the subcommittee.

Thank you for the opportunity to share my perspective as you continue your important investigation into various aspects of the opioid crisis confronting our country.

Our focus at Niznik Behavorial Health is in offering quality treatment to those seeking help at a time when such services are most in demand and when there's a shortage of available providers.

We help kids, mothers, fathers, individuals from a variety of walks of life as they seek to take control of their lives, overcome their battles with addiction, and return to their families. We've helped thousands of individuals through our inpatient and outpatient services at facilities we operate in Texas, Florida, and in California, several of which fill a need in underserved markets. In Texas, for example, our inpatient facilities in our rural county is served by only one other provider. We will soon be opening an additional facility in New Jersey which will also help individuals in an underserved market.

At the outset, I want to emphasize that neither NBH nor ARN has ever operated as a patient broker, nor have we made any payments to any intermediary or third parties for referrals. We have not engaged in any of the activities that would appear to be of concern to your and your colleagues as expressed in the committee's May 29th letter. NBH is in the business of treating patients. All of our NBH programs are licensed, in good standing, and are accredited by the Joint Commission.

Our staff include board-certified psychiatrists, licensed masters and doctorate-level clinicians as well as a comprehensive nursing team. We offer a variety of specialized programs, including an adolescent program.

I am very proud of what we have accomplished in only 5 years. We started with one facility in Miami, and upon being licensed by the State of Florida, that facility began answering calls from individuals seeking its services. As we added other facilities, the customer service function relating to all facilities was assumed by NBH. We now employ over 500 individuals and support hundreds of additional jobs. In fact, I'm proud to say that we've given jobs to people in recovery.

Based on our experience, I would be pleased to share with you how we market and advertise our services with full transparency. Like you, we want to make sure that prospective patients and their families are as well-equipped as possible when they're seeking treatment for a loved one or for themselves.

Choosing a healthcare provider is an important decision. We believe it is essential that prospective patients know who a provider is and that it described with full transparency what services it offers, where it makes them available so that prospective patients can make an informed decision.

When one of our customer service representatives receives a call, the individual answering the call immediately identifies himself or herself as an NBH employee. That way, all callers know at all times that they are speaking directly with NBH.

If a caller seeks admission to an NBH facility, trained and licensed medical and clinical personnel determine the medical necessity and the clinical appropriateness of the services to offer that individual.

The work of an NBH customer service representative is akin to a receptionist in a doctor's office. A person who answers a call, provides information regarding the service that the doctor offers, and then schedules an appointment for the doctor if a patient requests help.

We believe there are several factors that a patient should consider when looking to identify a quality provider such as whether they are accredited. They also want to know what programs, therapies, and specialty that provider offers. They will then be in a position to determine whether a provider can help them or a loved one.

We're in the business of helping people and are only able to succeed as a company when we provide quality and effective care. Our patients consistently report that they are overwhelmingly pleased with the quality of care and the services they have received.

We have helped thousands of individuals get control of their lives. And as part of our goal of helping people in need, we have provided 296 full scholarships. With a full scholarship, the patient's entire stay through all levels of care and services is free.

In closing, I want to emphasize that we appreciate this opportunity to put in perspective how we operate our business, how our license and medical and clinical personnel help people in need and how we believe individuals seeking treatment can identify a quality provider.

Thank you again for the opportunity to make this opening statement. I will be glad to answer your questions.

[The prepared statement of Mr. Niznik follows:]

Written Statement

of

Robert Niznik

Chief Operating Officer
Addiction Recovery Now and
Niznik Behavioral Health, Inc.

Hearing

To Examine Advertising and Marketing Practices within the
Substance Use Treatment Industry

Before

The Subcommittee on Oversight and Investigations
The Committee on Energy and Commerce
U.S. House of Representatives

July 24, 2018

Chairman Harper, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to share my perspective as you continue your important investigation into various aspects of the opioid crisis confronting our country. I appreciate your interest in the advertising and marketing practices within the substance abuse treatment industry.

Our focus at Niznik Behavioral Health (NBH) is on offering quality treatment to those seeking help at a time when such services are most in demand, and when there is a shortage of available providers.

NBH is a national provider of behavioral health services. We help kids, mothers, fathers--individuals from all walks of life--as they seek to take control of their lives, overcome their battles with addiction, return to their families, and again become productive members of society. We have helped thousands of individuals through our inpatient and outpatient services at the facilities we operate in Florida, Texas, and California, several of which fill a need in underserved markets. In Texas, for example, our inpatient facility is in a rural county served by only one other provider. We will soon be opening an additional facility in New Jersey, which also will help individuals in an underserved market. Addiction Recovery Now (ARN), an affiliate of NBH, is a non-NBH branded free web resource that provides helpful information about addiction and related topics for NBH's wholly owned healthcare services and facilities.

At the outset, I want to emphasize that neither NBH nor ARN has ever operated as a patient broker. Neither ARN nor NBH has any affiliation with any third-party call centers, lead generators, or similar intermediaries. And neither company makes any payments to any intermediary or other third-party for referrals. In short, we do not now and never have engaged in any of the activities that would appear to be of concern to you and your colleagues, as expressed in the Committee's May 29 letter to me and other of the panelists appearing before you today.

NBH is in the business of treating patients. All of our NBH programs are licensed, are in good-standing, and are accredited by the Joint Commission, an independent, not-for-profit organization that accredits U.S. healthcare organizations and programs and maintains the most stringent standards for national accreditation. Our licensed medical and clinical care teams have successfully treated thousands of individuals. We have provided free services--what we refer to as "scholarships"--to nearly 300 individuals who otherwise would be unable to receive care.

Based on our experience, I would be pleased to share with you our thoughts on what comprises quality treatment. Like you, we want to make sure that prospective patients and their families are as well-equipped as possible when they are seeking treatment for themselves or for a loved one.

I am very proud of what we have accomplished in only five years. We built our services from the ground up, starting with one facility in 2013. We now employ over 500 individuals and support hundreds of additional jobs in the markets in which we provide our services. In fact, we have given jobs to people in recovery.

So that you have a better perspective on how we operate our business, let me provide some background about our structure and our growth.

We opened our first Inpatient Detoxification Facility in May 2013 in Miami. Upon being licensed by the State of Florida, that facility--Harbor Village--began answering calls from individuals seeking its services. The employees working for that facility would answer calls for only that facility. As we added other facilities, the customer service function relating to all facilities was assumed, on a facility-by-facility basis, by NBH.

When one of our customer service representatives receives a phone call, the individual answering the call immediately identifies himself or herself as an NBH employee--that way all callers know at all times that they are speaking directly with NBH. The work of an NBH customer service representative is akin to a receptionist in a doctor's office--a person who answers a call, provides information regarding the services the doctor offers, and then schedules an appointment for the doctor if the prospective patient decides to seek help.

Upon receiving a call, NBH customer service representatives collect information from the caller regarding the purpose of their call and what services they are seeking. They then

provide information about NBH programs that might meet the caller's anticipated needs. Our customer service personnel do not select a particular facility for a caller. Rather, they seek to answer questions and educate a caller on the various facilities we operate, and the types of services we offer. This assists a caller in identifying which, if any, NBH facility can meet their needs, considering factors such as age (NBH serves adolescents in Florida but not in Texas and California), certain types of therapy, specific foreign language-based programs, and the like. Based on this information, callers make their own selection of the facility they consider most appropriate for their needs. Or they decide we don't offer the services they are seeking and they look elsewhere. In short, callers are simply provided with the array of available NBH facilities and programs, and make their own choices based on what we have to offer.

If a caller thereafter seeks admission to an NBH facility, trained and licensed medical and clinical personnel determine the medical necessity and clinical appropriateness of the services to offer that individual.

How does ARN fit into this system? ARN was developed several years ago to offer a free online resource for individuals searching for information about addiction and behavioral health services. Today, the website does not have a significant online presence, accounting for approximately 1% of all calls answered by NBH. A telephone number on the ARN website allows callers to reach an NBH customer representative. The fact that NBH will be answering the call is disclosed to visitors to the website. As noted above, the customer service center consists of employees of NBH who answer telephone calls on behalf of NBH facilities. As a result, individuals accessing the ARN website who call the phone number listed on the website are interacting at all times with an NBH employee.

We're in the business of helping people. We are only able to grow as a company when we provide quality and effective care. Our patients provide us with feedback on their experience. They consistently say they are overwhelmingly pleased with the quality of care and the services they've received. As I noted at the outset, we have helped thousands of individuals get control of their lives and return to becoming productive members of society. We have provided 296 full scholarships to individuals in need. With a full scholarship, the patient's entire stay through all levels of care and services is free. We also have provided partial scholarships as part of our goal of helping individuals in need.

Despite the help we provide, we face zoning challenges, NIMBYism, and landlord discrimination regarding the use of their properties to provide our services. Another unique problem stems from the fact that we are required to respond to a number of different standards of care depending upon the insurance carriers with whom we are dealing. Unfortunately, there is no uniform standard. As a result, complying with a multiplicity of standards is a logistical and administrative ordeal. Finally, there is the ever-increasing challenge of securing authorizations from carriers to provide the treatment required for our patients.

We believe we are providing a much-needed service. We appreciate this opportunity to put in perspective how we operate our business, how our licensed medical and clinical

personnel help people in need, and how we believe we excel in the way in which we deliver care to people from all walks of life who need help.

Thank you again for the opportunity to provide this statement for the hearing record.

Mr. HARPER. Thank you, Mr. Niznik.

The chair will now recognize Mr. Brian for 5 minutes for his opening.

TESTIMONY OF JASON BRIAN

Mr. BRIAN. Thank you. My name is Jason Brian, and I founded Redwood Recovery Solutions, the organization that owns TreatmentCalls.com. It is my pleasure to be here today to share with this committee my perspective on marketing and treatment.

My background prior to this industry is in insurance and automotive marketing. Although we were successful in those areas, my team and I shared the vision of wanting to make a difference. And so Redwood started by quoting projects where this was a strong purpose motivator not just a profit motivator.

Redwood's model was at its core simply an advertising and marketing firm that worked closely with many different types of media companies that operated in TV, radio, search engine advertising, and other marketing channels to generate inbound phone calls from persons seeking substance abuse help and then get them connected with a licensed treatment center. Redwood did not own these sources or the agencies that ultimately built or controlled the distribution of the media companies' advertisements. Due to this, Redwood developed a strict set of marketing standards and requirements for these agencies to follow in order to work with us as an affiliate. These rules forbid the use of any sort of incentive to the caller for making the call. The use of any treatment centers intellectual property, any attempt at intentionally deceiving the caller, or any provision of any clinical guidance, just to name a few.

These affiliates were compensated a flat pre-negotiated rate per call to Redwood. And at no time was their fee structure contingent on the outcome of any call or the placement of any patient. After receiving a call from an affiliate, Redwood would then route this inbound phone call directly to a licensed treatment provider within its network. Redwood did not answer any of these inbound phone calls, but rather, the licensed treatment providers were responsible to answer the calls. It was in the sole discretion and professional judgment of the licensed treatment program answering the inbound call along with the caller themselves, to make any decision about the appropriateness or lack thereof, of a program best suited for the caller or their loved one. If a referral was needed to another facility or level of care, it would have been done solely by the licensed treatment provider as Redwood made no referrals whatsoever.

I need to add clarity surrounding my past tense use of Redwood, and share my brief opinion on the unfortunate reality of painting with broad strokes. In January of this year, collectively with my team, Redwood decided it was time to move on from this industry. Far too often this industry and those watching it from the sidelines, want to typecast marketing companies as bad and unethical because of the abuse of a few immoral, disgusting individuals. I would liken this to saying that all treatment centers are bad simply because a few have given the industry a black eye. That would be wrong and misleading and unfortunate to those that they could have ultimately served. Inevitably, when I discussed this topic

within the industry, people want to use a crisis moment and vulnerability as a supporting argument for why companies like mine are bad or unethical.

This past week, a good friend of mine lost her husband to an overdose. He went to the best treatment money could buy, she said. We all prayed this day would not happen, but his family and I knew that this day might come. And indeed, our worst nightmare came true.

The reality is that people seeking treatment do so for some time. They search for months and even years in some instances for a solution. This disease often gets worse over years or even decades. I am in no way downplaying the seriousness of, or the importance of, making the phone call, but to suggest that the calls received are random impromptu decisions caught in a moment of vulnerability is simply inaccurate.

The second point that always comes up pertains to the appropriateness of a facility that the call is routed to. If you find yourself asking how do you know if a generic help line call was a good fit for a specific center, consider this. If you search for treatment online and called any treatment center that came up directly, would you finding them online qualify that center to be the best fit for you or your loved one? If you used a phone book and called one listed there, would that be a perfect fit? If a center placed an advertisement on television directly, might that do the trick in finding the right one?

Of course, none of these things independently change anything about the quality of care or experience one might receive at any given center. Don't lose sight that these treatment providers are licensed to do the work that they are doing. And outside of gross negligence, these centers who share the same licensure, even internally, still disagree largely on what type of treatment is best for the same client. And ultimately, that subjectivity is largely part of the disparagement on where a call would be best suited. We've never entered that conversation and have always taken the stance that their licensure was good enough for us to work with them.

Placing a scarlet letter on marketing companies like so many have doesn't change how treatment centers will handle the phone call. And in fact, at least in our case, actually chases away good people and good corporations that want to do good work helping people.

Over 519,000 individuals place calls that were routed through my company to facilities licensed to provide them with help. Regardless of anything anyone may claim, lives have been changed and saved because Redwood cared enough to do something that made a difference. And I'm proud of that.

I would strongly urge anyone in this industry and those who are tasked with creating legislation in it, to reconsider how they look at marketing companies.

Quickly summarized, without them less money will be spent connecting people with the help that they desperately need, and even if all the marketing companies were gone, there wouldn't be any fewer people in need of help and the bad centers would still exist.

I'm happy to be part of this conversation and continue any dialogue that helps accomplish the initial goal Redwood set out on of helping people.

[The prepared statement of Mr. Brian follows:]

My name is **Jason Brian**, and I founded Redwood Recovery Solutions ("Redwood"), the organization that owns *TreatmentCalls.com*. It is my pleasure to be here today, to share with this Committee my perspective of the opioid epidemic in this country.

My background prior to my involvement with Redwood was in insurance and automotive marketing. After successfully building a lead company that specialized in those two arenas, I found myself pondering my childhood moment – when I said: "when I grow up I want to be…." This was always followed by my response: a career that makes a difference in the lives of others -- I never thought: "when I grow up I want to sell leads to insurance agents and car dealerships." Although successful in those areas, my team at Redwood shared the vision of wanting to make a difference in the lives of others, so we started courting projects where there was a strong "purpose motivator" rather than just a profit motivator. The Redwood goal was to take the proven model we had developed in the past -- connecting people -- and applying it to connecting people in need of treatment from fully licensed treatment providers who could guide them on that journey.

Redwood's model was, at its core, simply an advertising and marketing firm that worked closely with many different types of media companies that operated in TV, radio, search engine advertising and other marketing channels. Its purpose was to generate inbound phone calls from persons seeking substance abuse help, and then connect them to a licensed treatment center. Redwood did not own these sources or the agencies, and ultimately did not build or control the distribution of the media companies' advertisements. Rather, Redwood developed a strict set of marketing standards and requirements for these agencies to follow. These rules prohibited the use of any sort of incentive to the caller for making the call, as well as forbidding: 1) the use of any treatment center's intellectual property; 2) any attempt at intentionally deceiving the caller; 3) providing clinical guidance; and 4) other safeguards. These affiliates were compensated a flat,

pre-negotiated rate per call sent to Redwood. More importantly, this fee structure was never contingent on the outcome of any call or the placement of any patient.

As part of the operations, after receiving a call from an affiliate, Redwood would route this inbound phone call directly to a licensed treatment provider within its network. Redwood did not answer these inbound phone calls, but rather the licensed treatment providers did. Redwood made it clear that it was in the sole discretion and professional judgement of the licensed treatment program answering the inbound call, along with the caller themselves, to make any decision about the appropriateness (or lack thereof) of a program best suited for either the caller or the person on whose behalf they were calling. Furthermore, if a referral was needed to another facility or level of care, it would have been done solely by the licensed treatment provider, as Redwood made no referrals whatsoever.

It is important to clarify my "past tense" reference to Redwood and share my opinion on the unfortunate reality of painting with broad strokes the problems with treatment for addition. In January of this year, collectively with my team, Redwood decided that it was time to move on from this industry. Far too often, this industry itself and those watching it from the sidelines want to type cast all marketing companies as "bad and unethical" because of the abuse of a few unethical, disgusting individuals. Not all treatment centers are bad; however, a few have given the industry a black eye.

Inevitably, when I discuss this topic within the industry, the first criticism that people make as support for the notion that marketing companies are "bad or unethical" is that the decision to choose a treatment facility occurs at a crisis moment when the individual is most vulnerable. This past week a good friend of mine lost her husband to an overdose, and in conversation she candidly told me: "[o]ver and over Robert went to the best treatment money could buy. He would do

anything for me and his family -- anything -- but he would not quit using. We all prayed that it would not happen, but his family and I knew that this day might come, and indeed our worst nightmare came true." The reality is that persons seeking help for addiction do try all sorts of remedies – daily or weekly meetings, visiting therapists, joining religious groups, or whatever they can do to help themselves or their loved ones. They search for months, and even years, for solutions. But their addiction did not catch anyone by surprise, as this disease often gets worse over years, or even decades. I am not downplaying the seriousness and importance of someone making the phone call, but to those that suggest that the calls received are random, impromptu decisions, caught in a moment of vulnerability, is just not accurate.

The second criticism voiced always pertains to the appropriateness of the facility to which the call is routed. The question is asked, "How do you know if a generic help line call is a fit for the center that received the call?" Consider that if you searched for treatment online, and called any treatment center that came up directly, would your discovery of them online then qualify that center to be the best one? Would it not qualify as a perfect fit? If instead you used a phone book and called one listed there, would that one qualify as a perfect fit? If a center placed an advertisement on television directly, might that help someone find the best fit? Of course, none of these mechanisms independently change anything about the quality of care or experience one might receive at any given center.

More importantly, these treatment providers are licensed to do the work that they are doing. Outside of gross negligence, these centers who share this licensure even internally disagree on what types of treatment are best for the same client, and ultimately that subjectivity is used as part of the disparagement on where a call would be best suited. Redwood never took part in that

conversation – but rather objectively viewed a treatment center's licensure as sufficient proof of the professionalism that allowed Redwood to work with them.

Criticizing the marketing companies, as so many have done, by placing a scarlet letter on them, does not change how treatment centers will handle a phone call, and in fact, at least in our case, actually chases away persons and corporations that do want to help others in need. Over 519,000 individuals -- moms and dads, brothers and sisters, sons and daughters, coworkers and friends -- have placed phone calls that were routed through Redwood to facilities licensed to provide them with help. Regardless of any criticism, there is no doubt that lives have been saved and changed because of Redwood. I am proud of that.

In conclusion, I strongly urge anyone in this industry, as well as those tasked with creating legislation in it, to reconsider how they look at legitimate marketing companies. The real fix lies in creating increased guidelines for what "good treatment" is, requiring licensure which mandates that agreed upon *minimum standard of care*, and then holding individuals and corporations accountable to the new licensure. I am happy to be a part of this conversation and continue the dialog that accomplishes this goal – of helping people – a goal that Redwood set out to accomplish. Thank you.

Mr. HARPER. Thank you, Mr. Brian. The chair will now recognize Dr.Stoller for his testimony.

TESTIMONY OF DR. KENNETH STOLLER

Dr. STOLLER. Chairman Harper, Ranking Member DeGette, and members of the subcommittee, thank you for giving me the opportunity to speak with you today.

With 64,000 overdose fatalities in 2016, we are fortunate to have at our disposal effective evidence-based approaches to treating substance use disorders.

In my experience, the impact of treatment is optimized when three sequential actions are taken. Number one, using opportunistic times and settings to engage potential patients. Number two, completing a comprehensive initial assessment to determine the best setting and type of treatment for each individual. And number three, offering treatments that are evidence-based, high quality, and dynamically adjusted.

Regarding action number one, I focus on referrals from locations where people are most in need of treatment. Accepting patients who have already been engaged in the healthcare system prevents lost opportunities for lifesaving treatment. Hospital emergency rooms and inpatient units have patients who survived overdoses, are being treated for medical problems, resulting from injection drug use, or are contemplating suicide. Other referrals come from medical offices, other treatment programs, and, of course, community walk-ins. By focusing on these sources of referral, we serve patients who are most in need and who otherwise would incur tremendous costs to the healthcare system as high utilizers of costly services.

Regarding action number two, a comprehensive assessment is done by my clinical staff as each patient is unique in terms of their disorder, as well as their personal strength, liabilities, and resources. Past treatment experiences can also inform what to try next. For example, for those who have repeatedly failed limited time episodes without medications, I may recommend a medication trial in a setting of long-term outpatient counseling and those who have severe mental health and social problems might best succeed in a comprehensive program with resources to effectively address all of those problems.

Regarding action number three, the actual treatment, I consider there to be five critical approaches that providers of high quality treatment aspire to offer. Number one, they use medications as clinically appropriate, including the three FDA approved medications for opioid use disorder and three for alcohol use disorder. They should be started, stopped, and switched over time according to ongoing response. Number two, they combine it with psychosocial treatments, including counseling delivered by skilled professionals. Number three, they use behavorial therapies that motivate positive change and increase treatment adherence. Number four, they use adaptive step care models. This means they use ongoing measurement of outcomes to continually adjust the intensity and types of treatment and to motivate engagement. And number five, they incorporate wraparound services provided within the program or through linkages with outside agencies to support a holistic ap-

proach to recovery. This can include, medical, mental health, housing, vocational, 12-step, and certified peer support services.

Solid linkages to aftercare must be facilitated at the time of discharge to ensure continuation of the recovery process.

As an illustration of some of these points, Mr. A was a 55-year old man referred after a hospital detox admission to us for alcohol and heroin use. He had HIV, hepatitis, and a multitude of other medical problems. We began him on buprenorphine and later switched him to methadone. We provided him with counseling and housing when needed, and coordinated with his local medical providers.

One day I received an inquiry from his managed care organization after they determined that over the prior 17 months, he had 81 ER visits incurring tremendous cost.

On further examination, I discovered that only 4 of the 81 visits were during his time with us. The reduction in cost for ER visits was ten-fold from a monthly average of over $3,000 to $325 when he was with us, illustrating that fiscal gains can result from comprehensive addiction treatment.

In conclusion, we are fortunate to have the ability to meet these challenges head on with effective treatments for the opioid epidemic. Comprehensive opioid treatment programs are well-positioned to be hubs of expertise and coordination and can be scaled up nationally to narrow the gap between treatment, need, and availability.

I applaud your recent work in Congress to both increase access and quality of substance use disorder treatment.

Thank you.

[The prepared statement of Dr. Stoller follows:]

Testimony of:

Kenneth B. Stoller, M.D.

Submitted to The United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
for hearing on "Examining Advertising & Marketing Practices within the Substance Use Treatment Industry"

Tuesday, July 24, 2018
RHOB 2123, 10:00AM

Main points

- Substance Use Disorders (SUD) can be effectively managed when treatment is accessible and of high quality.
- There are three primary steps necessary to provide impactful treatment:
    1. Begin engagement in treatment during times and in settings of opportunity.
    2. Complete a comprehensive assessment of the individual to determine the best type, intensity and setting of initial treatment, and based on that, admit or make appropriate referral.
    3. Provide treatment that:
        - uses medications for addiction treatment (MAT) when medically indicated;
        - uses verbal therapies delivered by skilled professionals;
        - uses behavioral therapies to facilitate change and reinforce treatment engagement
        - uses adaptive models, that adjust treatment type and intensity based on ongoing indicators of patient response
        - incorporates wrap-around services that are embedded when possible, and otherwise through solid linkages with community resources.
- By facilitating treatment that is both accessible and of high quality, gains can be made over time that reduce the devastation of SUD on the individuals, families, and communities.
- This can also lessen the extraordinary health care and other societal costs related to SUD.

Testimony

Chairman Harper, Ranking Member DeGette, Committee Chairman Walden, Committee Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to speak with you today about the treatment of substance use disorder (SUD), in the context of this national health crisis.

I am an addiction psychiatrist, and direct the outpatient SUD treatment program at Johns Hopkins Hospital, the Broadway Center for Addiction. I am also the medical director of a similar program at a Johns Hopkins affiliate hospital, and am an inpatient attending psychiatrist on hospital unit that focuses on SUDs.

With an estimate of approximately 64,000 individuals dying from overdose in 2016,[1] most of which were related to opioids, we are fortunate to have at our disposal effective, evidence-based approaches to treating SUD. I feel privileged to be part of a system that treats patients with SUD, and as a member of local and national associations that endeavor to shape treatment systems to optimize care.

3 Steps Enabling Impactful Treatment

In my experience, the impact of treatment is optimized when we ensure that three sequential actions are taken: 1) Engage potential patients during opportunistic times and in opportunistic settings; 2) Complete a comprehensive initial assessment to determine the best setting and type of treatment for each individual, and 3) Offer treatments that are evidence-based, high quality, and dynamically adjusted. I will be focusing on these three actions for the next few minutes.

Action #1: Referral and Engagement

[1] Centers for Disease Control and Prevention. National Center for Health Statistics. Available online at: https://www.cdc.gov/nchs/products/databriefs/db294.htm

Addressing the first step, where do I seek out patients for my treatment programs? I focus on locations where the individual is most in need of treatment and is experiencing a "teachable moment" when their likelihood of considering treatment entry is high. Accepting patients from settings where others have already engaged the individual, and are now seeking facilities to which to link them, helps to avoid the all-too-common experience of having the person drawn back into continued use, and missing an important and perhaps life-saving opportunity for treatment entry. Sadly, there is no shortage of potential patients in Baltimore, and many require immediate engagement. They are found in hospital emergency rooms and inpatient units - having survived an overdose, being treated for medical problems resulting from injection drug use, or contemplating suicide due to being demoralized by the devastation of ongoing SUD. Hospitals are aware of our program and refer those individuals to us. Other sources of referral that I have cultivated include Baltimore-area primary care practices. Through that work, I established CoOP, a hub and spoke model of collaborative buprenorphine treatment that is gaining national recognition.[2] Two other common sources of referral include other treatment programs who may decide that one of their patients would be best served in our program. And of course, we accept citizens walking in from the community. Johns Hopkins considers improving the health and well-being of the community surrounding our hospitals to be a critical mission. By focusing on these and related sources of referral, we serve patients who find themselves on the cusp of tragic consequences from their SUD, to themselves and their family. It also can avoid what would otherwise be tremendous costs to the health care system if active substance use continued to result in frequent avoidable emergency room visits and repeated costly hospital admissions, for people with the most severe substance use, other medical and social problems.

For example, I examined the emergency room utilization of a patient of mine whose managed care organization informed me that he had high volumes of ER visits. I was given data from the prior 17 months, which included 1 year when he was not in our program, and 5 months when he was. He

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[2] Stoller, K.B. *A collaborative opioid prescribing (CoOP) model linking opioid treatment programs with office-based buprenorphine providers.* In Addiction Science & Clinical Practice. 2015; 10(Suppl 1):A63.

had an astounding 81 visits to the emergency room, but only 4 of them were during the time that he was in our program. The others were from prior to his admission, and during a brief period that he dropped out of care. For the MCO, this translated into a 10-fold reduction in monthly spending on ER visits alone.

Finally, by focusing on treating people primarily in their own community, it is easier to leverage potential community supports such as family, friends, and local agencies who can help increase the strength of our patients' recovery foundation over the long term.

Action #2: Comprehensive Assessment

Moving on to the second of the three steps – the initial comprehensive assessment. When people ask me what causes SUD, my response of late always starts the same way – "It's complicated." In the field of medicine, complex problems require multipronged and prolonged treatment elements. To treat asthma effectively, treatment recommendations are based on patient needs and change over time – including environmental abatement, steroid inhalers, nebulizers, pills, rescue inhalers, allergy testing, immunotherapy, and other approaches. To most effectively treat each individual with SUD, my clinical and medical staff spend 2 or more hours to develop an initial clinical impression and treatment plan. Although SUD can be described by a common set of criteria such as those listed in the DSM-5 manual,[3] the number, combination, and severity of symptoms that individuals experience vary widely; and each person brings with them differing strengths, liabilities, and resources. Additionally, the person's past experience in treatment can determine next steps to try. You may have heard the saying "the definition of insanity is doing the same thing over and over and expecting different results." Past treatment episodes can inform what has worked and what has not been helpful. I have had patients report repeated inpatient or residential treatment episodes that have resulted in prompt relapse, and that medications have never been tried. For them, I was more likely to recommend a medication trial in the

[3] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

setting of long-term treatment including counseling in an outpatient program. When other patients with opioid use disorder and co-occurring severe mental health and social problems report failing office-based buprenorphine treatment, I express that hope is present through participation in a comprehensive specialty SUD treatment program that has the resources to effectively address those problems alongside their SUD-specific treatment.

Action #3: Five elements of high quality treatment

This leads to the third key to impactful treatment – the treatment itself. I consider there to be 5 critical elements of high quality approaches.

1) They use medications as clinically appropriate. We are fortunate to have three FDA-approved medications for the treatment of opioid use disorder – methadone, buprenorphine and naltrexone;[4] and three for alcohol use disorder – naltrexone, disulfiram and acamprosate.[5] These medications should be chosen, started, discontinued, and restarted over time, according to scientific evidence, considering patient ongoing response and preference.
2) They combine it with psychosocial treatments. This includes counseling or psychotherapy, delivered in individual and group-based settings, by skilled, experienced staff who are well-trained to work with this population.
3) They use behavioral therapies, such as contingency management, that motivate positive change, discourage drug use, and increase adherence to medication and psychosocial treatments.[6]
4) They use adaptive stepped care models. This means that objective measures of treatment response, like toxicology results and treatment adherence, are measured continually over time and are used to adjust the intensity and types of treatment – while motivating a high level of

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[4] SAMHSA TIP 63: *Medications for Opioid Use Disorder*. Full Document available for download at: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

[5] SAMHSA. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*. Available for download at: https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907

[6] Petry NM, et al. *Contingency management treatment for substance use disorders: How far has it come, and where does it need to go?* Psychol Addict Behav. 2017 Dec;31(8):897-906.

engagement in those treatments. We have studied adaptive treatment approaches extensively at Johns Hopkins, and have demonstrated its powerful impact;[7] and our accreditation body, The Joint Commission, publicly recognized it as an exemplary treatment program.[8]

5) They incorporate wrap-around services, whether provided within the program or through linkages, to support a holistic approach to recovery. This can include resources such as mental health assessment and treatment, supportive housing, vocational rehabilitation, 12-step facilitation, connections with the spiritual community, primary medical care or health home services, hepatitis C and HIV testing and specialty services, and certified peer recovery specialists. I recognize that not every program or provider can become a "megamall" of embedded services, but when services cannot be integrated directly into the program, strong linkages through referral can also be powerful. And speaking of linkage, the most important linkage is to carefully-chosen treatment resources at the time of program discharge. Those linkages should be facilitated in a way that maximizes patient follow-through and continuation in recovery.

Conclusion

We are fortunate to have the ability to meet the challenge of the opioid epidemic head-on with effective treatment. The treatment workforce must be adequate in number, well-trained, well-paid and supported, and be hopeful and empathic. Comprehensive, highly-regulated, federally-approved opioid treatment programs are well-positioned to be hubs of expertise, resources, and care coordination.[9] They are an element of a treatment system that can be scaled up locally and nationally to close the treatment gap. I appreciate the recent work in congress to increase access to care, such as efforts to create a

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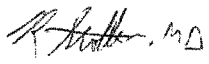
[7] Brooner, R.K., Kidorf, M.S., King, V.L., Stoller, K.B., Peirce, J.M., Bigelow, G.E., Kolodner, K. *Behavioral contingencies improve counseling attendance in an adaptive treatment model.* Journal of Substance Abuse Treatment. 2004; 27(3):223-232. PMID: 15501375.

[8] The Joint Commission Ernest Amory Codman Award. National Health Care Award for Performance Measurement. https://www.jointcommission.org/assets/1/6/Addiction_Treatment_Services_of_John_Hopkins.pdf

[9] Stoller, K.B., et al. *Integrated Service Delivery Models for Opioid Treatment Programs in an Era of Increasing Opioid Addiction, Health Reform, and Parity.* Substance Abuse and Mental Health Administration. http://www.aatod.org/policies/mat-hub-setting-whitepapers/ Published online July 13, 2016.

Medicare reimbursement model for our seniors in need of treatment. And I applaud your efforts to ensure that when encouraging increases in treatment access, we do not inadvertently sacrifice quality of care.

Sincerely,



Kenneth B. Stoller, M.D.

(Note: The statements above reflect the opinion of Dr. Stoller, and not necessarily that of Johns Hopkins Medicine.)

Mr. HARPER. Thank you, Dr.Stoller.

It is now time for the members to each ask questions of you as witnesses. And I'll begin by recognizing myself for 5 minutes.

As part of its investigation, the committee has learned about a variety of advertising and marketing business models within the treatment industry, including the use of websites and phone numbers. There is a wide variation within the industry. For example, Hazelden Betty Ford Foundation has three websites that advertise its hotline.

Niznik Behavorial Health has ten websites. American Addiction Centers has 13 facility-specific websites, and in addition, has a subsidiary Recovery brands who operates a portfolio of websites.

And Jason Brian of Redwood Recovery, TreatmentCalls.com has 84 domains, most of which appear to be related to substance use disorder treatment.

So my question is, and I'll start with you, Mr. Mishek, but also Mr. Cartwright, Niznik, and Brian, do each of your websites contain information that discloses which company or which facilities the websites are affiliated with?

Mr. MISHEK. Our main website, HazeldenBettyFord.org, most of our web hits come to that website. The other two that you referenced are prior to our merger with the Betty Ford Center.

The Hazelden.org is about our publishing, and the other website relates to philanthropy. So for consumers seeking treatment, they go to one website, HazeldenBettyFord.org.

Mr. HARPER. And have those disclosures always been on your website?

Mr. MISHEK. Absolutely.

Mr. HARPER. OK. Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

Yes, we have a variety of websites that specifically to American Addiction Centers or our drug and alcohol treatment centers in the different States, Desert Hope, Green House and Texas, we have a treatment center. And then we have Recovery Brands, which is the portfolio that you are concerned about.

Mr. HARPER. OK. My question is, to be sure that I'm clear here, do those disclose which company or which facilities those websites are affiliated with at that point?

Mr. CARTWRIGHT. Yes, sir, they do.

Mr. HARPER. OK. And have those disclosures always been on those websites? And if not, when were they added?

Mr. CARTWRIGHT. They were not. We had bought Recovery Brands. It was a company that was out of the State of California. And when we bought that company, one of the things that we do as a publicly traded company, we have a group of lawyers that vetted those sites, went through them, looked at those websites, looked at where we should be, make sure we're in compliance. And we've done that over about a 2-year period.

Mr. HARPER. Were they——

Mr. CARTWRIGHT. Go ahead.

Mr. HARPER. Were they operational while they were being reviewed and looked at by your team?

Mr. CARTWRIGHT. They were. They were owned by another company. We had a group of attorneys that reviewed them, looked over

the websites, and we found that they were the most ethical, straightforward websites that we saw as related to third-party websites that we could find out there.

We asked them to do some changes, which they did, and before we bought that organization. When we bought that organization and since we've operated, it has absolutely been 100 transparent websites.

Mr. HARPER. Mr. Niznik.

Mr. NIZNIK. Of the websites you mentioned, the majority of them are facility websites. And when you go on the website you know that it is the facility you're calling, or the NBH websites, so you know who you're reaching. And then of the other two websites we operate that are now branded as our programs, they do disclose who owns them, who answers the calls, and then when someone does call, the employee answering the call identifies themselves as an employee of the company.

Mr. HARPER. Have those disclosures always been on those websites?

Mr. NIZNIK. They have.

Mr. HARPER. From the beginning?

Mr. NIZNIK. They have.

Mr. HARPER. OK. Then Mr. Brian?

Mr. BRIAN. Thank you. You referenced that we own 84 websites.

The question that was directed to me prior to this in the phone call that I had was to provide a list of any domains that I owned. Those 84 domains, I own. The company owns.

None of which are geared towards addiction treatment outside of TreatmentCalls.com and Redwood Recovery Solutions.

Mr. HARPER. OK.

Mr. BRIAN. And so those two sites are business-to-business sites. So we don't have any sites. We've never owned sites that induced a call from a treatment-seeking individual to a treatment center. That wouldn't be our model.

Mr. HARPER. OK. So those other 82 domains?

Mr. BRIAN. Yes, sir.

Mr. HARPER. Are not related to addiction or recovery?

Mr. BRIAN. They were domains that were purchased. They probably, most of which don't even have any content on them. They were just websites that were listed that we purchased from an online domain buying service.

Mr. HARPER. Are they operational today?

Mr. BRIAN. No, sir.

Mr. HARPER. Not operational?

Mr. BRIAN. I would imagine that less than a dozen of those are operational, which are business-to-business like TreatmentCalls.com is.

Mr. HARPER. All right. And those dozen or so, they are set up to, if you contact them, where does it go?

Mr. BRIAN. It would ring directly into TreatmentCalls, to Redwood Recovery Solution, to our organization. There's no business-to-consumer or consumer-facing sites designed to have somebody call in for addiction help.

Mr. HARPER. Does that domain, does it show on its face that it's affiliated with Redwood?

Mr. BRIAN. Yes, sir.

Mr. HARPER. All of those?

Mr. BRIAN. To other businesses, to treatment centers seeking our service? Yes, it would say that.

Mr. HARPER. All right. And my time is expired. So I will now recognize the ranking member of the subcommittee, Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman. Mr. Chairman, I have here in my hand a list of Mr. Brian's websites that you were referring to. I would ask unanimous consent to put it in the record.

Mr. HARPER. Without objection.

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

Ms. DEGETTE. So Mr. Brian, I'm looking at all this list of websites. I'm trying to figure out exactly how your business worked.

Mr. BRIAN. Yes, ma'am.

Ms. DEGETTE. So what would happen is somebody—here's one, TreatmentCalls.com. Somebody might go on to that website and see a phone number and call, and that would go into your call center. And then you would, your business would refer that off to a certified treatment center, is that correct?

Mr. BRIAN. No, ma'am. And I can——

Ms. DEGETTE. OK. Tell me what happened, please, briefly.

Mr. BRIAN. Yes, ma'am. So TreatmentCalls.com is a site that offers treatment call services to treatment centers. It's not a site designed for consumers who might be looking for help.

Ms. DEGETTE. I see. So the way your business works though——

Mr. BRIAN. Yes, ma'am.

Ms. DEGETTE [continuing]. Is treatment centers would pay you to refer calls to them. So there would be advertising, people would call in——

Mr. BRIAN. Yes, ma'am.

Ms. DEGETTE [continuing]. To your phone numbers, and then they would be referred out, right?

So there was no judgment on the part of your business about which centers would be appropriate to send the calls to. The calls would be referred to the centers based on who, which centers paid you money to refer the calls to them, right?

Mr. BRIAN. If I can just correct one portion of it.

Ms. DEGETTE. Please.

Mr. BRIAN. We did not own the phone numbers or the websites. We worked with third-party affiliates that we——

Ms. DEGETTE. OK.

Mr. BRIAN [continuing]. Made a per call fee.

Ms. DEGETTE. Right.

Mr. BRIAN. We paid them.

Ms. DEGETTE. Right.

Mr. BRIAN. And the treatment centers ultimately paid us a per call fee for sending them calls.

Ms. DEGETTE. So people called the phone number.

Mr. BRIAN. Yes, ma'am.

Ms. DEGETTE. And then that went somewhere else.

Now, Dr.Stoller, has your organization ever used a system like this to get patients for your facility?

Dr. STOLLER. Well, fortunately or unfortunately, the prevalence of substance use disorders——

Ms. DEGETTE. Yes or no will work.

Dr. STOLLER. No.

Ms. DEGETTE. Have you ever used a substance like this, and why not?

Dr. STOLLER. No, we haven't.

Ms. DEGETTE. Why not.

Dr. STOLLER. We don't need to do that sort of outreach for patients.

Ms. DEGETTE. Do you think that's an effective way for patients to get matched with an appropriate treatment facility?

Dr. STOLLER. We prefer to link with other providers who have already engaged with patients.

Ms. DEGETTE. So, in other words, you think the best practice, as you testified in your testimony, is when a doctor or somebody else sees a patient or an emergency room refers them to you. Is that right?

Dr. STOLLER. I do.

Ms. DEGETTE. Now, Dr. Mishek, let me ask you that same question. Does your organization use call centers like this where people come in and are referred to you?

Mr. MISHEK. Absolutely not.

Ms. DEGETTE. And why not?

Mr. MISHEK. Well, we don't need to. Number one, we're overwhelmed with calls directly into our call center. And number two, we need to take the people who come to us and assess them. We don't need a third party to be funneling someone to us who may have an eating disorder and shouldn't be coming to us in the first place.

Ms. DEGETTE. Well, this is an interesting question to me because the two of you gentlemen are here representing two of the premier centers in this country, but there are thousands of people who need addiction services who might be going to other centers. So do you think there's some kind of inherent problem with using these call aggregators like we heard about from Mr. Brian?

Mr. MISHEK. I certainly do. Only 1 out of 10 people who need help get help, so there are plenty of patients out there who need help. It's not like there's a scarcity of patients and we're all fighting over the next patient.

Ms. DEGETTE. Right.

Mr. MISHEK. It's not that way at all.

Ms. DEGETTE. Right.

Mr. MISHEK. So, treatment centers that are accredited, have good, licensed staff, and are doing great work generally don't have any trouble acquiring and attracting patients, both through professional referrals, through word of mouth, and through community reputation.

Ms. DEGETTE. Mr. Ventrell, you look like you want to add.

Mr. VENTRELL. Well, I was nodding along, Congresswoman. The issue becomes whether a clinical assessment is being made or——

Ms. DEGETTE. Right.

Mr. VENTRELL [continuing]. A sales assessment is being made——

Ms. DEGETTE. Right.

Mr. VENTRELL [continuing]. And that's essentially the distinction that's drawn here today by Dr. Stoller and Mr. Mishek. People are looking for healthcare.

Ms. DEGETTE. Right.

Mr. VENTRELL. The word "rehab" itself has caused us to go down the wrong path, but people are looking at healthcare and you look for healthcare at the hospital. You look for healthcare at the facility that provides that healthcare. To have a website that does not identify primarily as its owner, the clinical provider is fundamentally deceptive, in our view.

Let me just also say quickly that the little "I" isn't good enough. The little "I" isn't good enough. So one of the questions that the chairman asked is, does your site identify or disclose your identity?

Ms. DEGETTE. Yes.

Mr. VENTRELL. That's a very thoughtful question, but I don't think it should even have—that question shouldn't even have to be asked.

Ms. DEGETTE. Right. They should know who they're calling.

Mr. VENTRELL. It should simply be the site of the individual.

Ms. DEGETTE. Right.

Mr. VENTRELL. I don't go to the little "I," and consumers in crisis certainly don't know how to do that. And the fact that it ultimately identifies it is, frankly, wholly inadequate.

Ms. DEGETTE. Thank you very much. Thank you, gentlemen.

Mr. HARPER. Ranking Member DeGette yields back.

The chair will now recognize the chairman of the full committee, Chairman Walden, for 5 minutes.

Mr. WALDEN. Thank you very much, Mr. Chairman.

Again, thanks to everybody on the panel as we try and dig into this issue and figure out how things are working, how they're not working, and where there needs to be improvement.

So I guess one of the questions I'd have off the top is, the business model for one of today's witnesses, Mr. Brian of Redwood Recovery, appears to be entirely based on the sale of prospective patient calls to treatment facilities. And my question is, have your companies, your facilities, or your subsidiaries ever paid or sold for leads? And I would address that to Mr. Niznik, Mr. Cartwright, and Mr. Mishek.

Mr. NIZNIK. So we advertise in a lot of mediums online, on television, on the radio. So the only sorts of advertising we do is that sort, the traditional advertising where someone sees an ad or comes across our website and calls us.

Mr. WALDEN. OK. So the question is, have your facilities or your subsidiaries ever paid for or sold leads?

Mr. NIZNIK. No, we haven't.

Mr. WALDEN. OK. Next, Mr. Cartwright.

Mr. CARTWRIGHT. With Recovery Brands' websites, it's a business model very similar to YP.com, yellowpages.com, or WebMD. We have advertisers on those websites. Three hundred advertisers are NAATP members. Actually, Betty Ford Center used to be a pretty

large advertiser of ours as well. So we have advertisers on our websites, recoverybrands.com.

So thank you very much.

Mr. WALDEN. All right.

Mr. MISHEK. No, we never have.

Mr. WALDEN. Never paid or sold leads?

Mr. MISHEK. No, we never have.

Mr. WALDEN. OK. Mr. Ventrell, the National Association of Addiction Treatment Providers recently updated its code of ethics, with particular focus in the advertising and marketing space, to fight back against practices of patient brokering, including this kind of lead generation. Can you explain and perhaps write a few examples for what practices the Association was seeing in the substance use disorder treatment industry that led it to revise its code of ethics? What did you see?

Mr. VENTRELL. Yes, Mr. Chairman. Thank you. National Association had a code of ethics for some time. In spirit, it prohibited all the kinds of practices that have been discussed here today. However, it wasn't thought necessary, prior to last year, that we specifically articulate exactly what right and wrong is. Our good providers didn't need to be told right and wrong. They were just doing right. But we came to understand that that's not true across the board, and we approved our new ethics code 2.0 on December 31, 2017, and it became effective on January 1. It specifically defines and prohibits the kinds of conduct we're talking about today.

The first and foremost of these would be patient brokering. Under no circumstances may an NAATP member or under any circumstances should any treatment provider, in our view, buy leads or sell leads. And so if there's a connection with doing that, it is prohibited by our code and you may not be an NAATP member.

A second area that came up frequently was licensing and accreditation misrepresentation. It is difficult enough for the consumer to understand what they need. When the provider misrepresents or does not adequately display precisely what they are licensed or accredited for, the consumer can't know what they are getting, and that lack of regulation is extremely dangerous.

The third and most prevalent reason why we removed certain members from our rolls, Mr. Chairman, is what we call unbranded or inadequately branded sites. You received information from your staff that indicates, among other things, that we have sacrificed approximately $100,000 in dues revenue and removed 24 parent companies from our membership rolls primarily for this reason.

There are multiple reasons, but the primary reason why members were not renewed, or as incoming applications occur and are denied, is because we find that there is inadequate branding on the site for the same reason that I just discussed with Ranking Member DeGette: The ability to somehow investigate and determine ultimately that the site is connected to a provider is simply not adequate. It should be branded as, for example, the Hazelden Betty Ford site is.

So for the most part, where we have removed members or not invited members or declined an application it has been because of the deceptive websites.

Mr. WALDEN. All right.

Mr. VENTRELL. It's just a question of transparency, Mr. Chairman.

Mr. WALDEN. Thank you. Thank you.

I want to go back, because I maybe didn't hear this right, to Mr. Cartwright. I was looking at my notes here. Just yes or no, have your companies, your facilities, or your subsidiaries ever paid for or sold leads?

Mr. CARTWRIGHT. No, we don't pay for or sell leads. Recovery Brands has an advertising model very similar to WebMD or yellowpages.com, and I'm assuming that Hazelden Betty Ford and NAATP must like that model, because about 300 of the NAATP members are advertisers of ours. About half of our advertising revenue comes from NAATP members, so we hold ourselves up as a solid organization of the way you can do and should do advertising on the internet.

Mr. WALDEN. I'm just sensing, Mr. Chairman, with your indulgence, maybe a disagreement on the other end of the panel. Is that accurate? Mr. Cartwright——

Mr. VENTRELL. Mr. Chairman, are you recognizing me?

Mr. WALDEN. Yes.

Mr. VENTRELL. Thank you. I—Mr. Cartwright's written testimony, which I saw for the first time yesterday, indicated this 300 number, that there are 300 NAATP members which advertise on the site. I am unfamiliar with this. I'm surprised to hear this information, but I am entirely open to finding out exactly what it is.

I would ask for the opportunity to determine whether that's true by being provided a list of those 300 members, and then also ask ourselves what do we mean by advertising, right. There is a common practice generally among the problems on the website to bring in good providers, put them on the site.

I'm not saying this is the case here. I don't know that. But there is a common practice to grab a Hazelden Betty Ford or a Caron or a Harmony Foundation and put their information on the site as if it were part of when, in fact, there is not a motive to produce that——

Mr. WALDEN. Right, OK. Mr. Cartwright, are you OK sharing that information with them so we can get to the bottom of this?

Mr. CARTWRIGHT. I would be happy to share it. And the easiest way to look at it is, we generate about $8 million a year of our $400 million annual budget through advertising. And about one-half of that $4 million a year is coming from NAATP members.

Mr. WALDEN. Thank you for your indulgence, Mr. Chairman.

Mr. HARPER. Chairman Walden yields back.

So if you'll make sure, Mr. Cartwright, you get us that list, that would be very helpful.

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

Ms. CASTOR. Thank you, Mr. Chairman and Ms. DeGette, for calling this hearing.

There are all sorts of press reports out there about unscrupulous actors that engage in deceptive marketing practices and who take advantage of patients, and I've heard directly from many families back home in Florida. And I'd like to discuss some of the problems and what we can do to solve it.

Mr. Ventrell, you've gone into some detail here with—could you further expand on what you see as major problems with deceptive sales in the addiction treatment industry and how they prevent patients from getting the care that they need?

Mr. VENTRELL. Thank you, Congresswoman. If one begins by assuming that we need a transparent clinical assessment, much of the problem goes away. The fundamental problem is that most of the problematic areas do not promote a clinical assessment where the patient or the consumer understands who is performing that assessment. It's compounded by the fact that folks don't know what clinical assessment that they need.

The primary areas continue to be licensing and accreditation confusion and misrepresentation, unbranded or inadequately branded sites. And toward those goals, we have been very clear in two ways: One, you must have that clearly branded site, and now our association has, as of this month, adopted a new requirement that all NAATP members must be accredited.

There needs to be a system whereby quality and safety are adequately regulated and business operations are adequately regulated. The accrediting, certifying, licensing bodies traditionally and appropriately handle quality and safety. There has been very little regulatory oversight as it concerns business operations, and that is why we are producing the guidebook for operations, which I will hopefully commend to the committee for study.

Ms. CASTOR. First of all, you have a family or an individual that is searching for information on how to get substance use treatment, you're not shopping for clothing or something else.

And, Dr. Stoller, you highlight this problem too. Is it appropriate to go shopping on the internet for how you're going to be treated for addiction?

Dr. STOLLER. I would recommend somebody looking for treatment on the internet to go to particular sites, such as the SAMHSA treatment locater. The National Institute on Alcoholism and Alcohol Abuse has recently created a website that helps consumers to look at those sorts of things.

The other thing is that jurisdictional entities, such as county health departments, are really good sources for information about substance use disorders and also where they—that people might be able to go to achieve the best match for the person's needs with the treatment program that can provide them with those services.

Ms. CASTOR. Rather than shop in general on the internet and see what comes up in the ranking on that page and then hit the first one and——

Dr. STOLLER. That's correct.

Ms. CASTOR. So, Mr. Ventrell, you said your organization has removed members for failing to adhere to the code of ethics. You went into some detail on that, on patient brokering and buying and selling leads. Is it possible that conduct by one of your former member organizations that violated the code of ethics also violated the law?

Mr. VENTRELL. It's possible, Congresswoman, but I don't know specifically of an instance of that. Certainly, it is possible.

Ms. CASTOR. Does that need to be clarified? What do you understand the law to say?

Mr. VENTRELL. Relative to what precisely?

Ms. CASTOR. To patient brokering.

Mr. VENTRELL. Well, the law of patient brokering has been very confusing and, to some extent, nonexistent and State-by-State based. It needs to be clarified, and I would support Mr. Mishek's recommendation that there be a Federal law in this regard.

So we've all heard of the horrors that occurred in south Florida. Certainly, there was similar activity in Arizona and also southern California, and it's probably not isolated to those States. If patient brokering, body brokering, paying for the delivery of a body for care was made, one would have to determine what the State regulation was and that would be a legal determination.

I will say, however, that if Federal moneys were being involved in the treatment of that individual, Medicare, Medicaid, that I believe I would be correct in saying that that would have been a legal violation, irrespective of State law.

Ms. CASTOR. Thank you very much. I yield back.

Mr. HARPER. The gentlewoman yields back.

The chair will now recognize the vice chairman of the subcommittee, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman.

I'm going to build on some of the prior testimony and questions about NAATP's updated code of ethics.

Mr. Cartwright, as you've indicated to Chairman Walden, there are about 300 treatment providers that are members of NAATP who advertise on your website. So my question is, if I go to your website later today, am I just going to find your traditional straight advertising, treatment center A, treatment center B, treatment center C, and it just rotates based on who's up next like the line of cabs? Is that how your system works?

Mr. CARTWRIGHT. No, sir, it doesn't. It operates very similar to YP.com, yellowpages.com. If you go into a particular area in the State of Colorado and you went into Denver, it would only list operators within that State, and then there would—I'm sorry.

Mr. GRIFFITH. No, that's fine. I got it.

And so the question is, it helps focus where you're going, is what you're saying. But my question is, is it just advertising? Are you telling us that you don't get paid anything for a straight referral or for a head count?

Mr. CARTWRIGHT. That is correct. It's straight advertising.

Mr. GRIFFITH. And that's never been the case?

Mr. CARTWRIGHT. That's never been the case.

Mr. GRIFFITH. And so when these ads are up there, your folks don't actually talk to the people, and it just focuses them in and—the next question is, what sort of vetting, if any, does AAC do before letting another treatment provider advertise on your website?

Mr. CARTWRIGHT. They would need to be on the samhsa.gov. We really take that website very seriously, that we're assuming the Substance Abuse and Mental Health Administration in their listing is vetting folks. They have to be licensed, joint commission accredited or CARF accredited.

Mr. GRIFFITH. OK. Is AAC itself a member of the NAATP?

Mr. CARTWRIGHT. We're a member of a different organization, National Association of Behavioral Healthcare. It's been around for

about 85 years. A lot of the larger companies join that. You've got to remember, most of NAATP is smaller, not-for-profit organizations. We feel like that with HCA and Acadia and UHS, some of the larger organizations, that's meeting our needs more appropriately.

Mr. GRIFFITH. Prior to the new ethics standards that we've talked about today, weren't you all a member of the NAATP?

Mr. CARTWRIGHT. I go back two decades being a member of NAATP, back to when I was on their board of directors. So, again, back when I was a not-for-profit agency, I thought that was a very effective organization. I could go back and look at the exact date that we're no longer members, but you're right, Marv asked us not to be members based on their new marketing practices or ethical guidelines that he has.

I really don't think he fully understood, though, our websites. I think he got confused with some other websites that are absolutely websites that are nontransparent. And we're supportive of new marketing standards. In the State of Tennessee we just passed the toughest law on marketing standards, and we would recommend, just like Mr. Mishek did, let's take that national. Let's do that on a national basis and take a law like Tennessee or take a law like Florida—they've been working very, very hard in the State of Florida to get this right. We would support that. We actually were extreme supporters of that measure that passed in the State of Florida, California, and Tennessee. If you want to talk to some of the legislators in those States about our activity, I'm happy to put you in touch with them.

Mr. GRIFFITH. Mr. Ventrell, you want to make any comment on that?

Mr. VENTRELL. I must be demonstrative in my demeanor that suggests to the members of the committee to call on me when I haven't raised my hand, but thank you.

Mr. GRIFFITH. Was there merely a misunderstanding? That's what I'm trying to find out. Did you not understand what he's doing?

Mr. VENTRELL. Mr. Cartwright just suggested that I might not fully have understood what American Addiction Centers was doing. What happened was at the expiration of American Addiction Centers term, which was December 31 of 2017, we reviewed its practices and determined that it wasn't in sufficient compliance with our ethical rules. The primary reason for that was the website issue, the inadequately branded or unbranded website, so we did not invite them back.

Mr. GRIFFITH. OK.

Mr. VENTRELL. It's as simple as that.

Mr. GRIFFITH. So the primary issue was that you couldn't tell—if you just went there—you couldn't tell whether it was one of theirs or somebody else's or what treatment center was being referred and who was telling folks to do that. Is that accurate?

Mr. VENTRELL. Yes. We believed it was inadequately transparent.

Mr. GRIFFITH. All right. I've got to move on to some other questions.

Mr. Cartwright, I'm going to switch gears on you. AAC operates several websites that might appear to consumers—and it gets to the same vein—but it might appear to consumers to be unaffiliated third-party resources, such as drugabuse.com, rehabs.com, projectknow.com.

Mr. Niznik, your company does the same thing through its operation of addictionrecoverynow.net and findingtreatmentnow.com. Unless consumers click on the information buttons next to the 1–800 numbers advertised on the website, isn't it true they may not realize who is behind the websites or answering their calls?

First, Mr. Cartwright, yes or no. And then, Mr. Niznik, isn't it true they may not realize who's behind the websites or answering their calls?

Mr. CARTWRIGHT. I think it's very clear on our websites that they know who they're calling.

Mr. GRIFFITH. Mr. Niznik?

Mr. NIZNIK. I also believe it's pretty transparent on our sites who they're calling, and then, more importantly, when they do call, they immediately know who they're talking to. So even if they've read a blog or content online, as soon as they speak to someone, they know who they're dealing with.

Mr. GRIFFITH. And I see I'm over my time. But Mr. Ventrell earlier said pushing on the "I" doesn't work. I'm out of time. I apologize.

I yield back.

Mr. HARPER. The chair will now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair. Thank you to our witnesses.

When opioid addiction patients are seeking help, what matters most is that they get the quality care that they need. The problem is many families don't know what to look for in an addiction treatment provider. And the promises that some facilities make, such as expensive housing and various forms of therapy, sound enticing, but families need to know what will actually help their loved ones in their treatment.

So, Dr. Stoller, you run the addiction center at Johns Hopkins, which has an excellent reputation for high-quality treatment. And I understand you also provide all of the medication-assisted treatment options such as buprenorphine and methadone with that MAT concept. How do you determine whether a patient should receive MAT and which MAT therapy is appropriate?

Dr. STOLLER. Thank you. We do a comprehensive evaluation upon consideration of admission of any patient. At the end of that comprehensive evaluation, we might recommend that the person go someplace else. Maybe they need an inpatient admission for alcohol detoxification or something else.

The most important thing is that the patient has particular needs that we feel like we can match. The way that we match that, let's just look at medication-assisted treatment, is that we look at, number one, patient preference. So some people come with a particular preference. Number two, we look at their past history of treatment, both their successes and their failures. Both are important in determining what the person might need right now. We also look at other medications that they might be on, their par-

ticular symptoms of disorder, how long they've been using, and the severity of their use.

Mr. TONKO. Thank you.

And as we know, millions of Americans are affected by this crisis, and not every family can afford the higher-end facilities. Dr. Stoller, what treatment options are there for people with limited means, and do you have to spend a lot of money to get quality care?

Dr. STOLLER. So I'll go back to my written and oral presentation. I think that there are particular requirements of a treatment program in terms of delivering care that is comprehensive. The use of medication-assisted treatments for people with opioid use disorder is very important, and if the particular program doesn't deliver it themselves, for whatever reason, then connections and very strong linkages with programs and physicians who do is very important.

We have a hub-and-spoke model where we use our opioid treatment program as a hub, and we work very closely with area primary care providers and psychiatrists who might be providing that medication-assisted treatment.

Mr. TONKO. Thank you. And what are some reliable metrics to use to demonstrate a success rate for opioid addiction treatment?

Dr. STOLLER. One of the most important ones is retention within the system of care at a level of care that matches the person's need. So when somebody leaves treatment with us, despite the fact that they need ongoing treatment and they're leaving the treatment system, that's not an indication of success. That said, if the person is leaving with a very positive sense of hope of what a treatment program can offer them and they come back to us, that could be good. We also——

Mr. TONKO. OK. I've got a few questions here to go, so I want to get to everyone.

Mr. Mishek, Hazelden Betty Ford is another gold standard in this industry. Your written testimony speaks to quality standards you've identified for addiction treatment providers. Briefly, how do you determine what a successful treatment is, and how do you measure outcome for your patients?

Mr. MISHEK. We measure outcomes by checking back with our patients at 1 month, 3 months, 6 months, 9 months, and 1 year after they leave our care, at whatever point they leave our care, whether it's after an extensive long-term treatment or after, let's say, 3 weeks of residential care. We measure three things: continuous abstinence during that period of time; second of all, we measure percent days abstinent. That is, they may have relapsed during that period of time, but if they got right back into the program with hope and move forward, that's great, and we would consider that a success. And then finally, we have a series of quality-of-life measures that we measure over that period of time. So those are the metrics that we have in place that we've had for a number of years.

Mr. TONKO. Thank you.

And, Mr. Cartwright, turning to you, I'll ask you about how your facility ensures high-quality care. And first of all, in your response to the committee's letter, you provided your client outcome study that found "63 percent of AAC patients maintain abstinence 1 year after treatment." How many patient responses is that 63 percent

success rate based upon, and just how many patients enter the doors of AAC treatment centers each year?

Mr. CARTWRIGHT. Thank you very much. I'm most proud of the outcome studies. We partnered with an organization in Nashville, Centerstone Research Institute, to do a 3-year longitudinal study. Many times you'll see SAMHSA do these studies or NAADAC do these studies. We had 4,000 patients that went through this study with Centerstone Research Institute. They're the ones that conducted the followup calls, very similar to Mr. Mishek. They did that on the intake process, 2 months, 6 months, and 1-year posttreatment. And we have an entire study. We can get all the members of the committee that study. Be happy to dig in and get you in touch with Centerstone Research Institute that actually conducted the study.

Mr. TONKO. And how many are you saying completed that 1 year?

Mr. CARTWRIGHT. Four thousand. Four thousand people went through the study, and I can get you the details on the entire study. TCenterstone Research Institute is the one that did the study. We didn't do that ourselves. We didn't have our staff members calling the patients back. It was a research institute that did that for us.

Mr. TONKO. So I'm clear on the response, so you said you sent—you had—approached how many people to respond?

Mr. CARTWRIGHT. Four thousand.

Mr. TONKO. And how many responded that had that 63 percent success rate? How many of those 4,000 responded?

Mr. CARTWRIGHT. Again, I can get you the exact numbers from Centerstone Research Institute. They're the ones that conducted the study. My staff didn't conduct the study, but I can get you the details on that study if you'd like it.

Mr. TONKO. Thank you very much, Mr. Chair. I yield back.

Mr. HARPER. The gentleman yields back.

Before I recognize the next member for questions, I just want to be clear, Mr. Ventrell, you had stated earlier that the little "I" isn't good enough. And I assume by that you're referring to the little circle, the information button on a website that you have to click on?

Mr. VENTRELL. That's correct.

Mr. HARPER. OK. With that, the chair will now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Well, thank you, Mr. Chairman.

And, Dr. Stoller, thank you for your testimony, and thank you for your honesty when you address the fact that it's complicated. In the treatment of these patients, the disease itself is complicated. The people who are affected by the disease themselves can be sometimes very complex individuals with very complex histories and, oftentimes, there are confounding comorbidities that have to be taken into consideration. And as a consequence—well, let me just back up a little bit.

Your expertise that you bring to this, you are a board certified psychiatrist? Is that correct?

Dr. STOLLER. Yes, I am, and with additional qualifications in addiction medicine.

Mr. BURGESS. So the committee had the ability to refer everyone with this problem to you or someone of similar qualifications, but unfortunately, that's not always the case. And we are left with trying to provide as much care as possible to protect the greatest number of people, but recognize that it's an imperfect process.

But at some point I would love to visit with you and get your perspectives on how much is OK, how much is too much. And I suspect you have some pretty keen insights into this, and I really would welcome the opportunity to follow up with you on your experience in treating, again, this very complex type of patient.

Dr. STOLLER. My pleasure.

Mr. BURGESS. Mr. Ventrell, let me ask you a question.

And thank you for that answer.

Your organization, the National Association of Addiction Treatment Providers, so you had some people that you did not renew because they did not meet your standards. Is that correct?

Mr. VENTRELL. That's correct.

Mr. BURGESS. And tell me again how many different centers you did not renew?

Mr. VENTRELL. Yes. First of all, let me explain that sometimes we will hear a number that represents campuses, other times you will hear a number that represents the parent corporation.

The answer to your question is 24 parent corporations, 99 facilities. And that is the number, sir, as of last week, Friday.

And so what has happened is the majority of NAATP membership functions on a calendar year. The majority of members expire on December 31 of the calendar year. So that is why the vast majority of those who are no longer part of our rolls were deleted at that time. But this continues to go on throughout the year, and as we receive applications or see other issues, we may remove based on that.

So the number has increased since December 31, which was the number that that your committee staff gave you.

Mr. BURGESS. So you're in the rehabilitation business or you represent companies that are. Are there some of those people who fell through that—some of those organizations or those facilities that were just one or two clicks off of being OK where you could work with them and bring them back into the fold, or was it once you're done, you're done?

Mr. VENTRELL. Thank you for that question, because our goal is not to remove members. Our goal is to create a society, a professional society of treatment providers that are aligned in terms of values-based care and ethics. And so what we want to do when we receive a complaint or become aware of an act is to contact that treatment provider and say, this is a problem. Can you fix it?

Mr. BURGESS. Let me ask you about that, that becoming aware of something. And I'm purposely not asking our other witnesses about any history of lawsuit activity or pending litigation. I don't want to get into that. But is that something that you consider through NAATP, if there has been a settlement, if there has been an action or an allegation, is that something that you evaluate?

Mr. VENTRELL. As it concerns potential liability to our organization, is that your question?

Mr. BURGESS. No. The liability experience of one of the providers. Is that something that would be a red flag?

The reason I bring that up is I cited the testimony that we had last December from Eric Gold, who was an assistant attorney in the Massachusetts Attorney General's Office. And I asked him the question, I said, look, I'm a doctor. I practiced for years. If things are not going well, you worry about liability lawsuits, and where are those liability lawsuits for the types of organizations that he brought before our committee that morning. And he said, well, it just doesn't happen. And that was a little bit astounding to me. I've got to believe that sometimes litigation does result.

Do you evaluate that litigation when that's all public knowledge, correct?

Mr. VENTRELL. Certainly. We want to know what all of our centers are doing in terms of clinical and business operation, and if we become aware of that, that would certainly be a red flag that concerns us.

Mr. BURGESS. And so has that happened?

Mr. VENTRELL. Not specifically to my knowledge, no.

Mr. BURGESS. Has not. And, again, I find that surprising.

I just have one last observation, and I want to ask our treatment centers predominantly to get back to me with this information. One of the family members that was interviewed in our roundtable earlier this year talked about her son. She said it was continued on her medical insurance up to age 26, eventually died of an overdose, but not before he had been resuscitated seven times with Narcan in emergency rooms.

And her question to us was, how can he still be on my insurance and I not be informed of this type of activity, and what was preventing someone from telling me that my son was in an emergency room seven times requiring Narcan? So, again, I'm going to submit that question for the record, but I would be interested in your responses to that.

And I yield back, Mr. Chairman.

Mr. HARPER. The gentleman yields back.

The chair will now recognize the gentlewoman from Indiana, Chairman of our Ethics Committee, Mrs. Brooks, for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

And I would like to talk a little bit about the call center employees and concerned about the types of incentives that might happen relative to call centers and connecting. Although I certainly appreciate that, as we've talked and heard, those with addictions that I've talked to or their families, I appreciate that it is incredibly difficult work that treatment centers provide. And success rates are very difficult. Relapses are common. Dropping out of centers is common. This is an incredibly difficult group of people to work with.

Unfortunately, it's large and growing, and we've got to make sure, in our oversight role, that we are providing and making sure that these folks are not being taken advantage of.

And addicts that I have talked to, by the time they get to the point where they're ready for treatment, they are that desperate or their families are that desperate and have usually tried many cen-

ters. The last center I visited, one young man said it was about his third or fourth center he had been in.

And so I think that this is a really difficult problem we're trying to work on, and that's why we want to make sure, whether they go to the internet, whether they're going to a phone book—I don't even know that anybody is using that anymore—but whatever they're doing, we want to connect them with the best treatment possible.

And with all due respect, no one knows what SAMHSA is. An addict doesn't. I would say, we as government and providers do, but we have got to get this figured out. And there also aren't nearly enough psychiatrists coming out of our med school classes and addiction specialists. And so we've got to keep focused on this problem because we are losing far too many people.

I'd like to know, maybe Mr. Cartwright, Mr. Mishek, and Mr. Niznik, how are your call center employees paid, and are they given bonuses?

Mr. Cartwright?

Mr. CARTWRIGHT. Yes. Thank you very much. And I appreciate your comments. You're so right in terms of the devastation of this disease in keeping it on treatment and quality of care. I'm in a unique position because I——

Mrs. BROOKS. And I'm sorry, I have several questions. And I appreciate that, comments on my comments. But how are your call center employees paid and what fact—and are they given bonuses and what determines whether or not they receive a bonus?

First, how are they paid, Mr. Cartwright?

Mr. CARTWRIGHT. Today they're paid a salary.

Mrs. BROOKS. OK. A salary. No bonuses?

Mr. CARTWRIGHT. Today it's a salary. Prior to July 1—and again, I go back to the Tennessee State law that was passed. I think it's the most aggressive law in the State related to these bad practices that we all want rid of. They were paid on a commission basis.

Mrs. BROOKS. And you've changed that?

Mr. CARTWRIGHT. Yes, ma'am.

Mrs. BROOKS. Mr. Niznik, how about you, how are your call center employees paid?

Mr. NIZNIK. So our call center employees are all salaried employees who also do receive a discretionary bonus. It's based on many factors that you'd expect someone who answers calls to measure, so courtesy, returning calls, not missing calls.

But I think what's important is that no one that answers these calls has any impact on the sort of care someone receives. So when a patient comes to us, the doctors, the nurses, the therapists, they make that determination. Really just being measured how good of a job they do in explaining the services that we offer and performing just the typical job duties of answering calls.

Mrs. BROOKS. But how would one call center employee get a bonus versus another call center employee? How does that information come to you or whoever their supervisor is as to whether or not they receive a bonus? And is it monthly? How is it determined?

Mr. NIZNIK. The bonus is monthly. And, again, it is discretionary. It's based on maybe 7, 8, 10—it's based on a list of factors that I provided in my written testimony. But you measure things like do

they answer the call? Have they missed calls? Are they helpful? When the managers walk around and hear a call, are they being polite? Are they knowledgeable in the program? So all these factors are relevant in determining is the person answering the call doing a good job.

Mrs. BROOKS. OK. Mr. Mishek, are your call center people paid?

Mr. MISHEK. Our call center employees have always been salaried?

Mrs. BROOKS. Without bonuses?

Mr. MISHEK. Correct.

Mrs. BROOKS. Are there any minimum admissions goals for any employees, kind of like sales quotas?

Mr. MISHEK. No.

Mrs. BROOKS. Mr. Cartwright?

Mr. CARTWRIGHT. Today, no.

Mrs. BROOKS. OK. There have been in the past, but there are not any longer?

Mr. CARTWRIGHT. Yes, ma'am. Again, I go back to the State law in Tennessee, and we'd love to see that nationwide.

Mrs. BROOKS. OK. Thank you.

Mr. Niznik, are there any imposed minimum admission goals?

Mr. NIZNIK. There's no minimum admission goals per person, but collectively as a group, we want to make sure that people answering the calls are doing a good job. And like I said in my oral testimony, that like a receptionist in a doctor's office, you want to make sure the person answering your questions is being polite and doing a good job.

Mrs. BROOKS. I'm sorry. My time is up, and I may submit a couple of more written questions. Thank you. Thanks for your work.

Mr. HARPER. The gentlewoman yields back.

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

Mr. COLLINS. Thank you, Mr. Chairman.

And the witnesses, it's an intriguing hearing because this problem is almost insidious in its nature and it's almost hard to begin. Let's start with the Federal regulations versus Tennessee.

Mr. Mishek, you pretty much were calling on Congress to do something and to call on the FTC to regulate.

Mr. MISHEK. That's correct.

Mr. COLLINS. Maybe quickly, if I could ask the other witnesses, do you agree that this situation we need—in this case, Mr. Cartwright, you talked about Federal law versus State law, which is popping up here or there, you believe this is a place the Federal Government should step in and broadly regulate what's going on, especially in the advertising area?

Mr. CARTWRIGHT. I do. I think there are existing FTC laws that get to this, that need to be enforced. But I also think your attention to this is much welcomed.

Mr. COLLINS. Yes.

Mr. NIZNIK. I think it's important that, just broadly, all providers are transparent in the service they offer, that when someone receives a call, they identify themselves. So I think, even though we practice that in all of our facilities, even the States where there isn't necessarily regulation, I think it would be helpful. And I think

equally as important would be regulation that would look at standardizing care so that providers——

Mr. COLLINS. But you're talking about in Federal—but you're saying some States aren't doing anything, others, Tennessee, may be doing a lot——

Mr. NIZNIK. Right.

Mr. COLLINS [continuing]. In which case you're saying the Federal Government, in this case, should step in. We're always somewhat cautious about Federal versus States' rights and so forth, but it's sounding like, in this instance, you're calling for the Federal Government to step in?

Mr. NIZNIK. Right. Because, for example, the standard of care, there isn't a national one that's consistent from provider to provider. So even as a facility, we defer to the professional judgment of our doctors and clinicians, but I think it would be better if they knew exactly what was, at least at a minimum level, expected from them.

Mr. COLLINS. Mr. Cartwright.

Mr. CARTWRIGHT. I do think we need Federal intervention and not just in marketing practices. We have a similar issue related to licensure. Licensure standards in the State of Minnesota or the State of Tennessee or the State of California can be completely different where, for example, out in California, in six-bed houses, you could be doing detox services. We both, Mishek and myself, through our organizations have CDRHs. They're hospitals for detoxification services. So we should have some standardizations across the country.

One of the difficulties is we have 19,000 different treatment centers across the United States with an annual budget of about $5 million. We've never really caught the attention of the Federal Government or even the healthcare system. And today we do, right. We have people dying in the streets all over this country, and we really do need to do something about this.

And I'm very impressed with Congress in respect to what all you all have done over the last 2 years on this issue. But now I think we're starting to get to the things that Mr. Ventrell, Mishek, myself want to see, and that's consistency around advertising and marketing, but also consistency around quality of care and licensure standards.

Thank you.

Mr. COLLINS. Mr. Brian.

Mr. BRIAN. From the advertisement perspective, I couldn't agree more. We want nothing more, wanted nothing more than to work with great centers that were licensed to do what they were tasked to do. And I think that the ultimate underlying message that I would like to leave is that people will search however they choose to search, not how we think might be most appropriate for them to search. So if they decide to go online, they're going to go online. That's what they're going to do.

And so if we are holding our treatment programs to a higher standard and ultimately the licensure required for them, I think we'll be in much better shape regardless of who's on the other end of the phone call.

Mr. COLLINS. Dr. Stoller.

Dr. STOLLER. I'm afraid my work doesn't overlap advertising enough to render a very informed opinion, but what I would say is that access is very important. And I really appreciate the work that the Congress has done to increase access, for example, through Medicare reimbursement for opioid treatment programs and anything else that could be done to make sure that treatment is accessible and that parity is enforced.

Mr. COLLINS. So, Mr. Ventrell, finishing with you, NAATP is the organization that is certifying and riding herd on these. Is that organization well known like almost we think of the Good Housekeeping Seal or something as in the vernacular? Somebody searching would know, I've got to start with do I see NAATP stamp of approval?

Mr. VENTRELL. Well, I would hope so. And that certainly would be——

Mr. COLLINS. Or is there work to be done there?

Mr. VENTRELL. There is work to be done, Congressman, as is demonstrated by the fact that we removed certain members so that we could have a moral high ground in order to say, look, if you want to be a member of the society, you have to follow these rules.

So NAATP has been in existence for 40 years, so certainly we're the longstanding trade association. I think that what you will find as this process develops and we continue to articulate best practices, that that is, in fact, the case, that you need to be part of this national association and that demonstrates a meaningful——

Mr. COLLINS. That would certainly be one way to weed out the very bad actors because they're not part of the NAATP. So we'd encourage you to continue to promote your brand.

Mr. VENTRELL. Thank you.

Mr. COLLINS. With that, Mr. Chairman, I yield back.

Mr. HARPER. The gentleman yields back.

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

Mr. COSTELLO. Thank you, Mr. Chairman.

Mr. Brian, information your company provided committee staff as well as your testimony indicates you routed more than 519,000 calls to treatment providers from December 2014 to the present. Can you describe how those calls were generated?

Mr. BRIAN. Yes, sir, of course. We work with third-party media agencies that operate in television, radio, search engine advertising, amongst other avenues, and they generate—in advertisement, typically it would be in the form of a help-line related call that clearly indicates that their call will be routed to a treatment center who pays to receive that phone call. That call is then routed directly to the treatment center through our platform, never stopping with us.

Mr. COSTELLO. Contractually, do you have any approval over the type of language that they utilize in their advertising in order to generate that call?

Mr. BRIAN. Yes, sir. Indirectly, we have what we call our marketing standards and practices attestation form, which allows and provides them a very clear guideline of what we allow and what we don't allow, most of which is congruent and consistent with the same dialogue that we've had today.

Mr. COSTELLO. Do you pre-approve that?

Mr. BRIAN. Not in all instances, but in most instances, yes.

Mr. COSTELLO. Have you ever had occasion to tell them to remove a particular type of advertisement that did not accord with those guidelines that you just referenced?

Mr. BRIAN. Yes, sir.

Mr. COSTELLO. How much did you pay per call?

Mr. BRIAN. It would vary depending on the type of call. It would range anywhere from $10, $15, $20 dollars on up to $60 or $70, depending on how the call was originated.

Mr. COSTELLO. How did treatment facilities find Redwood?

Mr. BRIAN. We participated in numerous trade shows, conferences. I've spoken at several of these conferences, and ultimately the organizations would find us typically through that. We also had a strong web presence where we would advertise directly to the treatment programs through our website, which was treatmentcalls.com.

Mr. COSTELLO. So did Redwood find the facilities online?

Mr. BRIAN. In some instances, yes, sir. Not in all instances.

Mr. COSTELLO. OK. Let me shift gears. This is for everyone but Mr. Ventrell. I want to talk about success rates, because in a lot of these advertisements you hear talk of there being a successful treatment. We don't necessarily know what success means.

So for each of you, what is your facility's success rate, and how do you define success? Is it admission to your facility? Completion of the program? Maintaining sobriety for a month? Six months? One year? Five years? Starting with Mr. Mishek.

Mr. MISHEK. Thank you, Congressman. First of all, we don't use that word, "success." It's outcomes. This is a chronic disease. You're going to have it for your lifetime. Hopefully, you are in recovery and are happy, joyous, and free, as they say in the big book.

We measure, as I said earlier, outcomes after 1 year of being with us, whatever point you leave us, and——

Mr. COSTELLO. Do you list that in your advertisement at all, what's your outcome——

Mr. MISHEK. We don't advertise it.

Mr. COSTELLO. OK. And I want to hone in on the advertisement and the use of the word "success" or anything related thereto. Mr. Cartwright.

Mr. CARTWRIGHT. We don't use success rate on our advertising. We conducted an outcome study that we've published and put out there just recently over the last several months where 4,000 patients went through that, that I'm very, very pleased and proud of. But that doesn't encompass all of our folks that are going through treatment annually.

Mr. COSTELLO. Mr. Niznik.

Mr. NIZNIK. We don't advertise what our success rate is or define it in any of our ads.

Mr. BRIAN. We don't have treatment centers at all——

Mr. COSTELLO. Right.

Mr. BRIAN [continuing]. So we don't have success rates.

Mr. COSTELLO. Dr. Stoller.

Dr. STOLLER. Our position is similar to Mr. Mishek's. We measure outcome over a continual time period.

Mr. COSTELLO. Mr. Mishek, share with me some of the other challenges in tracking success within the substance abuse industry.

Mr. MISHEK. Well, again, success for us is lifetime recovery. It's a chronic disease. One of the unfortunate features of it being a chronic disease is people relapse. People come back to treatment often many times. It's important never to give up hope, to bring them back, get them back in the continuum.

So success for us are things like, yes, completion of a particular episode of care is really important; participating in recovery management is really important; making it to 12-step meetings, if that's the route you're going, is really, really important. Those are the things that we really focus on and those are the things we look to for success. I hope that answers your question.

Mr. COSTELLO. It does. Thank you.

I yield back.

Mr. HARPER. The gentleman yields back.

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

Mr. CARTER. Thank you all for being here. Very important subject. I've always described the opioid epidemic as being two types of problems: One is, how do we control that what I consider to be the tangible part, how do we control the number of pills out there, the number of prescriptions; and two, the intangible, and that is, what do we do with those 2.5 million people who are currently addicted? How do we help them? That's why you're here today because we need answers to that. That's very difficult.

I'll start with you, Mr. Brian, and ask you this: Are you familiar with the Addiction Network?

Mr. BRIAN. Yes, sir.

Mr. CARTER. You are familiar with that? As I understand that features a gentleman, a bearded gentleman in blue scrubs saying call this number and you can get help. And is that your company doing that or what?

Mr. BRIAN. It's not our company doing that, sir. We——

Mr. CARTER. It's not your company doing it?

Mr. BRIAN. No, sir.

Mr. CARTER. OK. So you have a list of companies that you refer people to,

Mr. BRIAN. Yes.

Mr. CARTER. Is that correct?

Mr. BRIAN. Yes, sir.

Mr. CARTER. OK. What are the qualifications for a company to be on that list?

Mr. BRIAN. Licensed in the State that they are——

Mr. CARTER. Just licensed.

Mr. BRIAN. Yes.

Mr. CARTER. Anything else?

Mr. BRIAN. Not with us, no.

Mr. CARTER. Not with you.

What about you, Mr. Cartwright? You do the same thing, the same business model. Is that correct?

Mr. CARTWRIGHT. A little bit different business model, sir.

Mr. CARTER. OK. Very quickly, how different?

Mr. CARTWRIGHT. It's an advertising model.

Mr. CARTER. It's an advertising model.

Mr. CARTWRIGHT. They don't call into our call center, and then we don't refer them out.

Mr. CARTER. OK. Do you have any requirements for them to be on there?

Mr. CARTWRIGHT. We do. They have to be part of SAMHSA's website——

Mr. CARTER. OK. You mentioned that earlier.

Mr. CARTWRIGHT [continuing]. Which I'm assuming is vetted. They have to be a licensed organization with CARF or JCAHO accreditation.

Mr. CARTER. Do you take into consideration, as my colleague just asked, outcomes? Do you take that into consideration? Do you ask those companies before you put them on your list, tell me about your outcomes?

Mr. CARTWRIGHT. We do not.

Mr. CARTER. You do not.

Mr. Brian, do you?

Mr. BRIAN. No, sir.

Mr. CARTER. You do not?

Mr. BRIAN. No, sir.

Mr. CARTER. So the outcomes has nothing to do with it. They're just on the list.

When you refer, Mr. Cartwright, a patient to one of these clinics, if you will, do they reimburse you for that?

Mr. CARTWRIGHT. No, sir, we don't refer people to clinics.

Mr. CARTER. OK. When you refer people——

Mr. CARTWRIGHT. Correct.

Mr. CARTER [continuing]. The company that you refer them to?

Mr. CARTWRIGHT. If a call comes into our call center and we refer it out to another facility, no, we would never take money from them.

Mr. CARTER. Does that facility reimburse you in any way at all?

Mr. CARTWRIGHT. No, sir.

Mr. CARTER. How do you make money then?

Mr. CARTWRIGHT. We don't make money from that at all.

Mr. CARTER. Where do you make your money?

Mr. CARTWRIGHT. We are a treatment organization. We have 39 treatment centers in 9 States, and that's where we make the bulk of our revenue, just like Hazelden Betty Ford Center.

Mr. CARTER. Do you refer patients to other facilities besides yours?

Mr. CARTWRIGHT. If somebody calls into our call center and they're in a local area and we don't have a treatment center in that area, absolutely, we'd refer them to the SAMHSA website. We may even walk through that SAMHSA website with them and let them know about local facilities in that area, but we would never take money from them.

Mr. CARTER. OK. What about you, Mr. Brian, when you give a referral to another clinic, do you get reimbursed?

Mr. BRIAN. We don't make any referrals. So we don't have a call center that accepts phone calls.

Mr. CARTER. You don't have a call center. So when you route them——

Mr. BRIAN. Yes, sir.

Mr. CARTER [continuing]. To that clinic——

Mr. BRIAN. Yes, sir.

Mr. CARTER [continuing]. Do they reimburse you any at all for that referral, if you will?

Mr. BRIAN. For the phone call, we receive compensation for it, yes, sir.

Mr. CARTER. Do you receive it from the clinic?

Mr. BRIAN. For the phone call itself, yes.

Mr. CARTER. OK. So, again, you don't take into consideration, there's no prerequisites for that company, for that clinic to be on your list. You just simply go in and list them.

Let me ask you something. When you make these kind of referrals, if you will, do you interview the patient? Do you sit there and say, OK, tell me what your problem is, tell me what your pay type is, tell me what you're looking for? Do you do anything like that or you just say, hey, this is in your area, this is who we recommend?

Mr. BRIAN. We don't recommend. We don't talk to the client ever in that engagement at all. We don't have any interaction at all with the prospective——

Mr. CARTER. Then how do you know who to refer them to?

Mr. BRIAN. We refer them to a licensed facility, sir. The prerequisite to work with us, if it was good enough for the State to issue licensure for them, that's our prerequisite in order to do business with us.

Mr. CARTER. OK. Do you think that serves the best interest of the patient?

Mr. BRIAN. I believe it serves the law in the State of Florida that I live and work in. And I would welcome this conversation. I believe that a lot more can be done to route these calls to the appropriate facility.

Mr. CARTER. I would think so.

Mr. BRIAN. I agree.

Mr. CARTER. I would think if I called that, I'd want to have some information before I said, OK, this is where you need to go.

Mr. Cartwright, you've referred to State laws that have been passed. Have they addressed any of that?

Mr. CARTWRIGHT. I think what you're getting at is the quality of the facility that you're referring someone to.

Mr. CARTER. The quality and the type of facility. If I say, I've got an addiction and I'm looking for something that's faith based and I need your recommendation, do you take into consideration anything like that?

Mr. CARTWRIGHT. Again, if Congress would support something like that through SAMHSA, I think that would be excellent. I do think that this is where it needs to land is in Congress' lap, because each of the States are so different in terms of how they license——

Mr. CARTER. OK. I'm out of time. But listen, we're very responsible people up here, and we want to do and we're going to do what's right. But we also look to you to have a certain level of responsibility as well. So don't always look to Congress as being the ultimate answer here, OK.

Thank you very much, Mr. Chairman. 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 very much.

Thank you for your testimony as well. And thank you, Mr. Chairman, for holding this very important hearing.

If there's one thing that's been made clear in today's hearing is that there is a lack of clarity on how individuals can ensure they are seeking care that will best meet their needs. I want to better understand how we can serve our constituents by creating a clear path forward here.

Mr. Ventrell, does the Association have a definition of what quality care is? And then, what resources exist for the consumers to seek out quality care?

Mr. VENTRELL. Thank you, Congressman. Yes. As part of the quality assurance initiative, NAATP developed a research called the NAATP Guide to Treatment Program Selection. It's a comprehensive consumer tool, also useful for the field, that provides red flags and positive references.

It is premised on four principles. Addiction treatment is healthcare and should be chosen as such. There are knowable indicia of quality of care. It's not a mystery. We know what produces quality care. Third, there needs to be transparency in the marketing process. And fourth, the institution that you go to should adhere to a recognized code of ethics.

Mr. BILIRAKIS. Let me ask you a question, and maybe this is for the panel as well. Would a star rating system be very helpful? Because that kind of simplifies it in certain areas rating the particular facility. I think that that might be simpler. Again, these are their loved ones and they want to make the right decision for them.

So if anybody wants to chime in on that, I'd appreciate an answer.

Yes, sir.

Mr. VENTRELL. May I, sir? It's an attractive solution, but I think it's a dangerous one. Things are more complicated than ranking by star. I don't think that that's achievable in a reliable way.

Mr. BILIRAKIS. Well, we do it for nursing homes. I distinguish that a nursing home as opposed to a substance use disorder facility or mental health facility.

Mr. VENTRELL. Yes. Thank you. The floor needs to be clearly established in order for a process like that to work. In other words, nursing homes must exist, I believe, at a certain level of quality before you can start to talk about that.

What I propose, or what we propose or suggest instead is that the floor, the basic operational requirements should be regulated sufficiently such that if you read, if they are, and then you read the services offered, the consumer can rely on that, and a star system wouldn't be necessary.

Mr. BILIRAKIS. OK. I just want to make it clear and less complicated for the consumer. And I want them to know where to turn to, where to find this information out. I want it to be easily accessible.

Let's see, a big concern that this committee has is ensuring that when an individual or their loved one is seeking substance use disorder treatment, they know what things to look for. And you mentioned the flags. What things to avoid, again, to best protect themselves from falling prey to any deceptive marketing schemes that may be out there, and there are plenty out there.

Could you identify a few red flags that individual should be on the lookout for when seeking care, as well as a few green flags that might indicate that a treatment center provides quality care?

For example, some reports suggest paying attention to whether or not the facility lists a staff page or asking the person who answers the phone whether or not they are actually at the treatment center.

So, Mr. Ventrell, you can start, if you like.

Mr. VENTRELL. Sure. As part of the same document which I have referenced, we've listed red flags and questions to ask. Red flags generally that we believe should be observed are generic websites, call directories, or websites offering treatment placement. Many of these make referrals based on business relationships. That's the problem.

Questions to ask include licensing, accreditation. It's all based on transparency. We would like them obviously to be members of our national association. How long has the facility been in operation? Who are the staff? What levels of care are provided? What are the placement criteria? What is your procedure for the continuum of care as the chronic disease exists one's entire life? The list goes on, and I'm happy to provide that. In fact, it is part of the record.

Mr. BILIRAKIS. OK. Let me ask one more question. I do have several here, but with regard to payment, because it's difficult for a person to—obviously, you want to make the right decision, OK, but also, how many treatment centers take private insurance? What's a percentage?

Whoever wants to answer that question would be fine with me, or you can even just talk about your particular treatment center, whether that center accepts private insurance.

Mr. CARTWRIGHT. Congressman, thank you very much, and going back to your previous question as well. I do think that the addiction treatment industry is very similar to the nursing home industry. It's a maturing industry that could benefit from a star system like you were referring to. I think it's very, very similar to the nursing home space where Federal regulation needs to be tighter across the board. That would be my personal opinion. So I really appreciate you bringing that up.

Mr. BILIRAKIS. Oh, absolutely. Thank you. Thank you for your opinion.

Mr. MISHEK. If I could talk about insurance.

Mr. BILIRAKIS. I guess I probably have to yield back.

Thank you very much. If maybe you can have some time, Mr. Chairman, for him to answer the question. But I'll yield back.

Mr. HARPER. The gentleman yields back, and I've got a couple of followup things, but I'll recognize Ranking Member DeGette for purposes of entering a document.

Ms. DEGETTE. Mr. Chairman, thank you.

We just received a letter from the Federal Trade Commission regarding this issue. And what Commissioner Chopra talks about in this letter is the for-profit treatment centers and what that can do in terms of driving up costs for insurance and for Medicare and Medicaid programs, as well as cost for patients out of their pockets.

The letter also cautions about the deceptive trade practices in trying to match individuals to centers and the advertising. And it finally urges this committee to take a close look at the advertising and marketing practices in the industry to make sure that incentive compensation practices for employees and operators of treatment centers, as well as financial conflicts of interests with other firms, are addressed.

And so I'd like unanimous consent to enter this into the record so that we can continue to look at these issues as we continue our investigation.

Mr. HARPER. Without objection, so entered.

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

Mr. HARPER. Any other comments, Ms. DeGette?

Ms. DEGETTE. No.

Mr. HARPER. I had a couple of followup items I just wanted to touch on.

Mr. Cartwright, how do companies and their phone numbers end up on their website?

And I ask that because we understand that there's at least one phone number that doesn't call the named facility that it is listed with. So how do companies and those phone numbers end up on your websites?

Mr. CARTWRIGHT. We utilize the SAMHSA website in terms of the listings on there. And so if it's not been updated through SAMHSA, maybe we didn't update that. I'd love to know the phone number that didn't go through correctly. We would certainly like to look at that.

Mr. HARPER. Sure. We will make sure you have that info to clear that up.

Also, Mr. Cartwright, I know that you do operate, a portfolio of websites under your Recovery Brands business line. Are you able to tell us how many websites are operated under Recovery Brands and give us that information today?

Mr. CARTWRIGHT. I can get you the exact websites themselves. I think we've been asked by staff to provide that, and we can certainly do that.

Mr. HARPER. That would be very helpful.

One issue that this committee has explored, obviously, is abuse of billing practices, especially with urine drug testing. For example, the reports of clinics and labs charging more than $4,000 for a single urine test and for treatment facilities to test individuals two or three times a week.

So for Mr. Mishek, Mr. Niznik, and Mr. Cartwright, can you explain how often your facilities test patients and what the average cost is? And answer, if you can, as quickly as you can.

Mr. MISHEK. Sure. We do a urine drug screen upon admission for any level of care: Residential, day treatment, intensive outpatient. During the course, the patient may get two or three additional

tests, depending on whether they came up on the randomized thing we do or whether it was for cause.

We don't charge. We have no revenue from drug testing. The cost that we incur is about $20 a test roughly. It's very, very low cost.

Mr. HARPER. Are those tests performed at your facility or sent out to a lab?

Mr. MISHEK. They are sent out to a national lab.

Mr. HARPER. OK. Mr. Cartwright.

Mr. CARTWRIGHT. Very similar. We use the same guidelines just like Hazelden Betty Ford Center, very similar in terms of intake. We generate about $50 for a urine sample, but we also own and operate our own laboratories.Two of them, one in Tennessee and one in the State of Louisiana.

Mr. HARPER. So those are sent out to those facilities for testing?

Mr. CARTWRIGHT. Correct.

Mr. HARPER. OK. Mr. Niznik.

Mr. NIZNIK. We also test upon admission. And then on average, it's about 1 ½ times per week, but it's generally in the discretion of the medical doctor that's overseeing the care of the patient to order whatever test they think is medically necessary. We send it out to the lab that we operate in Florida.

Mr. HARPER. Is your mic on?

Mr. NIZNIK. Yes.

Mr. HARPER. How many labs and what do you charge, that you own.

Mr. NIZNIK. We own one lab. We operate one lab. It services all of our facilities. And our average, I think, reimbursement is somewhere around $200 to $300.

Mr. HARPER. OK. I'll yield to Ms. DeGette for a followup.

Ms. DEGETTE. So you say that you test on the average of 1 ½ times per week. You send it out to your lab. Are you then billing the insurance the $200 to $300?

Mr. NIZNIK. Yes, that's the reimbursement we receive from the—no, that's the reimbursement we receive from the insurance company.

Ms. DEGETTE. Right. So you're billing the insurance $200 to $300 per 1 ½ times a week, whereas these other facilities aren't charging their people anything.

Thank you, Mr. Chairman.

Mr. HARPER. Final question, and Mr. Cartwright, I pulled up drugabuse.com, which is yours. And going through the website it has lots of information. It talks about the opioid crisis. It has an 800 number. "It's not too late to turn your life around," "overcoming your addiction."

While we don't measure success or outcome, it certainly might imply to one, that I will get that outcome if I go there. But you have to go to the small "I" that I asked Mr. Ventrell about earlier to find out that your visit will be answered by American Addiction Centers, AAC, or a paid sponsor.

Why wouldn't you just list that information at the top of your web page? You have to go hunt for that, either under the number or other things. Why wouldn't you do that?

Mr. CARTWRIGHT. Again, our business model is very similar to WebMD. If you'd like us to change it and put it at the very top, I'm happy to do——

Mr. HARPER. I'm not asking about WebMD. I'm asking you, if we're talking about transparency and what we're looking at here so that it's nothing is viewed to be deceptive, wouldn't it be easy just at the beginning of your web page to say that information?

Mr. CARTWRIGHT. Yes, sir, we can do that.

Mr. HARPER. Who are the paid sponsors?

Mr. CARTWRIGHT. It's the advertisers that we were referring to earlier in the conversation.

Mr. HARPER. Who determines on that call whether or not it goes to AAC or to a paid sponsor?

Mr. CARTWRIGHT. All of the phone calls that are coming in through the 1–800 number that is like that, they all come to American Addiction Centers.

Mr. HARPER. OK.

Mr. CARTWRIGHT. The paid sponsors is referring to if they have an ad, and it's very clear who that company is.

Mr. HARPER. Do you send anything to an unpaid sponsor? Or is there such a thing as unpaid sponsor?

Mr. CARTWRIGHT. Yes, there is.

Mr. HARPER. OK. And how do you rotate—a call comes in, how do you determine who it goes to?

Mr. CARTWRIGHT. It's not a call that comes in. If they're looking on the website, and if you go down through the website and you look in Denver, Colorado, it would have all the local providers in that area. They wouldn't have to pay for that listing. It would have all of them listed there. All the not-for-profit agencies, all the hospitals, treatment centers.

Mr. HARPER. But if I call that 800 number, or 877 number, whatever it is, if I were to call that, it would go to a facility or go to the hotline?

Mr. CARTWRIGHT. That would only come to American Addiction Centers.

Mr. HARPER. OK. All right. I got it.

I want to thank everyone for their testimony. This is an issue that we're obviously concerned about, but I thank you for your time, your patience, for your responses.

I would remind members that they have 10 business days to submit questions for the record. And I would ask the witnesses that you respond as promptly as possible when you get such questions.

With that, the subcommittee is adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
EST. 1795

July 20, 2018

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing entitled "Examining Advertising and Marketing Practices within the Substance Use Treatment Industry."

The Subcommittee on Oversight and Investigations will hold a hearing on Tuesday, July 24, 2018, at 10:00 a.m. in 2123 Rayburn House Office Building. The hearing is entitled "Examining Advertising and Marketing Practices within the Substance Use Treatment Industry." The purpose of the hearing is to examine practices within the substance use treatment industry, including advertising and marketing and quality of care.

I. WITNESSES

- Jason Brian, Founder and Owner, Redwood Recovery Solutions and TreatmentCalls.com;
- Michael T. Cartwright, Chairman and CEO, American Addiction Centers;
- Mark Mishek, President and CEO, Hazelden Betty Ford Foundation;
- Robert Niznik, CEO, Addiction Recovery Now and Niznik Behavioral Health, Inc.;
- Kenneth Stoller, M.D., Director, Johns Hopkins Hospital Broadway Center for Addiction; and
- Marvin Ventrell, Executive Director, National Association of Addiction Treatment Providers.

II. BACKGROUND

The United States remains in the throes of a national opioid epidemic, with 115 Americans dying every day from opioid-involved overdoses.[1] Approximately 2.1 million Americans over the age of 12 are believed to have an opioid use disorder[2] and, amid the epidemic,

[1] Centers for Disease Control and Prevention, Understanding the Epidemic, Opioid Overdose, (Aug. 30, 2017), *available at* https://www.cdc.gov/drugoverdose/epidemic/index.html.
[2] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*, (HHS Publication No. SMA 17-5044, NSDUH Series H-52) *available at* https://store.samhsa.gov/shin/content//SMA17-5044/SMA17-5044.pdf.

the demand for treatment has increased greatly. The number of treatment facility admissions for opiate use increased 58 percent between 2005 and 2015.[3]

Beginning in April 2014, the Subcommittee on Oversight and Investigations has undertaken an examination of many of the root causes of the opioid epidemic and explored possible solutions to enable greater access to effective, evidence-based treatment for substance use disorders. As part of this work, in July 2017, the Committee began examining the practice of patient brokering, through which individuals known as patient or body brokers are paid by treatment facilities for successfully enrolling patients in their treatment programs.

The Committee wrote to the Department of Health and Human Services (HHS)[4] in July 2017, and to six states[5] in November 2017, about the practice of patient brokering. On December 12, 2017, the Subcommittee held a hearing examining concerns about patient brokering and addiction treatment fraud.[6] The Subcommittee heard testimony about problems stemming from the dramatic surge in substance use disorder treatment facilities, including practices employed by businesses known generally as "call aggregators." The President and Chief Executive Officer of one treatment facility testified that call aggregators "are essentially collecting leads for treatment centers who are willing to pay a price" and that the call centers will prescreen potential patients with the goal to "ultimately sell the patient's information to the highest bidder."[7] On May 29, 2018, the Committee sent letters to eight substance use treatment businesses requesting information and documents about their advertising and marketing practices and to understand whether and, if so, how they utilize call centers or call aggregators, websites, and ad optimization.

The need for quality substance use disorder treatment facilities is critical. An estimated 21 million people over the age of 12, or one in 13 people in the United States, are believed to have needed treatment for a substance use disorder in 2016.[8] Yet, only 3.8 million people received any form of substance use treatment in 2016, and just 2.2 million received treatment at a

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[3] TEDS data includes admissions to facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment and may not include admissions to all private for-profit agencies. See Substance Abuse and Mental Health Services Administration, *Treatment Episode Data Set (TEDS) 2005 – 2015*, *available at* https://wwwdasis.samhsa.gov/dasis2/teds_pubs/2015_teds_rpt_natl.pdf.

[4] Letter from Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., to Tom Price, Sec'y, U.S. Dept. of Health & Human Services, (July 13, 2017), *available at* https://archives-energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/20170713HHS.pdf.

[5] Letters from Greg Walden, Chairman, H. Comm. on Energy & Commerce, et al., to Mr. Thomas J. Betlach (AZ), Dr. Karen Baylor (CA), Dr. Robert Werthwein (CO), Ms. Ute Gazioch (FL), Ms. Allison Bauer (MA), and Ms. Jennifer Smith (PA), (Nov. 17, 2017), *available at* https://energycommerce.house.gov/news/letter/letters-departments-six-state-governments-patient-brokering-allegations/.

[6] H. Comm. on Energy & Commerce hearing, *"Examining Concerns of Patient Brokering and Addiction Treatment Fraud,"* (Dec. 12, 2017), *available at* https://energycommerce.house.gov/hearings/examining-concerns-patient-brokering-addiction-treatment-fraud/.

[7] Testimony of Douglas Tieman, President and CEO, Caron Treatment Centers at H. Comm. on Energy & Commerce hearing, *"Examining Concerns of Patient Brokering and Addiction Treatment Fraud,"* (Dec. 12, 2017), *available at* http://docs.house.gov/meetings/IF/IF02/20171212/106716/HHRG-115-IF02-Wstate-TiemanD-20171212.pdf.

[8] SAMHSA, *supra* note 2.

specialty facility.[9] Opioid and heroin overdoses continue to plague communities across the country. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2016 National Survey on Drug Use and Health, 11.5 million people over the age of 12 reported misusing prescription pain relievers in the past year.[10] In total, more than 351,000 people have died since 1999 due to an opioid-involved overdose.[11] The crisis has become so severe that the average U.S. life expectancy declined in 2016, largely because of an increase in drug overdoses, including opioid overdoses.[12]

The increased demand for treatment has brought with it new concerns about treatment facilities' marketing practices as well as the quality of care patients receive. Patients in need of treatment resources often look for help on the internet, where some providers have used aggressive, and, at times, allegedly deceptive advertising tactics.[13] Many treatment-focused websites advertise phone hotlines that lead potential clients to call centers or call aggregators. These call centers may appear to be unaffiliated third-party referral services, but, in some cases, they are wholly operated by treatment facilities or are paid by facilities to refer calls. While some centers disclose their relationship with treatment facilities, others do not, and may engage in deceptive marketing tactics to hide the relationship. Reports indicate that call aggregators may refer patients to facilities that do not meet their needs, and once patients enter treatment, they may be vulnerable to exploitation by unscrupulous business owners. [14]

Though rates of opioid prescribing are on the decline,[15] the number of people receiving treatment for either heroin or prescription opioids has increased substantially over the last decade.[16] According to SAMHSA's latest Treatment Episode Data Set, opiates were the primary substance for which treatment was sought in more than 526,000 treatment facility admissions in 2015, up from 332,000 primary opiate admissions in 2005.[17]

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[9] *Id.*
[10] *Id.*
[11] Centers for Disease Control and Prevention, Data Brief 294. Drug Overdose Deaths in the United States, 1999-2016, *available at* https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#page=4.
[12] Catherine Roberts, *Opioid Overdoses Are Major Cause Behind Life Expectancy Decline, CDC Report Says*, CONSUMER REPORTS, (Dec. 21, 2017), *available at* https://www.consumerreports.org/drug-use/opioid-overdoses-life-expectancy-decline/.
[13] Teri Sforza, Tony Saavedra, Lori Basheda, *Rehab Riviera: Addiction advertising can trick you to death*, ORANGE COUNTY REGISTER, (March 2, 2018) *available at* https://www.ocregister.com/2018/03/02/rehab-riviera-addiction-advertising-can-trick-you-to-death/, and Cat Ferguson, *Searching for help: She turned to Google for help getting sober. Then she had to escape a nightmare,* THE VERGE, (Sept. 7, 2017), *available at* https://www.theverge.com/2017/9/7/16257412/rehabs-near-me-google-search-scam-florida-treatment-centers; David Segal, *A doctor with a phone and a mission*, THE NEW YORK TIMES, (Dec. 27, 2017), *available at* https://www.nytimes.com/interactive/2017/12/27/business/drug-addiction-ads.html.
[14] *Id.*
[15] Opioid prescribing rates peaked at 255 million prescriptions in 2012 and have since dropped to 214 million prescriptions in 2016. See Centers for Disease Control and Prevention, U.S. prescribing rate maps, Opioid overdose, (last updated July 31, 2017), *available at* https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.
[16] SAMSHA, supra note 3.
[17] *Id.*

a. **Marketing and Advertising**

The increased demand for substance use disorder treatment has created a large and complex treatment industry, that has remained largely unregulated at the federal level and has wide variability in terms of how facilities are regulated at the state level. Competition for potential patients is significant, with some providers reportedly employing a host of aggressive and sometimes deceptive advertising tactics. A 2016 Palm Beach County, Florida grand jury report on fraud and abuse in Florida's treatment industry highlighted a number of problematic marketing abuses, including false representation of services, false representation of location, and real-time auctioning of patients through clearing houses or lead generators.[18] The report found that deceptive marketing practices "are detrimental to a patient's chances of receiving quality care and the appropriate level of care" and also harm reputable treatment centers.

Some treatment facilities utilize call centers or call aggregators to engage with potential customers. One type of call center functions as an unaffiliated third-party referral service, which routes calls to treatment facilities for a per-call fee. In some instances, these call centers do not speak with potential patients to determine their needs before routing them to the treatment facilities paying for calls. The price per call varies, but the Committee's investigation has found that some call aggregators charge between $20 to $40 per call. Other call centers are operated by businesses that also own treatment facilities, and the call centers are used to advertise their own facilities and services. In these cases, the Committee found that some call centers pay bonuses to employees for each successful enrollment of a patient in their treatment facility. While some call centers and websites disclose that they are owned and operated by treatment facilities, others do not clearly list or otherwise disclose their ownership or affiliations. In some instances, the contact information included in online listings for treatment facilities has been altered so that anyone who calls seeking treatment would be funneled to a call center or another treatment facility rather than the facility listed.[19] Those answering the calls could then either encourage a prospective patient to enroll in their treatment programs or collect the person's contact information and sell it to other interested treatment centers.[20]

In addition, some facilities or companies own and operate multiple websites, domains, or URLs to advertise treatment. Like call centers, the level of disclosure offered by treatment facilities about their ownership of treatment-related websites varies widely.[21] Some companies advertise solely through branded websites that disclose their treatment facilities and ownership structure. Others develop unbranded websites that may appear to be unaffiliated third-party sites meant to offer resources and helplines. To reach the greatest number of potential clients, some businesses have developed dozens of treatment-related websites. At least one business told the Committee that they developed unbranded websites in order to reach additional potential clients. The Committee has also found multiple examples of treatment industry business URLs that closely mirror other well-established treatment facilities or highly trafficked websites in an effort

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[18] Palm Beach County Sober Homes Task Force Report, (Jan. 1, 2017), *available at* http://www.sa15.state.fl.us/stateattorney/SoberHomes/_content/SHTFReport2017.pdf.
[19] Teri Sforza, et al., *supra* note 13.
[20] *Id.*
[21] *Id.*

to capitalize on similar terms or misspellings. Businesses have also indicated they occasionally use television advertisements to promote 1-800 hotlines for treatment facilities.

Online advertising practices in the treatment industry have also come under scrutiny. In 2017, Google began restricting online advertising by treatment providers, with company officials citing "a number of misleading experiences among rehabilitation treatment centers."[22] Online search advertisements can be lucrative and Google was considered one of the largest referral sources for individuals seeking treatment.[23] Before Google suspended treatment industry-related searches within its AdWords keyword auction system, treatment centers could bid to buy online ads that would show up when someone searched for terms like "drug rehab" or "addiction." Reports indicate that businesses were willing to pay upwards of $90 a click for specific search terms and AdWords suggested a minimum bid of $187 per click for the term "drug rehab locations."[24] Google plans to resume treatment industry advertising this year through a partnership with the company LegitScript, which will vet and certify drug and alcohol treatment providers before they are allowed to advertise with Google.[25] Through the partnership, LegitScript's President and Chief Executive Officer said he hopes to provide better information to consumers about "which programs provide genuine treatment and which are, in essence, scams."[26]

The issue of ethical marketing has also been of great concern among groups within the treatment industry. The National Association of Addiction Treatment Providers (NAATP) recently adopted updated standards for advertising and marketing. Among the requirements outlined in the association's new code of ethics: members may not buy or sell patient leads, members may not engage in the practice of patient brokering, and members must be transparent regarding their identities and services.[27] NAATP announced in May that it did not renew 70 member facilities who were unable to meet the association's new standards – a decision that cost the association $100,000 in lost membership fees.[28]

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[22] Cat Ferguson, *Exclusive: Google is cracking down on sketchy rehab ads*, THE VERGE, (Sept. 14, 2017), *available at* https://www.theverge.com/2017/9/14/16309752/google-rehabs-near-me-search-adwords-crackdown.
[23] Michael Corkery, *Google sets limits on addiction treatment ads, citing safety*, THE NEW YORK TIMES, (Sept. 14, 2017), *available at* https://www.nytimes.com/2017/09/14/business/google-addiction-treatment-ads.html.
[24] Michael Smith, Jonathan Levin, and Mark Bergen, *Why it took Google so long to end shady rehab center ads*, BLOOMBERG, (Sept. 26, 2017), *available at* https://www.bloomberg.com/news/features/2017-09-26/why-it-took-google-so-long-to-end-shady-rehab-center-ads.
[25] LegitScript, *Addiction treatment certification nears end of pre-launch phase,* (July 12, 2018), *available at* https://www.legitscript.com/blog/2018/07/addiction-treatment-certification-enters-new-phase/.
[26] John Horton, *LegitScript's new certification program for addiction treatment providers will help those most vulnerable*, LegitScript, (April 16, 2018), *available at* https://www.legitscript.com/blog/2018/04/legitscripts-new-certification-program-for-addiction-treatment-providers-will-help-those-most-vulnerable/.
[27] *Code of Ethics*, National Association of Addiction Treatment Providers (last accessed July 16, 2018), *available at* https://www.naatp.org/resources/ethics/code-ethics.
[28] Alcoholism and Drug Abuse Weekly, NAATP leadership: By speaking truth, field will garner public trust, Volume 30, Number 21, (May 28, 2018). On file with the Committee.

b. **Concerns within the Substance Use Disorder Treatment Industry**

Some have described the treatment industry as the "Wild West," and ripe for exploitation by unscrupulous business owners.[29] Concerns within the industry range from employees who do not have adequate training or education to care for patients, to abusive billing practices, and kickback payments made in exchange for luring patients to facilities.[30] Further, there are concerns about a lack of transparency and use of overstated or unqualified success rates. Success rates often do not define what qualifies as a success – be it sobriety for a year, six months, or even a week after leaving treatment.[31] Further, many success rates are based on self-reporting by patients and can be difficult to verify.

Another concerning practice involves treatment facilities allegedly prioritizing profit over recovery by requiring a patient to undergo costly and medically unnecessary testing that is billed to the patient's insurance company.[32] Few national urine drug testing standards exist, therefore, decisions regarding who should be tested, how often they should be tested, and for which drugs they should be tested are largely left up to providers.[33] For example, there are reports of clinics and labs charging more than $4,000 for a single urine test, and for treatment facilities to test individuals two or three times each week.[34] According to the Healthcare Fraud Prevention Partnership (HFPP), the North American clinical laboratory services market is worth an

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[29] Teri Sforza et al., *How some Southern California drug rehab centers exploit addiction*, ORANGE COUNTY REGISTER, (May 21, 2017), *available at* http://www.ocregister.com/2017/05/21/how-some-southern-california-drug-rehab-centers-exploit-addiction/; Amy Julia Harris and Shoshana Walter, *Drug users got exploited. Disabled patients got hurt. One woman benefitted from it all.*, THE CHARLOTTE OBSERVER, (May 21, 2018), *available at* http://www.charlotteobserver.com/latest-news/article211600539.html.

[30] *See*, e.g., Paloma Esquivel, *Murder Charges Against Rehab Center are a First in California*, LOS ANGELES TIMES, (Feb. 28, 2016), *available at* http://www.latimes.com/local/crime/la-me-rehab-murder-charge-20160228-story.html; Amy Julia Harris and Shoshana Walter, *Drug users got exploited. Disabled patients got hurt. One woman benefitted from it all.*, THE CHARLOTTE OBSERVER, (May 21, 2018), *available at* http://www.charlotteobserver.com/latest-news/article211600539.html; Christine Stapleton, *2 addiction treatment center owners indicted after reaping $50 million*, PALM BEACH POST, (June 27, 2018), *available at* https://www.mypalmbeachpost.com/news/addiction-treatment-center-owners-indicted-after-reaping-million/3lNOb0jWXxYeA2rvVzv5AO/.

[31] Christopher Moraff, *Why Drug Rehab is Outdated, Expensive, and Deadly*, THE DAILY BEAST, (May 9, 2016), *available at* https://www.thedailybeast.com/why-drug-rehab-is-outdated-expensive-and-deadly; Melissa Locker, *John Oliver Shines a Light on the Unregulated Rehab Industry on Last Week Tonight*, TIME (May 21, 2018), *available at* http://time.com/5285151/john-oliver-rehab-last-week-tonight/.

[32] David Segal, *In Pursuit of Liquid Gold*, THE NEW YORK TIMES, (Dec. 27, 2017), *available at* https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html; Fred Schulte and Elizabeth Lucas, *How Doctors are Getting Rich on Urine Tests for Opioid Patients*, BLOOMBERG, (Nov. 6, 2017), *available at* https://www.bloomberg.com/news/features/2017-11-06/how-doctors-are-getting-rich-on-urine-tests-for-opioid-patients; Cat Ferguson, *Searching for Help*, THE VERGE, (Sept. 7, 2017), *available at* https://www.theverge.com/2017/9/7/16257412/rehabs-near-me-google-search-scam-florida-treatment-centers.

[33] Fred Schulte and Elizabeth Lucas, *How Doctors are Getting Rich on Urine Tests for Opioid Patients*, BLOOMBERG, (Nov. 6, 2017), *available at* https://www.bloomberg.com/news/features/2017-11-06/how-doctors-are-getting-rich-on-urine-tests-for-opioid-patients.

[34] David Segal, *In Pursuit of Liquid Gold*, THE NEW YORK TIMES, (Dec. 27, 2017), *available at* https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html.

estimated $87.3 million.[35] The HFPP highlighted both the potential for and examples of fraud and abuse within the market in a recent report. Their concerns include the routine use of definitive or quantitative urine drug testing in place of less expensive qualitative testing, fraudulent use of urine drug testing in sober living homes, and use of "excessively broad panels" to detect the presence of less commonly used substances in order to maximize reimbursements.[36]

c. **Federal and State Efforts to Combat Fraud and Abuse**

Despite both the growing need for treatment and the increase in operation of private for-profit treatment facilities,[37] the federal government has not been heavily involved in oversight. According to HHS, "[t]he federal government has oversight of opioid treatment programs (OTPs) but does not have oversight authority over other levels of care – states are responsible."[38] Other than for OTPs, there are no federal regulations of substance use disorder treatment facilities, and there is wide variability in terms of how facilities are regulated at the state level.

Several states have taken action to improve oversight of the treatment industry, including in areas related to advertising and marketing. Florida, which has seen an increase in growth of the treatment industry in recent years, passed legislation in 2017 that took aim at the practices of patient brokering and deceptive marketing. For example, the state now bans marketers from contracting with treatment facilities to generate patient referrals or leads through call centers or online advertising without disclosing the identity of the licensed treatment facilities paying the marketer.[39] A Tennessee law, which took effect in July, bans operators of alcohol and drug treatment facilities from making false statements in advertising materials about their identity, services, or geographical location.[40] Like the Florida law, the new Tennessee law also bans marketers from generating patient leads without disclosing which treatment facilities pay them. Tennessee also bans the payment of any commission, rebate, kickback, or bribe to anyone in exchange for the referral or patronage of a patient – a practice similarly banned in Florida.

In addition to Florida and Tennessee, Arizona has also taken steps to reform the state's substance use disorder treatment industry. Legislation adopted this year in Arizona bans treatment facilities from paying fees or kickbacks to recruit patients and individuals from soliciting or accepting fees to deliver patients.[41] The state also adopted laws that require sober

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[35] Healthcare Fraud Prevention Partnership, *Examining clinical laboratory services*, (May 2018), *available at* https://hfpp.cms.gov/HFPP-White-Papers/HFPP-Clinical-Lab-Services-White-Paper.pdf.
[36] *Id.*
[37] The number of patients treated for substance use disorder at private for-profit facilities grew from 328,763 in 2006 to 449,038 in 2016. See Substance Abuse and Mental Health Services Administration, *National Survey of Substance Abuse Treatment Services (N-SSATS): 2016, Data on Substance Abuse Treatment Facilities*, *available at* https://wwwdasis.samhsa.gov/dasis2/nssats/2016_nssats_rpt.pdf.
[38] U.S. Dept. of Health & Human Services Response to H. Comm. on Energy & Commerce Letter, (Sept. 12, 2017), *available at* https://energycommerce.house.gov/wp-content/uploads/2017/07/20170912HHS_Response.pdf.
[39] FLA. STAT. § 397.55 (2017).
[40] 2018 TENN. PUB. CH. 855.
[41] Ken Alltucker, *Arizona's booming sober-home industry gets new oversight*, Arizona Republic, (April 14, 2018), *available at* https://www.azcentral.com/story/money/business/health/2018/04/14/law-provides-new-oversight-arizona-booming-sober-home-industry/513243002/.

living homes to be licensed by the Arizona Department of Health and Human Services. Legislation is also being considered in California that would ban patient brokering and overhaul the treatment industry by requiring more oversight by the state.[42]

The U.S. is far from seeing the end of the opioid epidemic. The number of opioid-related overdose deaths continues to grow, as does the number of people in need of treatment for opioid misuse. Those who reach out for help to find substance use disorder treatment should be able to access appropriate care without being taken advantage of or misled. Understanding the scope of advertising and marketing practices within the treatment industry is essential in establishing a baseline for good practices and informing consumers about treatment options that meet their individual needs.

III. ISSUES

The following issues may be examined at the hearing:

- Advertising and marketing practices within the substance use disorder treatment industry;
- Transparency and disclosures within advertising and marketing in the substance use disorder treatment industry;
- Efforts made within the industry to promote ethical advertising and marketing practices; and
- How individuals seeking treatment can identify quality treatment that will meet their needs.

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Brittany Havens, Brighton Haslett, or Andrea Noble of the Committee staff at (202) 225-2927.

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[42] Teri Sforza and Tony Saavedra, *Legislators taking aim at scams in the drug rehab industry*, ORANGE COUNTY REGISTER, (April 24, 2018), *available at* https://www.ocregister.com/2018/04/24/legislators-taking-aim-at-scams-in-the-drug-rehab-industry/.

Name	Tld	ExpirationDate	Status	Privacy	Locked
admissionscoaching.com	.com	11/18/2018	Active	Public	Locked
allurespraytanning.com	.com	03/19/2019	Active	Public	Locked
ALLURETANNING.COM	.com	03/03/2020	Active	Public	Locked
apponlinetreatment.com	.com	03/02/2022	Active	Public	Locked
AUTOCRICKET.COM	.com	06/19/2020	Active	Public	Locked
BDDENTERPRISES.COM	.com	07/08/2018	Active	Private	Locked
behavioralhealthattorney.com	.com	09/05/2019	Active	Private	Locked
behavioralhealthattorneys.com	.com	09/05/2019	Active	Private	Locked
behavioralhealthlawyer.com	.com	09/05/2019	Active	Private	Locked
behavioralhealthzoning.com	.com	09/05/2019	Active	Private	Locked
behavioralsightings.com	.com	01/19/2020	Active	Public	Locked
BRIANENTERPRISES.COM	.com	04/02/2019	Active	Private	Locked
BRIANSTUDIOS.NET	.net	12/15/2018	Active	Private	Locked
BUCKETBRANDS.COM	.com	04/06/2019	Active	Public	Locked
CALLCONFIRMEDLEADS.COM	.com	09/21/2019	Active	Private	Locked
CARLBRIAN.COM	.com	06/20/2019	Active	Public	Locked
CBINSURANCEGROUP.COM	.com	03/09/2019	Active	Private	Locked
diedinrehab.com	.com	09/05/2019	Active	Private	Locked
diedintreatment.com	.com	09/05/2019	Active	Private	Locked
eventleads.com	.com	06/07/2019	Active	Public	Locked
harbouratlantic.com	.com	11/10/2018	Active	Public	Locked
hopeners.com	.com	01/02/2019	Active	Public	Locked
HOWCARES.COM	.com	06/26/2019	Active	Public	Locked
JASONBRIAN.COM	.com	01/26/2020	Active	Private	Locked
jasonbrianenterprises.com	.com	01/02/2020	Active	Public	Locked
JUPITERTANNING.COM	.com	02/21/2019	Active	Public	Locked
LEADBEAVER.COM	.com	06/26/2019	Active	Private	Locked
LEADSCONPARTY.COM	.com	01/24/2019	Active	Public	Locked
makomarketinggroup.com	.com	12/04/2020	Active	Public	Locked
makomarketinggroup.info	.info	12/04/2018	Active	Public	Locked
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makomarketinggroup.org	.org	12/04/2018	Active	Public	Locked
matleads.com	.com	03/29/2019	Active	Public	Locked
measurehope.com	.com	12/26/2018	Active	Public	Locked
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newcarleads.com	.com	03/13/2019	Active	Public	Locked
onlinetreatment.com	.com	04/03/2019	Active	Public	Locked
RECOVERYBUCKET.COM	.com	04/06/2019	Active	Public	Locked
RECOVERYCALLS.COM	.com	12/06/2018	Active	Public	Locked
RECOVERYCON.COM	.com	04/03/2019	Active	Private	Locked
RECOVERYCON.ORG	.org	04/03/2019	Active	Private	Locked
RECOVERYISCALLING.COM	.com	08/03/2018	Active	Private	Locked
RECOVERYRINGS.COM	.com	08/03/2018	Active	Private	Locked
RECOVERYSCALLING.COM	.com	08/03/2018	Active	Private	Locked
RECOVERYTRANSFERS.COM	.com	12/06/2018	Active	Public	Locked
redwoodexecutivesuites.com	.com	01/09/2019	Active	Private	Locked

REDWOODRECOVERY.COM	.com	11/11/2019	Active	Public	Locked
REDWOODRECOVERYSOLUTIONS.COM	.com	11/12/2019	Active	Public	Locked
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rehabcenterlaw.com	.com	09/05/2019	Active	Private	Locked
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rehabdeath.com	.com	09/05/2019	Active	Private	Locked
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rehablawsuit.com	.com	09/05/2019	Active	Private	Locked
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rehablawyer.com	.com	11/21/2019	Active	Public	Locked
REHABTRANSFERS.COM	.com	12/06/2018	Active	Public	Locked
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researchrehabs.com	.com	08/23/2018	Active	Public	Locked
salesopener.com	.com	11/30/2018	Active	Public	Locked
SEARCHENGINEBUCKET.COM	.com	04/06/2019	Active	Public	Locked
SEARCHENGINEPOOL.COM	.com	04/06/2019	Active	Public	Locked
suearehab.com	.com	09/05/2019	Active	Private	Locked
sueatreatmentcenter.com	.com	09/05/2019	Active	Private	Locked
theinsurancevillage.com	.com	08/14/2018	Active	Public	Locked
TREAMENTCALLS.COM	.com	12/06/2018	Active	Public	Locked
TREAMENTLEADS.COM	.com	12/06/2018	Active	Public	Locked
TREAMENTTRANSFERS.COM	.com	12/06/2018	Active	Public	Locked
treatmentattorney.com	.com	09/05/2019	Active	Private	Locked
treatmentattorneys.com	.com	09/05/2019	Active	Private	Locked
TREATMENTBUCKET.COM	.com	04/06/2019	Active	Public	Locked
TREATMENTCALL.COM	.com	01/15/2019	Active	Public	Locked
TREATMENTCALLS.COM	.com	01/15/2019	Active	Public	Locked
treatmentcenterattorney.com	.com	09/05/2019	Active	Private	Locked
treatmentcenterattorneys.com	.com	09/05/2019	Active	Private	Locked
treatmentcenterdeath.com	.com	09/05/2019	Active	Private	Locked
treatmentcenterdeaths.com	.com	09/05/2019	Active	Private	Locked
treatmentcenterlawsuit.com	.com	09/05/2019	Active	Private	Locked
treatmentcenterlawsuits.com	.com	09/05/2019	Active	Private	Locked
treatmentcenterlawyer.com	.com	09/05/2019	Active	Private	Locked
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treatmentcenterzoning.com	.com	09/05/2019	Active	Private	Locked
treatmentdeath.com	.com	09/05/2019	Active	Private	Locked
treatmenthelpline.org	.org	05/22/2019	Active	Public	Locked
treatmentlawsuit.com	.com	09/05/2019	Active	Private	Locked
treatmentlawsuits.com	.com	09/05/2019	Active	Private	Locked
treatmentlawyer.com	.com	09/05/2019	Active	Private	Locked
treatmentlawyers.com	.com	09/05/2019	Active	Private	Locked
TREATMENTTRANSFERS.COM	.com	08/07/2018	Active	Public	Locked

yogiweekend.com	.com	03/27/2019	Active	Public	Locked

UNITED STATES OF AMERICA
Federal Trade Commission

Office of Commissioner
Rohit Chopra

July 24, 2018

The Honorable Gregory Walden
Chairman
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Gregg Harper
Chairman
House Energy and Commerce Subcommittee
on Oversight and Investigations
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
House Energy and Commerce Subcommittee
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U.S. House of Representatives
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Chairman Walden, Ranking Member Pallone, Chairman Harper, and Ranking Member DeGette:

Nearly every eight minutes, an American dies of a drug overdose.[1] Across the country, opioid addiction is tearing apart the lives of individuals, their families, and their communities. There has been significant attention on pharmaceutical firms that withheld information about the misuse of addictive pain medication for years in the pursuit of profit.[2]

Today, a new crop of unscrupulous actors is targeting addiction sufferers not to help them, but to gouge them, their families, and their insurance companies. There are indications that there may be widespread abuse in the drug treatment industry. This is deeply harmful to honest treatment facilities and patients alike. I am concerned that Wall Street investors also see big profit potential and may be exacerbating the challenges our country faces.

In my experience, the government's response to the abusive practices that follow painful events, such as the foreclosure crisis and natural disasters, is too slow. Giving the scale of the opioid crisis, it is especially critical that law enforcement agencies and policymakers crack down on deceptive lead generation practices in the treatment marketplace.

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[1] *See* Christopher Ingraham, *CDC releases grim new opioid overdose figures: 'We're talking about more than an exponential increase'*, Washington Post, Dec. 21, 2017, *available at* https://www.washingtonpost.com/news/wonk/wp/2017/12/21/cdc-releases-grim-new-opioid-overdose-figures-were-talking-about-more-than-an-exponential-increase/.

[2] The views expressed in this statement are my own and do not necessarily reflect those of the Federal Trade Commission or any other Commissioner.

Golden Age for For-Profit Treatment Centers

When the foreclosure crisis devastated neighborhoods across the country, there were many actors who saw big opportunities for profit. When it comes to the devastation wrought by the opioid crisis, it is déjà vu. The opioid epidemic has led to a boom in the for-profit substance use treatment industry. Billions of dollars of capital have been flowing into the sector from Wall Street, primarily from private equity investors. Many nonprofit treatment centers report that investors are seeking to buy them in order to convert them to a for-profit model. A decade ago, 60% of treatment centers were nonprofit; today, 60% are for-profit.[3]

Private equity funds differ from funds that hold publicly traded stocks and bonds. Typically, private equity funds will purchase businesses and make certain strategic or operational changes. The hope is that these changes will lead to increased profitability, enabling the private equity fund to sell these businesses for a large increase in value.

A private equity fund will usually want to enter and exit the investment over a relatively short time horizon, often between five and ten years. When an investor is highly motivated to drive up operating margins in a short time period for an eventual sale, it can lead to predatory practices that put families and honest competitors at risk.

While private equity and other investments into the industry can support capacity expansion and facility upgrades, I am concerned that investors' financial incentives may create the conditions for unfair or deceptive practices to flourish. Bad actors employ these practices to lure in patients and soak their insurers with excessive bills, rather than setting them on the road to recovery.

Driving Up Margins

As a nation, we would hope that for-profit treatment centers would be rewarded for achieving solid outcomes for patients. However, the most lucrative strategies for these treatment centers may be at odds with helping a patient struggling with addiction.

For example, treatment facilities may heavily engage in frequent testing. This frequent testing, especially urinalysis, can be highly profitable. Lab and testing companies are now charging billions of dollars to insurers for urine tests, but these test orders may not be solely driven by medical necessity. Many of these companies have financial ties to doctors and treatment centers.

There have also been reports of bait-and-switch bill shock, where a patient is lured to a facility that is in-network within their insurance plan, but is later treated in that facility by an out-of-network physician, leading to far higher costs for the patient and their insurer. In addition to causing financial devastation, there is a real risk that this practice could lead patients to forgo needed treatment.

Patients seeking substance use treatment may find that private insurance actually makes them more vulnerable. Importantly, for treatment centers looking to drive up billing, patients with private insurance are the most enticing, since private insurers will typically pay rates that are higher than Medicare, Medicaid, and Tricare. Rather than seeking to serve any patient in need, unscrupulous treatment centers might specifically target these privately insured patients through lead generation.

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[3] *See* Jeanne Whalen and Laura Cooper, *Private-Equity Pours Cash Into Opioid-Treatment Sector*, Wall Street Journal, Sept. 2, 2017, *available at* https://www.wsj.com/articles/opioid-crisis-opens-opportunities-for-private-equity-firms-1504353601.

Lead Generators and Body Brokers

In 2016, the Federal Trade Commission (FTC) published a Staff Perspective on lead generation. Lead generation is the process of identifying and cultivating consumers who may be likely to purchase a particular product or service. The FTC Staff Perspective highlighted the possible pitfalls with potentially deceptive lead generation practices.[4]

In the treatment industry, lead generators may seek to collect sensitive information about a potential patient, including information about their drug use and insurance coverage. Lead generators can then sell – or even auction off – this information for hundreds of dollars.

Lead generators usually operate online, purchasing ads on Google and other search engines to attract potential leads. These leads are so lucrative that companies have reportedly been willing to pay hundreds of dollars per click.[5] In testimony last year, a nonprofit treatment center described how a lead generator hijacked its Google Local listing.[6] By masquerading as a legitimate treatment center and rerouting phone calls to its call center, the lead generator was able to intercept inbound inquiries from patients looking for help.

Similarly, the quest to rapidly drive up profits may also lead to a practice known as body brokering. Here, treatment centers might provide financial incentives to intermediaries who find patients in "sober homes" or other locations where the patients are seeking to recover, but may not be receiving medical treatment that is covered by health insurance. These body brokers can then earn kickbacks by steering these patients to treatment centers that will soak their insurers.

These practices raise serious questions about the adequacy of oversight in this market.

FTC Efforts

The Federal Trade Commission enforces laws that prevent unfair or deceptive business practices. The agency has brought two enforcement actions against marketers of bogus withdrawal and addiction treatment products.[7] Earlier this year, the agency partnered with the Food and Drug Administration to send warning letters to marketers selling products that claimed to help with opioid addiction. The FTC's jurisdiction includes for-profit treatment centers and lead generators, and unfair or deceptive practices by these entities may violate Section 5 of the FTC Act.[8]

Federal, state, and local law enforcement agencies are all working to confront the many challenges created by the opioid crisis. But, it is clear that we all must do more.

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[4] FTC Workshop, *Follow the Lead: An FTC Workshop on Lead Generation* (Sept. 2016), *available at* https://www.ftc.gov/system/files/documents/reports/staff-perspective-follow-lead/staff_perspective_follow_the_lead_workshop.pdf.

[5] Cat Ferguson, *Google is cracking down on sketchy rehab ads*, The Verge, Sept. 14, 2017, *available at* https://www.theverge.com/2017/9/14/16309752/google-rehabs-near-me-search-adwords-crackdown.

[6] US House Committee on Energy and Commerce, Hearing on Examining Concerns of Patient Brokering and Addiction Treatment Fraud, Dec. 12, 2017, (Testimony of Douglas Tieman, President & CEO of Caron Treatment Centers), *available at* https://docs.house.gov/meetings/IF/IF02/20171212/106716/HHRG-115-IF02-Wstate-TiemanD-20171212.pdf.

[7] *See* Compl., *FTC v. Catlin Enterprises, Inc.*, No. 1:17-cv-403 (W.D. Tex. filed May 3, 2017), *available at* https://www.ftc.gov/system/files/documents/cases/withdrawal_ease_-_complaint_w_exhibit.pdf; Amended Compl., *FTC v. Sunrise Nutraceuticals, LLC.*, Civil Action No. 9:15-cv-81567-DMM (S.D. Fla. filed Jan. 8, 2016), *available at* https://www.ftc.gov/system/files/documents/cases/160108sunrisecmpt.pdf.

[8] *See* 15 U.S.C. § 45(a)(1).

As Congress continues its work to investigate advertising and marketing practices in this industry, it must carefully look at how the billions of dollars of new investment in the sector may be spawning scams that harvest profits from patients and their families.

Congress should closely examine incentive compensation practices for employees and operators of treatment centers, as well as financial conflicts of interest with other firms. Importantly, we must work to crack down on illegal lead generation practices, both online and offline, for-profit and nonprofit.

Too many firms are looking to profit off the pain of families dealing with addiction. In the absence of vigorous enforcement and sensible safeguards, the opioid crisis will inflict even more financial, physical, and emotional damage throughout our country.

Respectfully submitted,

Rohit Chopra

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