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RPTR PETERS

EDTR ZAMORA

EXAMINING CONCERNS OF PATIENT BROKERING

AND ADDICTION TREATMENT FRAUD

TUESDAY, DECEMBER 12, 2017

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

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

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

Also Present: Representative Bilirakis.

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

Mr. Harper. The subcommittee will come to order.

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

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

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

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

evidence-based treatment option that meets the needs of the individual, but instead to simply fill beds with heads.

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

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

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

These practices are immoral but are even more monstrous because they prey on

people that are already in a very vulnerable state. These individuals with substance use disorders get caught in a scheme that incentivizes relapse and profit rather than treatment and, ultimately, recovery.

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

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

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

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

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

[The prepared statement of Mr. Harper follows:]

******** COMMITTEE INSERT ********

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

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

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

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

But, Mr. Chairman, as you said, some of these patient brokers and some sober

homeowners and treatment providers are fraudulently exploiting coverage of addiction treatment services in order to defraud insurers. I'd really like to know, and I'm hoping our panel can help us today, just exactly what the extent of this problem is or how widespread it is. I've seen the media accounts, like you have, and I was just as appalled as you were. But we really need to understand the scope of the problem so that we can determine what laws, rules, and regulations we need to look at to effectively deal with the issue.

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

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

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

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

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

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

[The prepared statement of Ms. DeGette follows:]

******** COMMITTEE INSERT *******

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

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

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

I'd like to thank the State Attorney for the 15th Judicial Circuit, Dave Aronberg, and the chief assistant, Alan Johnson, for their work and welcome them here to the committee. They are the ones that have been at the forefront of protecting families and taking on this issue in the State of Florida, including leading to the adoption by the State legislature of our patient brokering act. Thank you for being here today, and thank you for your public service.

Mr. Harper. The gentlelady yields back.

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

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

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

This hearing is important. We're here to examine the possibility, the likelihood

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

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

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

was done with the best of intentions, but now it's adding to the problems.

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

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

[The prepared statement of Mr. Burgess follows:]

******** COMMITTEE INSERT ********

Mr. Harper. The gentleman yields back.

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

Without objection, will be entered into the record.

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

Without objection, so ordered.

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

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

Mr. Costello. Thank you, Mr. Chairman.

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

I look forward to hearing Mr. Tieman testify this morning about standards for quality treatment, ways to improve our healthcare system to better treat the millions of

Americans struggling with substance abuse disorder, and obstacles that Caron and other organizations face as bad actors, as Ms. DeGette has suggested or raised, as bad actors seek to take advantage of vulnerable individuals seeking help.

Thank you, and I yield back.

Mr. Harper. The gentleman yields back.

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

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

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

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

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

I will swear you in.

[Witnesses sworn.]

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

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

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

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

TESTIMONY OF DOUGLAS TIEMAN

Mr. Tieman. Representative Costello, thank you for the kind introduction and your service to the --

Mr. Harper. Is the mike on?

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

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

As Representative Costello mentioned, I am the CEO of Caron Treatment Centers. We are a nonprofit addiction and behavioral healthcare provider based in Pennsylvania and Florida, with more than 60 years of experience in treating substance use disorder. We are one of the oldest and largest nonprofit addiction treatment centers in our

country. And over the past six decades, we have helped more than 100,000 individuals begin a life of recovery.

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

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

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

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

send you on an appropriate clinical path.

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

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

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

Three, we need to educate consumers so that they know where and how to get help. We need to work with government, particularly SAMHSA, so that there is an effective way to identify an appropriate treatment center. Caron Treatment Centers,

along with Hazelden Betty Ford centers, has actually established such a mechanism. We also have a bill of rights, which you'll see up on the screen, that we think everyone needs to be aware of so that they can know how to get help and what they can expect when they're in treatment.

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

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

[The prepared statement of Mr. Tieman follows:]

******** INSERT 1-1 ********

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

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

TESTIMONY OF PETE NIELSEN

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

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

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

Mr. Harper. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

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

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

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

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

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

Those struggling with addiction are often in need of a stable environment.

Cooperative housing offers a bridge to independent living, which is a critical piece of the puzzle. Sober living environments, or SLEs, is a term used to describe a specific type of housing. Sober living is not, nor has it ever been, intended to be the same as residential inpatient treatment. It is its own entity with its own set of standards and goals.

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

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

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

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

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

[The prepared statement of Mr. Nielsen follows:]

******** INSERT 1-2 ********

Mr. Harper. Thank you very much.

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

TESTIMONY OF DAVE ARONBERG

Mr. Aronberg. Thank you.

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

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

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

Outpatient care is -- those acronyms just mean 4 to 6 weeks, paid by insurance, of group counseling and urinalysis. And then to live in a sober home while they're doing

that. The sober home, as said previously, there's no treatment there. It's just a group living place, 6, 8, 10 people living together in a drug-free, supportive environment. And then, hopefully, after the insurance runs out, that individual is now sober and can go home. That's in theory.

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

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

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

What's also important to note, is that when it goes -- when it comes to the sober

home area, the Americans With Disabilities Act and the Fair Housing Act together prevent the regulation or inspection of these residences. And so many are little more than flophouses where drug abuse, human trafficking, and other crimes are prevalent.

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

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

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

Second, address the abuses in the sober home industry by clarifying the ADA and

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

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

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

[The prepared statement of Mr. Aronberg follows:]

******** INSERT 1-3 ********

Mr. Harper. Thank you for your testimony.

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

TESTIMONY OF ALAN JOHNSON

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

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

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

Currently, under the Federal Anti-Kickback Statute, which is known as AKS, Federal agents and prosecutors only have jurisdiction to pursue kickbacks related to federally assisted insurance programs, such as Medicare and Medicaid. Patient brokering abuses, regardless of whether the insurance is public or private, hurts patients and increases the

cost of healthcare to everyone. In other words, the same public purpose behind the Anti-Kickback Statute applies equally to both federally funded and private treatment. The private industrywide fraud has been estimated in the billions of dollars. I know you know that. The human cost of substandard care motivated by greed is incalculable.

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

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

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

The bona fide employee exception needs to be clarified in two ways. First, an employee should not be permitted to receive bonuses and commissions on the basis of the value of the services or the volume of the customers they refer. The delivery of healthcare is not the same as selling automobiles or computers.

This can be achieved by applying the safe harbor rules in the Federal statute

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

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

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

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

Lastly, and perhaps most importantly, the rules regulating the application of the ADA and FHA, as they pertain to sober homes, need to be clarified to allow standards to be required for the protection of the residents. There are standards out there. Oxford

House is recognized by Congress, and as well as the National Alliance of Recovery Residences.

Running out of time, so thank you very much.

[The prepared statement of Mr. Johnson follows:]

******** INSERT 1-4 ********

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

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

TESTIMONY OF ERIC M. GOLD

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

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

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

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

Earlier this year, the office began hearing devastating stories from young men and women from Massachusetts who were lured out of State by paid recruiters who promised

them free travel to addiction treatment centers in a warm-weather State.

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

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

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

Second, patients need transparency into the quality of addiction treatment providers nationwide. If patients are going to travel out of state for treatment, they need a reliable way to identify the high-quality providers. Right now, families rely on a patchwork of incomplete State directories, providers' own websites, and personal reviews online. Because so many patients are receiving treatment outside of their home State,

there is an opportunity for the Federal Government to play a role in getting patients and their families the information they need about treatment providers.

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

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

[The prepared statement of Mr. Gold follows:]

******** INSERT 1A-1 ********

Mr. Harper. Thank you, Mr. Gold.

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

Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

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

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

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

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

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

And that would be helpful, incredibly helpful, to be able to have a registry. How do you do it? That's hard, because how do you pick and choose? But, clearly, accreditation is not the answer. Because there are -- a Joint Commission and CARF, they

can accredit. And I can tell you that there are some really bad places that we have arrested that were accredited facilities.

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

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

And one of the things that we ask is that this committee explore a way to make the States more comfortable with being able to require certification of sober homes for that very reason, to protect the residents within. Right now, the State -- I can tell you right now the State of Florida will not mandatorily require certification of sober homes in the Florida Association of Recovery Residences because they are afraid of violating the ADA and the FHA. Thank you.

Mr. Harper. Thank you for that.

Mr. Aronberg, add to that?

Mr. Aronberg. Yes. Thank you, Mr. Chairman. It's an excellent question. As Al said, we have a Sober Home Task Force hotline, and we get a lot of tips on rogue operators. But we'll also get calls from families from around the country wanting to

know if their child's sober home or drug treatment center is legitimate. And in one case, we had to tell a mother to come down and get your daughter out of this facility right now. And when she tried, the daughter said, no, why would I want to leave? I have everything I need right here. She had free rent, transportation, friends. Why would she want to leave? And so there needs to be a way to separate the good from the bad.

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

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

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

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

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

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

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

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

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

Mr. Aronberg. Right. Okay. Yes, ma'am.

Ms. DeGette. Thank you. Sorry.

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

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

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

Ms. Degette. Right.

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

Ms. DeGette. Right. There's no regulations. Yeah.

Mr. Aronberg. Right. The only way that -- I'm sorry.

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

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

Ms. Degette. Right.

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

Ms. Degette. Right.

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

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

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

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

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

Ms. DeGette. Sure.

Mr. Johnson. -- the other investigations.

Ms. Degette. I understand. So --

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

Ms. DeGette. Forty-one arrests. Okay. And who are the arrests of?

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

Ms. Degette. Okay.

Mr. Aronberg. We even --

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

Mr. Johnson. If you look at it as a hub and the spokes of a wheel --

Ms. DeGette. Yeah, yeah.

Mr. Johnson. -- the hub is the facility that provides treatment --

Ms. DeGette. Yeah. I understand.

Mr. Johnson. -- the spokes are going to be the sober homes.

Ms. Degette. So how -- right. So how many hubs are there?

Mr. Johnson. The majority are sober homes.

Ms. DeGette. How many?

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

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

Mr. Aronberg. Twelve.

Ms. Degette. Twelve.

Mr. Aronberg. Twelve. In addition to that --

Ms. Degette. Now -- okay.

Mr. Aronberg. -- there have been many others who have packed up and left --

Ms. Degette. Okay. Yes.

Mr. Aronberg. -- because of our --

Ms. DeGette. Yes. Thank you.

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

Mr. Nielsen. We do not.

Ms. DeGette. Okay. Is anybody trying to do any factfinding to figure that out?

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

Ms. DeGette. Right.

Mr. Nielsen. -- a lot of them look like they're good actors, but really they're rotten to the core. So it's peeling away the layers --

Ms. Degette. Yeah.

Mr. Nielsen. -- to get to them.

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

I want to ask you, Mr. Aronberg, one thing I talked about in my opening was this ridiculous billing of laboratories for unnecessary urine tests. And I'm just wondering -- maybe some of the rest of you can talk about this too -- why would

insurance companies pay for these tests? I mean, any of us who've tried to get a prescription for anything know they'll give you like five pills and say you're good. Why would insurance companies pay thousands of dollars for daily urine tests which aren't medically necessary?

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

Ms. DeGette. Mr. Johnson?

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

Ms. DeGette. Yeah. I know.

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

Ms. DeGette. Uh-huh.

Mr. Johnson. The insurance companies are battling with providers over what is and is not --

Ms. Degette. Medically necessary.

Mr. Johnson. -- medically necessary, and that includes urine testing.

Ms. DeGette. Okay. I have one last question for you. And, you know, I apologize for romping through these questions. We really do only have 5 minutes.

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

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

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

Ms. Degette. Okay.

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

Ms. DeGette. Thank you. Thank you, Mr. Chairman.

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

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

So here's a problem I've got. Between Mr. Johnson and Mr. Gold, both of you have touched on the issue. You've identified two sides of the argument. And it's one

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

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

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

Mr. Gold. Sure. Thank you, Congressman. I obviously don't know the specifics in your district. From where we are in Massachusetts, we have a tremendous

supply -- or tremendous demand for treatment services, a large number and a limited supply. So from our perspective, if we can cut off the money that's flowing to these commissions, to the brokers that are trying to lure folks out of State, we think that would help in Massachusetts. People would still get access to the treatment that they need, and if they need to go out of State, can do so.

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

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

Mr. Griffith. Right.

Mr. Gold. Because people who are already in this -- you know, all the treatment centers in Massachusetts are pretty much full. And so my understanding is they're not out there on the ground doing that. But what I don't -- what I am concerned about is because there's -- you know, some people do legitimately need to travel out of State to get treatment, and I want to make sure insurance is still going to be able to cover that and people can go out of State if needed. But they're going to the treatment that they want,

not just that the recruiter/broker is getting paid a commission to send them to that treatment.

RPTR FORADORI

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[11:15 a.m.]

Mr. Griffith. Right.

Mr. Johnson.

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

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

Mr. Griffith. So they just have to a rearrange their business model.

Mr. Johnson. Fair market value.

Mr. Griffith. Okay.

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

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

Mr. Tieman. That's a good question. Thank you so much, Vice-Chairman. The

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

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

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

Mr. Harper. The gentleman yields back.

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

Ms. Castor. Thank you, Mr. Chairman.

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

and the Fair Housing Act.

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

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

Mr. Aronberg. Thank you, Congresswoman Castor. I realize also the challenge of opening up the ADA for amendment, so that's why we're -- we're suggesting clarification. This was requested for some time to HUD and DOJ because the Fair Housing Act and the ADA, they're the ones who had issued the clarification, and they did last year, but the clarification they issued was not helpful. It was a joint statement, and it seemed to ignore the realities on the ground. They were talking about senior housing and all these other issues, but they did not give any good guidance.

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

And so we're left now where local governments are starting to require these things, but they're doing so out on their own, waiting to get sued. The City of Boca

Raton tried to zone sober homes into an industrial area a few years ago. They got sued and they paid out and lost, and they had to pay out $3 million.

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

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

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

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

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

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

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

I had one guy say to me, we want to treat people so well that when they relapse, and we surely expect they will, that they want to come back, which is that whole idea of almost having an annuity when someone comes to treatment. So we've adopted the practice and, in fact, are slow in his recovery for life. We tell -- but we want you to get well. We'd love you to come back for an alumni reunion. We'd love you to come back as a sponsor. We'd love for you to come back and share your story, but we really don't want you to come back as a patient. And you're absolutely right.

And I think Mr. Aronberg mentioned the whole idea of incenting quality, incenting outcome. We're currently working with Independence Blue Cross trying to develop that exact model, where people who get substance use treatment costs Independence Blue

Cross less money for other kinds of healthcare. They save money in the jail system, the court system, emergency room system. That's where we need to get to, which is an outcome-based system, as opposed to just continuing to look at this as an acute episode.

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

Ms. Castor. Thank you very much.

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

Mr. Burgess. Thank you, Mr. Chairman.

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

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

And, Mr. Aronberg, in your written testimony, you talked a little bit about this, in response to the last questions, the private insurance -- address private insurance abuses by adopting the Affordable Care Act's outcome-based reimbursement model used in the Medicare program. I just need to add here that that is a process in evolution. It has not -- payment reform in Medicare actually predated the ACA by some time, and it is, again, it is still a work in progress. It is far from settled.

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

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

But in talking to the executives, they have said they were concerned about being sued. And then there was another issue, which I'm not an expert on, but, apparently, the 80/20 rule within the Affordable Care Act exists. And so, I guess, for some insurance companies, if you pay out more on the 80 percent, you can keep more, the 20 percent, the pie is expanded. So the 80/20 rule may have created incentives to pay out as much as possible. You just get reimbursed by the taxpayers, and now you get to keep that extra -- that 20 percent which you get to keep for profits is now expanded. So it's something to pursue, but we are seeing a correction.

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

Mr. Aronberg. Correct.

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

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

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

Mr. Aronberg. Congressman, we've seen physicians just leave pads for prescriptions for urinalyses and just walk away. I mean, the corrupted physicians who are part of this --

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

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

to that a little more, but we have gone after physicians and labs.

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

Mr. Gold. That's right.

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

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

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

Mr. Gold. No.

Mr. Burgess. And how many deaths in your State, in Massachusetts?

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

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

Thank you, Mr. Chairman. I yield back.

Mr. Harper. The gentleman yields back.

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

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

Mr. Harper. Thank you, sir.

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

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

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

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

driving the bus for profits.

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

Mr. Tonko. Thank you.

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

Mr. Tieman. Thank you so much for that question, Congressman. We were so concerned about that 2 years ago that, along with a Hazelden Betty Ford center, we actually authored a paper on how to select a treatment center. It's something that we would really love to see a part of the SAMHSA website so that people can look at it.

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

Drexel and Temple.

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

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

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

Mr. Tieman. Yeah. I think good ones to ask are, Are your medical, psychiatry, and psychology, are they on your staff or are they outside consultants? That's a great start. If they're on your staff, that is a terrific start. What is the staff to patient ratio? Are you gender separate? Are you age separate? I mean, an 18-year-old with a

48-year-old is not good treatment. Do you have a family program that's more than just an educational program? Do you do follow-up studies? Do you have outcomes?

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

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

I yield back.

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

Mr. Harper. Yes. Yes. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Tieman. Absolutely. Thank you.

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

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

Mr. Harper. Thank you.

Mr. Barton. So congratulations.

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

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

Mr. Barton. Mr. Gold.

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

Mr. Barton. Are there any other States that would have a law of -- a State law

that patient brokering is illegal? No?

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

Mr. Barton. Okay. Does any --

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

Mr. Barton. That's okay.

Mr. Aronberg. But we can get that information.

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

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

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

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

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

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

Mr. Barton. Okay.

Mr. Tieman. I'd like to just comment, we looked at like the Stark Laws and the

anti-kickback laws, and not being a lawyer, it seems like most of the things that we're seeing, at least to us, feels illegal, and kind of like if it looks like a duck and walks like a duck, it probably's a duck. But not being a lawyer, it's really a concern.

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

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

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

Mr. Barton. Public?

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

Mr. Barton. So Medicaid --

Mr. Tieman. Medicaid and Medicare is a large part of that 70 percent. I can't

remember the exact number.

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

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

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

Mr. Tieman. Again, with any chronic illness that is progressive, it's very -- there is no cure. Diseases can be put into remission. I think there are certain standards that --

Mr. Barton. I guess an outcome -- a positive outcome.

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

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

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

Mr. Harper. Thank you for clearing that up.

The gentleman yields back.

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

Mr. Ruiz. Thank you very much.

This is such an important conversation. I'm going to start big idea, then go into the granular. I think it's very important that we do get a grasp on the severity and the intensity and the frequency of these type of illnesses, because we need to prioritize how we're going to address the mental health/addiction opioid crises that we have in the United States of America. And the bigger picture here is that we are woefully short in providing the resources, in providing more providers, and in being able to improve healthcare access to mental health services. And instead of taking away health insurance or coverage for mental health services, that we will take care of our patients.

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

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

So I know that Congresswoman Chu has been working on legislation that would direct SAMHSA to publish best practices for operating recovering housing. And I know

that you've said that you want a certification. Perhaps SAMHSA could develop these kind of best practices, and those that can meet them can get this kind of certification for consumer marketing purposes.

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

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

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

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

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

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

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

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

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

Mr. Ruiz. Yeah. I mean, most of these drug urine tests, they're very complicated and they take awhile to get the results to begin with. So having daily

checks is medically even unnecessary.

Thank you very much.

Mr. Harper. The gentleman yields back.

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

Mrs. Walters. Thank you, Mr. Chairman.

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

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

Mr. Harper. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

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

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

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

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

Mr. Harper. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

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

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

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

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

Mr. Nielsen. That's a great question, Congresswoman Walters, and I ask myself the same question as well. It should be. They should license or certify outpatient

facilities; they do not. And I think it's just something that's been passed through time, that originally it was voluntary to have an outpatient facility. And we don't even have a licensure for drug and alcohol counselors to do private practice. So, actually, anybody can hang up a shingle and do private practice in California.

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

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

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

Mrs. Walters. Okay. Interesting.

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

Mr. Nielsen. I think they should be certified. And I think that Riverside County

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

Mrs. Walters. Okay. Thank you. And I'm out of time.

Mr. Nielsen. Thank you.

Mrs. Walters. Thank you very much.

Mr. Harper. The gentlelady yields back.

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

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

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

how Caron was -- the name of Caron was manipulated there.

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

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

Now, here's the catch. All of the phone numbers are going to go to the place, even if you call -- what you think is calling Hazelden Betty Ford, calling Caron, calling another reputable place, you're going to end up at the place that owns the call center. So call centers have become synonymous with a way for a marketing firm to be able to either sell that person to the highest bidder, wherever their insurance will pay them the most money, or if it's owned by a treatment center, it puts them in one of their facilities, the telemarketer is instructing you. You know, yes, you may be wanting to go to Minnesota, but let me tell you why our place in Florida is far better this time of the year. So that tends to be the ploy.

A call center -- for example, we have a call center at Caron, but when you call --

Mr. Costello. It's identified as a call -- but it's identified as your call center.

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

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

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

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

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

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

Mr. Tieman. No.

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

So you believe that there should be -- do you believe there should be some level

of accreditation in that respect?

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

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

Mr. Tieman. Yeah.

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

Mr. Tieman. Well, I definitely think the accreditors, right now, we are working with CARF and JCAHO to try to deal with them from an ethical perspective. They basically look at the standards, but we just think there needs to be more. And so having this higher level, this gold or platinum level is something that we think would be very important.

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

well.

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

Mr. Harper. The gentleman yields back.

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

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

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

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

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

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

Mrs. Brooks. And I saw that you had 41 arrests. And I realize it might be early

in the process, just out of curiosity, any convictions yet?

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

Mrs. Brooks. That's in one county?

Mr. Aronberg. Oh, yes. Yes.

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

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

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

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

Mrs. Brooks. And was this violation a Federal -- of which statute, if you recall?

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

Mrs. Brooks. And I assume -- did that individual plead guilty or go to trial?

Mr. Johnson. He pled guilty.

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

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

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

Mr. Johnson. Yes, we are.

Mrs. Brooks. Okay.

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

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

Mr. Johnson. And they're transient, so it's very difficult -- you can have

1,500 -- in one case we had 1,500 potential witnesses, and I think we're at a 2 percent rate of being able to find them and have them cooperate.

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

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

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

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

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

Mrs. Brooks. Okay. Thank you.

Mr. Tieman. Sorry.

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

Mr. Harper. The gentlelady yields back.

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

Mr. Carter. Thank you, Mr. Chairman. And thank all of you for being here

today. This is certainly an important subject.

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

Gentlemen, as a practicing pharmacist and currently the only pharmacist serving in Congress, this is a big problem that I have worked with closely over the years. And I can assure you that it's none -- no two people are the same, you all know that, that people react differently. And some people can rehab through little therapy, some people it's going to take a lifetime of therapy, and we all understand that.

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

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

resources you need and the ability that you need to get rid of these bad actors?

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

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

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

As we mentioned earlier, clarifying the ADA to allow reasonable regulations at the local level for the sober homes. To change the fee for service model of the ACA to an outcome-based reimbursement model. And then Mr. Johnson also had some areas we're dealing with a kickback statute.

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

Mr. Carter. Right. Right.

Mr. Johnson. -- with boots on the ground.

Mr. Carter. And that's exactly what I'm looking for. What do we need to put in

code that's going to help you, that's going to give you the ability to get rid of these bad actors?

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

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

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

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

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

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

Mr. Johnson. There's no -- no, not under State law. It's voluntary only, which is a problem.

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

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

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

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

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

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

Mr. Harper. The gentleman yields back.

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

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

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

I have a couple questions. Mr. Nielsen and Mr. Tieman, is there currently an

industrywide uniform code of ethics that bans patient brokering?

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

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

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

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

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

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

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

Mr. Nielsen. I have a followup.

Mr. Bilirakis. Yeah. Go ahead, please.

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

The International Certification and Reciprocity Consortium is an organization that credentials counselors. We need something like that for executives, and even for marketers and admissions specialists.

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

Mr. Nielsen's absolutely correct that you start at the top.

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

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

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

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

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

But this is something that you're going to see a lot of the scam -- the Florida shuffle move to other communities that are not as aware of this problem and don't have effective laws on the books. And that's why we're offering ourselves as a resource for

any community that would like to see what we're doing. We've trained prosecutors and law enforcement from throughout the State, and we'd be happy to help folks from across the country so they'll will be aware and ready to stop the Florida shuffle when it comes to them.

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

Mr. Aronberg. Thank you.

Mr. Bilirakis. I yield back, Mr. Chairman.

Mr. Harper. The gentleman yields back.

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

With that, the subcommittee is adjourned.

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