

**Testimony of Mark Mishek, President and CEO, Hazelden Betty Ford Foundation
Before the House Energy & Commerce Committee
Subcommittee on Oversight and Investigations
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Summary: Chairman Harper, Ranking Member DeGette, and Members of the Committee, thank you for inviting me to participate in this important hearing. I am grateful for your leadership in addressing the nation's opioid overdose epidemic and the addiction crisis that underlies it. I appreciate the opportunity to testify today about advertising and marketing practices in the addiction treatment industry and to contribute to the subcommittee's bipartisan investigation into patient brokering.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. **Accreditation and Licensure.** The first essential characteristic of a quality addiction treatment provider is ongoing accreditation from external regulatory organizations, such as the Joint Commission (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). It is also important to maintain a state license. Surprisingly, many addiction treatment providers throughout the United States have not received accreditation, and there is no mandate in the field requiring providers to have accreditation in order to operate. Accreditation and licensure should be “minimum requirements” of any organization offering addiction treatment.

2. **Qualified Clinicians.** Well-trained and credentialed clinicians are critical to providing quality care. Quality providers employ addiction medicine physicians, doctoral-level psychologists, and licensed or certified addiction counselors who have, at a minimum, a bachelor's degree from an accredited institution with a preference for those prepared at the master's level; they also implement clinical training programs that keep clinicians up to date in their fields and continuously advance their clinical skills. In addition, they develop staff from within to both improve performance and enable continuity of quality through periods of growth and changes in the ever-evolving and complex healthcare system.
3. **Technology and Data Systems.** Quality care providers use state-of-the-art tools for conducting all aspects of business, including clinical operations. Such tools include a well-designed, integrated electronic health record that allows information to be shared across all and providers of care. Organizations should have solid Information Technology (IT) platforms, case management systems and other data systems that facilitate care and allow quick and seamless communication among staff and stakeholders. It is also important for these platforms to provide accurate and reliable data that can be used for benchmarking and quality performance assessment. Quality care providers also use technology to deliver care and ongoing support for patients.
4. **Evidence-Based Treatment.** In this environment of under-regulation, the market has seen an influx of for-profit centers that offer exclusive, spa-like environments guaranteeing success, but little in the way of evidence-based treatment or demonstrated outcomes. Clinical services should be “evidence-based,” serve as “practice-based evidence” and/or be rooted in research and aimed at establishing new innovations in practice. In addition, quality providers should have a

hard-wired process for routinely reviewing the ongoing research literature and exploring ways to incorporate new practices and methods as the evidence base for these develops.

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

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

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

8. **Full Continuum of Care.** Quality care providers offer a full continuum of care that provides a complete range of services to meet patients' unique needs, based on the acuity of their condition and their social and environmental situation. Available services should be explained and offered at the outset, prior to admission. They should span a wide range of areas, including prevention and education, intervention, treatment and post-treatment recovery support. Quality providers also provide extensive services for families, including children affected by a loved one's addiction.
9. **Education and Scholarship.** The best addiction treatment providers collaborate with academic centers and universities to help advance addiction education and scholarship through programs, fellowships, internships and professional development opportunities, as well as by conducting or participating in research for publication in peer-reviewed scientific journals.
10. **Advocacy.** Quality providers engage their stakeholders in activities to educate the public about the problems of addiction and the promise of recovery; advance helpful public policy changes and reduce the stigma associated with addiction. This can be accomplished through membership with national trade associations, hosting and sponsoring events, and conducting interviews with the media, among other strategies.
11. **A Broad Reach.** Compared to the rest of healthcare, the addiction treatment industry has been slow to serve underprivileged individuals with limited financial means. To the extent possible, services should be available to people of all socioeconomic backgrounds through insurance utilization, scholarships and patient aid programs. Quality care providers also emphasize diversity and inclusion; this includes having culturally appropriate symbols and employing staff who are diverse and bilingual.

12. **Sound and Ethical Business Practices.** As outlined earlier, marketing and billing activities should be ethical, truthful and legal. Paying organizations for patient leads is highly inappropriate, as is presenting misleading data or results. Regarding financials, a provider should also be well-capitalized to ensure stability for patients, alumni and employees. We believe all addiction treatment providers should adhere to the previously mentioned NAATP code of ethics.

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

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

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

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

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

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

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