



October 11, 2018

Hon. Gregg Harper, Chairman
Honorable Diana DeGette, Ranking Member
Congress of the United States
House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Attn: Ali Fulling

Legislative Clerk
2125 Rayburn House Office Building
Washington, DC 20515-6115
Via Email: Ali.Fulling@mail.house.gov

Re: Hearing: "Examining Advertising and Marketing Practices within the Substance Use Treatment Industry." NAATP Response to Post Hearing Committee Questions

Dear Mr. Chairman Harper and Ranking Member DeGette:

Thank you again for the opportunity to testify in this matter. The following is the reply to your letter of September 26, 2018 posing certain questions. Our answers are provided following each question. Thank you for the opportunity to provide this additional information.

Questions from The Honorable Gregg Harper

1. How has the consumer been hurt by unethical marketing and advertising practices and a lack of universal quality standards?

These two conditions stated in the question, unethical marketing practices and lack of universal quality standards have harmed and continue to harm the consumer as follows:

a. Lack of Licensing Rigor: Treatment programs are licensed state by state. Unlike other areas of healthcare, state addiction treatment licensing requirements vary significantly between states, and verification of such are not rigorous and tend to be viewed as something less than critical healthcare. This means that substandard treatment becomes licensed and then goes undetected. Consumers logically rely that treatment programs are vetted for quality and safety, fall prey to marketing pitches, and find themselves in substandard and at times dangerous care. Further, because consumers typically do not understand what good treatment should be, they may stay in the substandard care and subsequently do not get the services that are clinically necessary.

b. Lack of Accreditation: Treatment programs not only lack the above licensure rigor, they are typically not required by the state regulatory provider to be accredited. Accreditation is a process whereby a program is audited on site for adequate practices, typically by an independent accrediting entity. While accreditation does not ensure high quality, it is a measure and indicia of such. Again, consumers are more likely to be harmed by substandard care because without accreditation by a recognized and competent body, programs may operate without an establish competence threshold.

c. Lack of Operational Standards: Uniform best operational practice standards do not exist. Accreditation, where it is opted into by the operator, is part of the solution. NAATP believes that while the primary accreditors do a good job, they need to do better oversight for their credential to be truly effective. But accreditors cover only safety and quality, not operational business practice. That is why NAATP is drafting and will soon publish a document titled "Quality Assurance Guidebook for the Operation of Addiction Treatment Programs." This Guidebook will list and explain the competencies for competent and ethical business operations together with implementation tools. (Please see the attached operational guidelines outline of competencies that include marketing guidelines).

d. Lack of Advertising Marketing Regulation: Consumers of addiction treatment are in crisis and typically are unaware of what kind of service is needed. They may not understand they are looking for health care rather than some sort of spa type facility. They also frequently lack financial resources and therefore are prey to both facility and payment deception. Again, as a result, the consumer suffers from lack of proper care at a financial loss.

e. Examples of Consumer Harm. NAATP has received numerous accounts of the following types of harm caused by these conditions:

1. Consumers have died in substandard care.
2. Consumers have suffered significant physical and emotional harm in care through direct victimization by providers, and inept clinical practices.
3. Consumers in need of treatment have been discouraged from seeking it due to reports of substandard care, and fraud. This leads to the continued suffering of individuals with Substance Use Disorder (SUD), and significant spending on secondary criminal and healthcare cost associated with SUD.
4. Consumers who receive substandard care are discharged without having been helped and without a long-term recovery plan (continuing aftercare such as medication, counseling, and 12 step assistance), relapse, and do not recover. Untreated addiction gets worse not better and is frequently fatal.
5. Consumers and their families suffer significant financial losses ranging from a few thousand dollars to hundreds of thousands of dollars. While good treatment may properly be costly and extend for several months through the continuum of care, consumers are lulled into paying unconscionable amounts.
6. Significant financial losses are also incurred by insurance companies under insurance billing fraud schemes that harm the industry at large by making the insurance company skittish to pay any addiction treatment bills.

2. Your testimony notes that the association recently approved a new membership requirement which will require members to obtain accreditation as an addiction treatment provider. Why did the association feel this was a necessary requirement for its members?

Accreditation is a necessary, recognized, and accepted practice in health care. Because addiction has long existed outside the mainstream of healthcare, not recognizing the brain disease that it is, it has been allowed to operate without a requirement or culture of accreditation. NAATP believes that addiction has now come of age as a recognized medical disorder and must be held accountable as such in order to establish competent delivery of service. While most NAATP members are accredited of their own volition, this is not true of the field at large. NAATP believes that it is our duty to promote best practice and, therefore, we must hold our members to this standard and lead the field at large by example.

a. How many of your members would you say are accredited today?

758 facilities representing 92% of our membership.

b. How many of your members will need to gain accreditation in order to maintain their membership?

68 facilities representing 8% of our membership.

3. In addition to touting potentially misleading success rates, another concern the Committee has heard is that some facilities or websites will post on their website or share with their potential client's which organizations they are accredited by, such as the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. However, the concern is that while the company often puts the accrediting organization's logo on their website — inferring that all of their facilities are accredited — sometimes only one

facility, parts of the program, or certain services are accredited. How common is this and what concerns does the association have for this kind of misrepresentation?

NAATP shares this serious concern. It is emblematic of the larger picture of consumer deception based on consumer unawareness of what addiction treatment truly is: healthcare. It is prevalent. Good ethical centers simply do not do this. CARF and The Joint Commission prohibit the misuse of their credential in this way but NAATP believes they need to do much more to combat the problem and enforce the rule. They are ideally situated to do so. As the question acknowledges, the abuse occurs both by misrepresenting accreditation of facility and programs within organization. This can also be a component of a misrepresentation whereby consumers believe they are entering residential care when they may be getting sober living and being transported to an Outpatient Program that may or may not be accredited.

a. Does the association have recommendations for how companies or treatment facilities can be more transparent about which parts of their treatment are accredited?

First, we believe it is the responsibility of the accrediting bodies to enforce their requirements against such misuse of their credential. They are ideally situated to do so. They control the credential of the particular provider and can make this a regular component of their quality control. NAATP stands ready to assist in any way we can and has implemented protocol to communicate with the two primary accrediting organizations about concerns at accredited facilities, or when misrepresentation is believed to occur.

As for program transparency, this very issue is covered by the upcoming NAATP Guidebook and existing NAATP Code of Ethics. Under these provisions, there can simply be no representation nor implication that a non-accredited component is accredited.

4. What policy reforms do you think would be helpful to ensure honest marketing and advertising practices and quality care in the substance use disorder treatment industry?

Policy reforms, whether by statute or regulation, addressing the following issues, will significantly reduce the risk of consumer harm while also improving the practice of addiction treatment:

1. Prohibition of patient brokering
2. Prohibition of buying or selling leads
3. Requirement of staff training and credentialing
4. More stringent and enforced operational licensing
5. Requirement of provider accreditation
6. Requirement of outcome tracking
7. Prohibition of patient inducement
8. Prohibition of waiving insurance deductibles in alignment with current CMS rules
9. Requirement of sober home fee collection of rent for non-clinical services
10. Prohibition of internet deception
11. Prohibition of client marketing exploitation

5. Given that the association's updated code of ethics specifically addresses patient brokering and financial rewards, gifts, or other remuneration — are kickbacks, disguised as a “bed reservation fee” in this case—common within the industry?

Various forms of kickbacks and patient brokering remain commonplace within the field. NAATP's membership has embraced the full prohibition of these practices. However, in the larger field the practice continues in varied forms. From paid referrals, marketing and interventionist contracts, to sending fake patients into treatment centers to recruit patients already in treatment to admit into a different facility. NAATP is pleased by the inclusion of a ban on patient brokering and remuneration in recently passed HR 6, and applauds the use of broad language which will also apply to unlicensed individuals and businesses that had been engaged in patient brokering.

a. What other deceptive practices have you seen across the industry? Why are they concerning to you?

I believe we have covered all the areas of concern in this letter and previous testimony and documentation.

6. Is there anything else that you'd like to add, clarify, or correct for the record?

Yes. Mr. Cartwright of American Addiction Centers (AAC) testified that 300 NAATP members advertise with AAC on its website(s) representing a significant percentage of AAC income. I questioned this statement during the hearing and asked Mr. Cartwright to provide a list of said advertisers to NAATP. The Subcommittee asked for the same. Following the hearing, having not received the information in 15 days following the hearing, NAATP requested this information through our legal counsel. Information was then provided to NAATP legal counsel as a list of 295 facilities represented to be the alleged advertisers. NAATP investigated this information and determined that only 21 such facilities were actually paying to advertise on the site. Such facilities are designated as "premium facilities" on the website. Further, while it is true that the remaining facilities do indeed appear on the site, it cannot be assumed that such facilities either wish to be nor consented to be listed. To the contrary, facilities that are listed and request removal, as we believe some have, are not removed, according to stated AAC policy removed. The following statement appears on the site: www.rehabs.com/faq/.

"Business Listing Policies

How can I remove my facility from your site?

Simply put, we do not remove facility listings unless the business has been closed. You may note similar policies on sites such as TripAdvisor.com or Yelp.com. Based on our mission to be a comprehensive source of addiction treatment information and our rights to use content under [Fair Use laws](#), we reserve the right to republish factual business information along with editorial content and/or user-generated, relevant reviews.

Isn't it illegal if a business requests its listing to be removed and you don't comply?

We are protected by numerous laws, statutes, and policies that support our efforts to publish public information, our reports, and users' reviews without legal concern. You can find more information and legal precedent here:"

Question from The Honorable Michael C. Burgess

1. To what extent does the National Association of Addiction Treatment Providers look into the liability history of its members when evaluating whether or not to renew their membership? For example, in 2015, then California Attorney General Kamala Harris filed a murder indictment against American Addiction Centers and its employees. Have you taken cases such as this one into account when considering membership eligibility?

Yes. NAATP did consider the above referenced murder indictment against AAC in declining to keep AAC as a NAATP member. NAATP is concerned with the entire record of a provider when considering appropriateness for membership. A criminal court or civil court record of a provider is relevant to such a determination. The NAATP Values Statement, NAATP Membership Criteria, and NAATP Code of Ethics each address the types of issues that would be involved in such court proceedings, ranging from the safety and quality findings obtained through the accrediting process to the business practices prohibited by the Code of Ethics. Allegations that patients' safety may have been jeopardized by a provider is a paramount concern of NAATP when considering membership.

Questions from The Honorable Gus Bilirakis

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2. What entity is responsible for auditing your facilities? Since opening your doors, how many times have you been audited, and is your experience unique or common in the industry?

Oversight of treatment facilities in the United States is the responsibility of each state's licensing authority. That authority is typically the state's health department or human services department. However, as has been stated previously in this document, licensing requirements are typically few and licenses are easy to obtain, unlike with other health care state licensing. Further, there is frequently little to no follow up or auditing post licensing. This dangerous condition is lessened, to some extent, by the national independent accrediting bodies, primarily CARF and The Joint Commission, but only if programs voluntarily seek to become accredited. In such cases, these accrediting bodies perform on site surveys to establish and maintain the accreditations of quality and safety. No such auditing body exists to audit the NAATP as we provide no direct addiction service but serve only as a voluntary membership society.

Thank you again for this opportunity. NAATP will be pleased to clarify this information and answer additional questions.

Sincerely,



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Attachment: NAATP Guidebook Table of Contents (Listing the Competencies of High-Quality Addiction Treatment Operation)