By Thomas A. Korf

Addiction Treatment: In Need of a New Prescription

Thomas A. Korf
ToneyKorf Partners LLC
New York

Thomas Korf is a managing director with ToneyKorf Partners LLC in New York. He has more than 25 years of experience in restructuring, including representing debtors and creditors in bankruptcy, out-of-court restructurings, mergers, acquisitions and refinancing transactions on behalf of internationally recognized corporations and lending institutions, among others.

The essential facts of the opioid crisis are well known. The prescribing of opioid drugs increased dramatically in the U.S., beginning in the early 1990s, based on assurances from the pharmaceutical companies and many members of the medical community that opioid drugs were an effective pain-management tool and, most importantly, not addictive. The exhibit makes a mockery of those claims by showing the total number of U.S. overdose deaths involving all drugs from 1999-2017. Drug overdose deaths rose from 16,849 in 1999 to 70,237 in 2017. The bars are overlaid by lines showing the number of deaths by gender from 1999 to 2017.[1]

Before Opioids

Before the opioid crisis, addiction-treatment centers were in idyllic destination resort-like locations. This treatment was a continuum of care that stretched from inpatient detoxification (also called "detox") treatment with a private nurse attendant to residential treatment involving intensive group and individual therapy, along with other holistic therapies and "concierge" services such as meditation, yoga, massages and the like. Most of this treatment was being done out-of-network at unnegotiated prices, which meant that it was lucrative for the providers but was limited to patients with the means to personally afford the cost. Treatment in this environment lasted between 30 and 60 days at costs ranging from $40,000 to $80,000, which translated into profit margins on these services of between 60 to 70 percent.

With the onset of the opioid and heroin crisis and the first groups of new addicts, the industry — accustomed to providing high-margin treatments — believed they saw an opportunity for growth, and soon there was a rush of investment and expansion of inpatient treatment centers in anticipation of the waves of patients to come. For a while, come they did, and the return on investment was double-digit, so expansions continued, providers went public, and the debt and stock of addiction-treatment providers traded at favorable multiples.

Current Headwinds in the Industry

Now, less than three years later, that landscape has completely changed, even while the fundamental drivers of that expansion continue to exist. While the number of patients grew under the crisis, the type of patients and their insurance coverage and out-of-pocket capabilities also changed. No longer was addiction limited to celebrities and the wealthy; now, the patients were middle and lower class, with little ability to pay the out-of-pocket costs not covered by their insurance provider on these out-of-network facilities. Thus came the sea change.

Out-of-Network Becomes In-Network: Medicaid Becomes Managed-Care Medicaid

The first change was a move from out-of-network to in-network treatment, which dramatically changed the pricing of certain services. Previously unnegotiated rates on each part of the continuum of care were now subject to market forces. However, before the impact of negotiated rates could even be factored in by addiction treatment providers, there was another sea change that no one saw coming, but that had been taking place out in the open.

The switch by many states from state-run Medicaid programs to managed care organizations (MCOs), which administered the Medicaid program on behalf of the state, led to an entirely new way of viewing the continuum of care. What followed was a compression of the overall continuum of care.

Under this new regime of compressed treatment, the detox portion of treatment rarely lasts more than three days, and residential treatment has been whittled down to as little as seven days. Thereafter, the patients are discharged from inpatient treatment and left to their own devices to attend the outpatient treatment therapies.

In addiction treatment, detox services cost the most per day (on average $800). The need for

1 Source: CDC WONDER. More than 70,200 Americans died from drug overdoses in 2017, including illicit drugs and prescription opioids — a two-fold increase in a decade. In 2017, the states with the highest rates of death due to drug overdose were West Virginia (57.8 per 100,000), Ohio (46.3 per 100,000), Pennsylvania (44.3 per 100,000), the District of Columbia (44.0 per 100,000) and Kentucky (37.2 per 100,000). Lawrence Scholl, Puja Seth, Mbabazi Kariisa, Nana Wilson & Grant Baldwin, "Drug and Opioid-Involved Overdose Deaths — United States, 2013-2017," *Morb Mortal Wkly. Rep.* Dec. 21, 2018. States with statistically significant increases in drug overdose death rates from 2016-17 included Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, West Virginia and Wisconsin. "Multiple Cause of Death 1999-2017 on CDC Wide-Ranging Online Data for Epidemiologic Research," CDC WONDER, CDC, National Center for Health Statistics, 2018.

detox treatment is determined by a physician based on the patient's presentment and initial observation. Two separate cases are illustrative.

The addict deep within a stretch of perpetual drug use, convinced by family and friends to go for treatment, arrives at the physician still in a state of intoxication. Another addict, taken in by the police for a domestic incident or DUI/DWI offense and who has "dried out" over the weekend in jail, is convinced to obtain treatment but arrives sober for their physician assessment. Both patients, based on their prior drug use, would have previously been admitted for detox. Under the new MCO regime, the former would qualify for the medical necessity of detox, but the latter would not and instead would be authorized for residential treatment only.

He Said, She Said

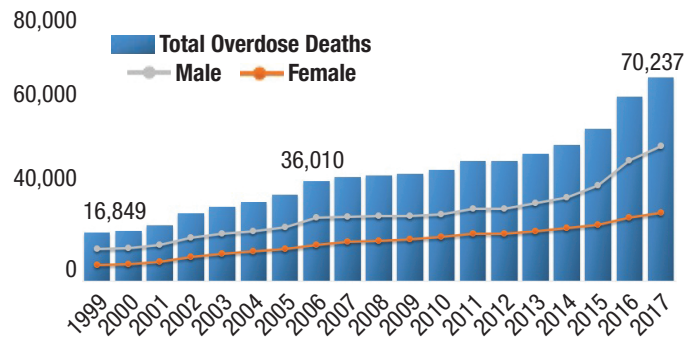
The conflict caused by the new scrutiny on medical necessity revealed itself in a growing level of denials of claims for detox services by the MCOs. While claims had been previously approved with limited documentation, denials were now being issued for everything from lack of medical necessity to failure to "pre-authorize" detox services. Many addiction treatment providers failed to notice this marked change in obtaining coverage authorizations until it was too late, and the denied claims either timed out or the necessary documentation was unavailable to dispute the denial. This created an immediate cash-flow impact and was a sign of what was to come.

The New Kid on the Block

As if enhanced scrutiny by MCOs was not enough of a change, now along comes medically assisted treatment (MAT), which combines the prescription of an alternative replacement drug for the addict's actual drug of choice (similar to the use of methadone in heroin addiction treatment), followed by outpatient therapy and an eventual weaning off the replacement drug. Outpatient treatments such as partial hospitalization programs, intensive outpatient programs and MAT have lower margins than inpatient treatments.

What is there to do with all those residential treatment facilities and licensed detox and residential beds built out during the expansion years? Well, they will be handled in the same way that all overcapacity is handled in any industry: by the natural market forces of consolidation.

National Drug Overdose Deaths (Number Among All Ages, by Gender, 1999-2017)



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Causes of Death 1999-2017, on CDC WONDER Online Database, released December 2018.

Some providers anticipated the transition from out-of-network to in-network and got ahead of the curve in increasing their covered lives. However, few providers anticipated the resulting changes of the MCOs taking over state Medicaid programs, so most have suffered equally under the new regime of pre-authorizations and compression of services.

The sea change in coverage has not been easy for the addiction services providers — the majority of which believe that their companies are in the service of a higher good, a public good really. Moreover, many of the providers are staffed by former addicts themselves who are intensely proud of and have invested in their patients' outcomes. These providers have cried foul and have argued that the MCOs are putting dollars before a patient's needs. They claim moving patients from a safe, secure and drug-free environment of inpatient treatment to leaving them to their own devices during outpatient treatment is happening too soon and leads to higher rates of recidivism. In response, many providers have developed phone-based apps that attempt to maintain contact with patients who have moved into the outpatient phase of treatment to ensure that they are attending therapy sessions, staying gainfully employed and are engaged in healthy relationships that foster sobriety.

Further complicating treatment is a high rate of co-morbidity with mental illness in patients with a substance-abuse disorder. The dual diagnosis is often not made or is not treated. Thus, recidivism in addiction treatment, according to the National Institutes of Health, is fairly high at approximately 60 percent.[2]

The Future Is Not What It Seemed

What does all this mean for lenders and investors in the addiction treatment space? It means that there will be a need for closely monitoring operational results as the industry adjusts to these new norms. The National Institute on Drug Abuse and Substance Abuse and Mental Services Administration has stated that at any given time, approximately 21 million Americans have a diagnosable illness with a substance-use disorder, but that only about 2.5 million people actually seek treatment. Further, of the approximately 700,000 people in the U.S. that died of an overdose between 1999-2017, about 400,000 of them were from opioid drug use. Thus, overcapacity of treatment centers needs to be measured on the future basis of regional locations and need. Consequently, there are several key performance indicators to monitor.

Census and Occupancy

Admissions and average daily census (ADC) drive revenues, so it is important to track them both, along with all

2 "Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)," Nat'l Inst. on Drug Abuse, *available at* drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-addiction-treatment (last visited Dec. 20, 2019).

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the levels of the continuum of care. Be sure to distinguish between authorized and billed days when calculating ADC, as it is easy to "pump" admissions and daily census with unauthorized inpatient treatments, which ultimately lead to denied claims later. There are no benchmarks for occupancy percentages, except to say that fixed carry costs and margins will drive break-even points; the important point is to be aware of what that point is.

Revenue and Length of Stay

The average length of stay and revenue per patient day will largely be a result of the compression of the continuum of care and the negotiated rates for what is, for now, mostly in-network inpatient treatment. The levels of care, in terms of intensity and generally in terms of higher to lower margins, include the following:

- Detox: conducted at an inpatient facility where patients are medically monitored 24 hours per day, seven days per week, by experienced medical professionals who work to alleviate withdrawal symptoms through medication.
- Residential Treatment: 24 hours per day, seven days per week treatment basis that includes individual and group therapy, along with other recreational activities.
- Partial Hospitalization: weekly individual and group therapy up to five days per week.
- Intensive Outpatient Services: weekly individual and group therapy up to three days per week.
- MAT: uses approved substitute medications in combination with weekly individual and/or group therapy working toward an eventual weaning off of the substitute medication.
- Other Services: many facilities have developed phone apps and other "coaching"-like services that assist with patients that have graduated beyond the more traditional treatments above.
- Sober Living: sober living arrangements provide an interim step for patients graduating to lower levels of care throughout the continuum of care treatment.

Revenue Cycle Management

Managing the revenue cycle in health care is unique and often best left to firms that specialize in this area of expertise. However, many of the addiction treatment providers are either small family-owned operations or grew during the heyday out of such operations, and thus have revenue-cycle departments that can be significantly less sophisticated and structured than the MCOs that are in the business of authorizing, auditing and approving the submitted claims — a sort of "David and Goliath" situation. Important leading indicators revolve around cash collections as a percentage of claims billed in each particular month, the level of and reasons for denials, and the times it takes from (1) discharge to "dropping" a bill, then to (2) collection of the same.

Marketing and Branding

Much of the marketing and branding in addiction services has been something of a black hole. Probably no other part of the business is changing more than this area. Previously, with margins so high, advertising campaigns that were focused solely on achieving admissions without creating brand equity were sustainable. However, this is no longer the case. As margins have fallen and the continuum of care has been compressed, the marketing budget is now being strained to yield admissions at significantly less cost. Further, falling margins and the breadth of the economic capability of patients has driven treatments toward regional and local options.

Another avenue for admissions is through referrals by local hospitals and community associations, sometimes called "local networks." Admissions generated from local networks rely on relationships with these institutions within the region and often rely on person-to-person relationships.

The cost of each admission should be calculated and monitored for each channel in terms of the marketing costs spent per admission generated. It is important to exclude alumni admissions from the admissions attributable to any channel, since these are returning patients due to recidivism.

Call Center Activities

Most providers will also have their own call centers to handle the calls that come in from business development and community representatives, as well as from those originating from internet searches. It is important that these calls are handled correctly and that all potential leads are actually fielded, as ineffective call centers can literally let admissions opportunities disappear.

Leading Indicators

The following represent leading indicators of provider distress: flat or falling admissions; flat or falling ADC census and occupancy; flat or falling cash collections; rising denials in revenue cycle management; falling average length of stay; falling per-patient-day revenue; and rising admission costs per patient.

Conclusion

The days of 30- to 60-day inpatient treatment with its corresponding higher margins appear to be over, while the lower-margin outpatient treatments will require higher volumes. As a consequence, closures of many of the destination treatment sites should be expected, and surviving providers will have to choose whether to (1) cater to the exclusive clientele that can afford the higher out-of-pocket cost of such treatment, (2) favor regional inpatient locations around higher-population urban areas or (3) spread outpatient facilities into the more rural areas. There will also likely be consolidation of those inpatient facilities and beds based on regional supply and as the accepted treatment options favor outpatient/MAT treatment. One thing that is for sure is that the addiction treatment industry is clearly in need of a new prescription. abi

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