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Substance Abuse Treatment: In vs. Out of Network

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"What is the optimal mix of in-network and out-of-network revenue?" It's a question often asked by substance abuse treatment provider management teams and investors. Marwood believes there is not a universal optimal mix, but rather the right mix will vary based on local market demand, supply, and reimbursement dynamics, as well as the provider's capabilities.

Before the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) mandated increased coverage for behavioral health issues such as substance abuse and co-occurring conditions such as depression, anxiety, and post-traumatic stress, substance abuse treatment providers emerged to serve self-pay customers. Treatment may include medically-supervised detoxification, residential care, partial hospitalization, and varying levels of outpatient care.

A main objective of detox and residential care is to remove patients from their typical environments and associated triggers for unhealthy behaviors. To facilitate this and cater to the tastes of the self-pay patient population, destination treatment facilities featuring an array of luxury amenities sprouted across areas such as Florida and southern California.

Commercial insurers' increased level of spend overall and on a per patient basis has led to their greater scrutiny and lower willingness to tolerate out of network care. Based on our discussions with commercial health payors across the U.S., the level of in-network utilization varies by state. Over 90% of substance abuse treatment in California and Florida is now in network, while 70-80% of treatment in Georgia, Washington, and Texas is in network. Marwood believes substance abuse providers in most local markets will experience significant pressure to shift in-network, threatening the revenue streams and potentially financial viability of these providers, given in-network rates may be 1/3 to ½ as much as typical out of network rates.

Despite commercial insurers' interest in moving substance abuse treatment providers in network, the payors cannot force the transition. However, they can apply pressure with slow payment, benchmarking out of network reimbursement to lower rates, and greater scrutiny through prior authorization on medical necessity and length of care. Ultimately though the shift is subject to demand-supply economics. Across the US, there is growing need for substance abuse treatment indicated by the increase in deaths due to overdose, yet the number of facilities and number of patients treated have remained relatively flat from 2006-2016. Marwood expects the substance abuse treatment provider supply to grow significantly over the next few years given investment in the space.

As long as there is an adequate demand from patients willing to pay out-of-network co-pays or co-insurance across all the providers such that providers can adequately fill out their capacity, these

providers will be unlikely to negotiate and accept lower in-network rates from insurers. Typically in healthcare, these supply-demand dynamics play out at a local level, but with substance abuse treatment, the dynamics can be more complex because patient demand may come from out-of-area ("fly-ins).

On the surface, provider negotiation on network status seems like an example of the classic prison's dilemma, in which providers would benefit from holding out against in-network rates as long as all other providers do. However, because providers are not equally able to draw patient volume to fill their capacity, the pay-off for accepting in-network rates will be higher for underperforming providers, and this will subsequently may put pressure on the higher performing providers. Lower performers accepting the in-network rates may get a near-term volume boost, but it remains to be seen whether that would be sustainable over the longer term as even more providers accepted in-network rates and the volume is further distributed.

The higher performing providers have better capabilities to protect their out-of-network revenue streams, namely 1) patient demand development and 2) out-of-network revenue cycle management. Patient demand development capabilities may include luxury facilities and/ or amenities targeted at patients willing to pay more for treatment out of pocket, marketing with local referral sources, internet marketing/ search engine optimization, and/ or vertical integration into upstream care (e.g., family therapy clinics). Out-of-network revenue cycle management may include an assessment of patient eligibility, up-front estimation of patient out-of-pocket financial responsibility, providing financing options, and aggressive management or prior authorizations to maximize revenue at each level of care. A provider with these capabilities may be able to withstand competition going in-network.

Without these advanced capabilities, a provider with good occupancy today at 100% out-of-network rates may not be able to withstand competition going in-network and the associated shift of patient volume. On the other hand, a provider that has 100% in-network revenue but was one of the first in its markets to go in network and has low occupancy rates is likely a lower performing provider. Because the patient selection criteria vary across the self-pay and commercial-insurance-pay market, some providers are adopting bifurcated strategies: a luxury facility for patients willing to pay without insurance or with higher out-of-pockets costs for out-of-network coverage, combined with a more basic facility targeted at patients paying with in-network benefits.

Marwood works with substance abuse treatment provider management and investors to evaluate and craft network strategies fit for their unique market circumstances and capabilities.

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As a leader of Marwood's Advisory Group, Mr. Sobel's primary responsibility is managing the execution of all aspects of the Advisory Group's integrated analysis—federal, state, private and third-party pay, market research, clinical quality and compliance—for healthcare corporations and investors. Prior to joining the Marwood Group, Mr. Sobel worked in Washington, D.C. as a health policy advisor to Senator John Cornyn (TX), a member of the Senate Finance Committee, and Senator Chuck Grassley (IA), former Chairman and ranking member of the Senate Finance Committee. Mr. Sobel had gone to Washington D.C. as the recipient of the post-graduate David. A. Winston Health Policy Fellowship. Mr. Sobel also has prior healthcare industry experience working with the executive office at the Veterans Affairs (VA) New York Harbor Healthcare System, doing provider contracting at Healthplex (largest dental insurance provider in New York), and conducting policy research at the Long-Term Care Community Coalition (LTCCC). Mr. Sobel received an M.P.A. in Health Policy and Management from the NYU Wagner School of Public Service and a B.A. in political science from SUNY-Binghamton.