

Robert Norris, CEO Pocono Mount Recovery Center
Testimony for HR590 9/21/2016

I want to thank you for the opportunity to share my staff's experiences and difficulties in assisting individuals accessing and remaining in treatment for substance abuse.

My name is Rob Norris and I am the CEO of Pocono Mountain Recovery Center (PMRC) and Huntington Creek Recovery Center (HCRC). My career path has taken me from a clinical support role, to the director of utilization review, executive director and now CEO. I have a degree in counseling with an emphasis on chemical dependency and substance abuse. I am typically a quiet man, however, people are dying and I feel it is my duty to speak out. Many of these deaths are people who have the benefit of insurance coverage which could have provided them the potentially lifesaving treatment they need. Therefore, I am grateful to be speaking with you today.

I want to discuss two issues with you today. First, the high out of pocket expense associated with some insurance policies. Next, the inconsistent and sometimes unrealistic criteria an individual must meet in order to be authorized for detoxification, inpatient rehab and residential treatment.

In the month of August alone, there were 23 individuals unable to admit to PMRC or HCRC due to their high out of pocket costs. These were 23 people with benefits covering our facilities and were clinically appropriate, however, could not access treatment because of high deductibles and co-pays.

Many people seeking substance abuse treatment are not financially stable. In response to this, our management team has instituted the financial hardship program and a free service program in an attempt to assist people in bridging the gap between finances and treatment. This system creates a financial burden on our company as we rarely collect any of the monies that fall into the hardship program. In the month of August, the cost to the company for administrative write offs through the hardship program and the free service program was \$121,986.

Even with the financial hardship program in place, there are still many instances where out of pocket costs inhibit someone from what could potentially be lifesaving interventions through medical detoxification and clinical treatment. Recently, we had a client with a Highmark BC policy. At PMRC, we are directly contracted with Highmark BC as a PPO, EPO, and HMO provider. This client's out of pocket costs for in network began with a \$4600 deductible. Once satisfied, the coverage would pay at 90%. He would be responsible for a 20% co-insurance up to a \$6550 out of pocket. For out of network, his out of pocket was \$10,000. With an income of \$45,000, he did not meet criteria for financial hardship. What does all this mean? If we as a company write off the co-insurance on this particular high deductible plan, we do not see the first penny from the insurance company until day 16 of the patients treatment stay. This would not be a sustainable formula to providing patient care.

Recently, an individual called to admit to detox after years of drinking a pint of vodka daily. His co-insurance maximum was \$13,500. Our self-pay rate at PMRC for 28 days of treatment is \$13,650. As such, it would have cost this client a very comparable amount to self-pay for his treatment.

The problem we are encountering is with the individuals and dependents who have a commercial insurance policy, make an honest living, yet cannot afford to cover high deductibles and co-pays. Chemical dependency has a significant financial impact on the individual suffering as well as their family.

As a company we have priced our treatment facilities reasonably at \$13,650 for PMRC and \$16,400 for HCRC. However, providing quality treatment in a safe, comfortable and clean setting comes at a cost.

Next I would like to discuss the “medical necessity criteria” an individual must meet to be admitted and remain in treatment. Specifically the increased demand on a patient having a co-occurring diagnosis to meet criteria and the lack of consistency in the prior treatment criteria. I purposely placed quotes around medical necessity in my written testimony. Yes, chemical dependency has a medical component to it, however, it is my belief the solution, in many cases, requires clinical based interventions in a setting removed from the temptations of daily life. Over the last 5 years, the emphasis being placed on the mental health and/or medical diagnosis by the insurance concurrent review process has increased. Without a co-occurring diagnosis requiring 24 hour nursing or medically assisted treatment (MAT), length of stays are being reduced drastically with some insurance companies. The result of this is individuals who have only a substance abuse/dependence diagnosis are experiencing difficulty getting approved for treatment stays. Additionally, the number of treatment experiences the individual has or does not have plays a significant role. There seems to be no consistency in the criteria a patient must meet. Either a patient is deemed to have not failed enough at treatment or has too many failures.

I would like to read an email I received from my Director of Utilization Review expressing her frustration over the current environment in her daily job of advocating for patient length of stays. It speaks volumes of the daily struggles patients have accessing and utilizing their insurance benefits.

Hi Rob,

In regards to our conversation yesterday, most insurance companies across the board use the ASAM 3.5 criteria to determine continued stay. These are the following problems I am running into with the following insurance companies: Aetna, Cigna, Capital BC/BS, BC/BS Empire.

If a client isn't struggling with significant paws, vitals are stable, and if they aren't utilizing PRNs (even if they are utilizing PRNs and may be med seeking), insurance companies feel that paws can be addressed at a lower level of care. I have had patients who are still struggling with cravings, racing thoughts, insomnia, depression, agitation, anxiety, but that didn't appear to matter, and I have been told that these symptoms can be managed at a lower level of care and do not require residential treatment.

As you are aware, insurance companies are looking for any medical conditions that require someone to need 24/7 care. If there is no medical, that has been a main reason insurance companies won't authorize a lot of time in residential.

For emotional/behavioral issues, insurance companies are looking for a mental health diagnosis and if they are taking any psychotropic medications. Insurance companies don't want to hear if they are struggling with emotional/behavioral issues, they just want to know if there is a clinical diagnosis and what meds they are taking and/or if they will be meeting with our psychiatrist and prescribed meds. In addition, if a client has history of SI/SA, they don't seem to take that into consideration if client is not currently expressing any SI.

God forbid you tell an insurance company that a client is making progress and doing well. As soon as you say that, an insurance company wants them stepped down. I have a client now with Highmark BC/BS. She has been in treatment for 14 days. No medical, no mental health, no meds. She is doing well in treatment, and insurance will not approve more time. The case is going to peer review.

Another huge component is past treatment history. If someone has significant treatment history, they are less likely to authorize more time, even if a client has failed to follow through with aftercare, has failed at lower levels of care,

etc. If someone has no treatment history, they feel that less time in a residential setting is appropriate because they need to try a lower level of care.

Additionally, if they have a supportive family, despite a client's ability to manipulate their family members or they have family who enables their behaviors, they believe they can be stepped down because they have a "stable" recovery environment.

Horizon is a nightmare. They do not see opiate withdrawal as life threatening and therefore they will not authorize time for detox if the client is only using opiates. They also believe that more than 5 days in residential is "long-term," and they do not typically authorize more than 5 days in residential. They believe in medication assisted treatment in all levels of care and encourage providers to start and maintain clients on MAT. I have had a few clients who had significant emotional/behavioral issues leading to and/or in conjunction with use, but Horizon offered PHP from the start or a stepdown to PHP immediately after detox was denied and a few days of residential was authorized.

My final comments are centered on a problem I am not sure we can fix, but we are caught directly in the center of. Due to our proximity to the State of New Jersey many individuals live in Pennsylvania and work in New Jersey or choose to come to Pennsylvania for treatment who have a BC Horizon policy. From this company in particular, we have been increasingly hearing opioid withdrawal is not life threatening and therefore detox can be done on an outpatient setting. They routinely approve only short stays (7 days or less) at residential level of care and send their policy holders back to the very same environment they used chemicals in with little or no skills to deal with the environment. This suggests to me they view the full time problem of opioid dependence only requires a part time solution. I will give a two case comparison. The names on the cases have been changed to protect identities.

Case #1: Jim Capital BC/BS (7 days detox; 22 days residential)

Jim is a 20 year old male who admitted to Huntington Creek Recovery Center for Opioid Use Disorder Severe and Cannabis Use Disorder. Jim reported the following symptoms related to addiction; blackouts, depression, insomnia, agitation, panic attacks, pronounced cravings, elevated anxiety. Patient had been using 15 bags of heroin IV for 3 months. The patient reported no medical issues. Prior treatment history includes two inpatient treatment episodes in 2015 followed by time in a sober house, which he did not complete. The patient's mother is a sober support. The patient recently lost his sister to a drug overdose. He continues to grieve the loss, and the anniversary of her death occurred while he was in treatment. He has been diagnosed with anxiety and depression. The patient reported that when he is actively using, he feels angry and hopeless. He has no history of SI or HI. No current legal issues. As a result of the patient's disease, he progressed from using socially with friends, to isolating himself in order to use. His job performance was affected due to his usage, and he lost his job as a result. It was evident throughout the patient's treatment that he was open to all aspects of the treatment and relieved to be there. The patient has a chronic history of relapse.

Case #2: Joe Horizon BC/BS (6 days of residential)

Joe is a 25 year old male who admitted to detox for Opioid Use Disorder Severe and Depressive Disorder. Despite Joe using 7 bags of heroin daily for the past 3-4 years, Horizon would not authorize any detox days, citing that opiate withdrawal does not meet medical necessity criteria. Joe's symptoms during detox included insomnia, elevated heart rate, tremors, nausea, diarrhea, bone and joint aches, and increased anxiety. Joe has past inpatient treatment history in 2012, 2013, 2014, and 2015. He is

diagnosed with depression and anxiety, and reported to have had SI a few months ago with a plan. He also reports a history of self-mutilation at age 15, as well as an eating disorder at age 13. No medical conditions reported. Mother and father gave Joe an ultimatum that he would not be allowed to reside in the home any longer without seeking rehab. The father has medical issues, and Joe's use has put further strain on the family. Joe does not work because his addiction has affected his ability to maintain employment. No legal involvement. After a peer review with the doctor from the insurance company, 6 days of residential treatment was authorized. However, after the 6th day insurance wanted him stepped down to a lower level of care despite the patient's pronounced cravings, emotional instability, and post-acute withdrawal symptoms. Citing that more than 7 days in residential treatment is considered long term, insurance denied the request, and the level of care recommended was PHP.

To summarize, I believe a portion of the population requires financial assistance in accessing treatment due to the high out of pocket expenses associated with their policy. It is my belief standardization in the criteria used to determine the necessity of treatment should be developed and enforced. Finally, a person suffering from any kind of chemical dependency diagnosis, who does not have a co-occurring diagnosis, deserves the same right to treatment as the person with a co-occurring diagnosis.

I would like to thank you for your time and letting my voice in this important matter be heard.