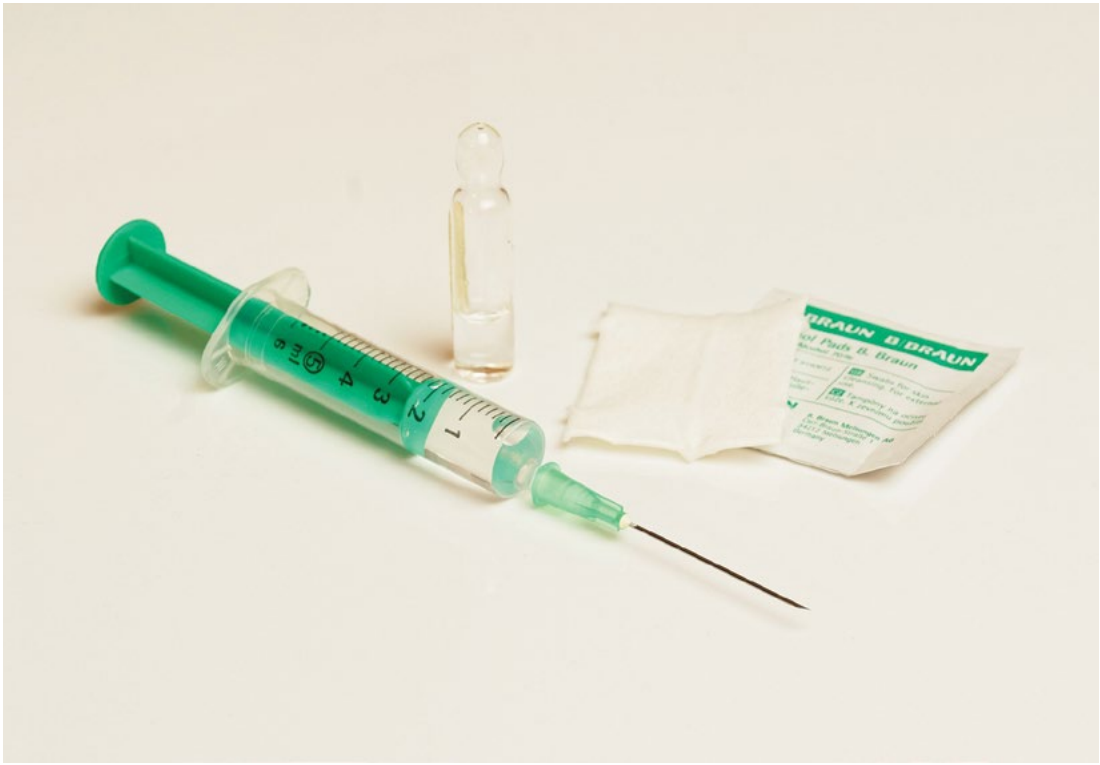


Opioid Epidemic, Substance Use, Predatory Treatment Facilities, & Complex Case Management Considerations

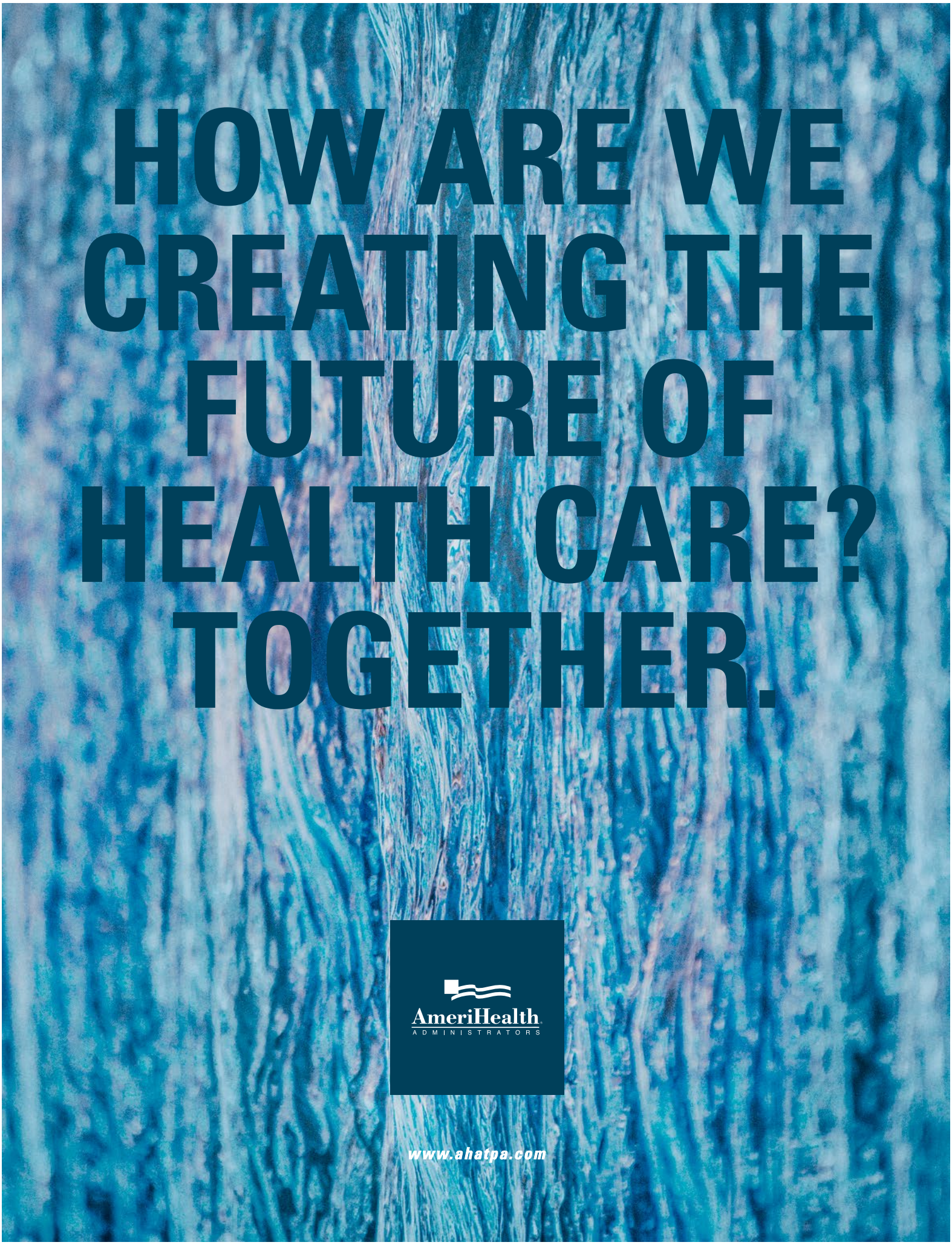
Written by: Richard T. Lindsey, Ph.D., COO & Psychologist, Robert A. Mines, Ph.D., Chairman & Psychologist & Dani Kimlinger, Ph.D, SPHR, SHRM-SCP. CEO

Statement of Problem

There are a number of changes in the USA that are contributing to a serious healthcare problem[1]. One notable example, is an increase in prescription drug abuse, particularly opioid abuse. As a response states are cracking down on medical prescribers. This has made it difficult for prescription opioid drug abusers to get opiates legally. Rather, they turn to street heroin to get access to cheaper and easier to obtain drugs.

These changes have contributed to a rise in the incidence levels of heroin abuse/addiction are rising. Heroin use more than doubled among young adults ages 18-25 in the last decade and increased among genders, most age groups, and all income levels[2]. The evident result to the healthcare system is an increased demand for services at all levels.

Since the Mental Health Parity and Addiction Equity Act virtually eliminated outpatient case management and oversight for both mental health and substance use disorders, the ability of health plans to clinically and appropriately manage their patient populations has been compromised.


HOW ARE WE CREATING THE FUTURE OF HEALTH CARE? TOGETHER.
AmeriHealth
ADMINISTRATORS
www.ahatpa.com

The Patient Protection and Affordable Care Act required that dependents up to age 26, married or single could stay on their parent's insurance plan even if they have coverage through another employer adding additional costs to benefit plans, especially since the types of expenditure caps of the past are no longer tenable under parity.

These factors have led to an increase in outpatient costs as providers have reverted to a conservative treatment approach of "more sessions rather than less." This is equally true at inpatient and residential levels of care and have contributed to an environment where "predatory substance use treatment facilities" have been touting 60-90 inpatient stays despite the fact that evidenced based treatment research has shown that the only difference in outcome between inpatient substance use treatment and intensive outpatient substance use treatment is a significant cost difference, no sobriety differences. Furthermore, self-insured entities, whether it's Self-Insured Employers, Captives, Taft-Hartley Trusts, or MEWA Trusts have out of network benefits that pay typically 60% of the cost of out of network care.

The predatory facilities are advertising on the internet, paying the cost of airfare for the patient to go out of state (usually to Florida or California), and then charging astronomical fees for care. For example, $4,000.00 a day for inpatient (usual and customary changes are closer to $800.00 - $1,200.00 per day), plus $600.00 to $4,000.00 or more per drug/alcohol test per day (usual and customary should be $15.00-30.00 per test). Partial hospitalization programs are added to extend care at $2,000.00 instead of $300.00-600.00 per day.

There are many treatment add-ons that are billed separately. These facilities purposely limit information to the case management and utilization review teams. The patient is then left with significant healthcare costs after the self-insured entity has paid outrageous fees already.

Medical bankruptcy is already one of the most frequent types of bankruptcy. The average employee cannot afford these cost overruns, which they sign paperwork agreeing to pay, upon admission. This is under the duress of seeking treatment and not signing would result in being turned away for treatment at the very time they need care.

Recommendations

Many self-insured client organizations are facing a crossroads related to their benefits structure. The current models that virtually all of these organizations have are no longer tenable in the current market place due to the exploitation by some, if not most, predatory programs.

As a result, we are recommending immediate changes to most of the Summary Plan Designs (SPD). Furthermore, enhanced utilization review criteria are available to implement the next generation of complex case management and further refine the definition of maximal medical improvement.

Case Management

When it comes to treatment, we have been guided by a number of core principles that are recommended for application in all care situations. These principles are enumerated below:

1. The best care occurs in the least restrictive environment necessary.
2. The best care occurs in the community in which the patient lives.
3. The best care occurs when the patient and their family system are actively engaged and thoroughly informed about all aspects of their care, including the financial implications, and are as involved as possible in their treatment.
4. The best care occurs when the treatment team actively partners with Case Management teams in all aspects and levels of care that are anticipated, already in progress, or when challenges in treatment occur.

These core principles are most critical when patients are admitted, or are being considered for admission, to more restrictive levels of care (inpatient, residential, partial hospitalization, and/or intensive outpatient programs).

Past Reality

Due to the parameters of the parity law, all case management and utilization review organizations have lost their authority to manage the full continuum of behavioral health care for patients (assumes the medical care is also not managed on the full continuum), and as a result, have not been afforded the opportunity to intervene as early in problem sequences as has been done historically.

In the past, case management teams could craft a clinical intervention treatment plan that minimized hospitalizations and emergency room visits, especially among the most troubled patients, through their ability to coordinate all levels of care and insure an active communication and cooperative pattern between all providers. The end result was a highly treatment-effective, cost-saving system of care.

Current Reality

As a result of the current policy changes in the field and aggressive online marketing tactics by predatory facilities, case management teams frequently learn of admissions after the fact, and may not hear until a patient has already been inpatient for a number of days. This is most troublesome when we learn that a patient has been admitted to an out-of-state, out-of-network, and extremely overpriced facility.

This compromises our ability to case manage these patients because the teams are arriving late to the scene. They spend significant time and resources catching up, filling in the back story, and attempting to secure Letters of Agreement to help manage the financial impact on the patient. Letters of Agreement from out-of-network providers have become increasingly difficult to secure, exposing the patients and the benefit plans to a level of financial risk that they may not be able to afford or sustain.

This de facto decrease in our level of involvement has led to an increase in overall admissions and regrettably to an increase in recidivism as discharge plans are often poorly outlined and inadequately executed.

Admissions to predatory treatment facilities represent the most egregious outgrowth because, under the rubric of treating a patient, they are compromising that patient and their family's future by creating a debt the patient may not be able to financially manage.

These predatory facilities are often aggressive in their marketing efforts and ultimately take advantage of patients who are, by circumstance, more vulnerable to manipulation due to their compromised mental health and/or substance use problems. These are the very practices, as history has shown, that were the key factors that initiated the managed mental health care era of the 1980s.

Future Reality

Most unfortunate are what we see as poorer outcomes, increased levels of recidivism and increased cost to the payor and the individual. As these patterns have become clear, a number of protocol modifications have been identified that can help patients and their benefit plans while remaining soundly within the parameters of the current parity laws.

These interventions would include:

1. Have benefit plans review their level of reimbursement to out-of-network and out-of-state programs to some percentage (%) of "usual and customary" charges of in-network fees or to Medicare reimbursement standards.

2. Ideally, case management would have the authority to deny care outright for treatment at these facilities. However, most current plan designs do not allow that. Case management teams can withhold an authorization for services until they are able to speak directly with the patient (unless medically compromised such that they are unable to do so) to insure that they have been thoroughly informed of all aspects of their care, including the actual cost(s) that they will bear for their stay.

   In addition, under current in network provider contracts, case management teams may have the authority to deny authorization to facilities for not precertifying care when they are in-network and the facility per those contracts the provider cannot pass through costs onto the patient or family that were incurred without approval. In the out-of-network examples, the patient signs a contract that they will pay the costs regardless of insurance reimbursement or authorization.

3. As a strategy to manage the continuum of care for those going inpatient for either mental health or substance use disorders, we recommend that the case management protocol be expanded to include aftercare follow up which includes required discharge/aftercare treatment plan meetings with a case manager and the facility.

   This extension is based on the clinical assumption that follow-up aftercare is part of the same episode of care continuum and not a discrete next outpatient episode of care.

This would be similar to viewing after surgery care as part of the surgery continuum of care on the medical side. Authorization for inpatient care can be contingent upon compliance with this and receipt by the case management team of the discharge materials. The case management team will follow the patient and family for their outpatient treatment.

The case management team will consult with the outpatient team and family on treatment issues and relapse prevention. It is our opinion that this does not interfere with the intent of the Mental Health Parity Act that medical and mental health benefits be treated the same as far as utilization review and authorization. Please have your attorneys review this and sign off on it.

Complex Case Management

Complex Case Management is the next level of care and intervention for those with chronic conditions or who have reached maximum medical/psychological improvement. Engagement of the patient in a "Complex Case Management" protocol occurs when there is evidence of previous treatment failures or repeated relapses with multiple stays.

This would involve determining a patient has reached "maximum medical improvement", due to multiple repeated treatment failures (two or more) at the highest levels of care (e.g., inpatient or residential substance abuse treatment), wherein only detoxification and outpatient (OP) treatment could be authorized thereafter. When there is no clinical evidence that a level of treatment is effective, it is not clinically or fiscally prudent to keep repeating the intervention.

For example, liver transplants are not done for those with alcohol dependence unless they have demonstrated a significant period of sobriety as it would be a waste of resources to transplant a healthy liver when the odds were high that this liver would also be compromised by the patient's alcohol consumption. There is no indication that substance use disorders get better as a function of level of care when the patient is not motivated to change or has not demonstrated behaviorally that they can change as well.

Healthy employees build strong businesses. What are you doing to strengthen yours?

As featured in the September 2016 issue of Self-Insurer

Strengthen your business with In-Sight, the first truly integrated Employee Benefits, Workers' Compensation and Health Management program.

In-Sight puts the administrative and cost control efforts of these programs into the hands of a single, integrated team. Why? Integration allows us to eliminate administrative oversight, prevent duplicate claims and address potential health issues before they become costly problems.

The result? Reduced claims spending and a healthier, more productive workforce.

Call IPMG at (888) 470-9569 to learn how In-Sight can strengthen your business.

IPMG.COM/CHANGE-THE-GAME

In-Sight

Other Benefit Considerations

1. Consider excluding coverage for all out-of-state facilities when there are comparable in-state, in-network options available. Emergent care is excepted if episode occurs when patient is out-of-state.

2. Move mental health and alcohol/substance abuse services under a **Disease Management Model** where the entire continuum of care can be case managed.

   Engaging in a Disease Management Model of case management is being granted, by the Self-Insured Organization, the authority to review and manage "all levels" of care for the patient, out-patient as well as inpatient, especially if the patient is not following through with treatment recommendations. If disease management models are already in place on the medical side for illnesses such as diabetes, chronic obstructive pulmonary disease (COPD) or others, it is not inconceivable for disease management programs to be put in place for depression or substance use disorders.

3. Human Resources considerations related to ADA and FMLA.

ADA: From a human resources point of view, early intervention and access is important for returning workers to work with full productivity. There may be necessary accommodations and return to work specifications which need to be complied with. Employers have a duty legally to reasonably accommodate known mental or emotional impairments of the applicant or employee unless it imposes an undue hardship on the employer.

When an employee returns to work, engage in the interactive process with the employee determine if there are reasonable accommodation needs. Some accommodations may include time off for treatment or modified work schedules. Time off may fall under FMLA as the time off for treatment not for use of the substance is also protected by the Department of Labor. These areas of law are mentioned as the employees covered under these benefits may need additional case management consideration and coordination with human resources and absence management personnel.

Our Complex Case Management (CCM) protocol is engaged under the following conditions:

1. A patient has been re-admitted to the same level of care for the same or similar diagnosis within a six (6) month period of time.
2. Evidence over a number of years of repeated admissions to the highest levels of care for the same clinical concern.

Summary

There are three key strategies to consider:

1. **Benefit plan design modifications to limit financial exploitation by out of network facilities.**
2. **Enhanced case management protocols to effectively intervene at the patient and family level to increase the likelihood of adherence and follow through with complex and/or chronic conditions.**
3. **Utilize a Disease Management Model that is Mental Health Parity compliant to manage the entire continuum of care which was highly clinically effective as well as fiscally successful.** ■

Richard T. Lindsey, Ph.D. is the COO and Clinical Director at MINES and Associates. Robert A. Mines, Ph.D. is the Chairman at MINES and Associates. Dani Kimlinger, Ph.D., SPHR, SHRM SCP is the CEO at MINES and Associates.

Information about MINES and Associates health psychology and managed behavioral health-care services can be found at www.minesandassociates.com

References

1 Johnson, A. & Vincent, L. k. (2015) Mental Health Management –Substance Abuse Treatment: What your Fund Needs to Know, International Foundation of Employee Benefits Plan Annual Conference, Honolulu, HI.

2 CDC report, Today's Heroin Epidemic, (July 2015) http://www.cdc.gov/vitalsigns/heroin/