

# **Substance Use, Predatory Treatment Facilities, & Complex Case Management Considerations**

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## **Statement of Problem**

There are a number of changes in the USA that are contributing to a serious healthcare problem (Johnson, A. & Vincent, L.k. (2015) *Mental Health Management –Substance Abuse Treatment: What you Fund Needs to Know*, International Foundation of Employee Benefits Plan Annual Conference, Honolulu, HI. There has been an increase in prescription drug abuse, particularly opioid abuse. As a result, states are cracking down on medical prescribers. This has made it difficult for prescription opioid drug abusers to get opiates. They turn to street heroin to get access to cheaper and easier to obtain drugs. 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 both genders, most age groups, and all income levels (CDC report, July 2015). Furthermore, the Mental Health Parity and Addiction Equity Act has virtually eliminated outpatient case management and oversight for both mental health and substance use disorders. 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.

This has led to an increase in outpatient costs as providers have reverted to a conservative treatment approach of “more sessions rather than less.” This has 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 Taft-Hartley Trusts, MEWA Trusts, Captives, or Self-Insured Employers, 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 charges are closer to \$800.00 - \$1,200.00 per day), plus \$600.00 to \$4,000.00 or more plus 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**

Our 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 the stated predatory programs. As a result, MINES is recommending immediate changes to most of the Summary Plan Designs (SPD). Furthermore, MINES has enhanced its utilization review criteria to implement the next generation of complex case management and further refinement of the definition of maximal medical improvement.

## **Complex Case Management**

At MINES, when it comes to treatment, we have been guided by a number of core principles that we strive to apply 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 the MINES Case Management team 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).

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 care for patients, 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, MINES could craft a clinical intervention treatment plan that minimized hospitalizations and emergency room visits, especially among the most troubled patients, through our 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.

As a result of the current changes in the field and aggressive online marketing tactics by predatory facilities, MINES frequently learns 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 we are arriving late to the scene. We 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 our patients and the benefit plans to a level of financial risk that they may not be able to afford or sustain. This 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.

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, we have identified a number of protocol modifications that we believe can help our 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, we would have the authority to deny care outright for treatment at these facilities. However, current plan design does not allow that. We can withhold an authorization for services until MINES is 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, MINES has the authority to deny authorization to facilities for not precertifying care when they are in-network and the facility per the MINES contract cannot pass through costs onto the patient or family. 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, MINES case management protocol is being expanded to include

aftercare follow up which includes required discharge/aftercare treatment plan meetings with MINES case manager and the facility. Authorization will be contingent upon compliance with this and receipt by MINES of the discharge materials. MINES will follow the patient and family for their outpatient treatment. MINES will consult with the outpatient team and family on treatment issues and relapse prevention. As this is not utilization review and authorization by MINES is not needed, 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 trust attorneys review this and sign off on it.

4. 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 MINES “Complex Case Management” protocol 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”, when there are repeated treatment failures (two or more) at the highest levels of care (e.g., inpatient or residential substance abuse treatment), wherein only detox 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 as well.

## 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 contingent upon MINES being granted, by the Trust, the authority to review and manage “all levels” of care for the patient, outpatient as well as inpatient, especially if the patient is not following through with treatment recommendations.

MINES 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.**