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PROVIDER NEWSLETTER

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From the Desk of CEO Liz Gibboney

In the last *Provider Newsletter*, I discussed the beginning efforts to repeal and replace the Affordable Care Act (ACA), and the potential impact to PHC members. Since that time, the Trump administration presented the American Health Care Act, to replace the ACA, including the adult Medicaid Expansion (MCE).

Of concern for us was the impact this would have on the 163,000 of our members who enrolled as a result of the MCE. The Congressional Budget Office scored the proposal as reducing Medicaid spending by $880 billion, reported that 14 million Americans would be uninsured next year, and 24 million Americans would be uninsured in the coming 10 years. After being debated on the House floor, the bill was withdrawn, at least for now.

Although a congressional repeal does not appear to be on the immediate horizon, it's important to keep in mind that the president still has regulatory authority to alter the Medicaid program, in meaningful ways, without congressional approval. Continuing to communicate the importance of the ACA to our communities, elected officials, and others will be critical in future congressional discussions.

I would like to suggest two ways that we can demonstrate the importance of maintaining the ACA and more specifically, the MCE population. First, tell the stories of your patients (as appropriate), and second, encourage all those who are eligible to sign up and then to use their benefits.

The successes of the MCE have been significant. In the 14 counties served by PHC, there was a 37 percent reduction in ER use among the MCE population from January 2014 through September 2016. These individuals who are no longer visiting the ER are receiving preventive care in less expensive and often more effective settings. Tell their stories, and help your communities understand that without coverage individuals will seek care at ERs, which results in an increase in uncompensated care.

The strongest demonstration of support for a program is in its use. Continue to encourage eligible individuals to sign up and those who have Medi-Cal benefits to use them. When Medi-Cal benefits are used for preventive services, we help our communities be healthy, and in turn reduce overall health care costs.

As we continue this journey, we will continue to advocate for access to quality health care for our members. Thank you for your support and efforts in this work!

In Partnership,

Alternative Facts on Alcohol Detox (Part 2 in a series on Substance Use Disorders)

Case Study

A 45 year old woman with a history of daily alcohol use (1 liter of vodka per day), a history of alcohol withdrawal seizures and mild cirrhosis is seen by her primary care clinician in the office. She lives alone and has no family support. She says she has decided to stop drinking yesterday, is attending Alcoholics Anonymous groups twice a day, and is tremulous, anxious, tachycardic, with an elevated blood pressure.

Questions to Consider

1. What is the risk of dangerous complications from alcohol withdrawal in this patient?

2. What is the appropriate setting for managing her alcohol withdrawal? How can a medical provider initiate this process?

Words Matter

Many of us think that a patient like this needs a place where they can "*detox*," short for detoxification, or removal of the chronic toxicity of alcohol consumption. Detox is also a contrast to acute *intoxication*, the effects of the high levels of a drug (in this case, alcohol) on the individual. When intoxication goes away, the patient is said to be going through "detox." The management of patients undergoing "detox" is called *withdrawal management*. The management of patients who are acutely intoxicated (for example from consumption of methamphetamines or large amounts of marijuana) is different, and called *intoxication management*.

Alcohol Withdrawal: Risk Assessment

Alcohol is by far the drug with the largest health risks associate with withdrawal. Alcohol withdrawal is associated with three symptom clusters:

- **Autonomic hyperactivity** (already present in the case presentation, above), including tremulousness, sweating, tachycardia, nausea, vomiting, anxiety and agitation. These symptoms peak in 24-48 hours.
- **Neuronal excitation,** including seizures, typically occurring 12-48 hours after abstinence (this patient has a history of this, and is therefore at high risk of this).
- **Delirium Tremens**, also known as alcohol withdrawal delirium, which includes confusion, impaired consciousness, and hallucinations, and severe autonomic reactivity. This typically occurs 48-72 hours after the last consumed drink.

The case presented above is at high risk of having more *severe* alcohol withdrawal symptoms, and needs to be managed in an inpatient setting. Here are the factors to consider in individual cases of alcohol withdrawal to determine the level of care needed:

Level of Intoxication Higher levels of acute intoxication (in this case drinking a liter of vodka per day) increase risk of more severe withdrawal

History of complicated withdrawal or co-morbid conditions In the case above, the history of past alcohol withdrawal seizures and current cirrhosis increases the risk of severe withdrawal symptoms.

Signs of Withdrawal Patient is exhibiting current signs of withdrawal

A high standardized withdrawal rating scale score

Social support Poor social support makes inpatient management more favorable (this patient has no significant support system).

Rapid tapering of benzodiazepines or barbiturates also can be risky, and may need inpatient care as well. Withdrawal from most other drugs can be managed in an outpatient setting.

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Alternative Facts on Alcohol Detox (continued)

Settings for Withdrawal Management

Potential settings include:

- *Home,* (or other residence such as a correctional facility) with occasional visits to a medical provider
- In an *office* or urgent care, during regular business hours
- In a *residential facility* with capability and skill in withdrawal management (sometimes called residential detox)
- In an *acute care facility* (either one specializing in alcohol detox, or a general acute care hospital).

Currently in our service area, patients with Medi-Cal have few options for medically supervised outpatient alcohol withdrawal management. Providers can confirm what is available in their community by contacting their county's substance use disorder services (the PHC website has a list of phone numbers for all counties at: www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx.

Future options promise to be more comprehensive. PHC is working with DHCS and 10 of our counties to develop a regional model for delivering Substance Use Disorder (SUD) treatment services starting in July, 2018. The other four counties (Marin, Sonoma, Napa and Yolo) are contracting with the state to provide a more robust range of options.

In the absence of local, covered outpatient Medical Management of SUD withdrawal, patients like the one in the case above could be managed at home, in the office setting (if the provider is willing to have the patient stay there all day), in jail (if arrested for some infraction), or in an inpatient setting. In the case above, inpatient withdrawal management is the treatment setting of choice.

Where can a patient like this be hospitalized?

High risk withdrawal management can be provided in any general acute care hospital. The hospital and physicians are paid directly by State Medi-Cal; a Treatment Authorization explaining the medical necessity is required. If a PHC member has another condition requiring inpatient care (acute alcoholic hepatitis, for example), PHC would cover the hospitalization, even if withdrawal management were incidentally provided. In either case, the admission history and physical is the key supporting documentation; risk factors for complicated SUD withdrawal should be referenced.

Optimal treatment of complex, inpatient withdrawal management of alcohol and other drugs was recently the subject of a PHC webinar. A recording of this webinar (presented by UCSF faculty Dr. Tauheed Zaman), with supporting materials can be found at: http://www.partnershiphp.org/Providers/HealthServices/Pages/Substance%20Use%20Disorder/Substance-Use-Disorder-Landing-Page.aspx

Substance Use Services for Partnership HealthPlan Members

In the last provider update, we described the various efforts regarding substance use services that are taking place among the 14 PHC counties. The services will include a full continuum of care that includes outpatient and intensive outpatient services; withdrawal management; medication-assisted treatment; residential care and case management. This is an update to that notice; further information and periodic updates are on the PHC website.

Four PHC-covered counties – Marin, Sonoma, Napa, and Yolo – are working to establish and administer the benefit, with Marin the first to "go live" this month. We are working with each of these counties to ensure the integration of care for our shared members.

There are now 10 PHC counties -- Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc Shasta, Siskiyou, Solano and Trinity – that are working with PHC to develop a regional model that would be administered by PHC. The proposed plan for this model, in draft form, is on the PHC website.

Most recently we held a positive meeting with the State and are confident that both the state and federal governments will work to approve our plan. We are also analyzing the grant requests from providers that are hoping to be part of the Regional Model.

We will continue to provide updates on the status of this planning in this newsletter and on our website.

Provider Relations Newsletter

Important Numbers - Claims Mailing Addresses

Medi-Cal

Attn: Claims Department

P.O. Box 1368

Suisun City, CA 94585-1368

Partnership*Advantage*

Attn: Claims Department

P.O. Box 610

Suisun City, CA 94585-0610

Healthy Kids

Attn: Claims Department

P.O. Box 3172

Suisun City, CA 94585-3172

PHC Care Coordination

Asthma, Diabetes, ESRD & Growing Together Perinatal Programs - (707) 863-4276

MEMBER SERVICES
Changing Primary Care Providers (PCPs)

Did you know that a PHC member can change their PCP by calling Member Services at (800) 863-4155, or signing a PCP selection form in their PCP's office, which can then be faxed to Member Services? Members are encouraged to seek care from their assigned PCP. If you are a PCP seeing a PHC member assigned to another clinic, please remind the member to change their PCP assignment. Most PCP changes are effective the first day of the following month.

The Managed Care Final Rule

The Centers for Medicare & Medicaid Services (CMS) released the Managed Care Final Rule last Spring. It is the first major overhaul of the Medicaid (Medi-Cal) managed care regulations since 2002.

The Final Rule sets forth advancements in delivery system reform by aiming to improve the quality of care, strengthen beneficiary protections, improve accountability and transparency, and align Medicaid with other health coverage programs. Implementation of the new provisions is phased primarily over three years. Some of the changes that will impact PHC include:

- **Provider Credentialing:** The State must establish a uniform credentialing and re-credentialing policy that addresses acute, primary, behavioral, substance use disorders, and Long Term Service and Support (LTSS) providers. The Plan must follow a documented process for credentialing and re-credentialing of network providers.
- **Provider Screening & Enrollment:** The State must screen and enroll all MCP network providers in accordance with the new requirements.
- **Grievances and Appeals:** Requires that appeals are exhausted at the plan level before proceeding to a State Fair Hearing. It also requires health plans ensure all grievances (exempt and non-exempt) are incorporated into the quarterly Grievance and Appeal report that is submitted to DHCS.
- **Subcontracting and Delegation:** Plan will have new subcontractor and delegated entity monitoring requirements including, but not limited to: new auditing requirements, developing policy and procedures to monitor quality and compliance of data, and meeting care coordination standards.