

HAP Q & A: Opioid Use Disorder Program

Question and Answers

1. Q: Can you provide definitions, particularly how DHS will determine qualifying patients and any excluding criteria?

A: Qualifying patients in the denominator are those with a diagnosis of Opioid Use Disorder (OUD) in the first 9 positions on an emergency department paid claim. A complete list of ICD-10 codes were provided to HAP. Patients that get admitted to an acute inpatient stay through the emergency department (ED) will not be included in the denominator. The only exceptions are: 1. when patients get admitted to an acute inpatient stay primarily for methadone, buprenorphine, or detoxification and 2. when patients go to outpatient observation for buprenorphine induction. These individuals will be included in the denominator and numerator.

The numerator will include anyone in the denominator that obtains treatment for OUD within 7 days of discharge from the ED. These treatments include any American Society of Addiction Medicine's (ASAM) level of care treatments such as: acute inpatient rehabilitation, detoxification, inpatient/outpatient residential rehabilitation, partial hospitalization programs, halfway houses, and any claim for medication assisted treatment (MAT). This is not an inclusive list. The spreadsheet for numerator claim type details was provided to HAP.

2. Q: Can you define the follow up process? Will there be a standard metric, or will it require active phone follow up on the provider side as was mentioned is done for other programs?

A: The metric will be defined by claims as described above.

3. Q: Is "warm handoff" specifically defined as the definition may be more stringent than we can realistically meet in the short term?

A: The warm handoff will be defined as "successful" if a claim for OUD services is performed within 7 days from discharge from the ED as defined above.

4. Q: Regarding Pathway number 3, the updated language simply indicates a specialized protocol to "address" pregnant women with OUD. Identifying and creating some type of connection to resources throughout the state would likely satisfy that requirement for now?

A: Yes, having a well-defined process for referring pregnant women for OUD treatment to providers with such expertise will meet the requirement.

5. Q: Regarding clinical pathway number 4:

- a. **Is there a mechanism for reimbursement to facilities for admission/observation for MAT induction?**
- b. **Will observation status with MAT induction be permitted in facilities that are not specifically licensed as an Opioid/Narcotic Treatment Program (OTP/NTP)?**

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- c. Will telemedicine evaluation by an x-waivered physician with subsequent e-prescribing of buprenorphine to that patient to allow community treatment engagement be permitted? Or does the buprenorphine prescription need to be provided by a physician who has directly (non-tele) evaluated the patient?**

A:

- a. Yes, reimbursement is available through inpatient hospitalization payment as well as outpatient observation payment.
- b. Induction with buprenorphine in the outpatient or observation status does not require licensing as an OTP/NTP program. Or will it only be permitted if there is a co-occurring medical diagnosis, e.g. vomiting, dehydration, etc.? Inpatient admission for methadone induction requires a co-occurring diagnosis and must follow current state and federal regulations.
- c. Yes. Telemedicine evaluation by an x-waivered physician with subsequent e-prescribing of buprenorphine to that patient to allow community treatment engagement will be permitted. The latter would result in a much more limited engagement and capability to provide "bridge" dosing of MAT pending community prescriber availability, particularly in areas with fewer MAT providers.

- 6. Q: Again, definitions and specifications needed. As for the tiers, the search criteria used by DHS may vary significantly from our internal search?**

A: Tiers are based on volume of visits in the ED for OUD as previously defined in question #1. (Tier 1: <20 ED visits, Tier 2: ≥20 ≤200 ED visits, Tier 3: >200 ED visits.)

- 7. Q: It does not specify that care management teams need to be on-site 24/7, simply on-call. [...the existing poison center infrastructure with 24/7 nurse specialist coverage, existing medical management pathways, patient and provider educational information, direct contact with all UPMC EDs, and capacity to follow up with these patients (see #2 of this list) may represent an opportunity to expand capabilities.]**

A: Care management teams need to be available 24/7 but not onsite at all times. Having on-call capability will meet the requirement with the expectation that face to face visits with the individual will have the most impact on OUD treatment engagement.

- 8. Q: How will OUD be defined for this program? Will providers and related pathways utilize current DSM V criteria for the diagnosis of OUD? Will all of the ICD-10 F11 behavioral codes be utilized for identifying these patients via billing systems? Or will the Department specifically identify which subsets of the F11 codes (specifically dependence) should be used?**

A: Please see answer to #1.

- 9. Q: Where does the HealthChoices data sit and how is access provided?**

A: We need clarification on this question. HealthChoices encounter data is maintained and accessed by DHS.

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10. Q: What is the process for attesting to pathway implementation? Is there a standard form?

A: HAP should work with providers to develop a brief check-list attestation form that allows health systems to verify they have developed the pathways by 9/28/2018 and have implemented the pathways by 1/17/19. DHS will require only submission of the attestations for each health system but may audit to assure the pathways have been developed and implemented. DHS considers a pathway implemented by the fact that recipients have been run through the pathway by 1/17/19.

11. Q: What documentation will be required that patients followed a pathway?

A: See answer to #10. If audited, health systems should be able to provide documentation that patients followed the pathway.

12. Q: In order to qualify as following pathway #4 (direct inpatient admission), does the patient have to be admitted to your facility or can it be another inpatient facility?

A: The individual can be admitted to any inpatient facility for the purpose of treating OUD. See question #42 for more details.

13. Q: Does a patient have to be admitted by a waived physician or can a patient be admitted by and (e.g.,) obstetrician with a waived physician consulting and prescribing?

A: Either option is fine. Each health system needs to develop their own protocols and follow applicable state and federal regulations.

14. Q: What evidence will you require that a pathway exists?

A: Please see answer to #10 above.

15. Q: What are the staffing requirements?

A: Each health system must have 24/7 coverage per #7 above. There is no specific staffing ratio since health systems vary in ED volume. Care management teams may include licensed and unlicensed professionals such as peer recovery specialists.

16. Q: Do health systems with multiple hospitals qualify for separate payments for each hospital? For instance, would Hospital A and Hospital B (2 separate counties, but under the same license) fill out 2 attestation forms and count as 2 sites that each qualify for separate payments?

A: Emergency Departments were rolled up to individual hospitals. The individual hospitals identified in DHS' analysis were similar to the hospitals used in the Potentially Preventable Admissions analysis and payment.

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17. Q: Do you have a list of the HealthChoices plans so we know which patients qualify?

A: The Physical Health HealthChoices plans are the focus of our analysis. They are as follows:

Aetna Better Health
AmeriHealth Caritas Pennsylvania
Gateway Health
Geisinger Health Plan
Health Partners Plans
Keystone First
UPMC for You
United Healthcare Community Health Plan of Pennsylvania

18. Q: Do we need to have the minimum number of patients in each pathway, or is it a sum of patients from all 4 pathways?

A: Each health system should submit a sum of patients across all developed pathways to meet the minimum Tier requirement based on volume.

19. Q: Please provide a list of the ways (codes, drugs, etc) that will satisfy the numerator in the 7-day follow up measure.

A: Please see the answer to question #1.

20. Q: Do we need to actually submit our pathway plans as part of attestation?

A: No, but DHS may ask to see the written date stamped pathways during a potential audit.

21. Q: [pathway 4] “Direct inpatient admission”. Does this mean the traditional “admit to a hospital” or does it mean “inpatient rehab”?

A: Pathway #4 means a direct admission to an acute inpatient stay for methadone induction. An admission to an acute inpatient drug and alcohol rehabilitation facility would fall under pathway #2. Inpatient admissions can occur at the same facility as the ED or arranged at a different inpatient facility than the ED. See question #42 for more details.

22. Q: I am searching for the data spec logic that defines the population. “Modified Healthcare Effectiveness Data Information Set (HEDIS®) specification of follow-up within seven days for opioid treatment after a visit to the emergency department (ED) for opioid use disorder (OUD).” Am I to use FU after ED Visit for Mental Illness?

A: The specification is “FUA” found on page 185 of NCQA’s HEDIS® 2018 Volume 2, Technical Specifications for Health Plans.

23. Q: In determining if our hospitals meet the threshold for the minimum number of HealthChoices recipients (volume of OUD related ED visits that occurred in CY2016), has

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that already been determined, or do we self-determine and report? If we are to self-report (to determine eligibility for the program) are there codes available or other demographics to consider in running this data?

A: The tiers will be determined by the OUD denominator volume based on claims to each ED in calendar year 2016.

24. Q: Is there a down side penalty to the program? If the Process Incentive Clinical Pathway is implemented, and the Outcome Incentive follow up seven days intervention is initiated and demonstrates no improvement, would that result in a penalty?

A: There are no penalties.

25. Q: For the possible handoffs listed, are we correct to assume that once committed, we would NOT be required to provide all of the related care services (i.e. deliver the baby), but we would be required to demonstrate that we have a good pathway in place and that this pathway is being followed?

A: The care rendered under pathways 2-4 do not have to be rendered at the same facility as the ED. Pathway 1 must be rendered at the same ED. For first year payment, hospitals must attest to the development and implementation of pathways for the minimum number of individuals seen in the ED with the diagnosis of OUD.

26. Q: Who will determine the number of OUD patients per year to identify what tier hospitals fall into? Will DHS give hospitals this number or are hospitals supposed to run their own reports and attest to a number?

A: DHS will provide HAP with the number of OUD visits from CY2016. This will determine the hospital's tier for attestation purposes.

27. Q: Clarification of the continuity of care document submission is requested – what do you mean by CCDs, electronic submission, etc. Can you describe what is expected from this requirement?

A: Emergency Departments should follow their hospital's protocols for electronic health records.

28. Q: Seeking clarity with the third bullet point of the attestation form “we will submit electronic continuity of care documents (CCDs) to the Department for Medicaid recipients seen in the ED with a diagnosis of OUD by 7/1/2019”? Need a better understanding of what information needs to be tracked on patients and their encounters...beyond the claims.

A: The Office of Medical Assistance Programs (OMAP) is asking hospitals to send electronic packages of information from their Electronic Health Record (EHR) to Department of Human Services (DHS). These formatted standardized electronic documents such as Admit, Discharge, Transfer (ADT) or Continuity of Care (CCD) documents are generated from the hospital's EHR; Many hospitals are connected to one of the Health Information Organizations (HIOs) and will have the capability of sending information to DHS through the HIOs. These standardized electronic documents such as

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ADTs or CCDs can also be sent to DHS via Direct (a secure email-like set up most hospitals have in place). The type of information that may be included in these electronic packages of information is provided in the weblink below that describes meaningful use requirements for the summary of care. https://www.cms.gov/Regulations-andGuidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEHModStage2_2018_Obj5.pdf

29. Q: Regarding the attached Attestation I have a question, and appreciate your clarification and guidance:

We will submit electronic continuity of care documents (CCDs) to the Department for Medicaid recipients seen in the ED with a diagnosis of OUD by 7/1/2019. Does this “CCDs” refer to normal/routine clinical documentation?

A: Emergency Departments should follow their hospital’s protocols for electronic health records.

30. Q: We are a multi-hospital system with all of our EDs under different licenses. The WSH pathway for buprenorphine initiation for pregnant addicted females with OUD differs slightly depending on which hospital (will use example naming hospitals A and B)

- **Hospital A: Pregnant women seeking treatment with buprenorphine or methadone for OUD are admitted with Maternity Unit for initiation of buprenorphine or methadone. If the patient is identified in an ambulatory office, she is usually direct admitted to Maternity. If she is identified in the ED of Hospital A – she is admitted to Maternity for MAT initiation from the ED.**
 - **Is this considered Pathway 3 or Pathway 4?**
 - **Is patient entirely excluded from the denominator if she is admitted from the ED since ED admissions resulting in inpatient stays are excluded?**
- **Hospital B: Pregnant women seeking treatment with buprenorphine or methadone for OUD are admitted with Hospital A’s Maternity Unit for initiation of buprenorphine or methadone. If the patient is identified in an ambulatory office, she is usually direct admitted to Hospital A’s Maternity. If she is identified in the ED of Hospital B – she is admitted to Hospital A’s Maternity for MAT initiation from the ED.**
 - **Is this considered Pathway 3 or Pathway 4 for Hospital B?**
 - **Is patient entirely excluded from the denominator if she is admitted from the ED since ED admissions resulting in inpatient stays are excluded?”**

A: The pregnant women directly admitted to the hospital (A or B) from the outpatient setting such as the obstetrical clinic **are not counted in the denominator**. Because this is an emergency room initiative, the patient must be seen in the Emergency Department (ED). If a pregnant patient is seen in the Emergency Department (ED) A and admitted to hospital A or B for induction of methadone within seven (7) days of ED discharge, she is included in the denominator and the numerator of hospital A. If a pregnant patient is seen in the Emergency Department (ED) B and admitted to hospital A or B for induction of methadone within seven (7) days of ED discharge, she is included in the denominator and the numerator of hospital B. This is an exception to the HEDIS® specification which does not include inpatient stays. Most pregnant patients initiating buprenorphine do not require inpatient admission but can be placed in observation or induced in an outpatient setting. If a pregnant patient is seen in the Emergency Department (ED) A and placed in observation at hospital A or B for induction

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of buprenorphine within seven (7) days of ED discharge, she is included in the denominator and the numerator of hospital A. If a pregnant patient is seen in the Emergency Department (ED) B and placed in observation at hospital A or B for induction of buprenorphine within seven (7) days of ED discharge, she is included in the denominator and the numerator of hospital B. Because both hospitals have a specific ED protocol for pregnant women this activity would fall under pathway 3.

31. Q: I've been asked to look at the requirement for us to send CCDs to DHS for the Hospital Quality Incentive Program. Are there more detailed technical specifications on how we would send the CCDs? I appreciate any information that you can provide. We will submit electronic continuity of care documents (CCDs) to the Department for Medicaid recipients seen in the ED with a diagnosis of OUD by 7/1/2019.

A: Emergency Departments should follow their hospital's protocols for electronic health records.

32. Q: When patient is treated in our ED for a OUD related condition listed in the ICD-10 codes previously provided, unless the patient is admitted to our detox unit, that claim is billed to the patient's medical insurance. When the patient is discharged from our ED to a community-based provider the community base provider will be billing the patient's carve out for behavioral health/substance use disorder (In NW PA it is CCBH). Who will be reconciling the claims between the medical and carve out insurances?

A: DHS will use the MCO submitted encounter data held in PROMISe™ to determine the benchmark and improved performance for HealthChoices members receiving treatment for Opioid Use Disorder (OUD) within 7 days of that member's visit to the hospital's Emergency Department for an OUD related diagnosis. Encounter data submitted from both physical health and behavioral health MCOs will be included in the determination of benchmark and improved performance.

33. Q: We would like to ask for clarification around the sending of CCD documents. The deadline of 7/1/2019 was included in the original attestation form. Does that mean that we would send all CCDs to DHS at one time, or is the expectation that we send them on an ongoing basis? If we have patients going through the pathways starting in October/November 2018, do we batch the CCDs and transmit them next year by the 7/1/19 deadline, or do we send them soon after the patient encounter? If we are expected to send them on an ongoing basis, is there a time requirement (i.e. within 24 hours of the encounter, 1 week, 1 month?). Also, will this requirement continue beyond 7/1/2019?

A: DHS wants hospitals to be onboarded/connected to one of the DHS certified Health Information Organizations (HIOs) between now and 7/1/2019. Once onboarded/connected to a HIO, new and existing hospitals should work with the HIO to push ADTs/CCDs from the emergency department to the HIO. DHS wants the ADTs/CCDs sent from the hospitals to the HIOs at least weekly. There is no need to retro-batch ADTs/CCDs back to September of 2018. Once the process of pushing ADTs/CCDs to the HIO is established, the hospital can send these documents to the HIO at least weekly. If by 7/1/2019 the hospital is not able to connect to a HIO and transmit ADTs/CCDs from the emergency department, the hospital can transmit ADTs/CCDs to DHS via a secure Direct Account at the following address: PADPW-OMAP-MAHEALTHIT@directaddress.net. Starting on 7/1/2019, the ADTs or CCDs must be sent from the hospitals to DHS at least weekly via Direct. There is no need to retro-batch ADTs/CCDs back to September of 2018. Yes, this effort will extend beyond 7/1/2019.

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- 34. Q: We do have a question, however, in regard to submitting the CCD documents to the Department. We have an inpatient detox/medical withdrawal unit and the CCD document for that population is confidential and cannot be submitted to the Department electronically. Can you please provide guidance as to how we, as an organization, can meet the program requirements when we cannot submit the CCD for that population? We appreciate your attention and assistance with this matter.**

A: Hospitals can meet this requirement by having their emergency departments (ED) participate in the Pennsylvania eHealth Partnership Program's Patient and Provider Network (P3N) Admission/Discharge/Transfer (ADT) Project, which enables the P3N statewide encounter notification service (ENS), by 7/1/2019. The P3N ADT Project is a real-time ENS that enables the alerting of a patient's care team when they are being treated in a participating ED, even if that patient's care team participates in a different health information organization (HIO) in Pennsylvania. In order to participate in the P3N ADT Project, hospitals must be members of one of the P3N certified HIOs. More information about PA eHealth certified HIOs can be found at: www.PAeHealth.org.

Hospitals can also meet this requirement by securely submitting electronic continuity of care documents (CCDs) to DHS for Medicaid recipients seen in the ED with a diagnosis of OUD. If a hospital ED is not participating in the P3N ADT Project by 7/1/2019, the hospital must begin sending all ED OUD CCDs for Medicaid recipients, at least weekly, via the MAHIT DIRECT Messaging Account: PADPW-OMAP-MAHEALTHIT@directaddress.net or through their HIO's P3N Public Health Gateway (PHG) connection to the DHS electronic Clinical Quality Measure (eCQM) registry.

The MA ED OUD CCD messages should conform to the HL7 Implementation Guide: CDA Release 2 – Continuity of Care Document (CCD), which is available for download online at: http://www.hl7.org/implement/standards/product_brief.cfm?product_id=6.

Technical questions regarding Direct submission of CCDs to DHS can be directed to Lisa McCutcheon, Project Manager, PA eHealth Partnership, at c-almccutc@pa.gov, or by phone at (717) 772-6634.

- 35. Q: To meet requirements stating we must submit electronic CCD documents to DHS for Medicaid recipients seen in the ED, can you let us know who to contact at DHS, so we can understand infrastructural options? Our goal is to automate this process. We already have automated processes in place to send data out to both DHS and a health share exchange; we are seeking clarification around whether we can modify those already established processes, or if this will require a whole new process. The team identified one possible route that would require using LPP 72044, but it would require a new DXO setup specifically for the DHS.**

A: DHS wants hospitals to be onboarded/connected to one of the DHS certified Health Information Organizations (HIOs) between now and 7/1/2019. Once onboarded/connected to a HIO, new and existing hospitals should work with the HIO to push ADTs/CCDs from the emergency department to the HIO. DHS wants the ADTs/CCDs sent from the hospitals to the HIOs at least weekly. There is no need to retro-batch ADTs/CCDs back to September of 2018. Once the process of pushing ADTs/CCDs to the HIO is established, the hospital can send these documents to the HIO at least a

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weekly. If by 7/1/2019 the hospital is not able to connect to a HIO and transmit ADTs/CCDs from the emergency department, the hospital can transmit ADTs/CCDs to DHS via a secure Direct Account at the following address: PADPW-OMAP-MAHEALTHIT@directaddress.net. Starting on 7/1/2019, the ADTs or CCDs must be sent from the hospitals to DHS at least weekly via Direct. There is no need to retro-batch ADTs/CCDs back to September of 2018. Yes, this effort will extend beyond 7/1/2019.

- 36. Q: Which MA promise ID should be used for the facility ID when completing the ED OUD QIP attestation form? Are you looking for the 11-digit base number or the 13-digit number with a specified location? If it is the 13-digit location specific number, do you want the Inpatient ID or the ED/Outpatient ID?**

A: You should include on the Attestation Form the 13-digit MA PROMISe™ ID number for your hospital.

- 37. Q: Can you explain what process will be followed in the event that a hospital has fewer patients presenting in their ED with OUD than the minimum required for their given tier (i.e., they will not have met the minimum number of patients utilizing pathways by January 17th)?**

A: DHS plans to use MCO encounter data to determine whether the number of HealthChoices recipients that have connected to OUD treatment services within 7 days of the visit to the ED. Where the number of recipients is determined to be less than the expected number, as determined by the hospital's tier, DHS will contact the hospitals for information.

- 38. Q: For rural or low volume hospitals and where coordination with the County SCA hasn't been able to result in a 24/7 resource, would filling in gaps in coverage with ED initiated contact to the PA Help line, (800)662-HELP (4357) satisfy Pathway 2? In those rare cases, the real time referral process could be initiated in the ED with assistance available to the patient to transition to that provider before they are discharged.**

I am very sure you are aware of the services provided by this resource, but a description is below:

"Your call to 1-800-662-HELP is completely confidential. This hotline, staffed by trained professionals, is available 24 hours a day, seven days a week and is available in both English and Spanish.

When you call the hotline, you will have several options. You can choose to speak to a representative who can refer you to a local substance use disorder treatment provider, you can request information to be sent to you, or you can get answers to your questions about health insurance.

If you choose to speak to a representative who can refer you to local services, a professional who is trained in substance use disorder counseling and knowledgeable about the resources available in Pennsylvania will listen to your specific situation and help guide you to the resources that are right for you."

This process, when performed in real time and activated by the ED staff would seem to satisfy the evaluation and referral portion of the warm handoff leaving the transition to the recommended service to the on-site staff.

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A: This does not meet the warm handoff criteria for this pathway.

39. Q: Can you tell me if it is optional for our hospital to participate or is it mandated?

A: The program is neither voluntary nor mandatory. It is an incentive program for all MA-enrolled acute care providers.

40. Q: If we do not have licensed detox beds in our facility, do we have to have written agreements for direct admission to facilities that are licensed for detoxification since the primary reason for admission must be for MAT?

A: Yes, any licensed drug and alcohol provider can receive the warm hand off. Also, any Medication Assisted Therapy (MAT) provider willing to take responsibility for managing the patient on buprenorphine or injectable naltrexone is acceptable. The Department of Human Services (DHS) encourages providers to work with the Centers of Excellence (COE) or Single County Authority (SCA) to facilitate the warm hand off but the key outcome is the patient gets into active treatment within seven days of leaving the Emergency Department (ED).

41. Q: Also, can we get credit if a patient is admitted for another primary reason, but the secondary is OUD and we initiate MAT during admission to the hospital?

A: Yes, the answer is #5b in Q&A. Inpatient admission for methadone induction requires a co-occurring diagnosis and must follow current state and federal regulations. Additionally, an inpatient admission can be for the co-occurring illness such as pregnancy, cellulitis, endocarditis, aspiration pneumonia, or respiratory failure. In order for the admission to be counted in the numerator, the patient **must initiate methadone or buprenorphine treatment during the acute inpatient hospital stay.**

42. Q: Can you provide a list of the Opioid Use Disorder ICD-10 codes? We would like to determine which tier we would be in and if we will see enough patients between now and January 2019 to be eligible for the incentive program.

A: The Opioid Use Disorder ICD-10 codes you are inquiring about can be obtained from the Hospital Healthsystem Association of Pennsylvania (HAP).

43. Q: Our hospital is in the low end of Tier two, 39 patients. We have seen a precipitous drop of in ED presentations over the past year, hopefully because we are making a difference. If in the year that participation in pathways is measured, will the Tiers be recalculated?

A: The Department of Human Services (DHS) does not plan to re-evaluate the Tiers, as the pathways payment is only for the initial performance year. The Tiers are established by number of OUD related ED visits not the number of patients.

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- 44. Q: My organization is participating in the HAP OUD incentive program. We have all steps in place but need to know where to send the CCD's. Either email, fax, hard copy, etc... and what is the destination?**

See responses in questions #33, 34 and 35.

- 45. Q: Does Pathway #4 need to be an admission/observation for Primary Diagnosis of OUD, or can that OUD be the secondary diagnosis?**

A: See response in question 5b above... Inpatient admission for methadone induction requires a co-occurring diagnosis and must follow current state and federal regulations. Additionally, an inpatient admission can be for the co-occurring illness such as pregnancy, cellulitis, endocarditis, aspiration pneumonia, or respiratory failure. In order for the admission to be counted in the numerator, the patient **must initiate methadone or buprenorphine treatment during the acute inpatient hospital stay.**

- 46. Q: Is the follow-up within 7 days of discharge or 7 days of ED visit? If patient admitted, 7 days follow-up after ED visit may be problematic.**

A: The patient obtains follow-up treatment for OUD within 7 days of discharge from the ED. When a patient is placed in observation or admitted for an inpatient stay, the patient is effectively discharged from the ED. These treatments include any American Society of Addiction Medicine's (ASAM) level of care treatments such as: acute inpatient rehabilitation, detoxification, inpatient/outpatient residential rehabilitation, partial hospitalization programs, halfway houses, and any claim for medication assisted treatment (MAT). This is not an inclusive list.

- 47. Does the patient need to be treated as inpatient by a waived physician or not?**

A: Yes, each health system needs to develop their own protocols and follow applicable state and federal regulations.

- 48. Q: I am preparing to complete the following attestation form for the implementation of pathways for treating patients with opioid use disorders. In preparing to complete the attestation form – I have the following question. To determine our tier assignment, do we report all OUD cases for all financial classes (commercial insurance carriers and Medicare) or do we report only the HealthChoices numbers? These numbers are quite different and will significantly impact our total number of cases and our tier assignment. I posed this question to HAP and have not heard back so I thought I would reach out to DHS. If this is the incorrect email address, I would appreciate you forwarding it to the proper person who can answer this question.**

A: DHS will provide HAP with the number of OUD visits from CY2016. This will determine the hospital's tier for attestation purposes.

- 49. Q: There are a few additional questions we have regarding the Maternal/Fetal pathway as well as the IP admission piece. Who would be the appropriate person to reach out to at your office in order to schedule a call with a team from our hospital to discuss?**

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A: Dr. David Kelley – Please contact (717) 787-1870 to schedule a conference call with him.

50. Q: In addition, regarding the IP pathway, are there best practice hospitals that you would recommend we could reach out to in order to discuss?

A: DHS has not seen the pathways developed by the hospitals at this time. We suggest contacting the Hospital and Healthsystem Association of PA to gain feedback on best practice hospitals.

51. Q: What the release of information consent process needs to be (waivered because it's public health?).

A: If a hospital ED chooses to participate in the P3N ADT Project, they will be required to follow the consent requirements of their HIO for participation in the ADT Project.

If a hospital ED chooses to report all ED OUD CCDs for Medicaid recipients to DHS via the MAHIT DIRECT Messaging Account: PADPW-OMAP-MAHEALTHIT@directaddress.net or through their HIO's P3N Public Health Gateway (PHG) connection to the DHS electronic Clinical Quality Measure (eCQM) registry, they will need to secure written consent from the affected patient for sending this protected health information to Dr. David Kelley, Chief Medical Officer, Office of Medical Assistance Programs, Pennsylvania Department of Human Services.

52. Q: How DHS will use this information – a DUA is standard procedure whenever data is exported outside of our environment?

A: If a hospital ED chooses to participate in the P3N ADT Project, their ADT information will be used to alert the patients' care team of their encounter using their HIO's encounter notification service (ENS) and when appropriate, the patients' care team in another HIO.

If a hospital ED chooses to report all ED OUD CCDs for Medicaid recipients to DHS via the MAHIT DIRECT Messaging Account, DHS will monitor the reported information on at least a weekly basis for changes in ED OUD encounters. Aggregate, non-identifiable, information may be shared with government agencies and managed care organizations to mobilize resources in response to changes in OUD incidence.

53. Q: I have been asked to clarify the following question regarding the attestation form. The form instructs you to enter the number of OUD ED visits in the most recent 12 months. Is the most recent 12 months the data from CY2016 that DHS has provided or most recent 12 months from date of attestation. The thought is that it is CY2016 data DHS provided since that is the only data given. Can you please confirm.

I attest on behalf of [insert provider name] that:

- [Insert provider name] has had [insert number of OUD Ed visit] OUD ED visits in the most recent 12 months and [use tiers listed above to determine the number of HealthChoices recipients to insert] HealthChoices recipients will need to use a newly established pathway by January 17, 2019.

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A: Yes, that is correct per the methodology published on the website, DHS is using CY2016 ED visits to determine the hospital's tier for Attestation. Data was run in the aggregate and rolled up to the hospital level.

- 54. Q: Regarding both the HQIP/OD 2018 process and 2019 outcome metrics, will OD patients be counted who are uninsured at the time of their ED visit, but are eligible and subsequently enrolled in HealthChoices retrospectively?**

A: Medical Assistance (MA) recipients are not retroactively enrolled in HealthChoices. Those recipients that receive retroactive enrollment are covered by Fee-for-Service for the retroactive period. Experience for recipients having Fee-for-Service coverage will not be counted in this program.

- 55. Q: If a patient visits the hospital with no insurance, but subsequently enrolls in a HealthChoices program, does that count toward the hospital's required number of HealthChoices visits?**

A: Medical Assistance (MA) recipients are not retroactively enrolled in HealthChoices. Those recipients that receive retroactive enrollment are covered by Fee-for-Service for the retroactive period. Experience for recipients having Fee-for-Service coverage will not be counted in this program.

- 56. Q: Can you advise if patients that have HealthChoices as a secondary insurance will be counted towards the minimum number of patients needed for pathway implementation?**

A: Yes, to the extent that the ED bills the MA MCO as secondary. For the HealthChoices recipient to be included the ED must bill and receive payment (including a \$0 paid amount) from the MA MCO.

- 57. Q: Has the attestation form for the New Opioid Measure for the Department of Human Services' Hospital Quality Incentive Program been finalized yet? The website says that it was being revised.**

A: The Attestation Form is available on the website at the following link:
http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_282409.pdf

- 58. Q: If we have three hospitals in our TIN, can we choose to pilot this program in only one of the hospitals, or does it have to be all?**

A: Attestations are accepted at the hospital level as identified by the hospital's Medicare CCN.

- 59. Q: A recipient (in the context of a minimum number of recipients needed by Jan 17, 2019) means someone who received OD treatment within 7 days of visit, correct?**

A: Yes. That recipient must also be covered by the HealthChoices program.

HAP Q & A: Opioid Use Disorder Program

60. Q: If we choose to attest to only one pathway by October 31st, but then have the capability to do another pathway, when can we attest to that additional pathway. Will there be another opportunity?

A: The hospital must have submitted the final Attestation form by November 30, 2018. No Attestations will be accepted after this date.

61. Q: if we attest and then are unable to implement successfully, can we "disenroll" from the program.

A: Hospitals that are unable to implement a pathway should notify DHS through this email address - RA-PWPQUALINCEN@pa.gov.

62. Q: how long is this program currently funded for? 2019 at least, but is there any committed funding after that.

A: The implementation of the pathways is funding for CY2019 only. Performance for increasing the number of HealthChoices recipients that get into OUD treatment within 7 days of the ED visit is expected to continue into future years.

63. Q: We have the list of HealthChoices recipients that DHS will include in this new incentive program. I would like to know if the other highlighted Medicaid programs will also be considered?

Primary Insurance Plan Description	Primary Insura..	2018
Null	Q49	1
	V81	1
AETNA BETTER HEALTH	1116001	22
	AETBH	1
	COAETBH	2
AMERIHEALTH CARITAS PENNSYLVANIA	1126001	7
AMERIHEALTH CARITAS VIP CARE	1126001	2
GATEWAY HEALTH PLAN	1041001	75
	COGATEHEAL	5
UHC COMMUNITY PLAN	1098001	21
UHC COMMUNITY PLAN OHIO	1098002	1
UPMC FOR YOU (MA HMO)	COUPMCMA	18
	UPMC4U	4
UPMC FOR YOU(MA HMO)	1104001	101

A: This program only includes the MCOs that participate in the Physical Health HealthChoices program: Aetna Better Health, AmeriHealth Caritas Pennsylvania, Gateway Health Plan, Geisinger Health Plan, Health Partners Plans, Keystone First, United Healthcare Community Plan of Pennsylvania, and UPMC for You.

