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)?
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.

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 9/28/18 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.
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 primary purpose of treating OUD.

13. Q: Does a patient have to be admitted by a waivered physician or can a patient be admitted by and (e.g.,) obstetrician with a waivered 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: What evidence will you require that a pathway exists?
A: Please see answer to #10 above.

17. 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.

18. 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.

19. 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
20. 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.

21. 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.

22. 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.

23. 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 primarily 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.

24. 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.

25. 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 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.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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 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.


31. 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: 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 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.

32. 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 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.

33. 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: 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 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.


HQIP ED OUD Q&A
September 10, 2018
34. 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.