COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Quality Improvement and Patient Protection Committee

November 12, 2015

Agenda

- Approval of Minutes from the September 22, 2015 Meeting
- Health Care Innovation Investment Program
- Risk Bearing Provider Organizations and Accountable Care Organization Appeal Process through the Office of Patient Protection
- Discussion of Program Design for the HPC's Pilot on Neonatal Substance Abuse Syndrome
- Schedule of Next Committee Meeting (December 9, 2015)

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Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on September 22, 2015, as presented.

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Health Care Innovation Investment Program background

Establishment of the Health Care Innovation Investment Program

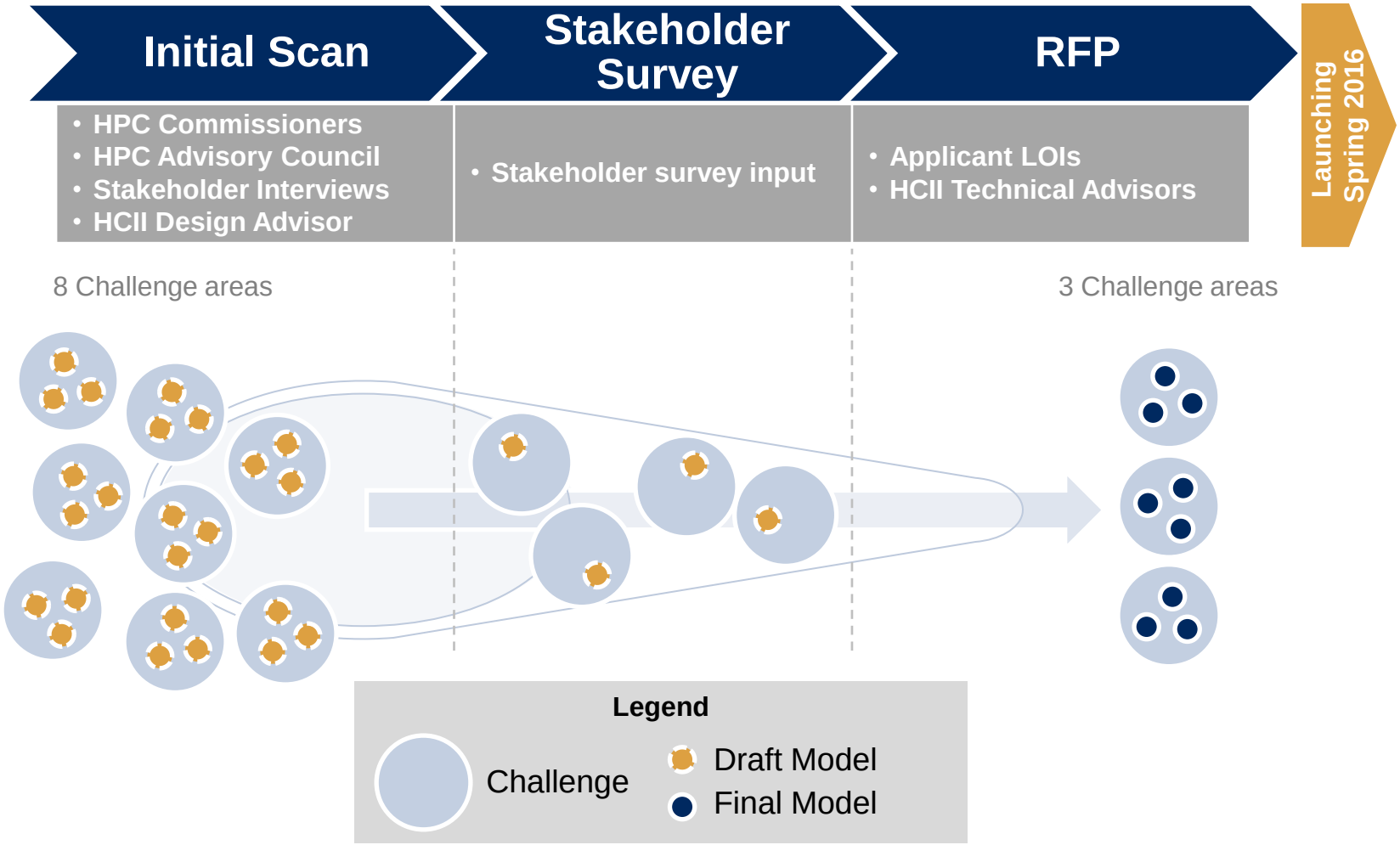
- M.G.L. c. 6D § 7
- Funded by revenue from **gaming licensing fees** through the Health Care Payment Reform Trust Fund
- Total amount of **$6 million**
  - *May increase if 3rd gaming license is awarded*
- Unexpended funds may to be rolled-over to the following year and do not revert to the General Fund
- **Competitive** proposal process to receive funds
- Broad eligibility criteria (*any **payer or provider***)

Purpose of the Health Care Innovation Investment Program

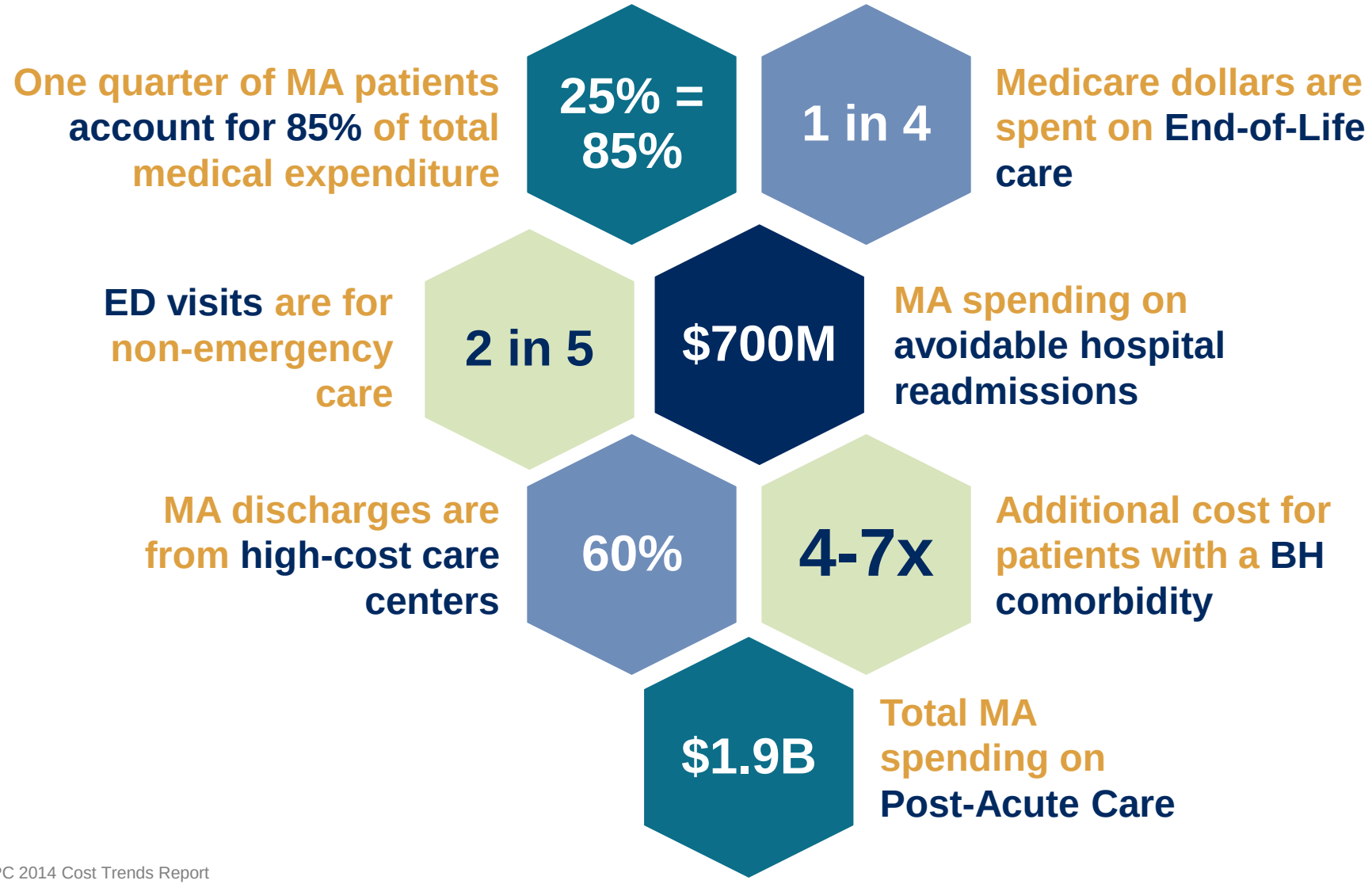
- To **foster innovation** in health care **payment** and service **delivery**
- To **align** with and **enhance** existing funding streams in Mass. (e.g., DSTI, CHART, MeHI, CMMI, etc.)
- To support and further efforts to meet the **health care cost growth benchmark**
- To improve **quality** of the delivery system
- **Diverse uses** include incentives, investments, technical assistance, evaluation assistance or partnerships

HCII Round 1 application process maximizes applicant input and engagement

*HPC shall **solicit ideas for payment and care delivery reforms** directly from providers, payers, research / educational institutions, community-based organizations and others.*



Primary cost drivers in Massachusetts identified by HPC

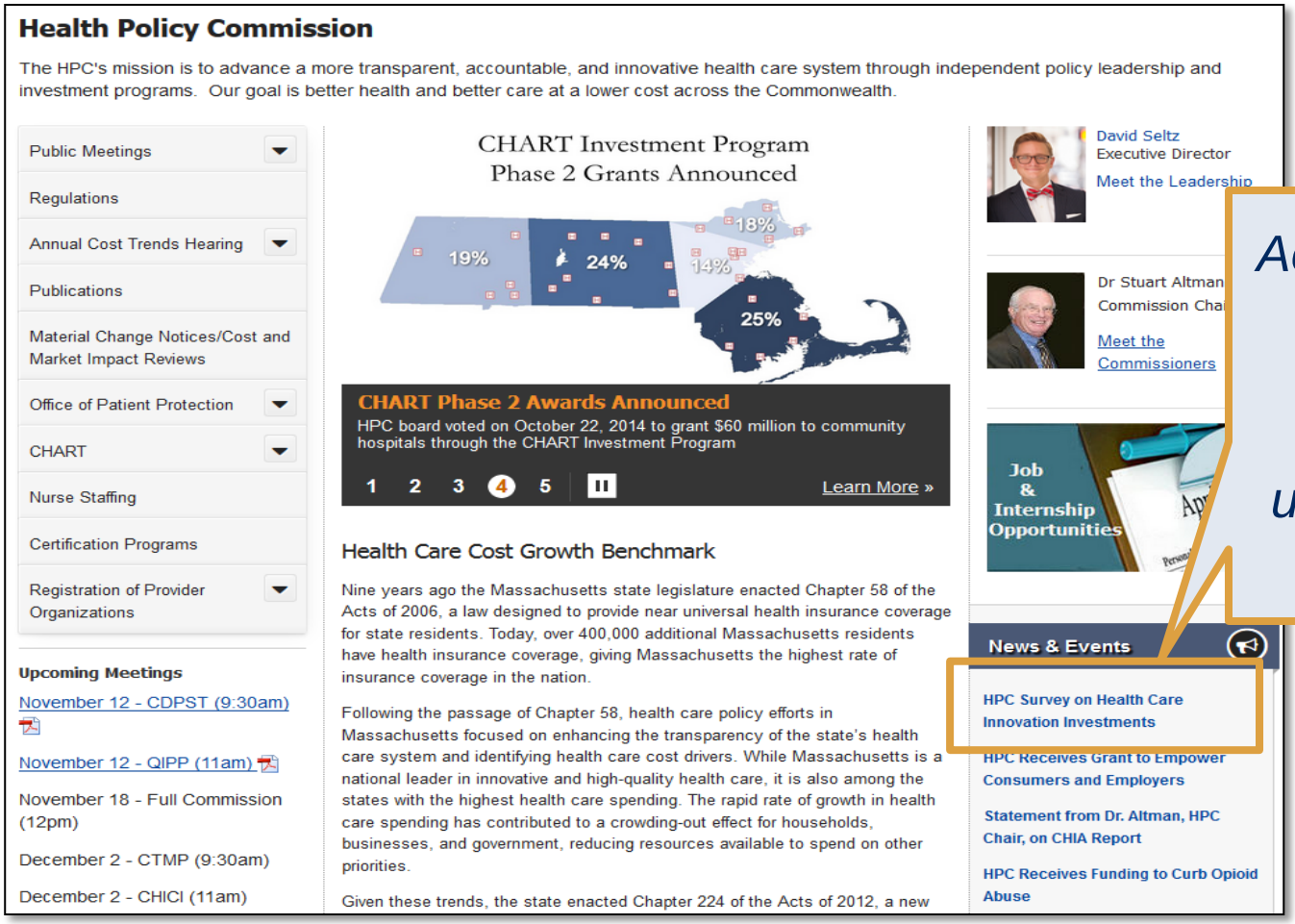


HPC 2014 Cost Trends Report
HPC July 2014 Cost Trends Supplement
HPC 2015 Annual Cost Trends Hearing – AGO Report

HCII Stakeholder Survey – we need your input!

Please respond to the HCII stakeholder survey. **LIVE** until next Friday, 11/20.

HPC Homepage – mass.gov/hpc



Access the HCII survey from HPC's homepage under "News & Events"

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Statutory Requirements

	RBPO	ACO
M.G.L. c. 6D, §15	N/A	(b)(vi) calls for internal appeals plan as required for RBPOs; plan shall be approved by OPP; plan to be included in membership packets
M.G.L. c. 6D, §16	N/A	(a)(8) OPP to establish regs, procedure, rules for appeals re: patient choice, denials of services or quality of care (b) establish external review including expedited review
M.G.L. c. 176O, §24	(a) certified RBPOs shall create internal appeals processes (b) 14 days/3 days for expedited; written decision (b) RBPO shall not prevent patient from seeking outside medical opinion or terminate services while appeal is pending (d) OPP to establish standard and expedited external review process	ACO is to follow M.G.L. c. 176O, §24 when developing internal appeals plan (see M.G.L. c. 6D, §15(b)(vi))

RBPO Statutory Requirements –M.G.L. c. 176O § 24

a) All risk-bearing provider organizations certified under chapter 176U shall create **internal appeals processes**. The appeals processes shall be available to the public in written format and, by request, in electronic format.

(b) The internal appeals processes in subsection (a) shall be completed in a period not longer than 14 days; provided, however, that an expedited internal appeal shall be completed in a period not longer that 3 days for a patient with an urgent medical need including, but not limited to, terminal illness or emergency situations, as defined through regulations by the office of patient protection. During the appeals process, the risk-bearing provider organization shall not: (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate any medical services being provided to the patient, including medical services which began prior to the appeal and are the subject of such appeal. The decision on the appeal shall be in writing and shall notify the patient of the right to file a further external appeal.

(c) Risk-bearing provider organizations shall inform any patient of the right to designate a third party to advocate on the patient's behalf during the appeals process including, but not limited to, a spouse or other family member, an attorney of record or a legal guardian. If the patient does not elect a person to serve as his or her advocate such provider organization shall offer to contact the office of patient protection and the office of patient protection may designate an ombudsman to advocate on the patient's behalf.

(d) The office of patient protection shall establish by regulation an **external review process** for the review of grievances submitted by or on behalf of patients of risk-bearing provider organizations. The process shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted and shall include the right to have benefits continued pending appeal. The office of patient protection shall establish expedited review procedures applicable to emergency and urgent care situations.

(e) The office of patient protection shall promulgate regulations necessary to implement this section.

ACO Statutory Requirements – M.G.L. c. 6D § § 15 and 16

MGL c. 6D §15(b)	"A certified ACO shall… (vi) develop and file an **internal appeals** plan as required for risk bearing provider organizations under section 24 of chapter 176O provided, that said plan shall be approved by the office of patient protection; provided further, that the plan shall be a part of a membership packet for newly enrolled individuals;…"
MGL c. 6D §16(a)(8)	OPP shall "establish, by regulation, procedures and rules relating to appeals by consumers aggrieved by restrictions on patient choice, denials of services or quality of care resulting from any final action of an ACO, and to conduct hearings and issue rulings on appeals brought by ACO consumers that are not otherwise properly heard through the consumer's payer or provider."
MGL c. 6D §16(b)	**"**The Commission shall establish an external review system for the review of grievances submitted by or on behalf of insurers of carriers under section 14 of chapter 176O. The commission shall establish an **external review process** for the review of grievances submitted by or on behalf of ACO patients and shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted. The commission shall establish expedited review procedures applicable to emergency situations, as defined by regulation promulgated by the division."

Updates Since March QIPP Committee

Staff Research

Continued examination of applicable models

Identification of consumer issues

+

Ongoing Stakeholder Outreach

Payers

Consumer advocates

Provider organizations

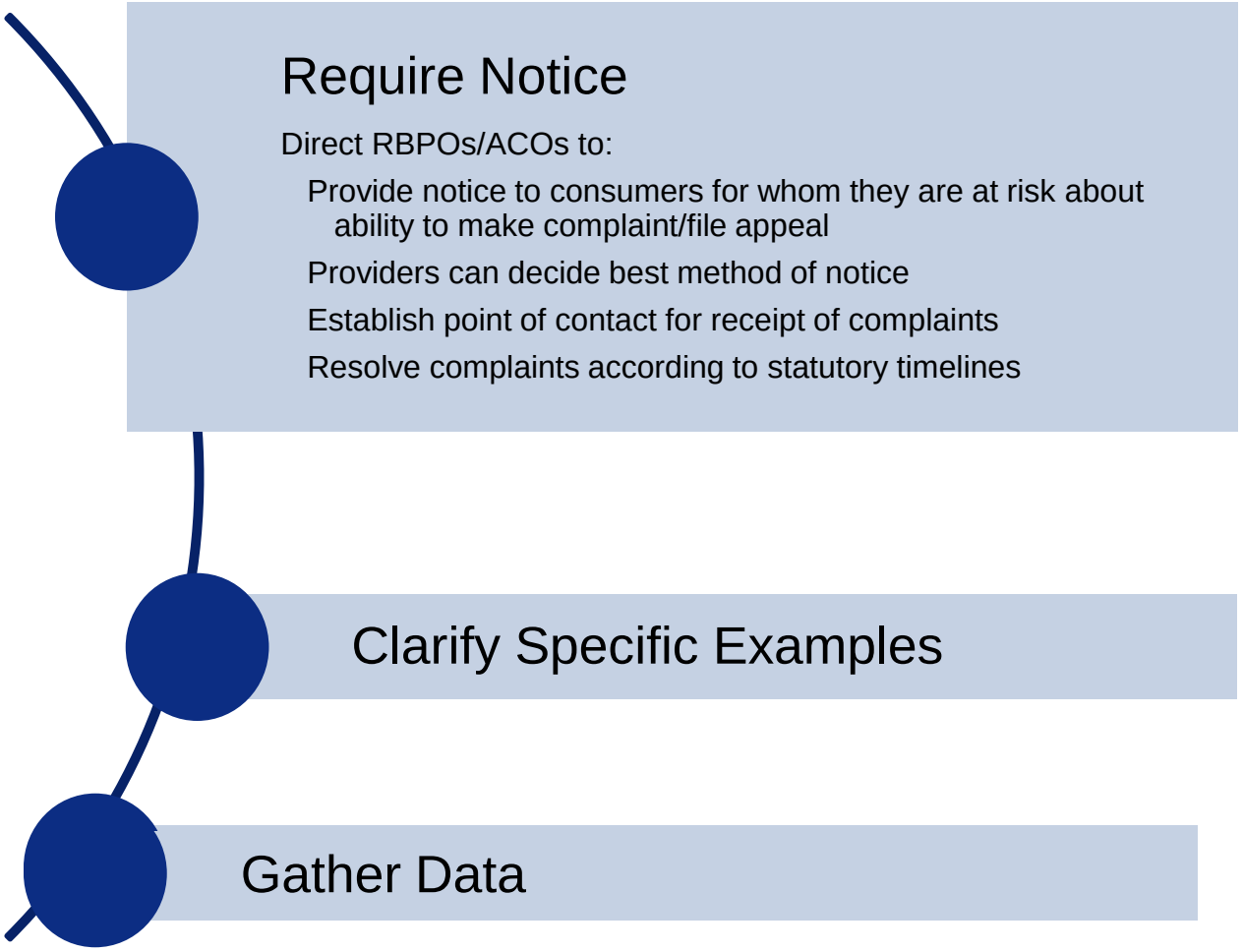
→

Growing consensus on the need for more data to guide implementation of RBPO/ACO appeals statutory mandates

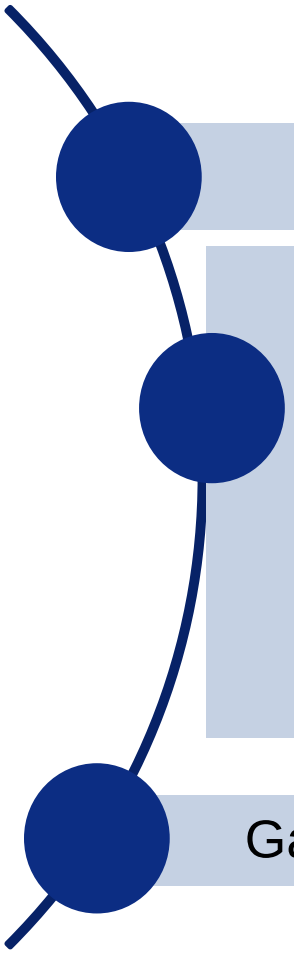
Objectives

1. Advance consumer protection established in Chapter 224 without duplicating existing rights under carrier insurance appeals
2. Protect patients while recognizing the needs of different providers and minimizing administrative burden and expense
3. Inform consumers about ACO/RBPO providers
4. Build on existing provider mechanisms for addressing complaints
5. Gather and analyze data, to provide foundation for developing appeals processes and rules

Proposed Bulletin



Proposed Bulletin



Require Notice

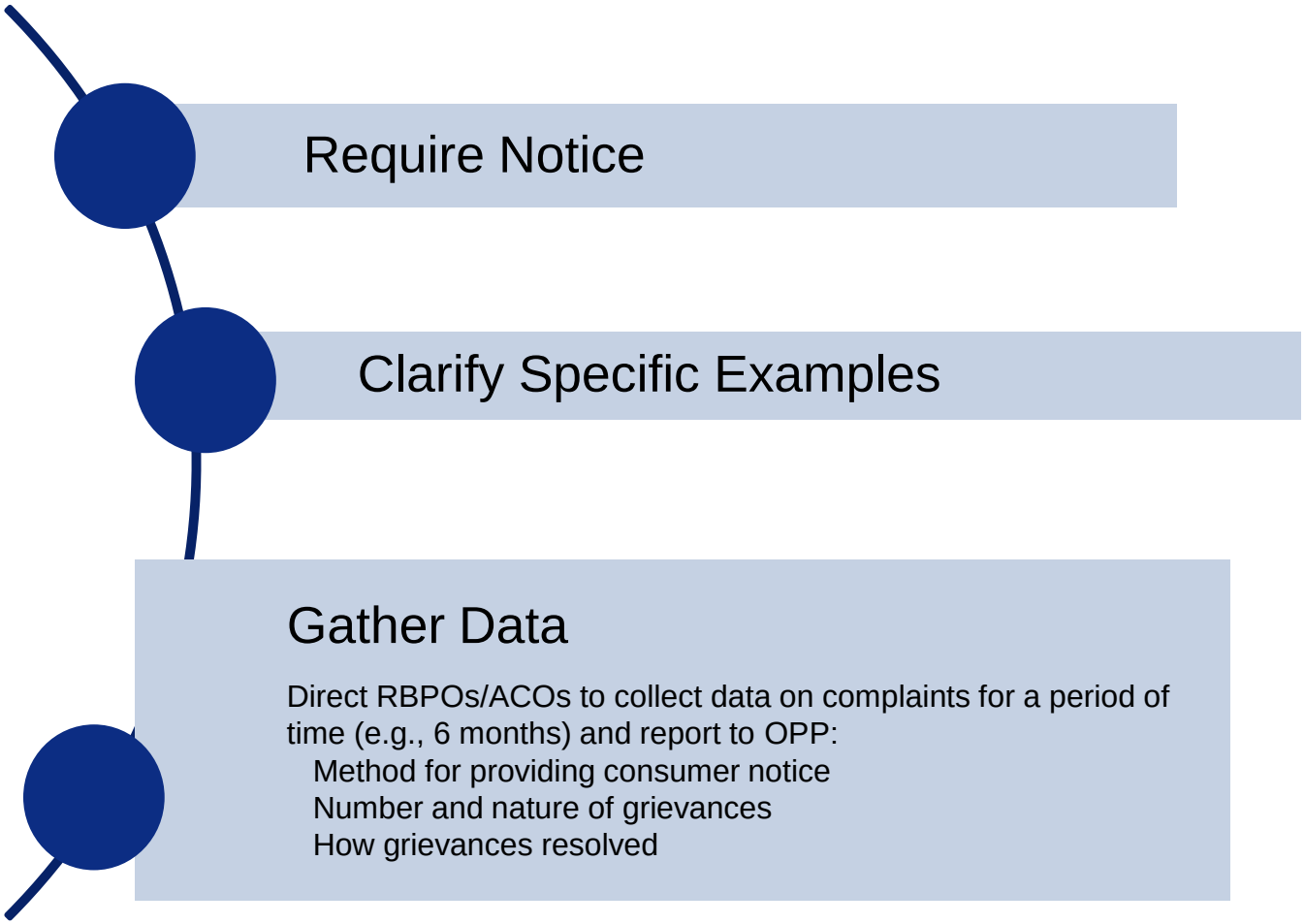
Clarify Specific Examples

Provide examples of types of complaints
- Issues not properly addressed by the insurance carrier or health plan sponsor involving potential limitations of care
  - Denials or restrictions on referrals to non-participating providers
  - Denials or restrictions on type or intensity of treatment or services
  - Denials or restrictions on timely access to treatment or services

Clarify that existing rules for Medicare patients apply

Gather Data

Proposed Bulletin



Next Steps

Ongoing processing with stakeholders

Issue Bulletin

Review data

- Opportunity to consider information gathered by RBPOs/ACOs on consumer appeals

Develop Regulation

- Public process including proposed regulation and public comment period

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  - Background
  - Pilot Development
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Neonatal abstinence syndrome (NAS)

- Clinical diagnosis resulting from the abrupt discontinuation of exposure to substances in utero (e.g., methadone, opioid pain relievers, buprenorphine, heroin)
- In 2013 - 1,189 hospital discharges in MA with NAS code (21 disch. for other states)
- Average LOS = **16 days** (ranges from 9 – 79 days)

Newborns with NAS are more likely to have complications compared with all other US hospital births.

Premature birth (gestational age <37 weeks)
2.6 – 3.4 times more likely

Low birthweight <2,500g
19.1% vs 7.0%

Seizures
2.3% vs 0.1%

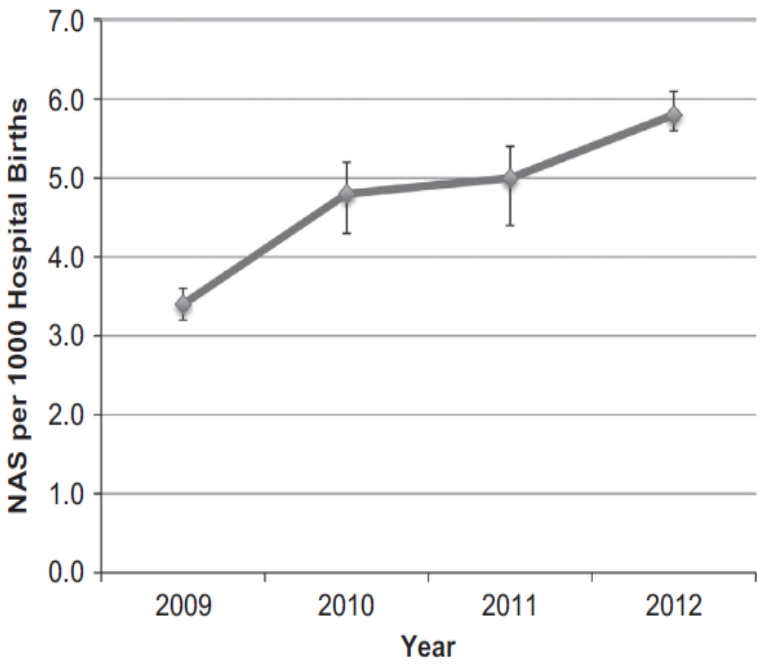
Respiratory diagnoses
30.9% vs 8.9%

Feeding difficulties / Difficulty gaining weight
18.1% vs 2.8%

Incidence of NAS is increasing nationwide

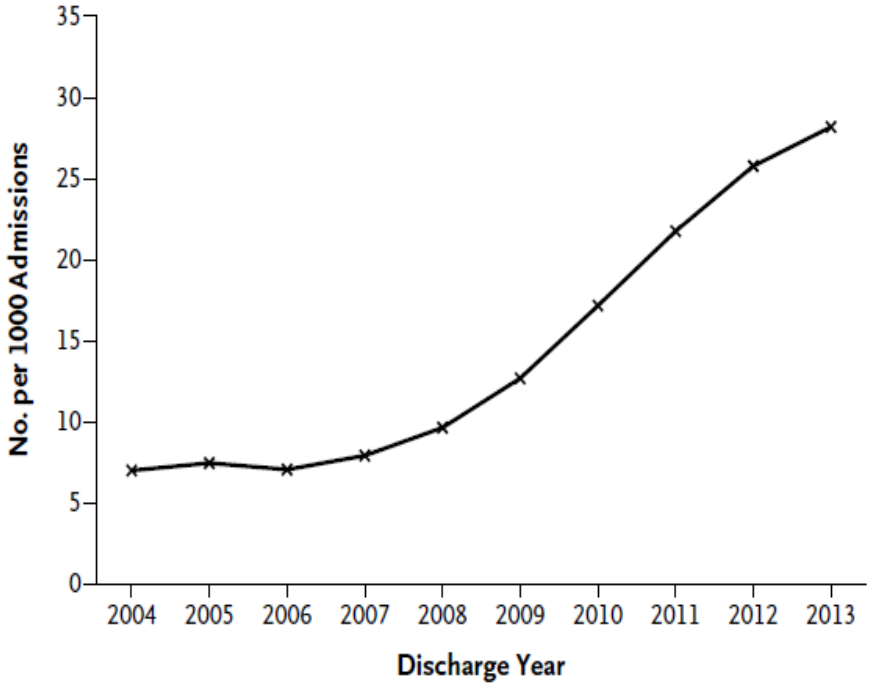
Proportion of hospital births that are NAS related increased 5 fold

1.20/1000 to 5.58/1000 hospital births/year (2000-2012)



Proportion of NICU stays that are NAS related increased 3 fold

increased from 7/1000 to 27/1000 (2004-2013).

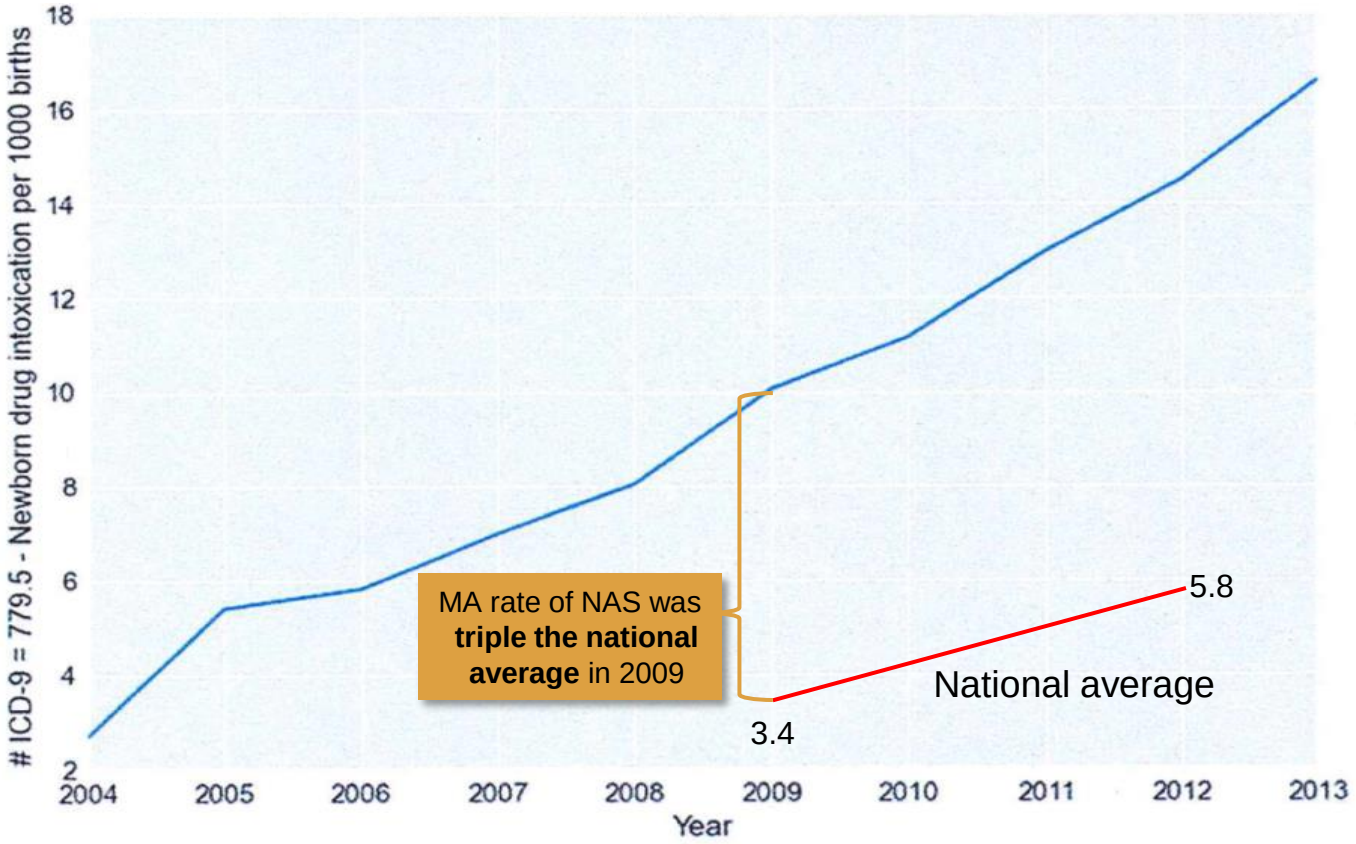


Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

Tolia V, et al. Increasing incidence of the neonatal abstinence syndrome in U.S. Neonatal ICUs. N Engl J Med 2015;372:2118 – 2126.

Incidence of NAS is increasing in Massachusetts

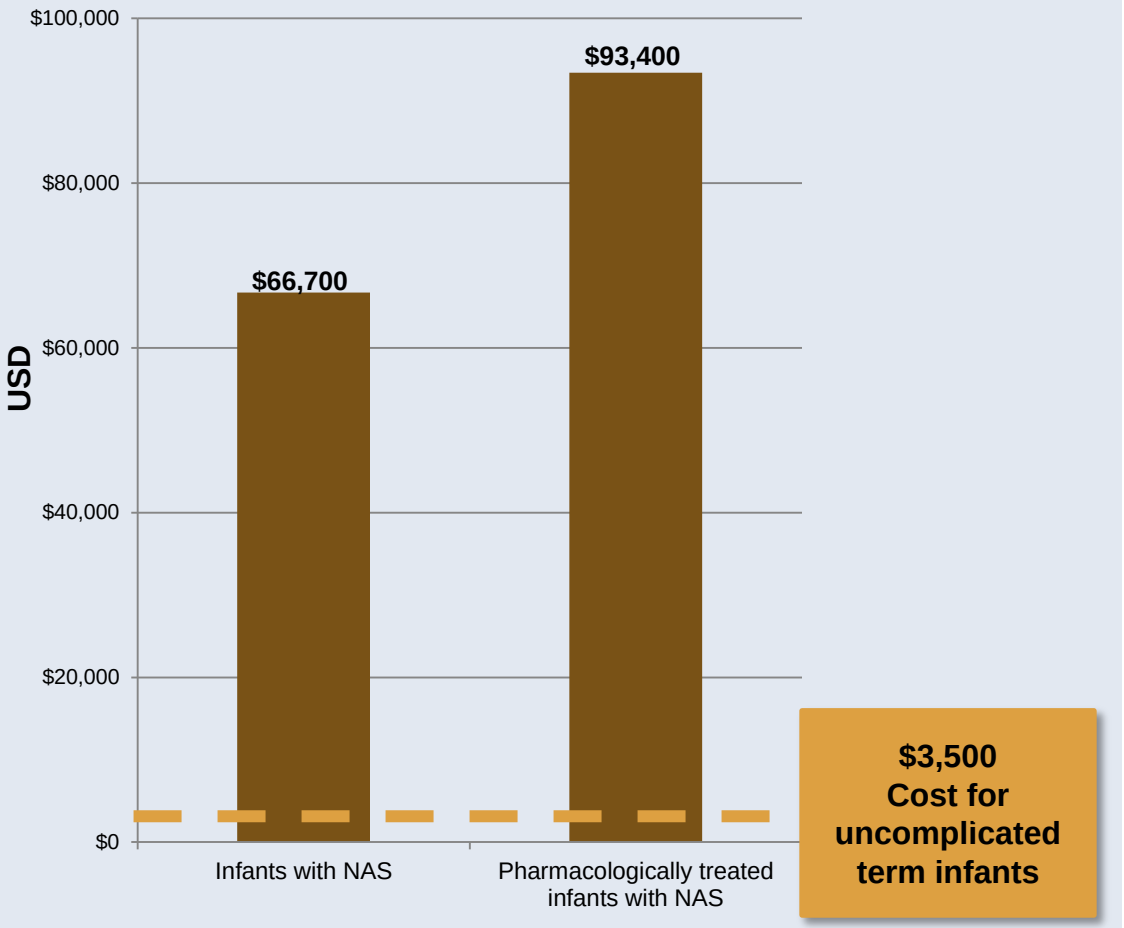
From 2004 to 2013 the Incidence of NAS increased from <3/1000 hospital births to **>16/1000 hospital births** per year

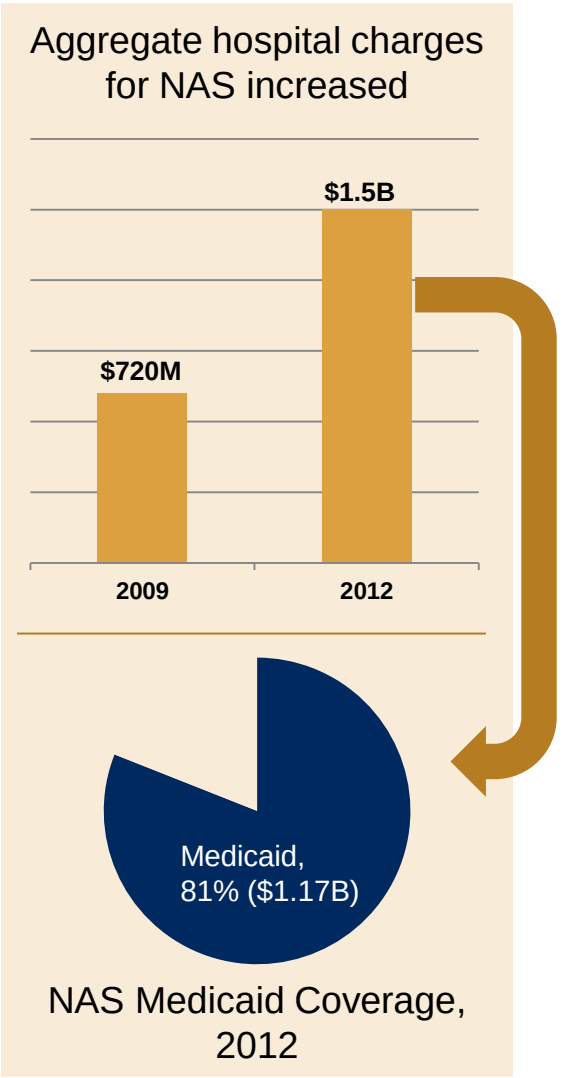


Gupta M and Picarillo A. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. neoQIC. January 2015. PowerPoint presentation.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015; doi: 10.1038/jp.2015.36. [Epub ahead of print]

Costs of NAS nationwide

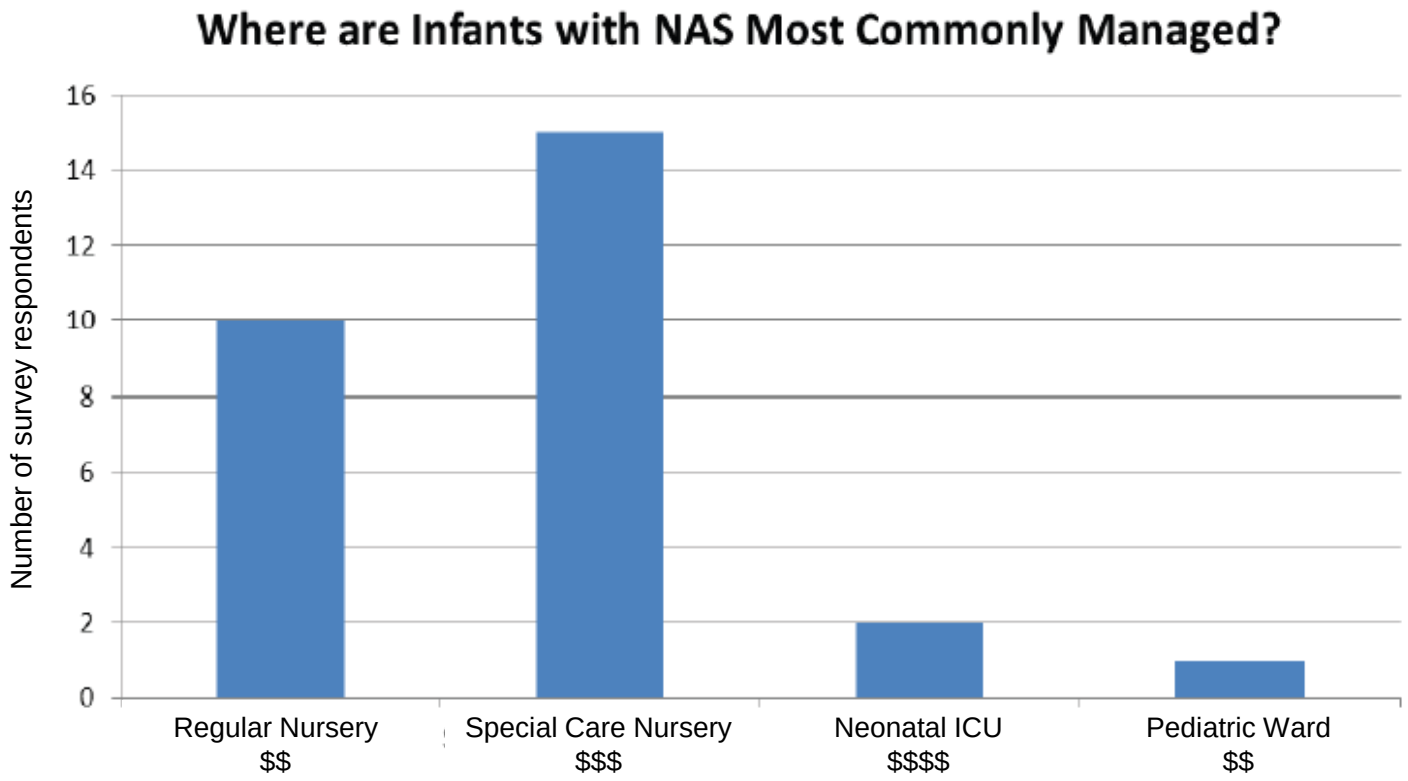




Patrick S, Schumacher R, Benneyworth B, *et al*. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. JAMA 2012;307(18):1934-40.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015. Apr 30. doi: 10.1038/jp.2015.36. [Epub ahead of print]

NAS most frequently treated in most expensive setting in MA



Relative Cost of Care Setting		
	$$$$	NICU
	$$$	Special care nursery
	$$	Regular nursery/pedi floor
	$	Outpatient

Gupta M, Picarillo A. “Neonatal abstinence syndrome: a statewide improvement initiative.” Massachusetts Perinatal Quality Collaborative. November 13, 2013.

Intervention opportunities across settings and time

Family Planning

- Integrated care (primary care, contraception, SUD treatment available in one setting)

Pre-natal

- Methadone / buprenorphine maintenance (vs. IV drug use)
- Wrap-around social services and coordinated multidisciplinary care

Post-natal

- Lower acuity of care (NICU → Special care nursery → pediatric floor)
- Rooming-in (mothers and babies together in the hospital)
- QI projects to decrease length of stay (staff training, breastfeeding)
- Wrap-around social services and coordinated multidisciplinary care

Childhood

- Wrap-around social services and coordinated multidisciplinary care
- Early intervention

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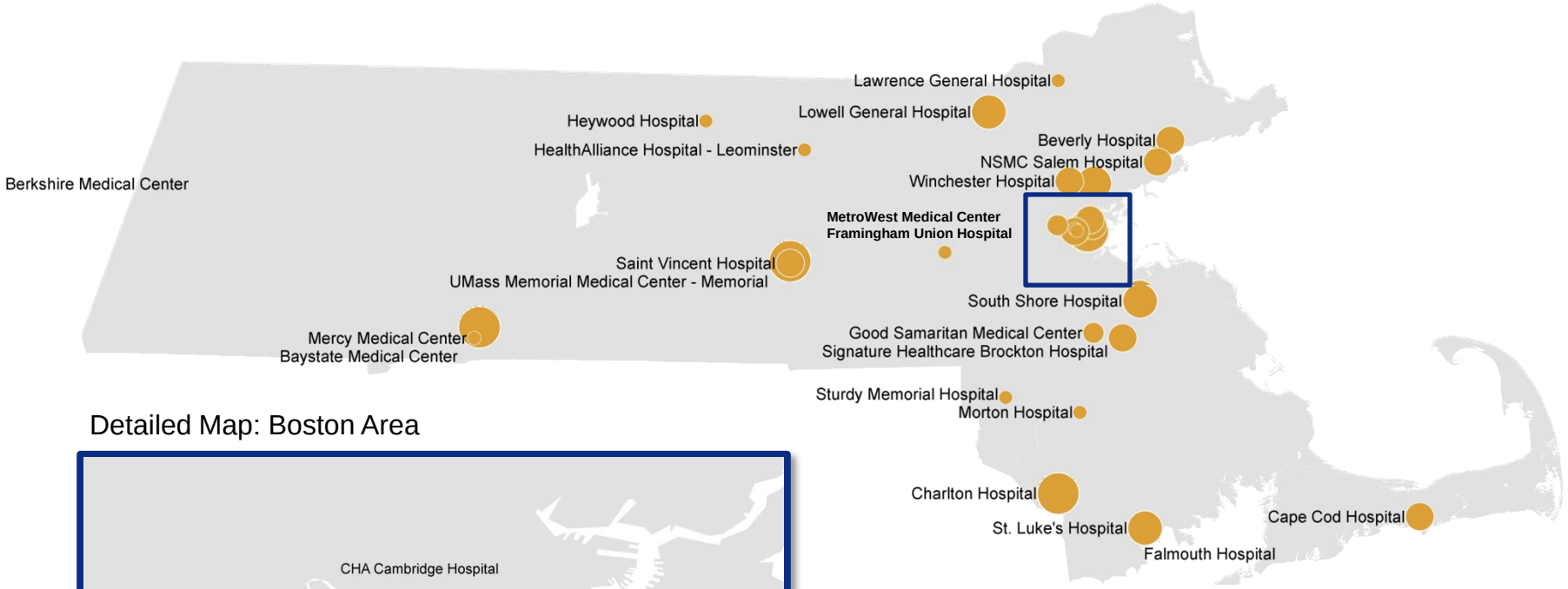
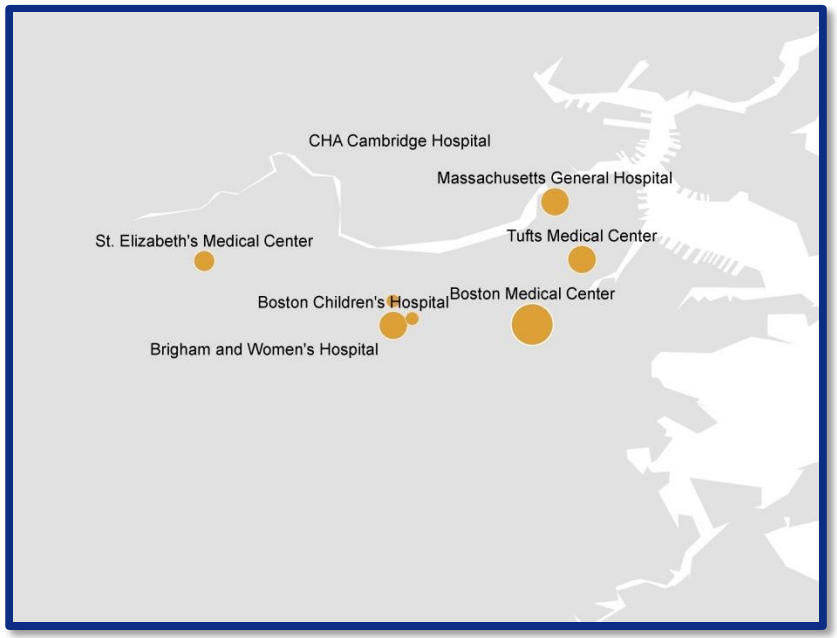
NAS discharge volume by hospital



Detailed Map: Boston Area



Source: Massachusetts Health Data Consortium (MDHC) 2013 hospital data

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HPC pilot funding to address NAS (1/2)

For a reserve to be administered by the health policy commission in consultation with the department of public health; provided, that not less than $500,000 shall be expended to develop a pilot program to implement a fully integrated model of post-natal supports for families with substance exposed newborns, integrating obstetrics and gynecology, pediatrics, behavioral health, social work, early intervention providers, and social service providers to provide full family care; provided further, that the commission shall implement the program to provide care for substance exposed newborns and their families at up to 3 regional sites in the commonwealth to be selected by the commission through a competitive process in which applicants demonstrate community need and the capacity to implement the integrated model; provided further, that in developing the program, the commission shall consider evidence-based practices from successful programs implemented locally, nationally, or internationally and shall consult with the department of public health and the department of children and families; provided further … the commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means not later than 12 months following completion of the pilot program … on the results of the programs, including their effectiveness, efficiency, and sustainability; and provided further, that funds appropriated in this item shall not revert and shall be available for expenditure through June 30, 2017.

HPC pilot funding to address NAS (2/2)

What	• Spend **$500,000** before June 30, 2017
	• Funding for **fully integrated model of post-natal supports from delivery to discharge** for families with substance exposed newborns, including:
	  • obstetrics and gynecology
	  • pediatrics
	  • behavioral health
	  • social work
	  • early intervention providers
	  • social service providers to provide full family care

Who	• HPC in collaboration with DPH
	• Design informed by:
	  • **evidence-based practices** from successful programs implemented locally, nationally or internationally
	  • **consultation with DPH & DCF**

Proposed Deliverables	• Fund **up to 3 regional sites** to be selected through competitive process, based on
	  • community need
	  • capacity to implement the integrated model
	• Report to the Joint Committee on Mental Health and Substance Abuse and the House and Senate Committees on Ways and Means on results including effectiveness, efficiency, and sustainability

Identifying emerging best practices to inform pilot design

Budget Language: *the commission shall consider evidence-based practices from successful programs implemented locally, nationally, or internationally*

- **Literature review**
- **Semi-structured interviews** with providers around North America
- **Collaboration** with Neonatology Quality Improvement Collaborative (NeoQIC)
- **Focus group** with key provider experts

International evidence based practices

National evidence based practices

Local evidence based practices

Identifying national & international evidence based practices

Prenatal intervention	Post natal intervention
Sheway (Vancouver, British Columbia) • Pregnancy outreach program in Downtown Eastside of Vancouver • Multidisciplinary • Integrated prenatal, intrapartum, postnatal/neonatal	
Children's Hospital at Dartmouth (NH) • Multidisciplinary • Integrated prenatal, intrapartum, postnatal/neonatal	
Hallmark Health *(in development)* (MA) • Multidisciplinary • Integrated prenatal, intrapartum, postnatal/neonatal	
	Nationwide Children's Hospital (Columbus, OH) • Quality improvement initiative to reduce length of stay for newborns with NAS
Boston Medical Center RESPECT Clinic (MA) • Multidisciplinary • Integrated prenatal, intrapartum, postnatal	
	Boston Medical Center (MA) • Quality improvement initiative to reduce length of stay for newborns with NAS
Toronto Centre for Substance Use in Pregnancy (Toronto, Ontario) • Multidisciplinary • Based in family medicine outpatient office • Integrated prenatal, intrapartum, postnatal/neonatal	
	Fir Square (Vancouver, British Columbia) • Inpatient, multidisciplinary recovery center
	Lily's Place (Huntington, WV) • Residential infant recovery center
	Cabell Huntington Hospital's Neonatal Therapeutic Unit (Huntington, WV) • Inpatient infant recovery center

Preliminary data: reduced LOS from 18.2 → 13.6 days, saved ~$9,000 per pharmacologically treated patient

LOS reduced from 36 days → 18 days in three years

BMC inpatient quality improvement project: LOS reduced from 25.1→ 21.6 days in 18 months

Wolfgang et al. Reducing length of stay for infants with neonatal abstinence syndrome: a quality improvement project. Poster session: General pediatrics and preventative pediatrics 2015. E-PAS2015:4170.5625.
Asti L, Magers J, Keels E, Wispe J, McClead R. A quality improvement project to reduce length of stay for neonatal abstinence syndrome. Pediatrics 2015; 135(6):e1494 – e1500.

Identifying local evidence based practices - NAS focus group

Organization	Attendee
Beth Israel Deaconess Medical Center	Munish Gupta, MD
Melrose Wakefield / Hallmark Hospitals	Laura Sternberger, LICSW Karen Harvey-Wilkes, MD Calla Harrington, MSW/MPH Jennifer Wallace, RN Carol Plotkin, LICSW
Cape Cod Health	Cheryl Bartlett
Boston Medical Center	Kelly Saia, MD Davida M. Schiff, MD Elisha Wachman, MD
Department of Public Health	Jayne Wilson, LICSW, LADC-I Amy Sorensen-Alawad Debra Bercuvitz, MPH
Department of Children and Families	Kim Bishop-Stevens, LICSW
Institute for Health & Recovery	Katharine Thomas, PhD
Community Catalyst	Gabrielle Orbaek White, MPH

Focus group input

Treatment protocols for babies born with NAS or at high risk of having NAS vary widely across the Commonwealth. Investment to enhance implementation of high impact standards of care would be very beneficial to enhance clinical care and reduce intensity of services (and therefore cost) across the state. Key opportunities and observations include:

1. *Many nurses / hospital staff are not trained in caring for NAS infants* **–** not equipped to assess clinical severity, determine when breast-feeding is appropriate or when infant can / should be with mother - **care practices are often conservative** to the detriment of mothers and infants.

2. *Mothers and infants with NAS are often separated during hospitalizations* **–** default practice at many hospitals is **contradictory to evidence-based care**. The rationale for separation is often an assumption that **DCF involvement** requires separation, judgements made about the mother based on **toxicity screens**

3. **Simple clinical protocols in the inpatient hospital setting improve treatment substantially –** e.g., hospital-based initiation of **early intervention** supports, improved engagement of **community-based social work** in the hospital setting, and better **hand-offs** to community based primary providers (both PCPs and addiction medicine providers).

4. *There is need for testing of emerging best practices* – e.g., **long term, residential care** for mothers and infants in a non-hospital setting after discharge was referenced by several participants as being potentially high value.

5. *There is broad support for the HPC engaging in and helping move forward best practices in care for babies with NAS.*

Continuum of NAS interventions

A fully integrated model for enhancing care for neonatal abstinence syndrome begins during pregnancy and continues long after birth

Pregnancy

- Improve knowledge and awareness of obstetricians about NAS, including linkage to opioid treatment providers and social supports
- Enhance engagement of pregnant mothers in opioid treatment
- Create social and peer recovery support networks and plan for support needs

Inpatient delivery - discharge

- Improve inpatient delivery and perinatal care to be sensitive to the unique needs of NAS parents and babies
- Increase use of non-pharmacological therapies
- Provide supportive social and clinical services to begin effective transition back to community settings
- Improve coordination with DCF and other social service providers such as early intervention
- Provide effective parenting supports to enable successful transition home

Discharge - 6 months

- Provide highly effective care transitions to the community
- Leverage multidisciplinary clinical and social supports and peers to support parents
- Integrate pediatrics, family medicine, and social supports to have an effective hand-off mechanism for long-term stability
- Engage child-oriented supports through EI, DCF, and other community-based programs

Aligning with DPH's SAMHSA grant allows for interventions to be applied throughout continuum

SAMHSA pilot and HPC expansion

Focus on engagement & retention in SUD treatment

DPH SAMHSA grant $3,000,000

- 3 year award to 2 health systems (1 rural; 1 urban) with at least 60 NAS births / year or ≥ 5 times nat'l average
- Increase # of buprenorphine waived OB/GYN & PCPs
- Hospitals partner with an organization that will coordinate post-natal care for the family (e.g., primary and pediatric care, EI services, continued MAT)
- Peer recovery supports (pre- and post-natal)
- Support services (e.g., transportation, childcare)
- TA (e.g., buprenorphine training, trauma informed care training)

HPC state appropriation & CHART

Focus on length of stay; inpatient NAS protocols; lowering intensity of care settings

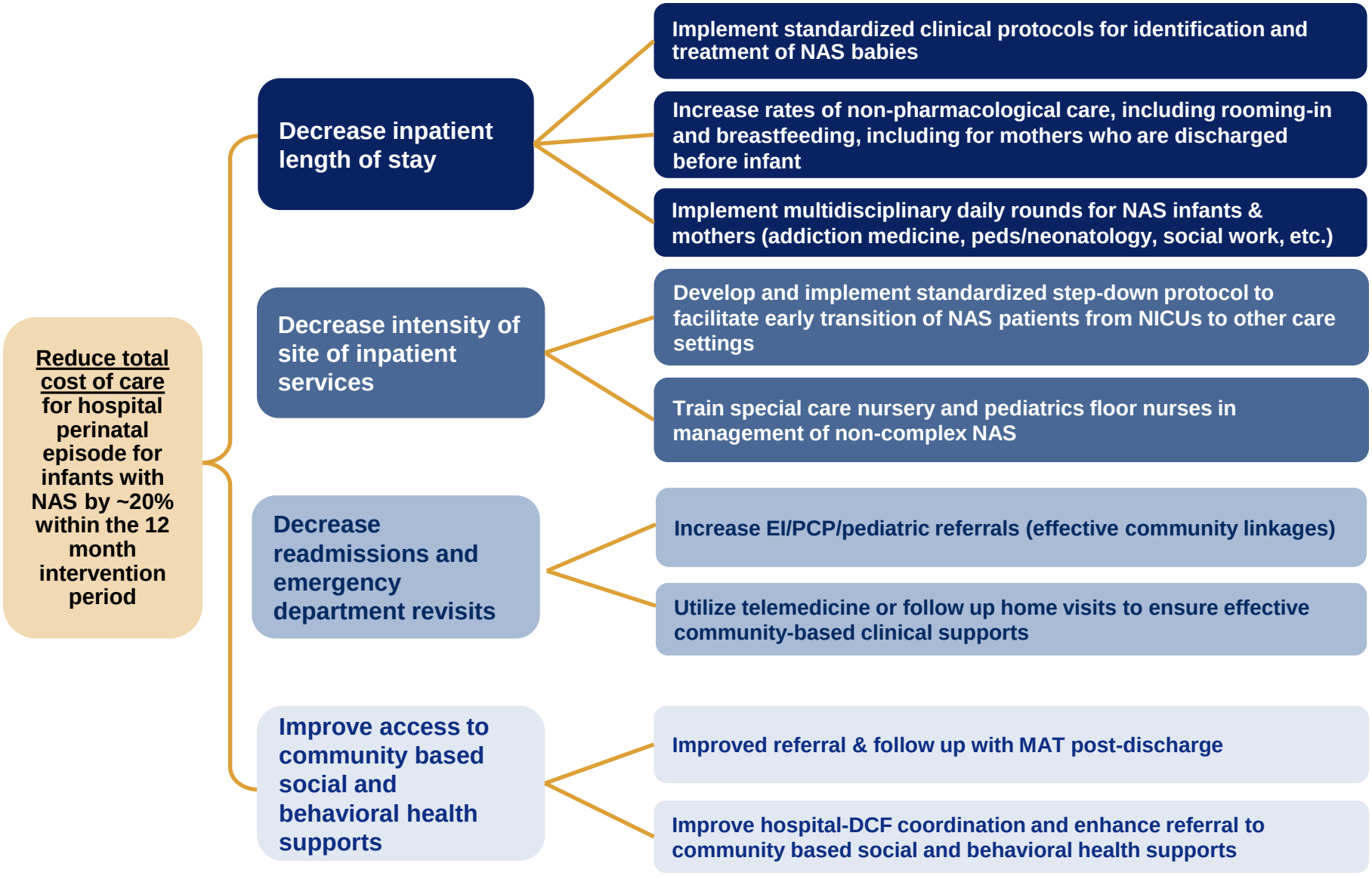
HPC NAS Reserve $500,000

- 1 year award
- Reduce total cost of care from delivery-discharge via quality improvement initiative
- Hospitals implement best-practices (e.g., breast-feeding, rooming-in, cuddling protocols, step-down plan, training for nurses on NAS)
- Technical assistance offerings support best practice implementation (e.g., learning collaboratives, trainings)
- Dissemination of learnings on a statewide basis to ensure lasting impact
- Opportunity to expand DPH program with commitment of additional resources

HPC's proposed "delivery to discharge" quality improvement initiative will accelerate uptake of best practices

- Adopt standardized scoring for identifying & assessing severity of NAS
- Reduce use of pharmacologic intervention
- Increase use of breastfeeding, rooming-in
- Implement multidisciplinary daily rounds (addiction medicine, pediatrics/neonatology, social work)
- Develop step-down protocol for transition from NICU to lower intensity settings
- Train special care nursery & pediatrics nurses on non-complex NAS management
- Improve hospital-DCF, hospital-EI, & hospital-outpatient (e.g., pediatrics, ob/gyn, family practice) coordination protocols

Delivery to discharge quality improvement initiative



HPC proposes to expand DPH's initiative by adding additional hospitals and aligning it with the HPC NAS investment

Budget language - *the commission shall consult with the **department of public health** and the **department of children and families***

1. Aligning with other state agencies through the Moms Do Care initiative (DPH & DCF) will create a fully integrated cross-continuum intervention
2. We will <u>complement</u> the DPH federally funded pilot with an **inpatient quality improvement initiative**, and <u>extend</u> DPH's **pre and post-natal coordination** by adding 2-3 CHART hospitals to the Moms Do Care program with additional HPC investment funds

Moms Do Care + CHART Hospitals	HPC Pilot Program	Moms Do Care + CHART Hospitals
Pregnancy	Inpatient delivery - Discharge	Discharge-6 months
• Increase # of buprenorphine waived OB/GYN • Peer recovery supports • Support services (e.g., transportation, childcare)	• Rooming-in capacity • Post-discharge area for mothers • Cuddling program • Breast-milk storing/feeding policy • Multidisciplinary rounds • Special care & pediatric nurses trained in NAS • Standardized step down protocol from NICU to lower intensity setting • Reliable Finnegan scoring • Organize post discharge referrals (pediatrics, addiction medicine, EI) • Improve coordination with DCF	• Increase # of buprenorphine waived PCPs • Peer recovery supports • Support services (e.g., transportation, childcare) • Hospital facilitated coordination to outpatient providers (e.g., OBOT, PCP, pediatrics, EI providers)

Proposed HPC investments in NAS

	HPC NAS Reserve $500,000	CHART Funds to extend DPH program $2,500,000
Intervention	One year	Two years
Eligible Applicants	Potential applicants are any non-CHART birthing hospitals with: ▪ At least 60 NAS births per year, **or** ▪ > 5x NAS national average	Potential applicants are any CHART birthing hospitals with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average
Proposed Award Cap	Up to **$250,000**	Up to **$1,250,000**
Application Process	Applicants must describe quality improvement initiative that will reduce **TCOC by ~20% over 12 months**	Applicants must demonstrate capacity to provide services along the care continuum (pre-natal; inpatient; post-discharge) through participation in Moms Do Care **and** Applicants must describe quality improvement initiative that will reduce **TCOC by ~20% over 12 months**

Agenda

- Approval of Minutes from the September 22, 2015 Meeting
- Health Care Innovation Investment Program
- Risk Bearing Provider Organizations and Accountable Care Organization Appeal Process
- Discussion of Program Design for the HPC's Pilot on Neonatal Substance Abuse Syndrome
- **Schedule of Next Committee Meeting (December 9, 2015)**

Contact Information

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