MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Meeting of the Care Delivery and Payment System Transformation and Quality Improvement and Patient Protection Committees

April 26, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- **Approval of Minutes**
  - January 25, 2017 QIPP Committee Meeting
  - February 1, 2017 CDPST Committee Meeting
- PCMH PRIME Certification Program – One Year Mark
- PCMH PRIME Practice in the Spotlight
- ACO Certification Technical Assistance – Preliminary Design
- Program Update: Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions
- Update on RBPO Appeals Process
- Schedule of Next Meeting (June 7, 2017)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the QIPP Committee meeting held on January 25, 2017, as presented.

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MASSACHUSETTS
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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the CDPST Committee meeting held on February 1, 2017, as presented.

MASSACHUSETTS
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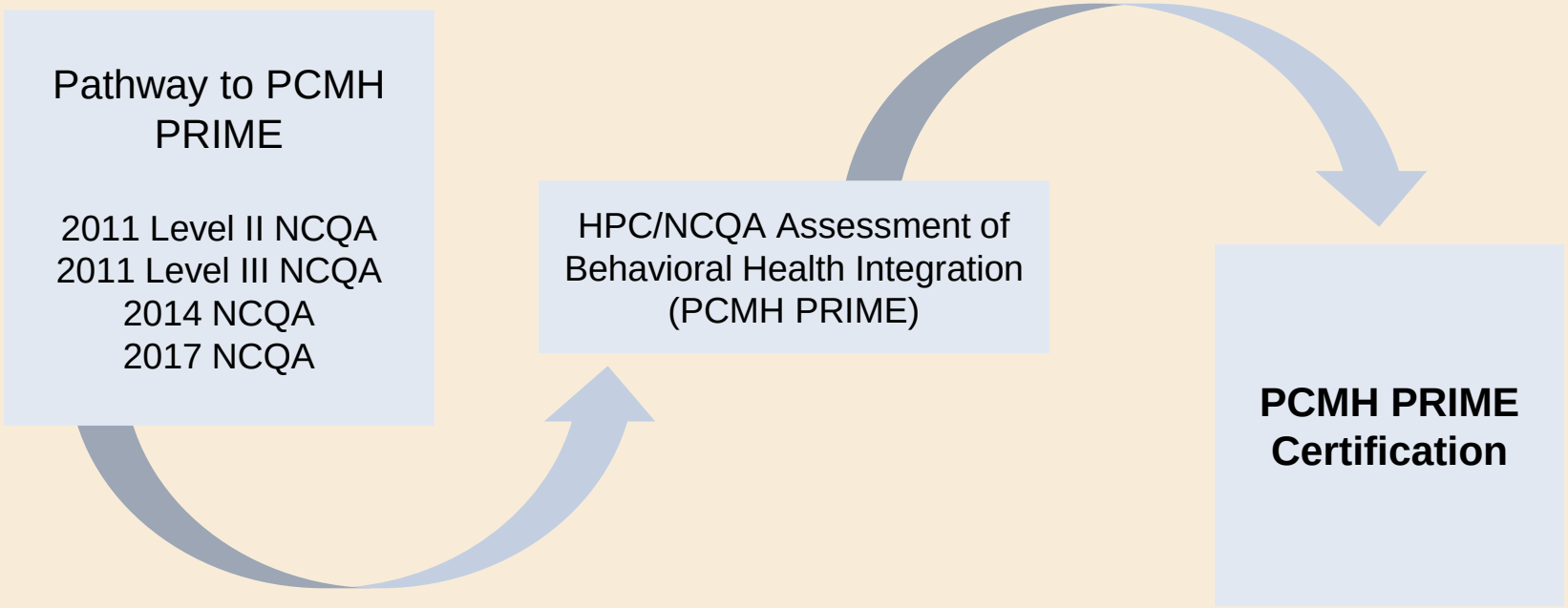
PCMH PRIME Certification Overview

Ongoing HPC Technical Assistance

Practices will achieve HPC's **PCMH PRIME** Certification by demonstrating enhanced capacity and capabilities in behavioral health integration (BHI). Practices are certified on a rolling basis. Practices on the Pathway to PCMH PRIME must meet the HPC's BHI criteria within a given timeline after submitting an HPC application.



33% of MA clinicians in NCQA PCMHs participate in PCMH PRIME

~18% of MA clinicians in NCQA PCMHs practice in a PCMH PRIME Certified site

538 MA clinicians practice in a PCMH PRIME Certified site

2968 MA clinicians practice in a NCQA PCMH Recognized site

~15% of MA clinicians in NCQA PCMHs practice in a site on the Pathway to PCMH PRIME

438 MA clinicians practice in a site on the Pathway to PCMH PRIME

2968 MA clinicians practice in a NCQA PCMH Recognized practice

Sources: 4/1/2017 NCQA PCMH Recognition list and HPC PCMH PRIME program status data. All analysis in this presentation uses status data current as of 4/14/17.
Notes: NCQA data includes clinicians who can be selected by a patient/family as a personal clinician. Clinicians listed in NCQA data include but are not limited to individuals with the following credentials: ACNP, ANP, APRN, CNP, CRNP, DO, FNP, MD, NP, PA, and PNP

Number of Practices Participating in PCMH PRIME

Since January 1, 2016 program launch

35 practices
are PCMH PRIME Certified*

Newly certified practices include:
Tufts Medical Center Primary Care - Boston
Brockton Neighborhood Health Center
Harbor Health Services (4 sites)
SSTAR Family HealthCare Center

*1 practice achieved certification on their second PCMH PRIME survey review

56 practices

are on the **Pathway to PCMH PRIME***

*2 practices failed their first PCMH PRIME survey review and remain on the Pathway to PCMH PRIME

1 practice

is working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently

92 practices currently participating in PCMH PRIME

HPC

Note: 3 practices achieved Pathway status but subsequently withdrew from the program, citing a change in system affiliation and/or timing considerations..

Practices Participating in PCMH PRIME

PCMH PRIME Certified	Pathway to PCMH PRIME	HPC application only
Acton Medical Associates	Caring Health Center	Manet Community Health Center at Taunton
Boston Health Care for the Homeless Program (3 practices)	Charles River Community Health (2 practices)	
Brockton Neighborhood Health Center	Emerson PHO (14 practices)	
Cambridge Health Alliance (12 practices)	Duffy Health Center	
Codman Square Health Center	General Internal Medicine, Boston Medical Center	
Community Health Center of Cape Cod (3 practices)	Greater Lawrence Family Health Center (6 practices)	
East Boston Neighborhood Health Center	Greater New Bedford Community Health Center	
Family Doctors	Harvard University Health Services	
Family Health Center of Worcester	Manet Community Health Center (4 practices)	
Fenway Health (2 practices)	North Shore Community Health Center	
Harbor Health Services (4 practices)	Pleasant Lake Medical Offices	
Lynn Community Health Center	Reading Pediatric Associates	
SSTAR Family HealthCare Center	Reliant Medical Group (14 practices)	
Tufts Medical Center Primary Care - Boston	Upham's Corner Health Center	
Whittier Street Health Center	Valley Health Partners (7 practices)	
Yogman Pediatric Associates		

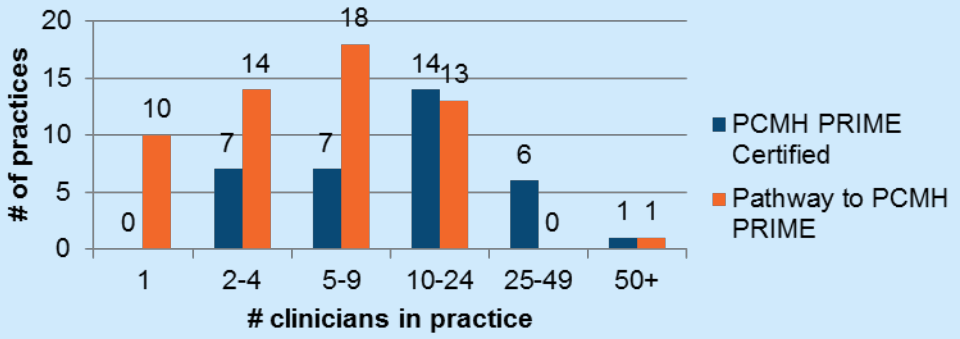
PCMH PRIME Practice Demographics

The majority of PCMH PRIME Certified practices are recognized as 2014 Level 3 PCMHs. The majority of practices on the Pathway to PCMH PRIME are recognized as 2011 Level 3 PCMHs.[1]

78% of practices on the Pathway to PCMH PRIME or PCMH PRIME Certified are part of provider organizations that participate in risk-based contracts.[2]

39% of practices on the Pathway to PCMH PRIME or PCMH PRIME Certified are Federally Qualified Health Centers.[3]

Number of Pathway to PCMH PRIME and PCMH PRIME Certified practices by practice size[4]

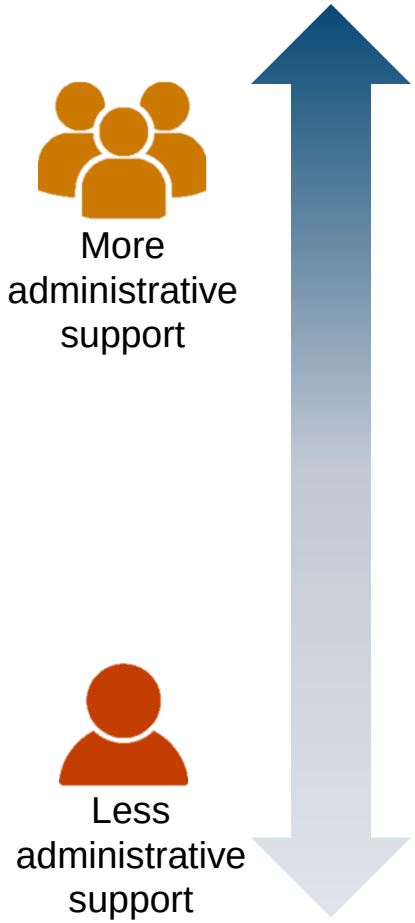


Both small and large practices participate in the PCMH PRIME program. Practices that are PCMH PRIME Certified or on the Pathway to PRIME range in size from 1 -70 clinicians.

[1] Source: HPC PCMH PRIME program status data and 4/1/2017 NCQA PCMH Recognition list
[2] Source and notes: Sources include RPO data and staff knowledge from ACO stakeholder engagement. Provider organizations that participate in risk-based contracts were identified using 2015 RPO data filings as Contracting Entities that establish global payment contracts with shared savings and/or losses
[3] Source: PCMH PRIME program status data and Health Centers And Look-alike Site Directory, 4/11/2017, Health Resources and Services Administration. https://datawarehouse.hrsa.gov/Topics/HccSites.aspx
[4] Source and notes: HPC PCMH PRIME program status data and 4/1/2017 NCQA PCMH Recognition list. NCQA data includes clinicians who can be selected by a patient/family as a personal clinician. Clinicians listed in NCQA data include but are not limited to individuals with the following credentials: ACNP, ANP, APRN, CNP, CRNP, DO, FNP, MD, NP, PA, and PNP

Many PCMH PRIME practices are part of provider organizations that may offer centralized support for practice re-design

Of practices that are PCHM PRIME Certified, on the Pathway to PCMH PRIME, or have submitted an HPC application only:



59% are part of a multi-site provider organization

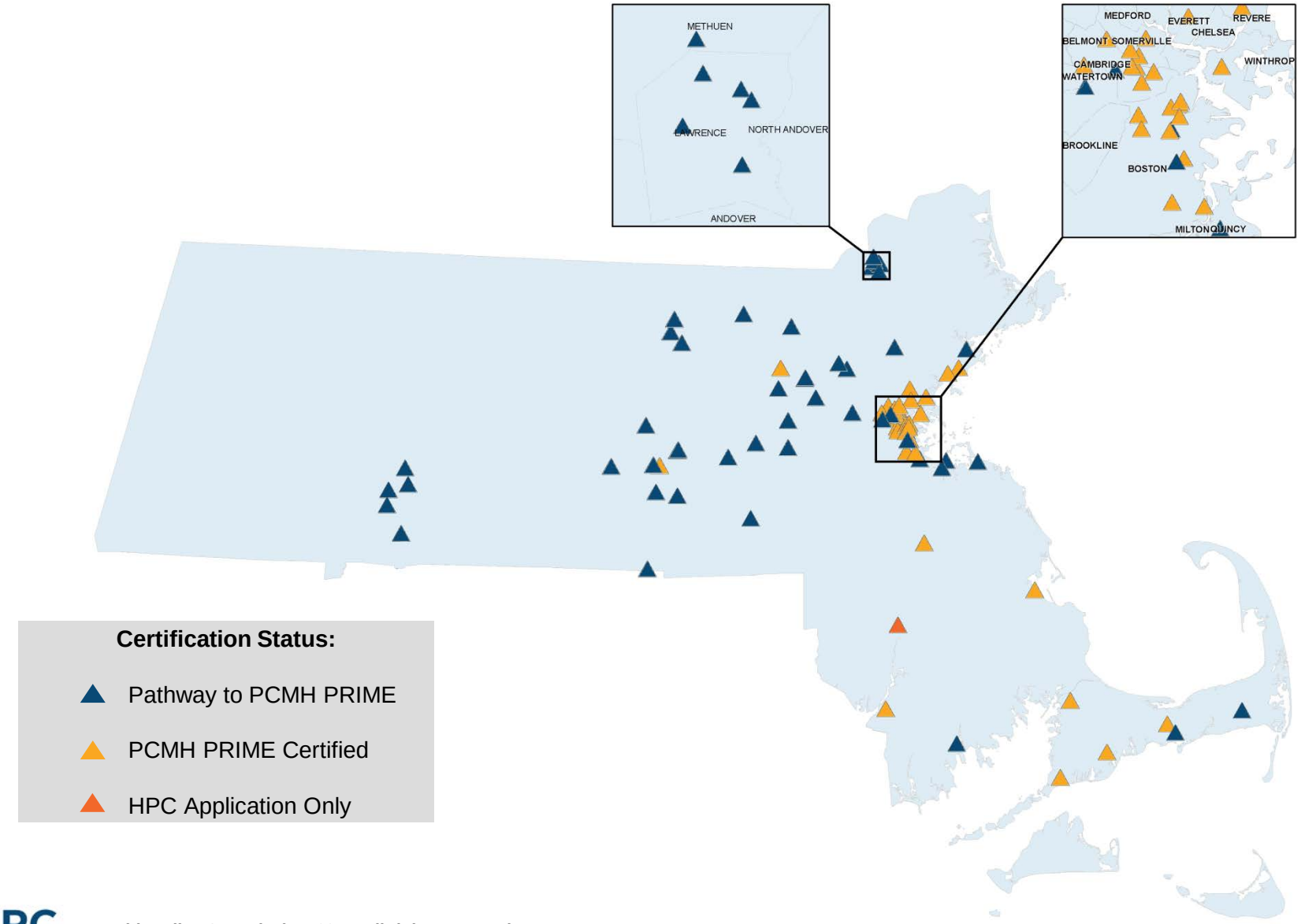
35% are multi-site FQHCs

4% are single-site FQHCs

2% are single-site primary care practices

Source: HPC PCMH PRIME program status data, practice websites, and Health Centers And Look-alike Site Directory, 4/11/2017, Health Resources and Services Administration. https://datawarehouse.hrsa.gov/Topics/HccSites.aspx

Certified and Pathway practices are located across the state, though concentrated in the Boston metro area



Payer Engagement in PCMH PRIME to Date

Harvard Pilgrim Health Care

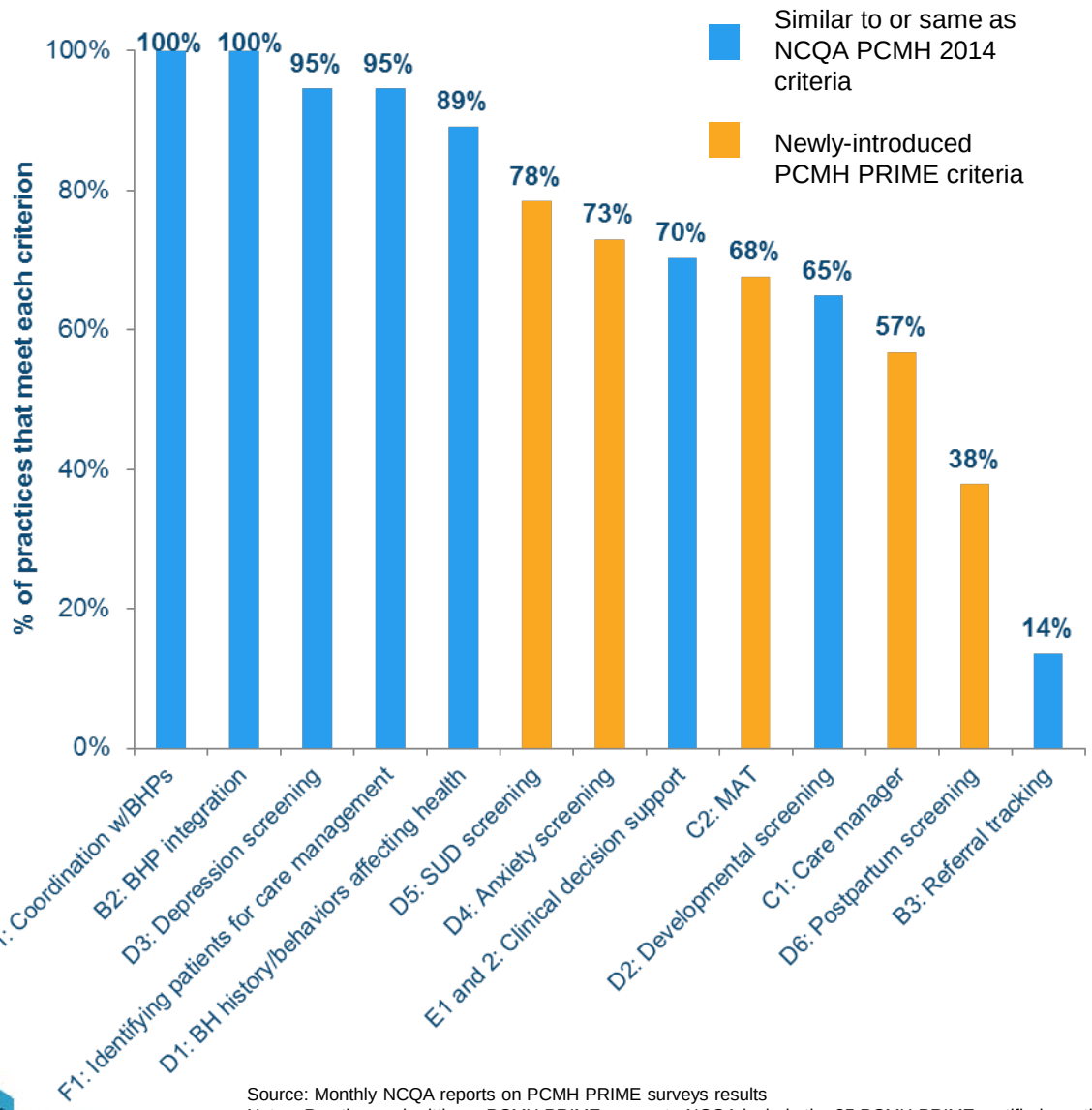
- Made 2016 BH Quality Grant dollars available to support grantees seeking PCMH PRIME
- Have indicated willingness to partner in additional ways, e.g. denoting certified practices within provider directory

Commonwealth of Massachusetts Group Insurance Commission

MassHealth

- Continuing to engage GIC on linkages between their quality improvement programs and HPC certifications
- MassHealth broadly supporting PCMH and BHI through ACO models; ACO RFR asked how bidder supports practices to become medical homes, including achieving PCMH PRIME

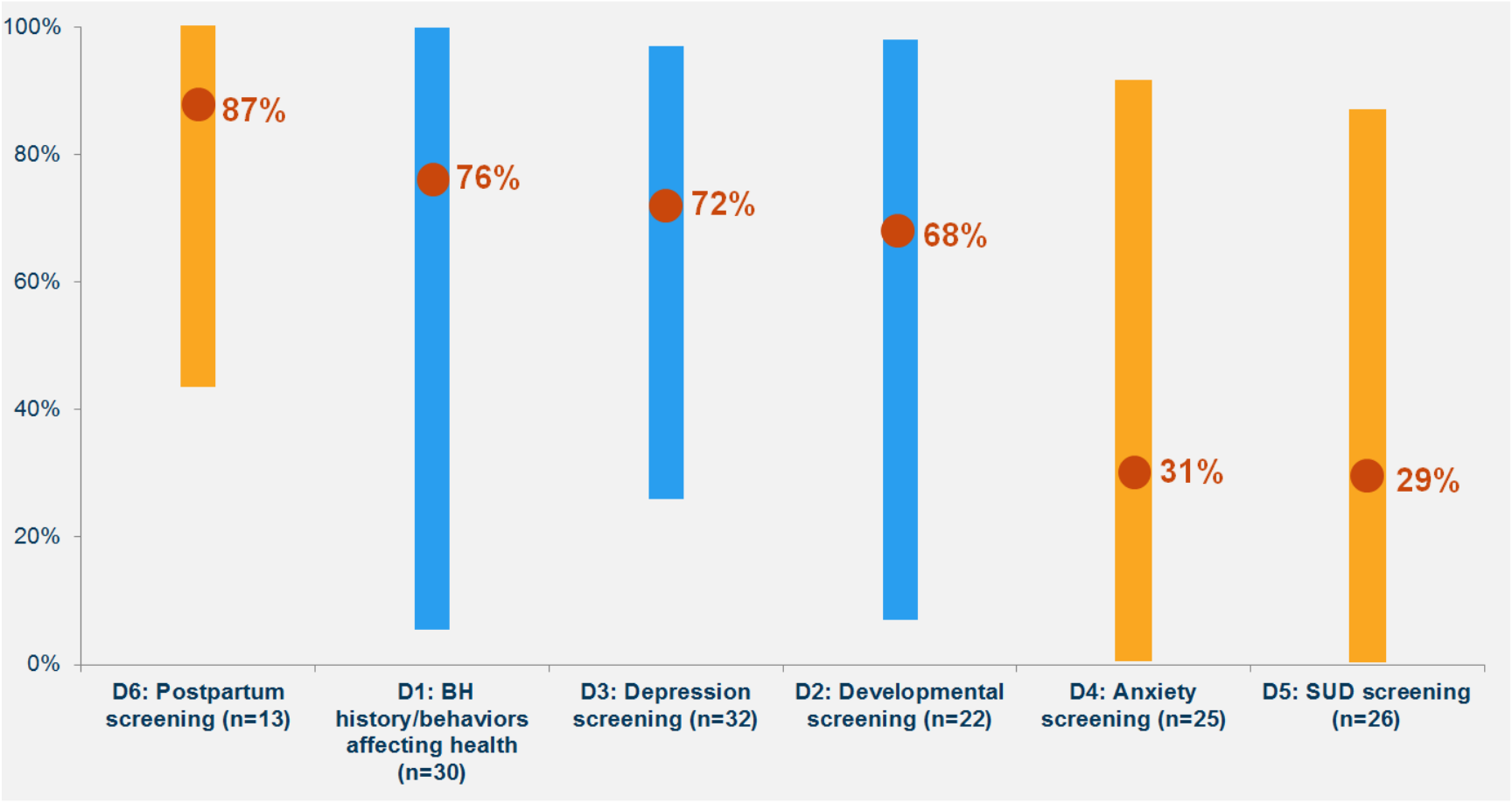
Percent of Practices that Submitted a PCMH PRIME Survey to NCQA that Meet Each Criterion



- **On average, practices that submitted a PCMH PRIME survey satisfy 9 criteria**
- The highest scoring practice met 12 criteria
- The most commonly met PCMH PRIME criteria is the integration of behavioral health providers into primary care sites (practices that satisfy B2 automatically receive credit for B1)
- The least commonly met criteria is tracking and following up on behavioral health referrals

Source: Monthly NCQA reports on PCMH PRIME surveys results
Notes: Practices submitting a PCMH PRIME survey to NCQA include the 35 PCMH PRIME certified practices and 2 of the practices that submitted a survey but failed to achieve certification. For the practice that initially failed the survey review but later achieved certification, only the second PCMH PRIME results survey are included.
For D2, practices that marked this criterion as N/A have been removed from denominator.

Average and Range of Screening Rates for PCMH PRIME Criteria



Source: Monthly NCQA reports on PCMH PRIME surveys results
Note: Screening rate based on all unique patients in a recent 3 month period. Practices are not required to submit screening rates to satisfy PCMH PRIME criteria; for this reason, the samples size for each criterion does not reflect the total number of practices meeting each criterion.

Successful Series of PCMH PRIME NCQA Trainings

In conjunction with NCQA, the HPC has held a variety of trainings on criteria, documentation requirements, and application processes.

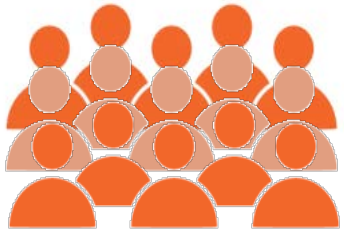
5 webinars

~125 attendees

77% of Pathway or Certified practices attended

98% of survey respondents found trainings effective

2 in-person trainings



65 attendees

38% of Pathway or Certified practices attended

100% of survey respondents found trainings effective

Source: HPC PCMH PRIME program status data, including evaluation surveys for NCQA trainings

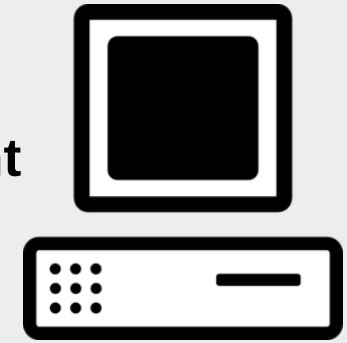
20 practices are participating in 1st PCMH PRIME technical assistance cohort

5 of the participating practices are PCMH PRIME Certified and 15 are on the Pathway to PCMH PRIME

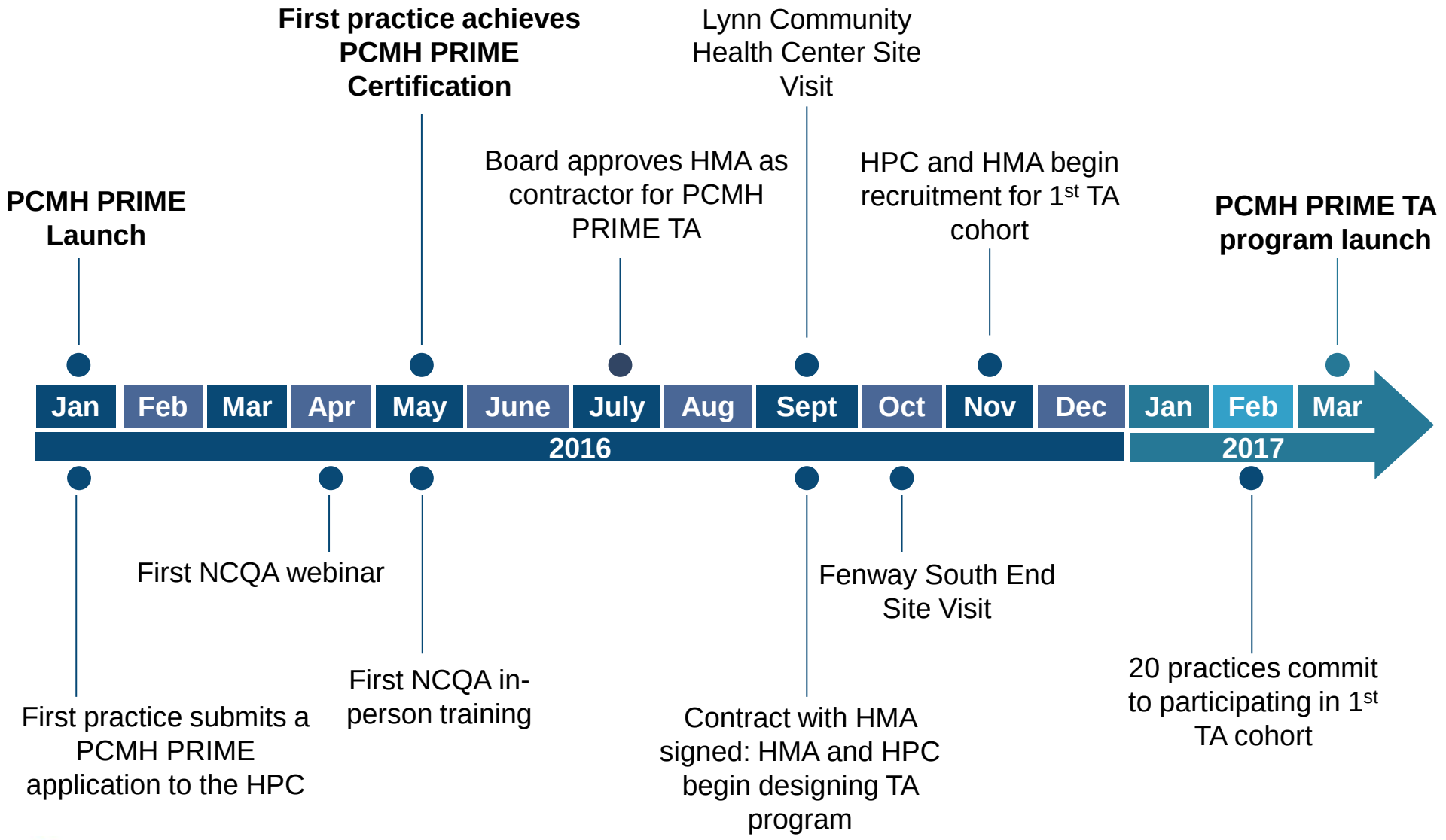
Practice coaching was launched in March 2017

2 Learning Collaboratives will take place in May 2017

7 webinars are under development



PCMH PRIME Milestones



Discussion of 2017 Priority Activities for PCMH PRIME

Proposed areas of focus for 2017

- Continue recruiting additional practices to participate in PCMH PRIME in order to extend market impact
- Facilitate peer-to-peer learning among PCMH PRIME participants, especially through ongoing implementation of TA program
- Analyze and report on baseline quality, utilization, and/or cost data of PCMH PRIME Certified practices versus others
- Engage payers to encourage use of PCMH PRIME Certification in product design and/or patient communications

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HPC Care Delivery Programs Focus on Specific Policy Levers

1. Fostering a value-based market
2. **Promoting an efficient, high-quality, health care delivery system**
3. **Advancing aligned and effective incentives**
4. Enhancing data and measurement for transparency and accountability

HPC Care Delivery Certification and Investment Programs Draw on Two Core Strategies

RESEARCH AND REPORT

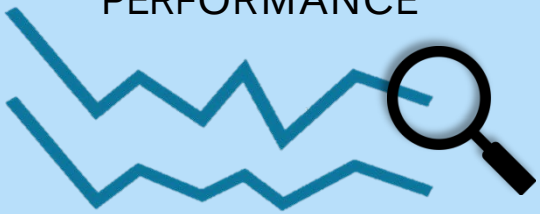
INVESTIGATE, ANALYZE, AND REPORT TRENDS AND INSIGHTS

CONVENE

BRING TOGETHER STAKEHOLDER COMMUNITY TO INFLUENCE THEIR ACTIONS ON A TOPIC OR PROBLEM

WATCHDOG

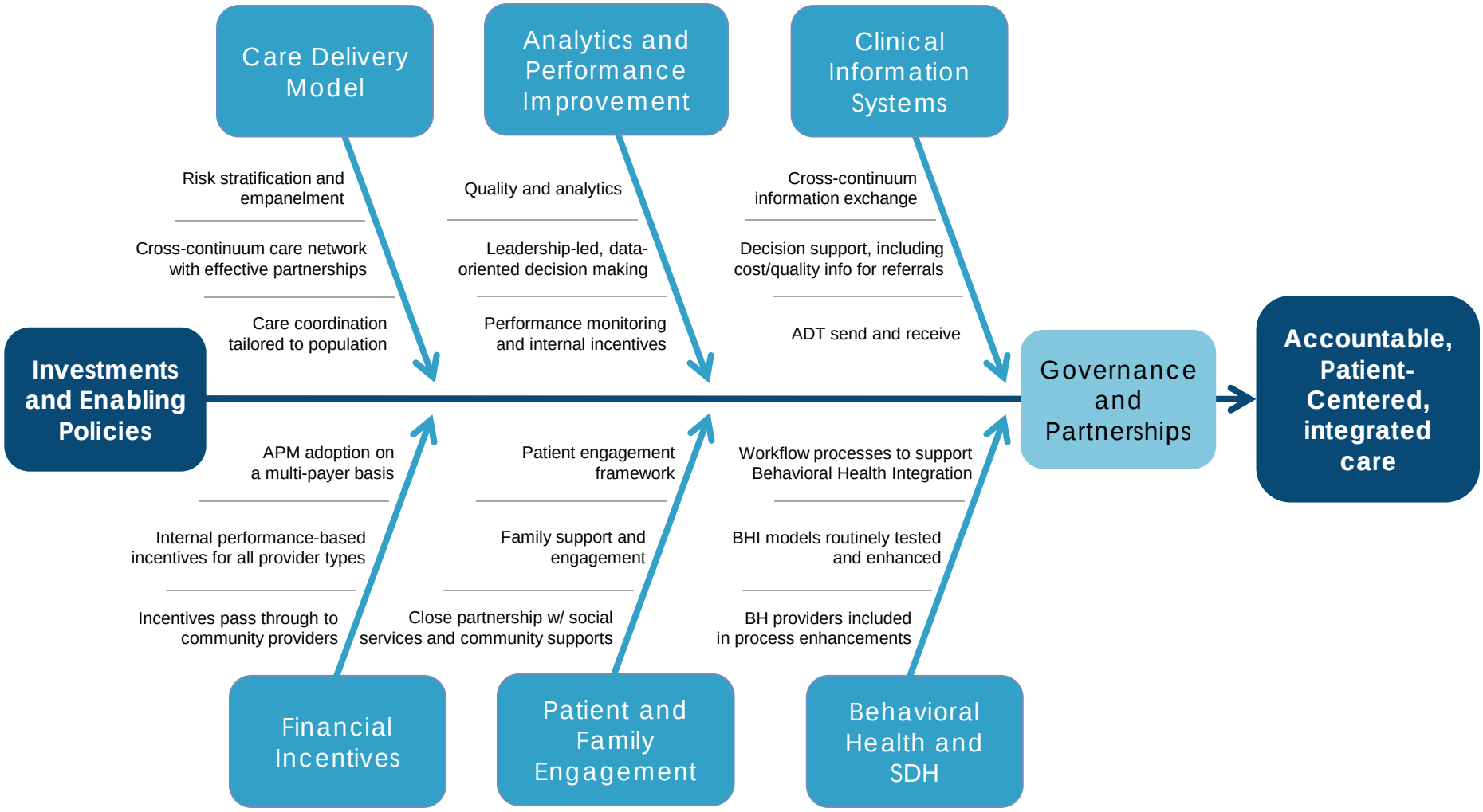
MONITOR AND INTERVENE WHEN NECESSARY TO ASSURE MARKET PERFORMANCE



PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS

Care Delivery Programs are Aimed at Core Health System Capabilities



HPC ACO Certification Program Standards

Patient-centered, accountable governance structure

1. Meaningful participation of ACO participants
2. Patient/consumer representation and Patient and Family Advisory Committee (PFAC)
3. Responsibility for assessment and improvement of the quality of and access to care

Quality-based risk contracts

4. Demonstration of quality performance in at least one risk-based contract

Population health management programs

5. Risk stratification and program implementation

Cross-continuum care: coordination with BH, hospital, specialist, and LTSS services

6. Effectiveness of collaborations, coordination, and tracking

HPC

HPC CHART Program

Phase 3

~$20M

- Support successful transition to a sustainability model supported by market incentives and APMs
- Continue and enhance promising interventions from Phase 2
- Strengthen relationships with community partners
- Supportive, but not duplicative, of DSRIP goals

Phase 2

$60M

- Incentivize care delivery transformation
- Maximize appropriate hospital use
- Enhance behavioral health care
- Improve quality and safety by optimizing processes

Phase 1

$9.2M

- Support capacity building through short-term, high-need expenditures
- Promote engagement and foster learning

HPC

MassHealth DSRIP Funding for ACO TA

MassHealth will commit ~$20-40 million from the DSRIP pool over five years to provide technical assistance to ACOs to support provider advancement in seven areas**.** Funding decisions are expected in Winter to Spring 2018.

1

Education

(e.g., governance requirements, network development, care coordination, quality and financial management analytics)

2

Performance management

(e.g., performance improvement on patient outcomes and other quality metrics)

3

Financial

(e.g., education and readiness assessments, patient attribution, budgeting, and practice management systems)

4

Culturally competent care

(e.g., to improve care of racial, ethnic, and other minorities, LGBTQ members, and members with disabilities)

5

Actuarial

(e.g., consulting to support participation in payment models)

6

Legal

(e.g., contracting between ACOs and Community Partners)

7

Health IT

(e.g., technology investment and workflow adjustments)

HPC

ACO Certification Technical Assistance

- **Accelerate delivery organization care transformation** towards value-based care delivery and development of core ACO competencies through discrete and targeted investments
- **Promote alignment** with other TA and investment programs at HPC (CHART TA, CHART Phase 3) and MA more broadly (MassHealth DSRIP TA)
- Focus TA offerings on areas covered within **HPC ACO Certification domains**

~$2 million in funding over 3 years

ACO TA Needs Assessment - Process

Strategic Consultation

- HPC contracted with Bailit Health to conduct a TA needs assessment of MA ACOs and develop recommendations for the HPC ACO TA program.

Methodology

- **Interviews** with four Massachusetts ACOs and two payers

- Communication with **industry experts on available TA resources** for MA ACOs

- **Meeting with MassHealth** to discuss TA for ACOs through DSRIP funding and to solicit feedback more broadly

ACO TA Needs Assessment – Key Findings

- There are **systemic barriers** to ACO readiness and success that are not ideal opportunities for a TA program but do represent areas where the Commonwealth or HPC could accelerate progress.
- Technical support could be beneficial in multiple **areas of focus related to HPC ACO certification standards**.
- There are **limited TA resources currently available** to Massachusetts ACOs.
- Strategic **coordination with MassHealth DSRIP** funding is important.

Summary of Findings: Systemic Barriers

ACO and payer responses revealed **systemic barriers** to ACO readiness and performance that are not ideal opportunities for a TA program but do represent areas where the Commonwealth or HPC could accelerate progress.

1. Fee-for-service payments remain the dominant reimbursement method for ACOs and their affiliated physicians, limiting the ability to adopt a financial and clinical strategy that is truly "value-oriented".

2. Delivery systems struggle to access real-time clinical data (e.g., ADT feeds, Rx utilization) and utilize shared care plans, important tools to understand the type of care patients are receiving and where, and to effectively manage care transitions.

3. Many ACOs lack the ability to benchmark their cost and quality performance against Massachusetts norms. Payer reports may not be cost-standardized, may only include a fraction of a practice's population, and do not allow for meaningful comparison across payer categories.

ACO TA Needs Assessment – Overview of Key Needs

1. Data Utility and Analytics
2. Care Delivery Redesign
3. Managing Total Cost of Care
4. Physician Engagement and Compensation
5. Strategy and Business Planning for Hospitals
6. Social Determinants of Health
7. Understanding and Managing Risk
8. Governance

ACO TA Needs Assessment – Summary of Key Needs

1. Data Utility and Analytics

- ACOs require sophisticated data use to inform and implement population health management strategies and support participating physicians. This capacity is not fully developed, perhaps due to limited ACO participation in risk-based contracts.
- Robust data analytics enables ACOs to a) identify variation in care and opportunities to define standard clinical pathways for participating providers, b) overarching population health issues in need of focus.

2. Care Delivery Redesign

- Behavioral health integration, care management, working with and integrating community partners, and hiring and managing community health workers were cited care delivery topics for which a TA program would be valuable.

3. Managing Total Cost of Care

- Support in managing cost and cost growth was identified as an area of need for ACOs.
- Note: ACOs and providers that are not at risk have little motivation to change.

ACO TA Needs Assessment – Summary of Key Needs

4. Physician Engagement and Compensation

- Physician understanding of the role and functions of an ACO is critical to obtaining buy-in and support for ACO operations. Physicians that are engaged and committed can support ACO leadership in driving changes in care delivery.

- ACOs with employed physicians, including community health centers, would benefit from understanding non-RVU payment models and non-financial incentives that motivate change, and an awareness of the barriers to successful implementation of new and alternative compensation arrangements.

5. Strategy and Business Planning for Hospitals

- Aligning hospital financial and business goals with the goals of health care payment reform is an area of opportunity. Sharing information on hospital-based payment models that have been implemented nationally and providing strategic consultation to hospitals in operating in a value-based payment environment may be of use to hospital-based ACOs.

ACO TA Needs Assessment – Summary of Key Needs

6. Social Determinants of Health

- Interviewees said they could use support in developing and implementing screening tools, coding, quality measurement, and flexible spending strategies and parameters.
- This could be an area for future investment ("stage 2"), once ACOs have developed core competencies.

7. Understanding and Managing Risk

- Interviewees indicated an opportunity to further educate and support ACOs on how to manage and distribute shared savings and risk.

8. Governance

- One payer indicated a strong need for ACO support in governance and strategic leadership, the latter being essential as the payer cited DSRIP funding as the sole reason MassHealth ACOs formed.
- ACOs did not identify this as an area of needed support.

Recommendations for Discussion

Selection Criteria

- The HPC should prioritize TA investment in ACOs that are:
  - (1) participating in the HPC ACO Certification program
  - (2) newly formed or comparatively less experienced
  - (3) comparatively under-resourced

Priority Areas

- The HPC should prioritize TA on the most central core competencies an ACO must develop and sustain in order to operate.
- HPC should target the following priority areas for TA based on the findings and observations of our research and our experience with ACOs nationally:
  A. Strategies and methods for analyzing data and applying it for management
  B. Care management of high-risk patients

Recommendations for Discussion: Priority Areas

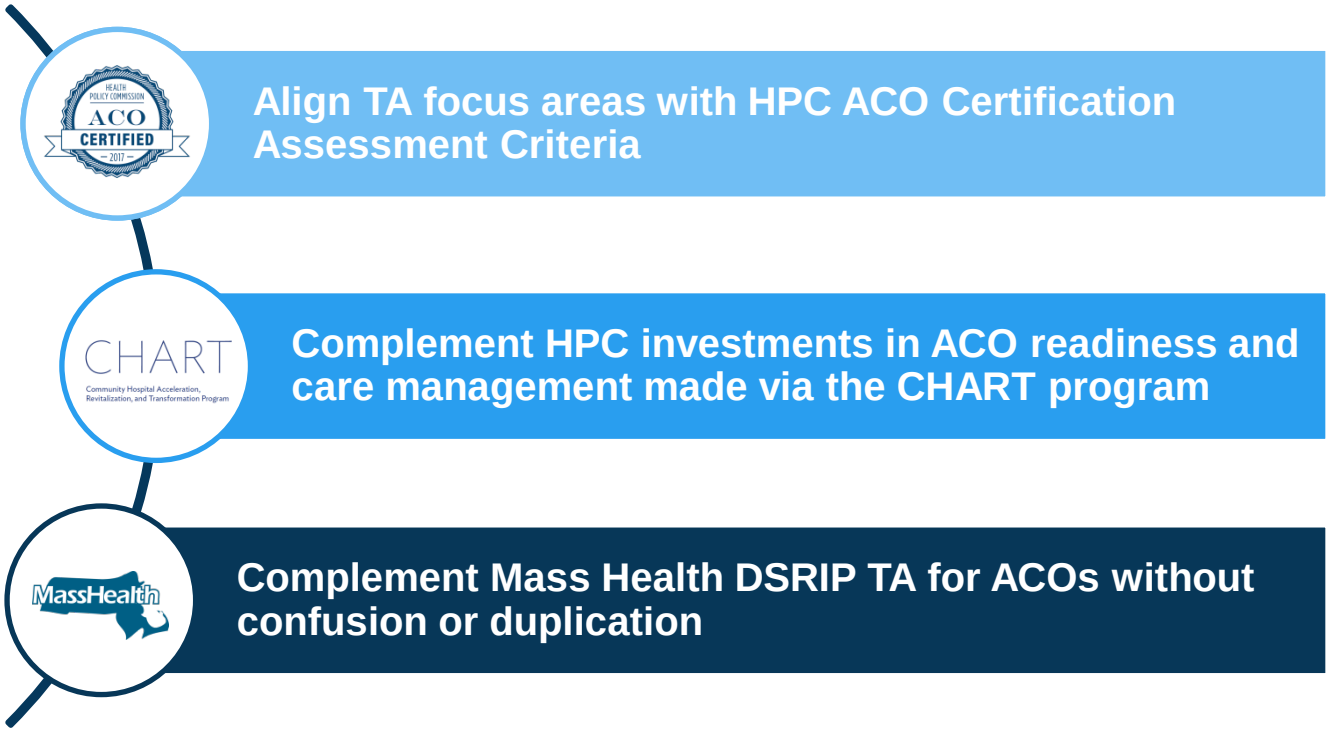
A. Strategies and methods for analyzing data and applying it for management

- Using data to inform population health management strategies is fundamental to the success of an ACO
- Effective and efficient support for participating physicians and attributed lives requires data analytics capabilities
- ACOs need to understand:
  - the type of data that are most valuable to their organization;
  - how to manage the data;
  - how to analyze the data;
  - how to convert the data into meaningful and actionable information; and
  - how to support physicians with relevant data.

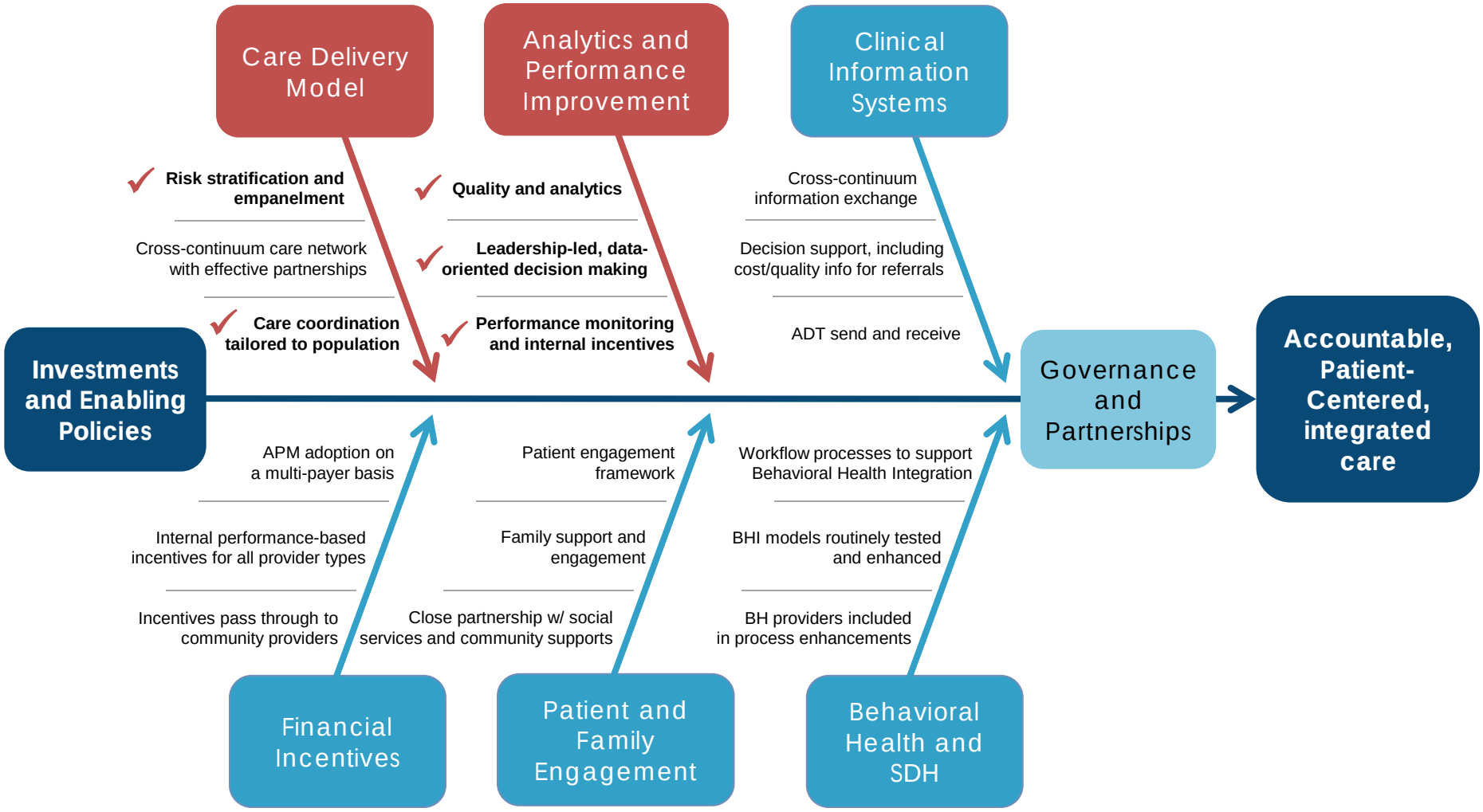
B. Care Management

- Identifying high risk patients
- Determining the most appropriate person/provider to deliver care management
- Delivering high quality and cost effective care management

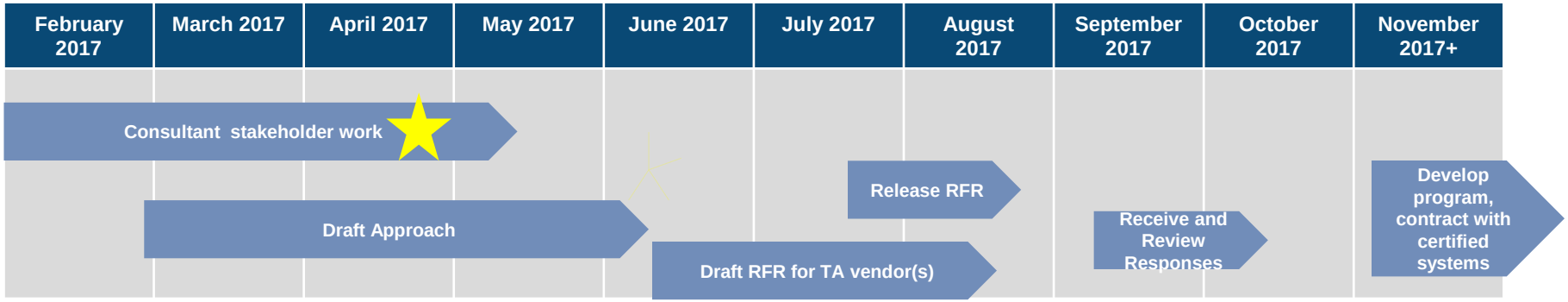
Alignment Priorities for HPC ACO TA Program



Context for Proposed TA Program Priority Areas



ACO TA timeline and next steps



	Goal Setting and Design	Vendor Procurement	Implementation
Activities	☑ Meet with subject matter experts and stakeholders on program design considerations ☑ Align with other TA efforts at state and federal levels ☐ Decide on TA framework, present to CDPST and Board (June 2017)	☐ Draft RFR ☐ Release RFR ☐ Receive and review proposals ☐ Selection of contractor	☐ Finalize program design, measurable goals, and contract requirements with vendor'(s) ☐ Begin TA program ☐ Support program implementation as needed and monitor performance
Output	• Program Goals • Current Landscape	• RFR development • Proposal process • Vendor selection	• Operational planning • Program monitoring

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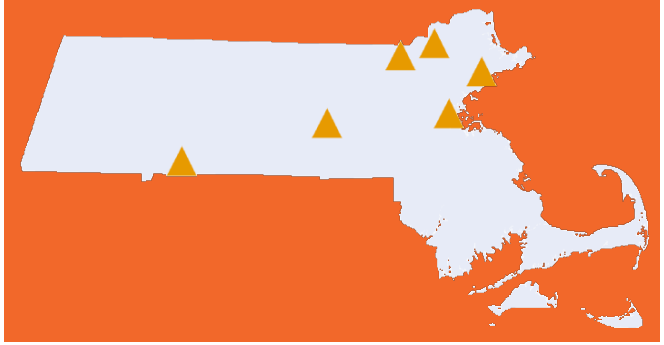
HPC's Mother and Infant-Focused NAS Interventions

6 initiatives
Funded by the HPC

$3,000,000
HPC funding

59 Organizations
(e.g. hospitals, primary care practices, behavioral health providers) collaborating

Initiatives span the Commonwealth:
From Springfield to the North Shore



>400 infants with NAS
treated by HPC's awardees in 2015

3 Initiatives Launched

HPC

Aligning with and expanding on DPH's initiative allows for interventions to be applied across broader spectrum of continuum

HPC Pilot Program
$1,000,000

DPH Moms Do Care Program
$3,000,000

HPC Moms Do Care Initiatives
$2,000,000

Stage of Intervention for Massachusetts Funding Sources to Address Neonatal Abstinence Syndrome

During pregnancy (prenatal care)

Post delivery and during in-patient care

After hospital discharge (post-partum support)

HPC Pilot Program

Funds: $1,000,000
Source: State appropriation & HPC's Distressed Hospital Trust Fund
Awardees: Baystate Medical Center, UMass Memorial, Boston Medical Center, Lawrence General

HPC Moms Do Care Initiatives
$2,000,000

Stage of Intervention for Massachusetts Funding Sources to Address Neonatal Abstinence Syndrome

During pregnancy (prenatal care)

Post delivery and during in-patient care

After hospital discharge (post-partum support)

HPC Pilot Program
$1,000,000

DPH Moms Do Care Program

Funds: $3,000,000
Source: Federal SAMHSA Grant
Awardees: Cape Cod and UMass Memorial Health Systems

HPC

Stage of Intervention for Massachusetts Funding Sources to Address Neonatal Abstinence Syndrome

During pregnancy (prenatal care)

Post delivery and during in-patient care

After hospital discharge (post-partum support)

HPC Pilot Program
$1,000,000

Funds: $2,000,000
Source: HPC's Distressed Hospital Trust Fund
Awardees: Beverly Hospital, Lowell General Hospital

HPC Moms Do Care Initiatives

HPC's NAS interventions grantee activity

HPC is investing in both inpatient quality improvement initiatives to address treatment of infants with NAS, and outpatient efforts to increase adherence to pharmacologic treatment among pregnant and post-partum women with opioid use disorder (OUD). HPC's 6 hospital grantees have begun work to achieve the following aims.

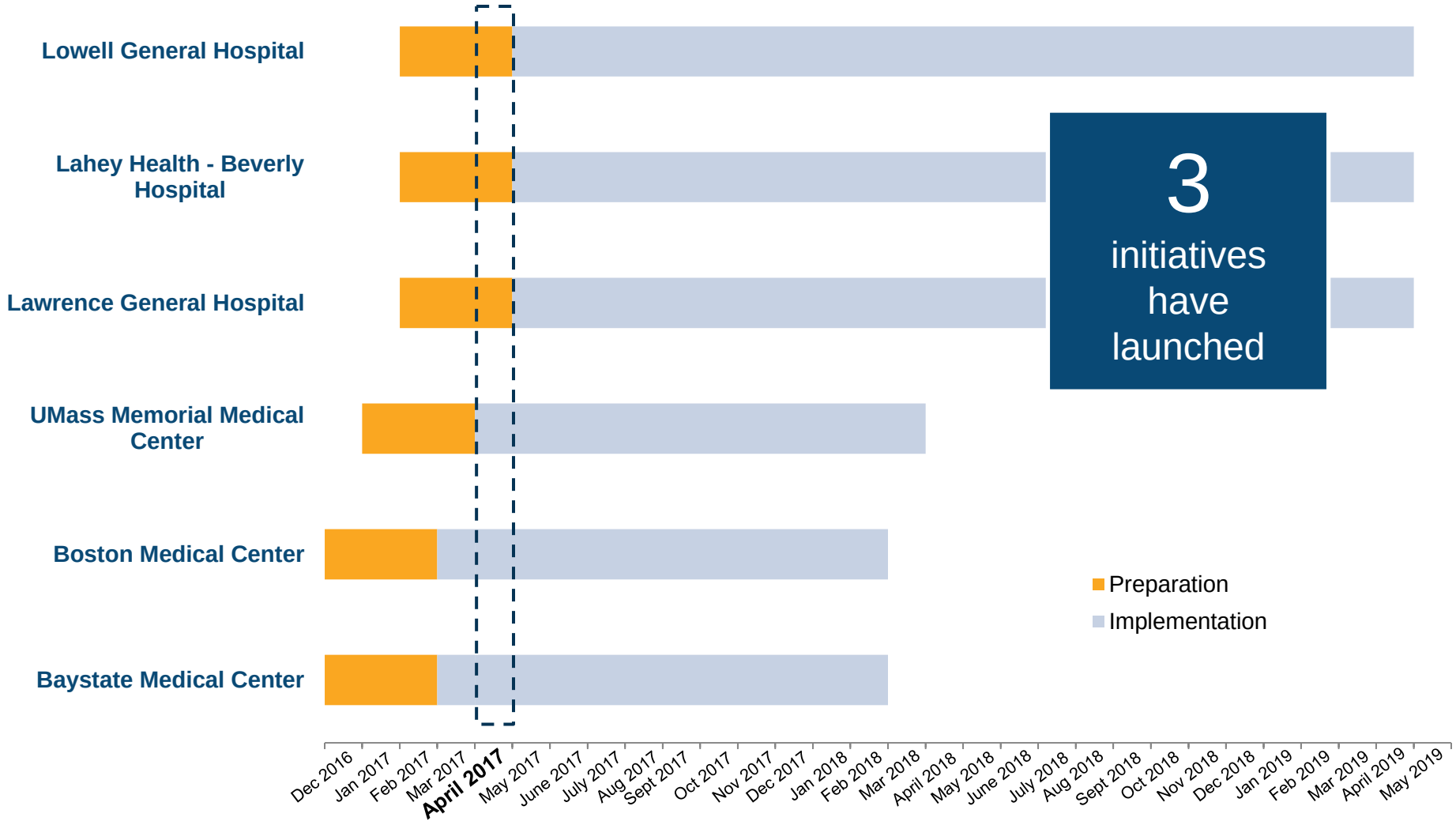
Inpatient activity:

- Facilitate "rooming-in" for eligible women and infants
- Increase breastfeeding rates
- Facilitate early initiation of skin-to-skin contact after birth
- Provide bedside psychotherapy to women after birth
- Increase number of infants discharged to biological family
- Make Early Intervention (EI) referral prior to discharge
- Treat infants in need of pharmacologic intervention with methadone instead of morphine

Outpatient activity:

- Screen pregnant women for OUD at first prenatal appointment
- Increase engagement in and adherence to pharmacologic treatment during pregnancy among women with OUD
- Provide same-day co-located BH and prenatal care
- Provide social supports to facilitate access to treatment (e.g., childcare, transportation)
- Improve post-discharge follow up with EI, pediatrics, and addiction treatment provider

Mother and Infant-Focused NAS Initiatives: Progress as of April 2017



Highlights from HPC's NAS Interventions

Successes

All hospitals
have done outreach to engage with community providers

4 hospitals
have fully staffed teams

3 hospitals
have completed all necessary staff training

Challenges

A number of hospitals have identified **finding and hiring peer recovery coaches** as a significant barrier. All six awardee hospitals are utilizing the peer support workforce for their work with families affected by NAS.

Spotlight on Baystate Medical Center: January-March performance

28
substance-exposed newborns delivered since January 2017

18 full-term infants

10 pre-term infants

20 days
Average inpatient length of stay

68%
of infants monitored for NAS required pharmacotherapy

10.5 days
Average duration of pharmacotherapy

61%
of infants had early initiation of skin-to-skin contact

89%
of eligible infants successfully started breastfeeding

53%
of infants were still breastfeeding at discharge

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MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- PCMH PRIME Certification Program – One Year Mark
- PCMH PRIME Practice in the Spotlight
- ACO Certification Technical Assistance – Preliminary Design
- Program Update: Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions
- **Update on RBPO Appeals Process**
- Schedule of Next Meeting (June 7, 2017)

Overview: Appeals Processes for RBPOs and ACOs

Chapter 224 requires the HPC to develop internal appeals and external review processes for RBPOs and ACOs

Office of Patient Protection (OPP) is directed to establish requirements for DOI-certified Risk Bearing Provider Organizations (RBPO) or HPC-certified Accountable Care Organizations (ACO) to implement appeals processes for reviewing consumer complaints as well as an external review process to obtain third party review of such complaints.

Statutory requirement are similar to existing OPP consumer protection rules regarding review of health plan medical necessity determinations but apply to provider determinations on referrals, appropriate treatments and timely access to care

Outline of Interim Guidance

Provide Adequate Notice to Patients

- Make notice available in writing at all locations where patients regularly seek care and include a phone number or other contact information for patients to file an appeal and include OPP contact information
- A sample, “Notice to Patients,” accompanies OPP Bulletin

Establish an Appeals Process by October 1, 2016

- Complete process within statutory timeframes
- Provide written notice of decision to patients with OPP contact information

Submit Reports to OPP that include

- Copy of patient notice
- Number, nature, and resolution of appeals handled by the RBPO, classified into designated categories
- Description of the RBPO’s appeals process to resolve patient complaints

OPP Support of Implementation of Interim Guidance

Office of Patient Protection ACO/RBPO Report	
Submission Element	**Regulation Requirements**
ACO-01	**Name of ACO or RBPO**
ACO-02	**Provider / Practice Name** (if Organization is submitting multiple reports)
ACO-03	**Name and professional title of the general contact person(s) within your organization for patient appeals?**
ACO-03A	**Phone Number**
ACO-03B	**Email Address**
ACO-04	**Copy of Patient Appeals Notice Attached / Sent to OPP (NOTE: The notice need only be submitted once unless it has changed since the previous report.)**
ACO-05	**Total number of appeals received by RBPO**
ACO-05A	**Total number of appeals provided an expedited review for patients with urgent medical need**
ACO-06	**Number of appeals regarding denials or restrictions on referrals to providers not affiliated with the RBPO**
ACO-06A	**Number of appeals in this category resolved in favor of the patient**
ACO-06B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-07	**Number of appeals regarding denials or restrictions on type or intensity of treatment or services**
ACO-07A	**Number of appeals in this category resolved in favor of the patient**
ACO-07B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-08	**Number of appeals regarding denials or restrictions on timely access to treatment or services**
ACO-08A	**Number of appeals in this category resolved in favor of the patient**
ACO-08B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-09	**Number of "Other" appeals and a description of the issues that consumers raised**
ACO-09A	**Number of appeals in this category resolved in favor of the patient**
ACO-09B	**Number of appeals in this category where the initial provider decision was upheld**
ACO-10	**Description of ACO/RBPO Appeals Process, including at what organizational level (i.e., individual practice or provider organization) the appeals process is initiated and the standards or guidelines used to review appeals. (NOTE: The second and any subsequent reports need only state any changes to the process since the previous report.)**
ACO-11	**Professional title, and clinical background of the individual(s) reviewing patient appeals. If multiple reviewers or a team of reviwers are utilized, please describe this operational approach. (NOTE: The second and any subsequent reports need only state any changes to the operational approach since the previous report.)**

- Held two information sessions for provider organizations in July 2016
- Developed FAQ for provider organizations on RBPO appeals process
- Created and distributed a template for provider reporting
- Managed consumer calls on RBPO appeals process
- Managed provider reporting for the period from October 1, 2016 through March 31, 2017

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Reporting Update

Appeals Data

- 22 provider organizations reporting
- Most (16/22) reported 0 patient appeals
- All appeals concerned referrals
  - Oct-Dec, 2016 - 8 patient appeals reported; 2 resolved in favor of patient
  - Jan-Mar, 2017 - reports under review

Reporting Update

Notices to Patients

- Provider organizations report providing notices to patients consistent with OPP guidance
- Organizations generally used OPP sample template
- Organizations posted the notices online as well as in physician offices
- Notices include OPP contact information
- Some organizations translated the notice in multiple languages

Appeals Processes

- Provider organizations describe varied patient appeals processes
- Some organizations have central intake for appeals; others seek to resolve at practice unit level before elevating
- Provider organizations identified a range of clinical staff who review appeals, e.g. Medical Director, Sr. Clinical Programs Manager, etc.
- Organizations track as appeals those issues that they are unable to resolve at the point of care

Next Steps

Continue Implementation of Interim Guidance

- Require continued quarterly reporting
- Further review of report submissions
- Manage provider and consumer inquiries

Continue Outreach

- Provider Organizations - seek feedback on implementation
- External Review Agencies and their accrediting agency URAC
- Consumers

Develop Regulation

- Public process including proposed regulation and public comment period

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Contact Information

For more information about the Health Policy Commission:

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Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

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APPENDIX

HPC's NAS grantees and extension of DPH's Moms Do Care program

2 HPC grantees are implementing both the inpatient quality improvement intervention and interventions that target pregnant and post-partum women with OUD to increase engagement in, and adherence to, pharmacologic treatment. This replicates a SAMHSA grant currently operated by DPH at UMass Memorial and Cape Cod Health Systems, called *Moms Do Care.*

Grantee	Award	Total initiative cost	Implementing HPC's Moms Do Care Initiative?	2015 NAS volume	Primary Aim
Baystate Medical Center	$249,778	$400,481	No	119	Increase rate of rooming-in by 30%
Boston Medical Center	$248,976	$357,053	No	110	Reduce inpatient length of stay by 40%
UMass Memorial Medical Center	$249,992	$354,794	No	81	Reduce inpatient length of stay by 30%
Lawrence General Hospital	$250,000	$677,719	No	28	Reduce the cost of NAS episode by 10%
Beverly Hospital	$1,000,000	$1,266,962	Yes	35	Reduce length of stay by 30%; Increase retention in treatment by 20%
Lowell General Hospital	$999,032	$1,451,364	Yes	46	Reduce length of stay by 15%; Increase utilization of pharmacologic treatment by 20%