Meeting of the Advisory Panel on Outreach and Education (APOE)

Centers for Medicare & Medicaid Services (CMS)
Wednesday, June 22, 2016
The Hubert H. Humphrey Building
200 Independence Avenue S.W., Room 305A
Washington, D.C. 20201

Executive Summary

Opening

Abigail Huffman, Designated Federal Official (DFO), Office of Communications (OC), CMS

Ms. Huffman called the meeting to order at 8:38 a.m. EDT and welcomed participants. She serves as DFO to ensure compliance with the Federal Advisory Committee Act (FACA). She stated that there would be an opportunity for public comment after the presentations, and anyone interested should sign up. Any lobbyists in attendance should identify themselves as such prior to speaking. She noted a change in the agenda: the CMS response to the recommendations from the January 13, 2016 meeting is still going through clearance and will not be discussed.

Welcome and Introductions

Miriam Mobley-Smith, Pharm.D., APOE Chair

Dr. Mobley-Smith welcomed APOE panel members. Since there were no new panel members, there was no need for introductions. She welcomed several guests who are pharmacists in training for the American Pharmaceutical Association.

Recap of January 13, 2016 Meeting

Dr. Mobley-Smith
Susie Butler, Director, Partner Relations Group, OC, CMS

At the January 2016 meeting, the panel heard presentations about three topics. The first was barriers and disparities related to post-Affordable Care Act (ACA) uptake of preventive services. Notable decreases in the use of such services (e.g., bone density testing, fecal occult blood tests, mammograms, Pap smears) have been documented. The panel discussed barriers such as cultural perceptions, stigma of some services such as HIV testing, and dislike of invasive procedures such as colonoscopy. Recommendations for this topic were divided into two areas: communication for beneficiaries and communication for providers. The recommendations included engaging nontraditional allies and emphasizing one-on-one conversations with beneficiaries. Recommendations for providers were to present preventive services as high-value, healthy wellness services. Navigators could help examine barriers and address the need to change behaviors. Better understanding of disparities is needed. Other recommendations proposed testing the utility of the Medicare beneficiary initial packet and using non-physician staff for education and follow up of screening.

The second topic addressed preparing assisters and navigators for year 4 of ACA open enrollment. CMS wants to move forward with what it has learned in previous years to enhance

assister and navigator programs and evolve programs, with better education, engagement, and recruitment. Recommendations were in three areas: evolving programs, educating assisters, and recruiting assisters. They included allowing higher-level problem-solving authority, tailoring training to points in the enrollment process where errors can occur, and providing a possible long-term career path with ongoing professional development for assisters. Other proposals were more comprehensive training, more call guidance with scripts for assisters, expanding navigator and assister certification training, and providing additional information about cost sharing for consumers.

The third topic was Next Generation Accountable Care Organizations (ACOs) and how to provide input to CMS to enhance communication to assist in better coordinating care and better educating beneficiaries and providers. This financial model seeks to test how strong financial incentives for ACOs can improve health outcomes and reduce expenditures for Medicare beneficiaries. The recommendations emphasized the need for patient education about ACOs, beneficiary-focused communications, and framing messages around the rapidly changing health care system.

Ms. Butler said that CMS will accept all the recommendations, but that is not yet official.

Ms. Butler welcomed APOE panel members and guests and thanked them for their efforts to attend the meeting and what they do for the panel. She thanked Dr. Mobley-Smith, noting that this was her final APOE meeting, and presented her with a certificate for her services, adding that she has taken CMS communications into the next era. APOE has a great deal of influence and helps shapes the CMS communications plans.

Quality Payment Program
Alison Falb, J.D., Public Health Analyst, Center for Medicare and Medicaid Innovation (CMMI), CMS
Jean Moody-Williams, R.N., M.P.P., Deputy Director, Center for Clinical Standards and Quality, CMS
Lemeneh Tefera, M.D., M.Sc., Medical Officer for Value-Based Purchasing, Center for Clinical Standards and Quality, CMS

Ms. Moody-Williams explained the Quality Payment Program, which is rooted in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and promises to change payment for clinician care for years to come. It is based on quality and value. Ideas from APOE can help shape the program, which must be both forward thinking and reflective. It repeals the Sustainable Growth Rate (SGR) formula with two parts—the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).

The program was based on extensive input from clinicians and policymakers. CMS learned that it needed a fresh start, a vision that puts beneficiaries first and is clinician-friendly. SGR was not the answer. While the adoption of electronic health records (EHRs) has been successful, the question remains of how to use EHRs to improve patient care. Special attention is needed for the medically underserved.

MIPS is a progressive and evolving new program that moves away from fee for service, improves data sharing, delivers information technology advances, and considers costs. The first step is to inform 700,000 clinicians that the way they provide care will be changing and the second is to engage clinicians in the process of developing care. CMS would like input from APOE about how to proceed in the months and years to come. The program faces many challenges; it is complicated and many clinicians already feel overwhelmed by other activities. Ms. Moody-Williams asked APOE panelists for feedback about what they are hearing from the field and what key factors should be considered.

Dr. Tefera reviewed details of MIPS and the APMs, emphasizing the value-based focus. MIPS streamlines three currently independent programs to work as one and ease clinician burden. A fourth component, advancing care information, promotes ongoing improvement and innovation to clinical activities and is built on EHRs. The first merit-based payment year will be 2019. By July 2017, single input and single feedback reports will be in place.

Most individual and group clinicians are eligible and expected to participate in MIPS, but hospitals and facilities are not. Clinicians will report to MIPS with similar patterns that they use for the Physician Quality Reporting System (PQRS) and meaningful use program. Reporting will not be duplicative. CMS is working to have a seamless transition. The four performance categories are quality, advancing care information, clinical practice improvement activities, and cost. The cost category is claims-based and calculated by CMS, with no clinician reporting needed. The categories in the overall MIPS score are weighted.

MIPS will adjust payments based on the MIPS composite performance score, with a maximum negative adjustment of -4 percent and a maximum positive adjustment of +9 percent. There is also a performance threshold for exceptional clinicians and a $500 million bonus pool for a secondary performance threshold above the original to incentivize continued excellence.

Ms. Falb reviewed incentives for participation in Advanced APMs, which are a stepped-up initiative for APMs and represent a new approach to paying for medical care through Medicare that incentivizes quality and value. Advanced APMs require use of certified EHR technology, base payment on quality measures comparable to those used in MIPS, and either require APM Entities to bear more than nominal financial risk for losses or to be medical home models, which have a unique financial risk criterion.

APMs likely to become Advanced APMs in 2017 include shared savings programs, next-generation ACO models, comprehensive end-stage renal disease care models, comprehensive primary care, and oncology care models. Qualified Advanced APM participants will be excluded from MIPS and receive a 5 percent lump sum bonus. Eligible clinicians qualify as APM participants by meeting a threshold score calculated by CMS. Fact sheets are available on the website.

In discussion, APOE panelists asked about the target for outreach and education and how feedback will be provided for clinicians, who often already feel overloaded. The primary outreach target is clinicians, but a broad range of stakeholders, including beneficiaries, has been identified. Dr. Tefera added that CMS is working to improve understandings of the MACRA

legislation. Feedback for clinicians has already begun through registries and other existing programs. Clinicians need to understand value-based payment, but these rules could drive them away from Medicare participation. Details are needed about moving through the models. Ms. Moody-Williams said there will be several sources of technical assistance. CMS will develop models to help clinicians determine the best fit for their practices.

Other questions addressed indexing the document, which is daunting; clarifying day-to-day steps; and clarifying how specialists fit into the programs.

Recommendations: Quality Payment Programs

Recommendations were to specify day-to-day steps for providers to enroll and participate in the programs and develop a Web-based application to predict the impact of MIPS on reimbursement. Unique needs of women of reproductive age also should be considered, as should rural/urban and medically underserved characteristics. Providers need to understand how they can evaluate their own performances and improve their scores, and it is necessary to ease the burden of access to clinicians' Quality and Resource Use Reports (QRURs) and link other performance databases, with increased reporting frequency. Other recommendations were to track regional Medicare clinician participation and termination and develop a timetable and process about eligibility. APOE also recommended sharing best practices and MACRA education in medical training. Social determinants of health in patient populations should be considered in risk adjustment.

State Approaches to Managing Opioid Abuse
John Coster, Ph.D., Director, Division of Pharmacy, Center for Medicaid and CHIP Services, CMS

Dr. Coster noted that each state and territory has its own Medicaid drug program. The Medicaid drug rebate program helps states save money on prescription drugs through rebate agreements with manufacturers, but unintended consequences are challenges related to prescribing opioids. Deaths from prescription opioids quadrupled in the U.S. between 1999 and 2013, and Medicaid beneficiaries have a 3 to 6 times increased risk of prescription opioid overdose compared to non-Medicaid recipients. Methadone prescribed for pain accounts for a disproportionate share of opioid prescription overdoses and deaths. It is included in many states' preferred drug lists. CMS has been trying to convince states to restrict methadone.

The 2015 Secretary's Initiative on Opioid Abuse had the goals of decreasing opioid overdoses and overdose mortality and decreasing prevalence of opioid use disorder by focusing on opioid prescribing practices, expanded use and distribution of naloxone, and expansion of medication-assisted treatment (MAT). States are required to have a drug utilization program (DUR) and a Prescription Drug Monitoring Program (PDMP). DUR has become an important part of helping states better manage drug use.

A preferred drug list is the cornerstone in how states manage their pharmacy benefits. Prescribing strategies include step therapy, prior authorization, quantity limits, patient review, and restriction programs. CMS does not have prescribing guidelines, but CDC recently issued guidelines, and CMS hopes that states will use them. PDMPs are designed to help prescribers

and pharmacies know whether a patient might be a drug abuser. Another technique is lock-in, in which certain patients are “locked in” to a single prescriber or pharmacy if there are indications of abuse. Lock-in is not foolproof, particularly when patients pay cash for their prescriptions or for emergency room patients. Problems of PDMPs are that they are not interoperable among states, reporting is not always real-time, and information can be difficult to access because of privacy concerns.

MAT is evidence-based treatment for a chronic disease, and buprenorphine, methadone, and naltrexone are FDA-approved to treat opioid dependence. State strategies for expanding use of naloxone include not requiring a prescription, providing overdose response training, Good Samaritan laws, and community education. Dr. Coster asked for APOE input on how to facilitate removal of methadone as a preferred drug, increase availability of PDMP data, increase access to naloxone, incorporate CDC prescribing guidelines into DUR programs, and evaluate state Medicaid managed care organization (MCO) opiate management programs.

In discussion, panelists asked about legal restrictions on access to PDMP data, which vary from state to state, and how to find the DUR state reports, which are on the CMS website. Another concern was securing treatment for those who have been identified as having an addiction problem; again, states have different approaches. Finding resources is a problem for providers. These are also issues for the Medicare population.

Recommendations: Managing Opioid Abuse

The panel recommended reducing barriers to buprenorphine use, listing substance use disorder and MAT treatment sites on PDMP websites, and expanding studies about opioid diversion and misuse to Medicare beneficiaries. Improved accessibility and training programs are needed for MAT and continuing medical education (CME) and training for buprenorphine. Better access to information and best practices are needed for naloxone, as is research on the effectiveness of lock-in programs. CMS should provide a forum for state Medicaid pharmacy programs to exchange ideas to decrease access to opioids and promote Vivitrol as a viable treatment to be used in a primary care office. The role of community health workers and homeless health centers can be explored. State programs should be monitored with federal guidelines for MAT requirements.

The panel also recommended evaluation of current utilization of Medicaid patients’ methadone use by primary diagnosis, provider type, and provider system and evaluation of Medicaid MCO opiate management programs. CMMI should issue a funding announcement to research the effectiveness of various programs to promote behavior change. Information about the lack of safety of methadone for pain control should be disseminated, as well as educational materials about reducing opioid overdose by removing restrictions of access to naloxone, increasing training for naloxone use, and having Good Samaritan laws in place. Pharmacy collaboratives and public health agencies can share best practices and provide standardized language.

CMS can work with EHR vendors to allow PDMP data access through the EHRs, with pharmacies to track naloxone access, and with the Association of State and Territorial Health

Officials to provide information needed to craft uniform state legislation supporting reduction in inappropriate opioid access.

Engaging the Healthcare Workforce to Effectively Manage Pain
Madeleine Shea, Ph.D., Deputy Director of Minority Health, CMS

Dr. Shea said the pain management priority grew out of the CMS effort to increase its ability to engage vulnerable populations and is a more proactive approach than the enforcement focus described in the previous presentation. Chronic pain affects an estimated 100 million Americans, one-third of the population. Opioids can be effective but often are overprescribed. Nearly 2 million Americans abused or were dependent on prescription opioids in 2014. There are disparities in pain management, with racial and ethnic minorities, women, the elderly, and those with cognitive impairment at risk for inadequate pain treatment. African-Americans are more likely to be referred for substance abuse assessment than to a pain specialist.

Pain can be unrecognized by providers, with cultural and linguistic influences (e.g., low literacy levels, language barriers) affecting patients' communication about pain. The priorities of the Department of Health and Human Services (HHS) and CMS to reduce opioid misuse focus on prescribing practices, expanded use of naloxone to treat opioid overdose, and expanded use of MAT with person-centered and population-based strategies.

One promising practice for vulnerable populations is Project ECHO, Extension for Community Healthcare Outcomes, a collaborative hub-and-spoke approach to increase the capacity of the workforce to get advice in specialty care without taking patients out of their communities. It includes a pain management component. Another pilot is Improving Pain Using Peer Reinforced Self-Management Skills (IMPPRESS), a peer-delivered self-management program for veterans with chronic musculoskeletal pain. In another approach, the Indian Health Service has adopted CDC pain management guidelines.

Dr. Shea asked for APOE input on how to strengthen the health care workforce to manage pain and reduce opioid overdose without worsening disparities, how to address barriers clinicians face in pain management, information about the most and least effective strategies for providers to improve pain management, and good metrics to improve chronic pain management.

In discussion, panelists raised a number of questions including the basic one of how to treat chronic pain and avoid addiction. Dr. Shea said CMS is assessing approaches related to the CDC guidelines. Consistent messaging is needed from different agencies and departments. Another issue is stigma for providers who treat pain management. Also, behavioral treatment can be an effective part of the treatment package. A multi-professional approach and team-based care are needed for pain management.

Clinicians need to be aware of treatment resources to which identified patients can be referred and how to identify the patients. Cultural differences can affect how patients communicate about pain. Metrics to assess pain can include activities of daily living (ADLs), functional status, and maintaining relationships. A balance is needed between appropriate prescribing and access to care and medications. Oncology patients can be underserved. Research is needed about

perceptions of vulnerability. Patients who are under-prescribed might turn to street drugs and injection drug use. Another area of potential disparities is newly insured beneficiaries, who might not be correctly communicating their level of need. Clinicians might feel pressure to mis-prescribe for patient satisfaction and quality measures. Most clinicians do not bring up pain unless the patient does.

Recommendations: Pain Management

The panel recommended creating an interdepartmental communications liaison to ensure consistent communications about pain management and distinct guidelines for providers differentiating acute and chronic pain management to ensure that quality measures harmonize with effective patient care. Disparities must be considered and the scope of outreach and education to providers broadened to explore culturally nuanced approaches to pain management in Native American and other ethnic communities. Effectiveness of current treatment programs should be evaluated to develop community-based strategies for prevention to remove barriers to HIV testing and treatment related to opioid abuse and injection drug use.

Funding is needed for extramural research on innovative approaches to pain management, including complementary and alternative medicine as well as allopathic medicine. Increased training in pain management should be provided for community health workers and other support staff. APOE also recommended working with CDC and maintenance of certification (MOC) organizations to improve the CDC pain guidelines and create pain step therapy management protocols for primary care, dentistry, and other specialties.

For pain measurement, the focus should be on ADLs and functional status rather than numeric pain scales, with integration of behavioral health and pain-specific patient education. Partnering with professional societies such as the American Academy of Family Physicians in creating CME and training around effective pain management would be useful, as would integrating PDMP data into EHRs. Another suggestion was to promote pilot complementary and alternative pain management payment programs in Medicaid and Medicare with specific outcome measures such as reduction in ER use for chronic pain or return to work. Instructional materials for providers and patients can indicate that narcotics should not be the mainstay of treatment for chronic pain and that alternative treatment could be safer, effective, and non-addicting.

Recap of Meeting and Final Comments
Louise Scherer Knight, M.S.W., APOE Co-chair

Panelists proposed a number of topics for future meetings including standards in the federal Marketplace and data matching issues, consumer education during plan selection in the Marketplace, special enrollment periods, functionality and training for the Marketplace, and improvements in Marketplace display of plan information. Other topics might examine outreach and education for local groups, including rural areas; review of Medicare patient education materials; the Medicare care choices demonstration project; and how CMS adopts innovations and integrates them into payment models. Also, several past presentations deserve follow up; these include the joint bundling project, care coordination fees, and the campaign to bring fraud and waste to public attention.

Ms. Knight congratulated Dr. Mobley-Smith for her service and said she will be missed. To recap the meeting, she said it has been one of the more complicated, detail-driven meetings APOE has had. Receiving slide decks further in advance of the meeting would be helpful.

Dr. Mobley-Smith thanked the panel for its support and a job well done.

Adjournment
Ms. Huffman

Ms. Huffman thanked panelists for their participation and adjourned the meeting at 3:37 p.m. EDT. The next APOE meeting will be on Wednesday, September 21, 2016.