

Centers for Medicare & Medicaid Services

Rural Health Open Door Forum

Moderator: Jill Darling

Thursday, January 24, 2019

3:15 p.m. GMT

Operator: Good afternoon. My name is (Maria), and I will be your conference facilitator today. At this time, I would like to welcome everyone for the Centers for Medicare & Medicaid Services Rural Health Open Door Forum.

All lines have been placed on mute to prevent background noise. After the speakers' remarks, there will be a question and answer session.

If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. Ms. Darling, you may begin your conference.

Jill Darling: Thank you, (Maria). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to the first Rural Health Open Door Forum of 2019.

Again, thanks for joining us, and we always appreciate your patience in the very beginning. We never know what folks schedules are like, so if they're not able to dial in a little ahead of time. So we appreciate your patience as always.

Before I hand the call off to John, one brief announcement from me. This open door forum is not intended for the press, and the remarks are not considered on the record.

If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have inquiries,

please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov). And now I'll hand the call off to John Hammarlund.

John Hammarlund: Great. Thanks (inaudible). Thank you very much, Jill, and hello everybody and happy 2019. This is John Hammarlund emanating from Seattle, Washington today. I hope you are doing well. Thank you so much for joining the call.

On behalf of the co-chair of this call, Carol Blackford, it's my pleasure to welcome you to the call. We have a lot of our CMS colleagues in our headquarters on the call today who will be presenting on some really important topics and timely ones. We also have others on the staff who are available to answer questions at the end of the call.

And we're also pleased to be joined with our colleagues from throughout the 10 CMS regional offices as well and members of the CMS Rural Health Council. So we've got a full compliment of CMS people on today to engage with you.

And we have a great agenda. We're delighted to have Alpha and Jim and Anna joining us today. That's my way of reminding of you that you all can help us build the agendas in the future for these calls.

At the end of the call, Carol Blackford will come on to let you know how you can reach us so that you can suggest agenda items for the future. We want to make sure these calls are designed to meet your needs.

So great. Great to have you on the call, and I will hand it back to Jill who will introduce our first speaker. Thanks.

Jill Darling: Thank you, John. First we have Alpha Wilson who will go over the extension of discharge planning final rule.

Alpha Wilson: Thanks so much, Jill, and good afternoon, everyone. So on November 2, 2018, we published an extension notice which extended the timeline of publication of the Medicare and Medicaid program revisions requirements for

discharge planning for hospitals, critical access hospitals, and home health agencies final rule until November 3, 2019.

And this rule addresses the discharge planning requirements in the conditions of participation and implements certain requirements of impact after 2014 for hospitals, HHAs, and (cause) that we proposed in the discharge planning proposal which was published back on November 3, 2015.

So we received well over 200 public comments from various individuals, organizations, and state health departments on the proposed rule.

And based on these public comments and stakeholder feedback that raised significant policy issues, we determined that it was appropriate to extend the timeline for publication as a final rule until November 3, 2019. Thanks.

Jill Darling: All right. Thank you, Alpha. Next we have Jim Poyer who will go over the National Quality Forum – NQF Measures for Rural Health Services.

Jim Poyer: Thanks, Jill. First I'll give a high level overview of the measure set. At CMS's direction, the National Quality Forum or NQF's Rural Health workgroup recommended a core set of Rural Relevant measures in summer of 2019.

Workgroup criteria included whether the measures were endorsed by the National Quality Forum, whether they were cross cutting across settings of care, resistant to low case volume, and addressed transitions of care.

And the NQF core Rural Relevant recommended clinical focus areas, there's nine of them – mental health, substance abuse, medication reconciliation, diabetes prevention, chronic obstructive pulmonary disease or COPD, hospital readmissions, perinatal conditions, and pediatric population.

And in that report and I would refer you to – I'll give you the website at the end of the presentation, the NQF recommended three Rural Relevant measure sets. The first for hospitals, nine measures, the second for ambulatory care, 11

measures, and then an ambulatory set for health plans and integrated delivery systems, a set of seven measures.

And from CMS, we assess applicability to our value-based payment and quality reporting programs, and I work in fee for service Medicare on quality reporting and valued-based payment programs using the Meaningful Measures framework, and it's CMS's initiative launched in 2017 to identify the highest priorities for quality measurement and improvement.

It involves only assessing those core issues that are most critical to providing high quality care and improving individual outcomes.

And there's 19 Meaningful Measures areas that serve as the connector between CMS's strategic goals and individual measures and initiatives that demonstrate how high quality outcomes and our beneficiaries are being achieved.

And we use the Rural Relevant measure sets as part of our meaningful measure framework and our measure consideration. And these topics are concrete quality topics that reflect the core issues that are most vital not only to rural providers but to all providers that are part of Medicare and to high quality care and better patient outcomes.

And examples of Rural Relevant measures used in our valued-based care programs at CMS in fee for service Medicare.

In hospital valued-based purchasing program, the hospital patient experience of care survey, or known as (HCAPS), were surveying patients in terms of their experience of care as well as the Center for Disease Control's healthcare associated infection measures.

A couple of the measures from that measure set are included in the Rural Relevant set also in the Hospital Acquired Condition Reduction Program, and this is relevant to rural providers that are paid under the inpatient perspective payment system.

Also for skilled nursing facilities, our readmission measure. That's an all-cause readmission measure. That is as well as last, but certainly not least, our newest valued-based payment program, the quality payment program, the merit-based (consentive) system, or MIPS.

There is a measure on diabetes as well as a two preventative care measures, influenza vaccination and depression screening. These are part of the Rural Relevant set and clinicians and providers can at least – clinicians can select these measures (to lead) as part of their MIPS requirements.

Now in part of HHS provides extensive technical assistance to rural providers and clinicians to report data and to improve on these core measures as well as other aspects of quality care.

For hospitals (hearses) Office of Rural Health Policy Flexibility Grant program, we collaborated in that – collaborated over the past decade in terms of assisting providers to report data and improve quality of care.

And at CMS, we also provide assistance to clinicians through practice transformation networks for MIPS and QPP support, also quality improvement innovation networks to provide the system to improve quality of care and care transitions on issues like skilled nursing facility readmission measures.

And last, but certainly not least, quality reporting and the value-based payment support for hospitals as well as other providers, and that – I'll give you in terms of more information, the measures set, we'll refer you to the National Quality Forum's website, [www.qualityforum.org](http://www.qualityforum.org) for these specific lists, the Rural Relevant measure sets as well as at CMS there is the [qpp.cms.gov](http://qpp.cms.gov) for more information on the quality payment program, and last but not least our quality reporting center website if you're a hospital in term – or other provider in terms of reporting like Ambulatory Surgical Center, [www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). And thank you very much and Happy New Year.

Jill Darling: Thank you, Jim. And last we have Anna Bonelli who will go over opioid roadmap.

Anna Bonelli: Hi, my name is Anna. As you know, CMS is a critical player in the space trying to address the opioid crisis. We've been doing this through three major approaches – prevention, treatment, and data.

Of course with prevention, our goal is to work to promote pain management using a safe and effective range of treatment options to address the unique needs of each patient.

We're focused on reducing the volume of prescription opioids, particularly at levels above evidence-based recommendations and those that put patients at risk of developing opioid use disorder.

Our Medicaid or Medicare prescription drug program has implemented policies that promote safe opioid prescribing practices. In fact, starting in January of this year, we made a couple of changes. One change is the default fill of prescription opioids for acute pain to seven days.

It's important to note that this policy is specific to first-time opioid sales for acute pain and it's not intended for current users of prescription opioids or for chronic pain patients.

Another policy that was implemented in January of this year directs pharmacists to coordinate across prescribers when a patient has received multiple prescriptions that results in higher than recommended doses.

Second, we're seeking ways to promote non-opioid alternatives to pain management like using acetaminophen, ibuprofen, et cetera, or physical therapy and exercise, but we are highly cognizant of the fact that many patients rely on prescription opioids for pain. We do not want reductions in opioid prescribing to negatively impact pain management.

Then turning to treatment, of course, we want to address those who have developed an opioid use disorder and help those who are suffering. Estimates

show that only 20 to 30 percent of people who have an opioid use disorder received evidence-based care like medication assisted treatments and counseling.

The goal of our treatment effort is to expand access to such treatment and we're doing this in a few different ways, and I'm going to talk about some of those ways in addition that have been developed in response to the Support Act.

We're looking closely – we're working closely with state Medicaid agencies to improve beneficiary access to MAT through substance use disorder demonstrations. You may have heard those referred to as 1115 waivers as well.

As of 2017, we announced additional flexibilities so that states could use 1115 waivers to cover a comprehensive range of opioid use disorder treatments including some patient care provided at institutions. Those are often referred to as institutions of mental disease or IMD facilities.

Those previously had not been available for Medicaid coverage in the past. As of this month, we have approved 21 such waivers.

As I said, we're also using data to monitor the success of our intervention and to analyze where we should target our policies and resources. The goal of our data efforts is to use data to better identify patients at risk of opioid use disorder and target areas most in need of prevention and treatment efforts.

We're doing this in many different ways. One of which is we work to share Medicare data with prescription drug plans and prescribers to identify patterns of potential misuse as early as possible.

For example, we've mailed over 24,000 letters, informational in nature, to notify Medicare physicians that they are prescribing higher levels of opioids than their peers.

And you may have heard that in October Congress passed the SUPPORT Act, and this had an enormous amount of work for CMS to do. It had about 50 provisions, which can entail multiple steps for us to change our policies, implement demonstrations, implement waiver programs, produce reports; produce guidance's.

So we really have our hands full with a full range of activities to address the opioid epidemic. I'm just going to highlight a few of those new things that are in the SUPPORT Act that we're working to implement.

One really important item is a provision in the SUPPORT Act that allows us to cover opioid treatment programs that we have not covered before in Medicare. So this permits Medicare to start covering treatment provided in OTPs including methadone.

So that's a new treatment option, and it needs to be effective – go into effect January 1 of 2020, so a really short timeline. As I mentioned before about the IMD coverage, there were a number of provisions in the SUPPORT Act that touch on the IMD provision in Medicaid as well.

It expanded benefits to provide more services to pregnant women who are residents in an IMD so that we can – we can make sure that Medicaid will continue to cover their prenatal care and other services for which they qualify under Medicaid.

Another SUPPORT Act provision will have us testing demonstration programs to test bundled payments for Medicaid assisted treatment. We have a couple different demonstrations in that space.

We're doing one under our innovation authority so that we'll include Medicare and Medicaid, and we're doing another demonstration program in just Medicaid that will eventually result in five states being chosen or grants in order to help them develop their capacity around MAT – develop capacity among providers to provide MAT.

And just mentioning a couple more, we have also – we also have a lot of work to do regarding incarceration. Incarcerated individuals, as you know, are particularly vulnerable to opioid overdose.

And so, one of the provisions in the SUPPORT Act requires us to issue guidance regarding suspending the Medicaid enrollment of juveniles while they're incarcerated so that when they walk out the door, we can help states to reenroll them as quickly as possible so that they can continue their treatment if necessary.

There are also provisions around former foster youth and using data to analyze the opioid use – to analyze opioid prescribing as well as treatment of opioid use disorder in Medicaid which had hitherto not been conducted.

So I could go on and on about the SUPPORT Act, but I want to give it back to our mediator so that we can take questions. Thank you very much.

Jill Darling: All right. Thank you, Anna, and thank you to Jim and Alpha. (Maria), we'll go into our Q&A, please.

Operator: Thank you. As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Please limit yourself to one question and one follow up to allow other participants time for questions. If you require any further follow up, you may press star one again to rejoin the queue. I'm showing no questions at this time, ma'am.

Jill Darling: All right, well I'll hand the call back to John or Carol for any closing remarks.

John Hammarlund: Let's see if Carol is on the line now. Thanks.

Carol Blackford: I am, John. Thank you, and thank you, everyone, who participated on the call today. This is Carol Blackford, one of the co-chairs of our Rural Health Open Door Forum call.

Again, I want to thank you for participating and we hope that you find this information valuable. And of course, as you know, really the purpose of these calls is for us to provide information and status updates to you in ways that are beneficial.

So to the extent that you have any thoughts or suggestions for information that you'd like to hear about on a future Rural Health Open Door Forum call, please share that information with me.

You can email that to me directly at Carol.Blackford, B-L-A-C-K-F-O-R-D, @cms.hhs.gov or you can also send that into our Rural Health Open Door Forum email box, and I believe that information is available on the website and on the agenda. So thank you, everyone, and look forward to your suggestions and your participation for our next call.

Operator: And thank you for participating in today's Rural Health Open Door Forum conference call. This call will be available for replay beginning today, January 24, 2019 at 7 p.m. Eastern and ending January 28<sup>th</sup>, 2019 at midnight. The conference ID number for the replay is 2872469. The number to dial in for the replay is 855-859-2056.

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