

Centers for Medicare and Medicaid Services
Long Term Services and Support
Open Door Forum
Moderator: Jill Darling
January 30, 2018
2:00 p.m. ET

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

All lines have been placed on mute to prevent any 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, please go ahead and press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Ms. Jill Darling, you may begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon everyone and welcome to the first Long Term Services and Support Open Door Forum of 2018.

Before we get in to today's agenda, 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 do have any inquiries, please contact us at press@cms.hhs.gov.

Up first, we've added an agenda topic. We have Monica Kay, who will go over the new Medicare card project.

Monica Kay: Good afternoon, everyone. My name is Monica Kay. And I am the deputy director for the Division of Program Management. And I wanted to speak to you today about the new Medicare card project.

Hopefully by now, you've heard about it. And I wanted to be able to share with you some updates and recent developments. For those who may not know, the Health Insurance Claim Number or HICN is a Medicare beneficiary's identification number. We use that for processing claims and for determining the eligibility for services across multiple entities. That includes the Social Security Administration, Railroad Retirement Board, states, Medicare providers, health plans, and long-term services as support organization such as yourself.

The Medicare Access and CHIP Reauthorization Act, MACRA of 2015 mandated the removal of the Social Security Number based HICN from the Medicare cards to address the current risk of beneficiary medical identity theft. This legislation required that CMS must mail out new Medicare card with a new Medicare Beneficiary Identifier or MBI by April of 2019.

So let's talk a little bit about the concept for the new Medicare card. The new Medicare cards and CMS must be able to generate new MBIs or Medicare Beneficiary Identifiers for all of our beneficiaries. This includes existing, currently active, deceased or archived members, as well as new beneficiaries that are accreting into the program.

We must also issue new redesign Medicare cards. This new cards will contain the MBI for our existing and new beneficiaries. And of course we must modify our systems and business processes. This requires update to accommodate the receipt, transmission, display, and processing of that new MBI.

CMS anticipates that we will use an MBI generator to assign 150 million new MBIs in the initial enumeration. And that includes 60 million active, as well as 90 million deceased or archived. As well as generate a unique MBI for each new Medicare beneficiaries. CMS must also generate a new unique MBI for any Medicare beneficiaries whose identity has been compromised.

So hopefully, you've been able to visit our website where we talk about the new MBI in some of those characteristics.

The new Medicare Beneficiary Identifier or MBI will have the following characteristics. It will be the same number of characters as the current Health Insurance Claim Number or HICN which is 11. But will be visibly distinguishable from the HICN.

It will contain uppercase alphabetic and numeric characters throughout the 11 digit identifier. It will occupy the same field as HICN on transactions. But most of all, it will be unique to each and every beneficiary.

For example, the husband and wife will have their own MBI. The MBI will be easy to read and limit the possibility of letters being interpreted as numbers. And it will exclude the following letters, S, L, O, I, B, and Z. It will not contain any embedded intelligence or special characters, nor will it contain any inappropriate combinations of numbers or strings that maybe offensive.

CMS anticipates that the MBI will not be changed for individual unless it has been compromised or for other limited circumstances that are still undergoing review.

So now, I'll talk to you about our MBI generation and transition period. CMS will have a 21 month transition period where we will mail out those new cards. We will activate our MBI generator and translation services. And during that 21 month transition period, we will both accept and process the HICN and MBI on transactions.

Starting April 1st of 2018, that is when our transition period begins. And it will end December 31st of 2019. On January the 1st of 2020, HICNs will no longer be exchanged with beneficiaries, providers, and plans and other third parties with some limited exceptions.

CMS also anticipates mailing out those cards between April of 2017 through April of 2018, excuse me, through April of 2019. That's when we plan to conduct our phased card issuance to our beneficiaries.

So hopefully, again, if you've been visiting our website and getting our publications via e-mail, you'll see our new CMS Medicare cards. And if you're joining us via the link, you will also see a copy of the new Railroad Retirement Board card which looks similar to our card. But the differences are the logo in the upper left hand corner and the Railroad Retirement Board indicator at the bottom of the card.

So now, I would like to talk to you about some of our outreach and education. CMS will provide outreach and education to approximately 60 million beneficiaries, their families, advocacy groups, caregivers, health plans, of course the provider community. And we've done that through our provider letter and fax sheet that has been sent out to our providers, as well as quarterly open door forum such as this.

We've also been in communication with states and territories and other business partners including vendors and billing agents.

CMS plans to conduct intensive education and outreach to all of our Medicare beneficiaries, their families, caregivers, and advocates, to help them prepare for this change from September 2017 through April of 2019.

Once beneficiaries received their new cards, they will be instructed to safely and securely destroy their own Medicare card. And to keep their new Medicare number confidential. CMS is also working to develop a secure way for beneficiaries to be able to access their new Medicare number when it's needed.

In terms of some of the outreach and education resources, we have resources for our providers to help them communicate with to our beneficiaries and people with Medicare. They are available on our website for printing and ordering. We have a flier, care of for patients, conference cards for beneficiaries, and a poster that can be used in offices.

We also have a full timeline for the records of the activities that will occur. So some of the key points that we want to ensure that we reinforce with patients is to understand that the mailing everyone a new card may take sometime. And that a card might arrive at a different time than a friend or neighbors.

We also want to ensure that the beneficiary's mailing address is up-to-date. And if an address needs to be changed that they need to contact the Social Security Administration, either via their website or through their phone line.

We also want to ensure that patients are aware of anyone who may contact them about their card. And that CMS will never ask to give personal or private information to get that new Medicare number and card.

So the big points to know in terms of a long care support and services, is that all providers and organizations need to be ready by April 1st, 2018. This includes your systems as well as your business processes and workflow. New cards will start to be mailed then. And they will also be new beneficiaries coming in to the system that will never know that they have had a HICN or a Health Insurance Claim Number.

Another key point to know is that there will be a 21 month transition period from April 1st to 2018 through December 31st of 2019, where we will allow dual processing with either the HICN or MBI.

Another key point to know is that providers will have three ways to get the new Medicare Beneficiary Identifier. A patient will present the card at the time of service. A provider receives it through a remittance advice or they will obtain it through a secure web portal with their Medicare administrative contractor.

We have a lot of resources that you can use when you talk to people about Medicare and our cards. And the link has been provided via the PowerPoint presentation.

Some final thoughts, I know this was a lot of information at once. We really want our stakeholders and other advocates to go to www.cms.gov/newcard where they can find all of the information related to the new Medicare card or you will not only see the MBI specifications, you will also learn about the exceptions as well as the implementation plans.

And if you have any questions or comments, please feel free to send them to the new Medicare card e-mail box, which is at newmedicarecardssnremoval@cms.hhs.gov.

Jill, back to you.

Jill Darling: All right. Thank you Monica. Up next we have Ronke Fabayo who has announcement about the low volume settlement opportunity.

Ronke Fabayo: Thank you, Jill. Good afternoon everyone. My name is Ronke Fabayo. And I'm the Deputy Director for the Division of Medicare Debt Resolution in the Office of Financial Management.

As part of the department's broader efforts to improve the appeals process, beginning February 5th, next week Monday 2018, CMS will make available an administrative settlement option for providers and suppliers or appellants with appeals pending at the office of Medicare Hearings and Appeals and the Medicare Appeals Council at the Departmental Appeals Board.

The Low Volume Appeal settlement option, or as we call it or referred to it LVA, will be limited to appellants with the low volume of appeals depending at OMHA in the council. Specifically, appellants with fewer than 500 Medicare Part A or Part B claim appeals pending at OMHA and at the council combined.

As of November 3rd of 2017 with the total bill amount of \$9,000 or less per appeal could potentially be eligible if other certain conditions are met. CMS will settle eligible appeals at 62 percent of the net approved amount.

CMS hosted a Medicare Learning Network provider call on January the 9th to discuss the process in detail. We have another call scheduled for February the 13th to go on further detail about the LVA post going live.

However, the transcript for this – for the January 9th call as well as the YouTube link for the full presentation of that call will be available on our LVA website. That website is go.cms.gov/lva. Again, it's go.cms.gov/lva.

There was a wealth of information regarding the settlement option on the website including the settlement process documents and frequently asked questions. As I indicated earlier, we're going to host additional Medicare learning provider network calls. One will be on February the 13th – February, excuse me, the 13th and the other one will be on March the 13th after the settlement process begins.

We encourage those who are interested to visit the LVA website for additional information on this new opportunity and to attend our future Medicare provider network calls.

As a reminder, the website again is go.cms.gov/lva. If you have any questions related to this process, please contact us at medicaresettlementfaqs. Again, all one word, medicaresettlementfaqs@cms.hhs.gov. Thank you, Jill.

Jill Darling: Thank you, Ronke. And for those, the e-mail address and the web link is on today's agenda. So last we have Kirsten Beronio who will go over the new section, 1115 policy on strategy to address opioid and other substance use disorders.

Kirsten Beronio: Good afternoon everyone. I'm going to talk a little bit about a new initiative we have underway at the Center for Medicaid and CHIP Services. I'm going to give you some background on that initiative. And my colleague Tyler Sadwith will walk through some of the specifics of that initiative.

Section 1115 of the Social Security Act provides some authority, some flexible demonstration authority to the Centers for Medicaid and CHIP

Services to enable us to work with states on innovative approaches to address issues that can help us basically fulfill the objectives of the Medicaid program.

So, in our efforts to address the opioid crisis, we are using that flexible demonstration authority to work with states to provide them with some flexibility around some of the restrictions that exist around how we can pay for substance use disorder treatment.

And in exchange, you know, want to work with those states to ensure that there's, you know, a strong continuum of care in place for our Medicaid beneficiaries who are struggling with, you know, opioid use disorder or other substance use disorders. We also are looking to work with states to ensure, you know, that the quality of the care being provided is, you know, strong, good quality.

This initiative is an option for states. It's not something we're requiring. It's just an opportunity that we're offering to states. And, you know, as part of that interest in ensuring that Medicaid beneficiaries have access to the treatment they need, we're offering some flexibility as I mentioned around a restriction that applies to treatment provided in residential treatment settings.

And I thought I would go over first some of the background on, you know, that we had in mind as we were developing this initiative that informed our thinking about this initiative. You know, one, of course important fact that we, you know, regularly highlighted in the news is the fact that drug overdose death has continued to increase over the past 15 years, driven largely by opioid abuse.

We know that Medicaid beneficiaries have higher rates of opioid use disorder than the general population. And not only a minority, it appears are getting access to treatment for that condition. So, you know, again, we wanted to really try to use our – all of our tools to try to address this issue.

And think about what are the problems in the delivery system that, you know, maybe we can work with states to address to this initiative. So one of the problems that we know exist is that, well, sometimes, you know, people may

get acute care for, you know, perhaps an overdose or acute care for withdrawal from opioids.

Often they're not getting follow-up care in the community, the kind of outpatient treatment. And we know that this is really critical for, you know, having to address the addiction that just getting withdrawal management, you know, acute care for the withdrawal is not sufficient that you really – it is a chronic condition that you really do need ongoing support.

And what we is, that because people, a Medicaid beneficiaries are not getting access to that follow-up care, that we do see that, you know, some of the top reason for readmissions to hospitals, for treatment, is our substance use disorder related conditions.

Another, you know, concern that we have, that we want to work with states on is that we know there's a lack of providers of substance use disorder treatment in a lot of communities across the country. So that's certainly a challenge that we want to see how we can help state address in this initiative.

And we also know that people with substance use disorders often have very serious comorbid conditions that can interfere with, you know, treatment for that substance use disorder that, you know, also can be very costly.

You know, states found significant reductions in their medical cost when they were able to, you know, improve access to treatment for their Medicaid beneficiaries. So that was another, you know, sort of issue that we wanted to try to address.

We also know from literature and from the treatment experts in the field that it's really important that there be a continuum of care. They mentioned not just acute care but outpatient treatment, also some sort of intermediate level of treatment, either intensive outpatient or partial hospitalization that they're (be).

Obviously, medication assisted treatment, this is critical for addressing opioid use disorders that's the, you know, the evidence really strongly points towards that approach is very effective for treating opioid use disorder in particular.

But also that, you know, residential treatment, some people particularly those who are struggling with addiction and also have serious comorbid medical conditions or psychiatric conditions are often comorbid, co-occurring with substance use disorders. You know, pregnant women, people who don't have a stable or living arrangement. You know, sometimes residential treatment can be very helpful for those folks.

However, you know, often opioid use disorder can be effectively treated in through an outpatient setting. So, anyway offering, you know, a continuum for people is really critically important.

So, in developing this new initiative, we took a little bit of a different approach. We're building on some prior – our prior initiative addressing substance use disorder treatment that was announced in the State Medicaid Director letter back in 2015. And really trying to streamline that initiative and focusing and make it very explicit up front kind of where we wanted to see progress.

In this initiative laid out some goals, very specific goals. And we chose the goals in part as something that against which we could measure our progress. So, you know, one goal that we identified was indeed to increase the rate of initiation and engagement in treatments.

You're really helping to do, you know, encouraging states to do more outreach to identify people who needed to get in to treatment. And then helping them stay in treatment in part by, you know, offering them levels of care that fits their needs.

Obviously, we really want to see our reduction in overdose deaths particularly due to opioids. And as another indicator of progress we want to, you know, see that people are using emergency rooms in inpatient settings less as there's improved access to a continuum of care.

And as I mentioned, you know, readmissions for substance use disorder treatment, obviously, you know, we would like to see reductions there as well

some indication that there's improved access to physical healthcare for the comorbid conditions.

So, those were goals that we laid out in a State Medicaid Director letter that we issued in November of 2017. If you want to find that letter, I should have mentioned at the outset you can Google CMS, State Medicaid Director letter and opioid. And that should pull it up for you.

And that goes over in detail, you know, this background that I went over, the goals of this initiative somewhere of the process for how states can apply. And, you know, I should also point out one of the ways that we are encouraging states to apply and work with us on this, is to offer more flexibility in terms of when some of the objectives of the demonstrations have to met.

Right now, I'd like to turn it over to my colleague Tyler Sadwith to talk a little bit more about some of the specific ways that we want to work with states through this initiative, Tyler.

Tyler Sadwith: Great. Thanks, Kirsten. My name is Tyler Sadwith. And what I'd like to do right now is take a little bit of time to just walk through some of the programmatic criteria that are described in the State Medicaid Director of letter that Kirsten mentioned.

The letter was issued November 1st. And you can find that on Medicaid.gov. And it really describes some new flexibilities and opportunities for states to take advantage of this 1115 waiver opportunity to introduce some program reforms and cover critical residential treatment services not otherwise coverable under Medicaid.

So, let me just describe some of the key features of this 1115 initiative that are described in the guidance. So, these are essentially six milestones that CMS is supporting states to meet over the course of their demonstration.

And as part of providing the federal match for some residential treatment services that otherwise are not coverable under Medicaid, CMS is hoping that

states would work to meet these key milestones over the course of their waiver so that individuals with substance use disorder and individuals with opioid use disorder in particular have access to a comprehensive system of care that is designed to meet their needs and improve their outcomes.

So, the first milestone is really around making sure that critical levels of care are covered in the states benefit package. So, the intention behind this first milestone which is around service coverage is making sure that not only are residential and other clinically intensive services available to individuals, but also other levels of care that are community based and that have a strong bases of evidence behind them to treat opioid dependence are also covered.

So, that extent, the guidance describe coverage of outpatient, intensive outpatient, medication assisted treatment, and medically supervised withdrawal management as critical levels of care that are described in industry guidelines that describe the addiction continuum of care.

CMS is working with states to ensure that these critical levels of care available with in the first two years of the states' SUD waiver to the extent that they're not available today. So, some states, as they apply for this SUD waiver and they're covering residential treatment for the first time, they're also identifying other levels of care, like, you know, intensive outpatient or a modality of medication assisted treatment that they're also introducing coverage for as part of their proposal.

The second milestone is really around the use of evidence-based substance use disorder-specific patient assessment tools and criteria. So, this milestone is aimed at ensuring that individuals are entering treatment in appropriate levels of care based on their need.

I think the goal is to make sure that individuals are being assessed with comprehensive patient placement tools like the patient placement criteria described in the ASAM Criteria or other validated assessment tools that ensure that individuals are able to enter into SUD treatment at the level of care that best meets their needs.

And so, CMS is providing flexibility to states to meet these milestones to the extent they don't today within two years of the demonstration. And as part of this milestone, CMS is working with states to ensure that there is a utilization management strategy in place to ensure that not only are these assessment tools incorporated into the patient assessment and placement process but that there are mechanisms in place to do some utilization review and some look-behinds to ensure that these tools are being used with fidelity and that folks are indeed receiving treatment at the level of care that is recommended by their assessment.

The third milestone is really designed to ensure that a high quality of care is being offered to Medicaid beneficiaries that do receive treatment in residential settings.

So, as part of the third milestone, CMS is working with states to ensure that there are provider and program standards in place specifically for residential treatment providers that are consistent with a few key benchmarks from national guidelines like the ASAM Criteria or other nationally recognized SUD-specific standards that are out there.

So, this is an area that states are looking at to ensure that as they bring new services on line and as they bring new providers into the Medicaid provider network, those providers are delivering care consistent with key standards, like the types of services that are delivered, the hours of clinical care and credentials and staffing pattern, again, for residential treatment settings specifically.

So, CMS is offering states flexibility to meet this milestone, again, within two years demonstration approval. And CMS is working states to ensure that there are processes in place at the state level or perhaps at the managed care plan level to ensure that residential treatment providers are being reviewed for meeting some of those key standards.

And as part of the third milestone, there is specific reference to ensure consistency with some of the national program standards that out there, to ensure that residential treatment facilities offer medication assisted treatment

on site or facilitate access to medication assisted treatment offsite within two years of demonstration approval.

And this goes back to the point Kirsten raised regarding, ensuring that, you know, the critical levels of care with the highest base of evidence available are available to Medicaid beneficiaries.

So, the fourth milestone is ensuring that there are processes in places at the state level to provide sufficient provider capacity. So, this is sort of complement to the first milestone around service coverage in addition to ensuring that services are covered in the Medicaid program. You know, this guidance is really looking for states to ensure that providers are actually available within the Medicaid network at those critical levels of care.

So, this criteria asks states to complete an assessment of Medicaid participating providers throughout the state and in key regions of the state for each critical level of care. And to do some assessments around ensuring that the distribution of providers is sufficient to meet the needs or to do some critical need assessments.

The fifth milestone is consistent, I think, with the core mission of those guidance which is to support states and their ongoing efforts to address the opioid epidemic. And so this fifth milestone is really around in ensuring that, you know, in addition to covering residential treatment services in settings otherwise not coverable, states are also implementing comprehensive prevention and treatment strategies to address opioid use disorder.

So, we're looking to better understand how states are implementing prescribing guidelines for prescription opioid pain medications, perhaps consistent with the guidelines that Centers for Disease Control and Prevention released in 2016 or other state base guidelines that ensure appropriate utilization of prescription opioids.

As part of this milestone, we're also working with states to look at strategies that the states are planning or implementing to facilitate the availability of

naloxone to ensure that rescue agent is available in the community to reverse opioid related overdoses.

And lastly, as part of this opioid strategy milestone, CMS is working with the states to support their efforts to increase the functionality and the utilization and the value of prescription drug monitoring programs which are a key lever in states' efforts to ensure appropriate opioid utilization. And for this milestone we're offering flexibility for states to describe their efforts to meet these items over the course of the waiver.

And the last milestone that I'd like to describe today is really regarding care coordination in transitions between levels of care. So, this is designed to supplement and enhance states' ongoing efforts to ensure that individuals transition between levels of care successfully.

And it's really zeroing in on the hand-offs that follow a discharge from a residential treatment setting into lower levels of care based in the community. So, it's really getting a better sense of how states are implementing policies and strategies to ensure that residential and inpatient providers are linking beneficiaries with community based services and support following short-term inpatient or residential states.

And so, to the extent, states are proposing to plan new strategies there. We're working with states to achieve those strategies within 24 month of approval.

So, I think that's a quick overview of the key milestones and the key programmatic criteria described in the guidance. In terms of process, CMS is offering flexibilities for states to receive approval of the waiver itself and then allow a little bit of time for states to describe in an implementation plan their proposed work plan for meeting these milestones.

And so, we're allowing a little bit of an onramp for states to get the waiver approved and then to submit an implementation plan following approval to describe these milestones.

So, again, these are described in the State Medicaid Director letter available on Medicaid.gov that was issued in November. And with that, I think, I'd like to turn it back Kirsten to walk through some of the quality monitoring aspects of this initiative.

Kirsten Beronio: Thanks, Tyler. You know, we just wanted to wrap it up with a little bit on some new features of this 1115 demonstration initiative. They're a little bit different than some other 1115 demonstration that we've undertaken in the past.

As I mentioned, we have laid out in the State Medicaid Director letter some specific goals for this initiative. And as a part of, you know, trying to monitor the impact that we're having on those goals, we want to work with states to identify.

We're working actually internally to identify a standard core set of performance measures that we want to work with state to have them report on as indicators of progress in terms of those goals that I talked about at the outset around engaging people in treatment, keeping them engaged, reducing overdose deaths, you know, reducing emergency room utilization, and inpatient readmission, all of those indicators.

We are going to be hopefully soon issuing a standard set of performance measures. And then part of the process will be to work with states to develop monitoring plans to come to agreement about how they are going to report to us on how things are going in terms of those performance measures and data.

And then, you know, as part of the – generally with this 1115 demonstrations states do have a quarterly reports and annual reports that they submit. So, some of that information on how things are going, what kind of progress is being made, both in terms of the performance measures. And then in terms of some of these milestones that Tyler described, will be in those quarterly and annual reports.

We will also as a new feature of these demonstrations work with states on a midpoint assessment to sort of see how things are going in a more formal way

at the midpoint in this demonstrations which are generally five years in length and then often can be renewed. But in terms of the first five years, anyway, at the midpoint between years two and three we will reassess kind of how things are going.

And then, also, generally with this Section 1115 demonstrations, there is a requirement to have an interim evaluation either at the point where they may be requesting a renewal of the demonstration or one year prior to then end of the demonstration. And then there is also requirement to have a final evaluation that's due 18 months after the end of the demonstration period.

So, those are additional important features of these demonstrations that hopefully will help us better understand some of these efforts are having an impact or, you know, helping us improve access to treatment for Medicaid beneficiaries are helping us to improve the quality of care being provided.

And I think with that, we'll wrap it up. And I'll turn it back over to Jill.

Jill Darling: All right. Well, thank you Kirsten and Ronke and to Monica. So, (Amy) will open the lines for Q&A, please.

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

Please limit your question to one question and one follow up to allow other participants time for questions. If you require any further follow up, you may again press star one to rejoin the queue. Again, that's star then the number in order to ask a question.

And at this time, there are no questions in queue. I'll turn the call back over to Ms. Darling.

Jill Darling: All right. Well, thank you, (Amy). And thanks to everyone for taking some time out of your day to listen to today's open door forum. The next long term services and support open door forum will be about the next three months so

you will receive an agenda if you are on our listserv. So, we thank you and have a wonderful day.

Operator: Thank you for participating in today's Long Term Services and Support Open Door Forum. This call will be available for replay beginning today, January 30th, 2018 at 5:00 p.m. Eastern until February 1st, 2018 at midnight. The conference I.D. number for the replay is 31086986. The number to dial for the replay is 855-859-2056.

This concludes today's conference call, you may now disconnect.

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