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HHS Takes Action on Opioid Use Treatment

In conjunction with the President's visit to the National Rx Drug Abuse and Heroin Summit, U.S. Department of Health and Human Services (HHS) announced a proposal to allow qualified physicians to prescribe the opioid use disorder treatment medication buprenorphine to an increased number of patients. The proposed change is designed to strike an appropriate balance between expanding access to this important treatment, encouraging use of evidence-based medication-assisted treatment (MAT), and minimizing the risk of drug diversion.

Buprenorphine is an FDA-approved drug used as part of MAT, which is a comprehensive way to address the recovery needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders. Buprenorphine, because of its lower potential for abuse, is permitted to be prescribed or dispensed in physician offices. This significantly increases its availability to many patients. When taken as prescribed, buprenorphine is safe and effective.

Under current regulations, physicians that are certified to prescribe buprenorphine for MAT are allowed to prescribe up to 30 patients initially and then after one year can request authorization to prescribe up to a maximum of 100 patients. This cap on prescribing limits the ability of some physicians to prescribe to patients with opioid use disorder.

If adopted, the proposal will allow for a qualified and currently waivered physician to prescribe buprenorphine for up to 200 patients.
HHS welcomes public comment on this proposed rule. The 60 day comment period on the proposal opened on, March 30, 2016. HHS Secretary Sylvia Burwell has made addressing opioid misuse, dependence, and overdose a priority. The evidence-based HHS-wide opioid initiative focuses on three priority areas that include: informing opioid prescribing practices, increasing the use of naloxone (a rescue medication that can prevent death from overdose), and expanding access to and the use of MAT to treat opioid use disorder. These efforts build on work that began in 2010, when the President released his first National Drug Control Strategy, which emphasized the need for action to address opioid misuse and overdose, while ensuring that individuals with pain receive safe, effective treatment. Also in 2010, the ACA improved access to substance use disorder treatment options by requiring coverage of substance use disorder services in the Health Insurance Marketplace and establishing important parity protections to ensure that substance use disorder coverage is comparable to medical and surgical care coverage.

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Inside this Issue:

CMS Awards Round 2 Recompete Contracts for Competitive Bidding

The Centers for Medicare & Medicaid Services (CMS) recently announced the Round 2 Recompete and national mail-order recompete contract suppliers for Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. This program has been in effect since 2011 and is an essential tool to help Medicare set appropriate payment rates for DMEPOS items, save money for beneficiaries and taxpayers, and ensure access to quality items.

Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas (CBAs). After the first two years of Round 2 and the national mail-order programs (July 1, 2013 - June 30, 2015), Medicare has saved approximately $3.6 billion while health monitoring data indicate that its implementation is going smoothly with few inquiries or complaints and has had no negative impact on beneficiary health outcomes.

The Round 2 and national mail-order program contract periods expire on June 30, 2016. Round 2 Recompete and the national mail-order recompete contracts will be effective from July 1, 2016 through December 31, 2018. The national mail-order recompete for diabetes testing supplies will be implemented at the same time as Round 2 Recompete and will include all parts of the United States, including the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

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Medicare: Spending Less

ACA continues to deliver better care, smarter spending and healthier people

HHS recently announced that Medicare spent $473.1 billion less on personal health care expenditures between 2009 and 2014 than it would have been spent if the 2000-2008 average growth rate had continued through 2014. In addition, if trends continue through 2015, that amount could grow to a projected $648.6 billion. To put this in perspective, those savings are greater than all of Medicare's spending for personal health care expenditures in 2015.

The ACA has reached its sixth anniversary, and has brought the share of Americans without insurance to below ten percent for the first time ever, while also constraining spending growth and supporting quality of care. The health care law gives HHS new tools to pay providers for what works, better coordinate and integrate care, and make information more readily available to those who can use it to improve health. Initiatives to limit avoidable hospital readmissions and to promote new payment models that focus on value are contributing to the moderation in overall health spending, and particularly for Medicare.

The expenditure report updates a previously released analysis that also examined Medicare spending growth relative to national health care expenditures. According to the report, national personal health care spending increased moderately in 2014, by 4.3 percent per person. The modest increase in growth relative to prior years is primarily the result of the ACA's success in expanding quality coverage to millions of previously uninsured Americans.

Many patients with preexisting and chronic conditions can no longer be excluded from insurance plans. Additionally, they are getting access to affordable health care due to the ACA. The report also explains that upward pressure on spending growth in 2014 due to expanded coverage will be transitory, and that the underlying cost growth trends experienced by payers have remained low.

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CMS Releases MACRA NPRM

CMS recently released a Notice of Proposed Rulemaking (NPRM) for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Supported by a bipartisan majority and stakeholders, such as patient and medical associations, the MACRA legislation ended more than a decade of last-minute fixes and potential payment cliffs for Medicare doctors and clinicians. It also made numerous improvements to America's health care system.

Proposed MACRA Requirements:

Currently, Medicare measures the value and quality that physicians and other clinicians provide through a patchwork of programs. In the MACRA legislation, Congress streamlined these programs into a single framework to help clinicians transition to payments based on value from payments based on volume. The proposed rule would implement changes through this unified framework known as the Quality Payment Program, which includes two paths (The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) :

The Merit-based Incentive Payment System (MIPS): Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS. MIPS allows Medicare clinicians to be paid for providing high value care through success in four performance categories:

1. Quality (50 percent of total score in year 1)
2. Advancing Care Information (25 percent of total score in year 1)
3. Clinical Practice Improvement Activities (15 percent of total score in year 1)
4. Resource Use (10 percent of total score in year 1)

Advanced Alternative Payment Models (APMs): Clinicians who take a further step toward care transformation would be exempt from MIPS reporting requirements and qualify for financial bonuses. These models include:

1. Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
2. Comprehensive Primary Care Plus (CPC+)
3. Medicare Shared Savings Program – Track 2
4. Medicare Shared Savings Program – Track 3
5. Next Generation Accountable Care Organization Model
6. Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

You can submit comments using one of the four methods in the rule until June 27.

For More Information:

HHS MACRA NPRM Press Release

Quality Payment Program Fact Sheet

Advancing Care Information

Provider Outreach Staff:

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E-mail your questions and comments to us at:

PartABInquiriesRO4@cms.hhs.gov.

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Medicare: Spending Less (cont'd)

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Prescription drug spending, in particular new specialty drugs, were an important secondary contributor to the uptick in spending growth in 2014. The report finds that setting aside these factors, the underlying growth in national health care would have likely remained close to the historical lows seen in prior years. For example, the prescription drug spending growth rate for traditional Medicare would have remained the same in 2014 as in 2013 in the absence of new Hepatitis C drugs, but instead increased by 4.5 percentage points.

HHS has undertaken a number of initiatives to increase access to quality prescription drugs while moderating cost growth. The ACA is closing the Medicare Part D Donut Hole to help seniors and individuals with disabilities afford their prescription drugs and HHS has increased access to information on drug spending by posting the Medicare Drug Spending Dashboard. HHS is also finalizing requirements in Medicaid to reduce costs to states and the federal government, and recently issued a proposed rule to test new models to improve how Medicare Part B pays for prescription drugs and to support physicians and other clinicians delivering higher quality care.

Please visit the below link for the full report: https://aspe.hhs.gov/pdf-report/health-care-spending-growth-and-federal-policy

SSN Removal Initiative (SSNRI)

The MACRA of 2015 requires CMS remove Social Security Numbers (SSNs) from all Medicare cards. CMS will send new Medicare cards with a new number to all people with Medicare by April 2019.

Why's this initiative important?
When we replace the SSN on all Medicare cards, we can better protect private health care and financial information, Federal health care benefits, and service payments

What's next with the SSNRI?
We're updating our systems and will reach out soon to help get beneficiaries ready for their new Medicare cards.

The Bureau of Labor Statistics Offers Help to Providers

You are probably familiar with the Bureau of Labor Statistics (BLS), which produces some of the most closely watched indicators of the U.S. economy such as the monthly payroll jobs report and national unemployment rates. Yet most people are not aware that the data published by BLS affects most medical care providers in a profound way.

Payments made through Medicare's Prospective Payment System (PPS) are adjusted through an annual process using a number of factors but are *primarily* based on BLS data. The BLS Employment Cost Index (ECI), Producer Price Index (PPI), and Consumer Price Index (CPI) comprise 98 percent of the "hospital market basket" used to adjust medical care providers' Medicare reimbursements every year.

BLS depends on widespread survey participation by medical care providers to ensure that their estimates are representative and as accurate as possible. Each month, we visit about 500 hospitals and hundreds of clinics and private healthcare providers across the nation. We survey these hospitals, clinics, and other providers regularly to ensure that their costs continue to represent the real pricing picture for medical care services. Unfortunately, despite the real importance of these surveys to providers, participation in BLS surveys has been critically low in many areas of the U.S.

Here are some other ways the lack of participation by healthcare providers affects health care economics and services:

Lack of Representation – Several large cities are underrepresented in BLS inflation measurements. Thus, BLS is getting an incomplete picture of nationwide changes in reimbursements and especially in areas with rapidly rising costs. Consequently, Medicare adjustments and other payment systems may not be keeping pace with health care inflation!

Volatility – With fewer medical price quotes being collected over time, a minor change in one can have a disproportionate effect on the reported price change. The more quotes, the more robust the sample, the more accurate the measurement will be over time.

Unreliable or Unavailable Data – In some cases, BLS can't even publish medical care data for metropolitan statistical areas which can affect health care policy development.

For these reasons, our field data collectors in BLS need your help. The bottom line is: ***Better data yield more accurate payments, appropriately escalated***. We believe that our job is to make sure that economic decisions are based on the best possible data. And in health care, everyone, and especially health care providers, are part of that team effort.

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Coverage to Care Initiative

From Coverage to Care is an initiative to help people with new health care coverage understand their benefits and connect to primary care and the preventive services that are right for them, so they can live a long and healthy life. We have developed written resources, videos, and provided ways to connect with us.

We encourage you to share these resources with consumers, and help them on their journey from coverage to care. We also hope you share information about local resources during conversations with your patients, to help individuals know where and how to access care in your community.

Learn when new resources become available by signing up for notifications through our Minority Health listserv by entering your email address at https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_610.

Order from Coverage to Care materials! Instructions are on the Order From Coverage to Care Materials page at https://marketplace.cms.gov/outreach-and-education/order-coverage-to-care-materials.html.

Print your own booklets by selecting a file and changing your printer to "booklet" setting before printing. Files will print on standard 8.5x11" paper.

The Bureau of Labor and Statistics Offers Help (cont'd)

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Please do not hesitate to click on http://tinyurl.com/ky9naj2 to learn how your survey responses are made part of BLS price measurements. For specific information on BLS surveys, data, reports, and speakers, contact your closest BLS regional information office from the list below:

Atlanta Regional Office, (404) 893-4222 or BLSinfoAtlanta@bls.gov

Boston Regional Office (617) 565-2327 or BLSinfoBoston@bls.gov

Chicago Regional Office (312) 353-1880 or BLSinfoChicago@bls.gov

Dallas Regional Office, (972) 850-4800 or BLSinfoDallas@bls.gov

Kansas City Regional Office (816) 285-7000 or BLSinfoKansasCity@bls.gov

New York City Regional Office (646) 264-3600 or BLSinfoNY@bls.gov

Philadelphia Regional Office, (215) 597-3282 or BLSinfoPhiladelphia@bls.gov

San Francisco Regional Office, (415) 625-2270 or BLSinfoSF@bls.gov

Opioid Use Treatment (cont'd)

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Starting 2010, the ACA began improving access to substance use disorder treatment options by requiring coverage of substance use disorder services in the Health Insurance Marketplace and establishing important parity protections to ensure that substance use disorder coverage is comparable to medical and surgical care coverage.

The President's FY 2017 Budget includes $1 billion in new mandatory funding over two years to expand access to treatment for prescription drug abuse and heroin use, helping to ensure that every American who wants to get treatment for opioid use disorder will have access. It also includes approximately $500 million, which represents an increase of more than $90 million on continuing and building on current efforts across the Departments of Justice and HHS to:

1.) Expand state-level prescription drug overdose prevention strategies;

2.) Increase the availability of MAT programs;

3.) Improve access to the overdose-reversal drug naloxone; and

4.) Support targeted enforcement activities.

Those seeking help with an opioid or other substance use disorder can contact SAMHSA's National Helpline at 1-800-662-HELP (4357) to receive information on how to get treatment and support services.

For more information on the proposed rule, visit:

http://www.hhs.gov/about/news/2016/03/29/fact-sheet-mat-opioid-use-disorders-increasing-buprenorphine-patient-limit.html

CMS Awards DMEPOS Competitive Bidding Contracts (cont'd)

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CMS has executed 586 DMEPOS competitive bidding program contracts (91 percent of contracts offered). The Round 2 Recompete contract suppliers have 2,200 locations to serve Medicare beneficiaries in these CBAs. CMS has also awarded 9 national mail-order recompete contracts (100 percent of contracts offered). Contract suppliers are required to meet CMS' quality standards, meet applicable state licensure requirements, and be accredited by a CMS approved independent accreditation organization.

The bid evaluation process ensures that there will be a sufficient number of suppliers, including small suppliers, to meet the needs of the beneficiaries living in the CBAs. In fact, 92 percent of contract suppliers are already established in the CBA, the product category, or both. CMS was required to include small supplier protections for the program, and instituted a 30 percent small supplier target in each CBA. For Round 2 Recompete, 92 percent of small suppliers, those with gross revenues of $3.5 million or less as defined for the program, accepted their contract offer and make up 62 percent of all contract suppliers.

Bidders that were not offered contracts were notified of the reason(s) why they did not qualify for the program. All suppliers that did not win contracts were provided a targeted period to ask questions or express concerns about the reason(s) why they were not awarded a contract. Suppliers that are not contract suppliers for this round of the Program may bid in future rounds, unless they are precluded from participation in the program. A list of Round 2 Recompete and national mail-order recompete contract supplier names are available at www.dmecompetitivebid.com. Current contract suppliers and product categories in each CBA can be found in the Supplier Directory at www.medicare.gov/supplier.

The complete Round 2 DMEPOS Contract Award Fact Sheet is available for viewing. Please visit CMS's DMEPOS Competitive Bid web site for additional information about the Program.