• CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019.

• These policies involve further partnership with providers and prescription drug plans.

• Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population.
MYTH:
“Medicare is requiring that all patients fill opioid prescriptions for a 7 days supply at a time.”

FACT:
• A fill for a prescription opioid will be limited to a 7 days supply only for Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 60 days).
• This does not apply to patients already taking opioids.
MYTH

“Medicare is forcing all patients to taper their prescription opioids below a certain amount.”

FACT:

• Decisions to taper or stop prescription opioids must be carefully considered and are individualized between the patient and prescriber.
• Tapering opioids can be especially challenging in established patients who have been on high dosages of opioids for many years.
• Policies seek to address opioid overuse without negative impact on patient-doctor relationship.
MYTH:
“There is nothing I can do to help my patients who need more opioids.”

FACT:
• If patient is subject to an opioid safety edit at the pharmacy, and the pharmacy can’t fill the prescription as written, the prescriber can contact the plan to ask for a coverage determination on their behalf.
• Prescriber can also request an expedited or standard coverage determination in advance of prescribing an opioid.
• Prescriber only needs to attest to the plan that the cumulative level or days supply is the intended and medically necessary amount.
1. Opioid Safety Alerts

- CMS expects Medicare Part D drug plans to implement the following safety alerts (pharmacy claim edits) for pharmacists to review when an opioid prescription is filled at the pharmacy:
  - Seven-day supply limit for initial opioid fills for opioid naïve patients (hard edit),
  - Care coordination edit at 90 morphine milligram equivalents (MME) (soft edit with pharmacist-prescriber consultation),
  - Concurrent opioid and benzodiazepine use (soft edit),
  - Duplicative long-acting (LA) opioid therapy (soft edit), and
  - Optional safety alert at 200 MME or more (hard edit).
- Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 60 days) will be limited to a supply of 7 days or less.

- *This alert should not impact patients who already take opioids.*

- Pharmacists can dispense partial quantities of an opioid prescription consistent with state and federal regulations.

- If a prescriber assesses upon re-evaluation that a patient will need additional opioid therapy, subsequent prescriptions will not be subject to the 7 days supply limit, as the patient will no longer be considered opioid naive.
Prescriber Actions

- If patient needs the full days supply initially, the patient or prescriber on the patient’s behalf has the right to request a coverage determination, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid (for example, for a surgical procedure).

- Prescriber only needs to attest to plan that the days supply is the intended and medically necessary amount.
Care Coordination Alert

- This alert will be triggered at the pharmacy when a Medicare Part D patient presents an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 90 MME.

- Once a pharmacist consults with a prescriber on a patient’s prescription for a plan year, the prescriber will not be contacted on every opioid prescription written for the same patient after that unless the plan implements further restrictions.

- If the prescription cannot be filled at the pharmacy, the patient or the prescriber on the patient’s behalf has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.
Optional Safety Alert at 200 MME or Higher

• Some plans may implement a hard safety alert when a patient’s cumulative opioid daily dosage reaches 200 MME or more.

• Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.

• This is not a prescribing limit. Decisions to taper or discontinue prescription opioids are between the patient and prescriber.
Prescriber Actions

• On the patient’s behalf, the physician or other prescriber has the right to request a coverage determination for the drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.

• In the absence of other submitted and approved utilization management requirements, the plan should allow the patient to access his/her medication(s) once the prescriber(s) attests that the identified cumulative MME level is the intended and medically necessary amount for the patient.
Drug Management Programs

- Medicare Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be “frequently abused drugs” (FADs) for patients who are considered to be at-risk for prescription drug abuse.

- For 2019, CMS has identified opioids and benzodiazepines as FADs.

- Potential at-risk patients are identified by their opioid use which involve multiple doctors and pharmacies.

- The goal of drug management programs is better care coordination for safer use.
• The plan will make clinical contact with the potential at-risk patient’s prescriber and conduct case management.

• The plan will ask the prescriber:
  – Are the prescription opioid medications appropriate, medically necessary, and safe for the patient’s medical condition and treatment;
  – Is the patient at-risk for misusing or abusing opioids and benzodiazepines; and
  – Would one of the drug management program tools help the prescriber better manage their patient’s prescription drug use?

• At this point, prescribers may also help plans determine whether a patient falls into one of the exemptions, since the plan may not always have this information.
Initial Notification

• After the Medicare drug plan conducts case management with prescribers, and before the plan implements a tool, the plan will notify the patient in writing that coverage of opioid and/or benzodiazepine medication(s) will be limited, or if the patient must obtain these prescriptions from certain prescriber(s) or pharmacy(ies).

• Plans are required to make reasonable efforts to send the prescriber a copy of the letter sent to the patient.

• The prescriber and patient will have the opportunity to provide a response to this written notice and the requested information to the Part D plan within 30 days.
CMS Approach

**COVERAGE**
CMS coverage policies now ensure some form of medication-assisted treatment across all CMS programs—Medicare, Medicaid, and Exchanges.

**AWARENESS**
CMS sent 24,000 letters in 2017 and 2018 to Medicare physicians to highlight that they were prescribing higher levels of opioids than their peers to incentivize safe prescribing practices.

**DATA**
CMS released data in 2017 and 2018 to show where Medicare opioid prescribing is high to help identify areas for additional interventions.

**TRACKING**
Due to safe prescribing policies, the number of Medicare beneficiaries receiving higher than recommended doses from multiple doctors declined by 40% in 2017.

**BEST PRACTICES**
CMS activated over 4,000 hospitals, 120,000 clinicians, and 5,000 outpatient settings through national quality improvement networks to rapidly generate results in reducing opioid-related events.

**ACCESS**
As of June 2018, CMS approved 12 state Medicaid 1115 demonstrations to improve access to opioid use disorder treatment, including new flexibility to cover inpatient and residential treatment while ensuring quality of care.
Maternal Opioid Misuse (MOM) Model
Primary goals are to improve quality of care and reduce costs for pregnant and postpartum women with OUD as well as their infants
Expand access, service-delivery capacity, and infrastructure based on state-specific needs
Create sustainable coverage and payment strategies that support ongoing coordination and integration of care

Integrated Care for Kids (InCK) Model
The InCK Model will award states and local communities cooperative agreements to build on existing delivery system innovations with the goals of:

1. Improving child health outcomes, including preventing substance use disorder
2. Reducing avoidable inpatient stays and out-of-home placements including substitute care (e.g. foster care)
3. Create sustainable APMs that ensure provider accountability for cost and quality outcomes.

https://innovation.cms.gov
Improving **data transparency and interoperability**, and expand tools like the Medicare and Medicaid “heat map” of prescribing rates that help determine where to target safe prescribing efforts.

Analyzing **prescription opioid use patterns** across CMS programs to identify patterns of potential misuse as early as possible.

Monitoring **success of prevention measures** related to reducing overuse and misuse of prescription opioids.

Supporting **state Medicaid program capacity** to track and report data.

Enhancing **program integrity efforts** to identify and reduce fraud and abuse related to inappropriate prescribing of opioids.
Medicare & Medicaid Part D Opioid Prescribing Mapping Tool

https://go.cms.gov/opioidheatmap
Data Follows the Person - MyHealthEData

- Long Term and Post Acute Care (LTPAC): SNF/NF, IRF, HHA, LTCH
- Acute Care/ Critical Access Hospitals (CAH)
- Other Providers (e.g., pharmacies, dentists...)
- Emergency Medical Services (EMS)
- Long Term Services and Support (LTSS)
- Home and Community Care Based Services (HCBS)
- Assisted Living Facilities (ALF)
- Primary Care Provider (PCP)
- Family Member/Caregiver
On February 11, 2019, the Centers for Medicare & Medicaid Services (CMS) proposed policy changes supporting its MyHealthEData initiative to improve patient access and advance electronic data exchange and care coordination throughout the healthcare system.


Interoperability and Patient Access Proposed Rule

- Health Information Exchange and Care Coordination Across Payers
- API Access to Published Provider Directory Data
- Care Coordination Through Trusted Exchange Networks
- Improving the Dual Eligible Experience by Increasing Frequency of Federal-State Data Exchanges
- Public Reporting and Prevention of Information Blocking
- Provider Digital Contact Information
- Revisions to the Conditions of Participation (CoPs) for Hospitals and Critical Access Hospitals
- Advancing Interoperability in Innovative Models
Two Requests for Information (RFI) included in the CMS Proposed Rule:

Requesting input on how CMS can promote wide adoption of interoperable health IT systems for use across healthcare settings such as long-term and post acute care, behavioral health, and settings serving individuals who are dually eligible for Medicare and Medicaid and/or receiving home and community-based services. Key topics include:

*Promote interoperability*
*Reduce burden for clinicians, providers, and patients, while encouraging care coordination, and*
*Lead change to a value-based healthcare system*
To view proposal: https://www.cms.gov/Center/Special-Topic/Interoperability-Center.html

In commenting, please refer to file code CMS-9115-P. Instructions are available in the first 3 pages of the rule.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

- Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.
- By regular mail.
- By express or overnight mail.

To receive more information about CMS’s interoperability efforts, sign-up for the listserv here: https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12443
EHR Interoperability: Opportunities and Resources

The Office of the National Coordinator for Health IT (ONC) is responsible for advancing connectivity and interoperability of health information technology (health IT).

ONC’s 10 year plan for advancing interoperability is laid out in a document entitled Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap version 1.0 (Roadmap) [PDF - 877 KB].

The Roadmap, shaped by stakeholder input and public comments, supports the vision that ONC outlined in Connecting Health and Care for the Nation: A 10 Year Vision to Achieve An Interoperable Health IT Infrastructure [PDF - 607 KB].

The collaborative efforts of stakeholders are crucial to achieving three goals:
1. the vision of a learning health system where individuals are at the center of their care and providers have a seamless ability to securely access and use health information from different sources.
2. to provide access to individuals health information, which is stored in electronic health records (EHRs), but includes information from many different sources and portrays a longitudinal picture of their health.
3. helping public health agencies and researchers rapidly learn, develop, and deliver cutting edge treatments.

https://www.healthit.gov/topic/interoperability
https://www.healthit.gov/news/events/oncs-2nd-interoperability-forum