Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

HHS' CALL TO ACTION ON OPIOID USE DISORDER TREATMENT

Centers for Medicare and Medicaid Services

Office of Program Operations and Local Engagement (OPOLE)

Disclaimer

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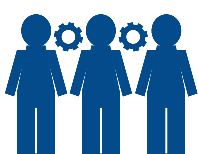
Office of Program Operations and Local Engagement

Vision:

- Extraordinary staff provide the finest level of service to beneficiaries and consumers, constantly focusing on ways to improve the customer experience and advance program innovation, while effectively collaborating with stakeholders and working with integrity and accountability as we serve the public.

Mission:

- We provide service to millions of CMS beneficiaries & consumers, giving a voice to stakeholders in CMS policy, program development, innovation and implementation. We protect the Nation's trust funds through high quality standards as we uphold the requirements of CMS programs.



- **Increase cohesion & integration** across program component regional operations and with program centers and external partners

- Achieve **high performance for customer service** in quality, integrity, consistency, and timeliness

- **Conduct local outreach and education** to strengthen customer understanding of national policy and Agency initiatives and support expeditious action in emergencies

- **Monitor implementation of and provide oversight** to CMS contractors to assure compliance with CMS policies and regulations

https://www.cms.gov/about-cms/leadership/organization/office-program-operations-and-local-engagement

Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

CDR Wanda Pamphile, PharmD, MPH

Robert C. Accetta, RPh, BCGP, FASCP

Karran Phillips, MD, MSc

Megan Meacham, MPH

Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Patient Safety: Using Data and Resources for Harm Reduction in SNF/PALTC with a Regional Stakeholder Collaborative

Robert C. Accetta, RPh, BCGP, FASCP

Senior Pharmacist,

IPRO, Health Quality Improvement Department

This material was prepared by IPRO, a Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The content presented does not necessarily reflect CMS policy.

The IPRO QIN-QIO

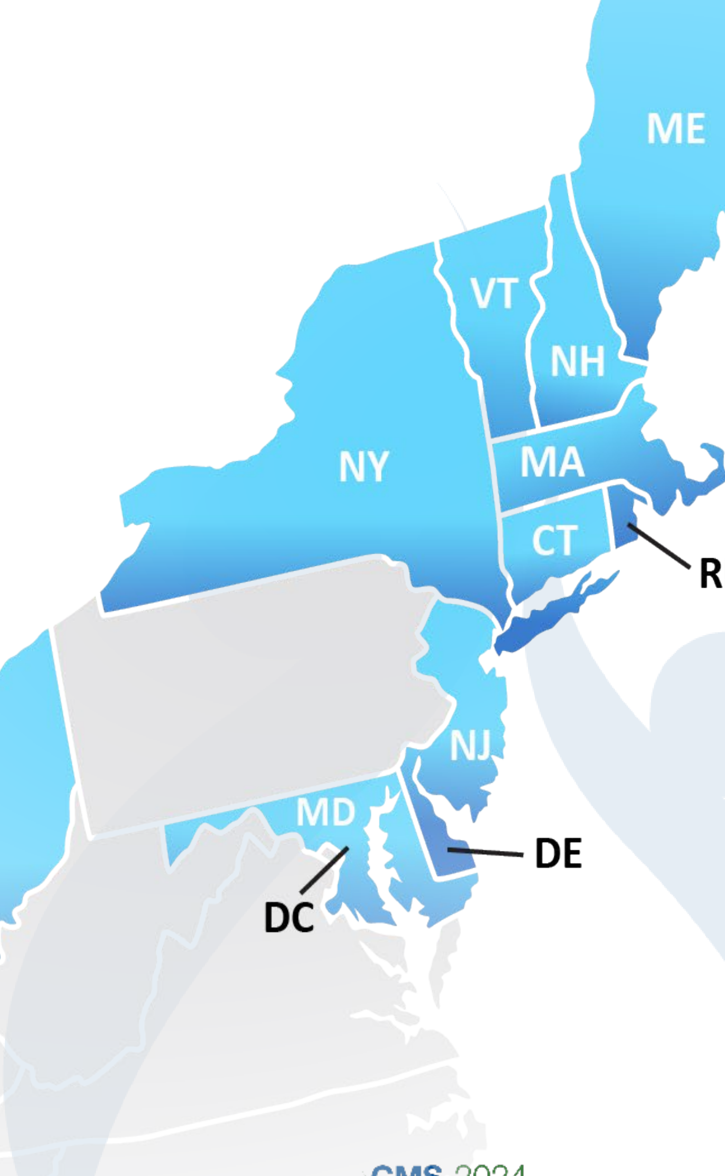
The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

IPRO:
New York, New Jersey, and Ohio

Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

CMS 2024 Quality Conference
Resilient and Ready Together

Opioid Crisis Underscores Needs and Points to Opportunities

OPIOID CRISIS AFFECTS PATIENTS AND PROVIDERS

Nearly 117,000 people experienced a non-fatal opioid overdose requiring an emergency department or hospitalization in 2022, per the Centers for Disease Control and Prevention.

- Beneficiaries requiring a hospital admission diagnosed with an opioid overdose or OUD, or experiencing opioid overdose, once stabilized, need placement options for post-acute or extended care services.
- Patients who have OUD and need the level of care provided by SNF/PALTC facilities face challenges to entry.

CONCERNS TO BE ADDRESSED

- Facilities and clinicians are unfamiliar with providing medications (buprenorphine) or counseling therapy for OUD.
- Facilities have not created relationships with Opioid Treatment Programs (OTPs) which provide methadone for OUD.
- Stigma associated with OUD.
- Access to opioids via external sources.
- Unfamiliarity with emergency protocols to treat suspected opioid overdoses by residents or visitors at facilities.

Abbreviations: QIN-QIO: Quality Innovation Network-Quality Improvement Organization; SNF: Skilled Nursing Facility; PALTC: Post-Acute Long-Term Care; NYS: New York State; DOH: Department of Health; BNE: Bureau of Narcotic Enforcement; OASAS: Office of Addiction Services and Support; OUD: Opioid Use Disorder

Quality in Action: Assessments and Planning

RISK ASSESSMENT IN SNF/PALTC SETTING

IPRO assessments identified:

- 29% of nursing homes occasionally, rarely, or never use opioid risk mitigation strategies including naloxone.
- Nearly 20% of nursing homes did not have naloxone in their emergency medication kits.
- 40% of nursing homes desired education on naloxone.

GAP ANALYSIS AND MITIGATION PLANS

Nursing home residents were at increased risk for opioid overdose deaths by both prescription drugs and non-prescribed substances.

Mitigation plans included addressing the following issues:

- emergency medications kits or Automated Dispensing System laws vary by state;
- unavailability of naloxone;
- confusion over multiple naloxone products;
- lack of policies or protocols.

Abbreviations: QIN-QIO: Quality Innovation Network-Quality Improvement Organization; SNF: Skilled Nursing Facility; PALTC: Post-Acute Long-Term Care; NYS: New York State; DOH: Department of Health; BNE: Bureau of Narcotic Enforcement; OASAS: Office of Addiction Services and Support; OUD: Opioid Use Disorder

Underwhelming Activity: Low Naloxone Prescribing

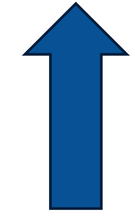
Results indicate very low co-prescribing in both populations.
Naloxone is also available through community distribution.

Eligible Fee For Service (FFS) Population

(in FFS for 12 months)

	Total FFS	Had Opioid Prescription	Had Opioid with Naloxone Prescription	% of Opioid with Naloxone Prescription
QIN	6,413,974	764,153	931	0.12%

Eligible FFS Population (in FFS for 12 months)				
State	Total FFS	Had Opioid Prescription	Had Opioid with Naloxone Prescription	% of Opioid with Naloxone Prescriptions
CT	299,615	35,300	54	0.15%
DC	59,281	4,917	18	0.37%
DE	152,998	21,179	23	0.11%
MA	860,640	113,960	103	0.09%
MD	802,907	97,974	243	0.25%
ME	150,122	16,185	54	0.33%
NH	205,329	21,159	20	0.09%
NJ	952,273	112,304	125	0.11%
OH	1,024,463	139,561	101	0.07%
RI	90,082	8,984	2	0.02%
VT	103,523	11,526	13	0.11%
NY	1,712,741	181,104	175	0.10%
QIN	**6,413,974**	**764,153**	**931**	**0.12%**



Eligible Nursing Home (NH) Population

(in FFS for 12 months)

	Total FFS	Had Opioid Prescription	Had Opioid with Naloxone Prescription	% of Opioid with Naloxone Prescription
QIN	242,174	58,843	149	0.25%

Eligible NH Residents (in FFS for 12 months)				
State	Total FFS	Had Opioid Prescription	Had Opioid with Naloxone Prescription	% of Opioid with Naloxone Prescriptions
CT	14,924	3,774	10	0.26%
DC	2,310	379	4	1.06%
DE	4,138	1,112	3	0.27%
MA	34,376	8,890	15	0.17%
MD	25,339	6,569	41	0.62%
ME	4,490	1,259	6	0.48%
NH	5,948	1,533	3	0.20%
NJ	37,160	8,890	23	0.26%
OH	36,177	10,290	20	0.19%
RI	3,694	773	-	0.00%
VT	2,897	784	2	0.26%
NY	70,721	14,590	22	0.15%
QIN	**242,174**	**58,843**	**149**	**0.25%**

An analysis of Medicare beneficiary opioid and naloxone co-prescribing. Data Source: Medicare Fee For Service (FFS) Part D Claims 10-1-22 through 9-30-23.

Data Claims Analysis: Community Beneficiaries Lacking Medication-Assisted Treatment (MAT)

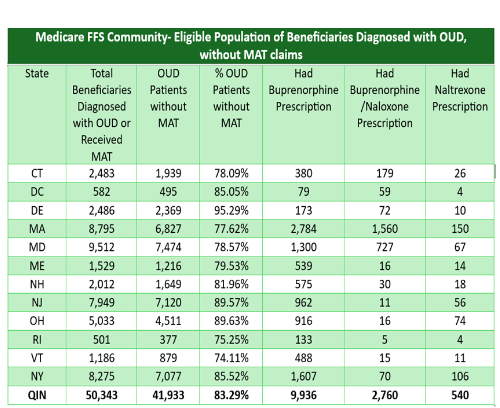
Results indicate very low MAT prescribing in both community and nursing home (next slide) populations.

Medicare FFS Community-Eligible Population of Beneficiaries Diagnosed with OUD, without MAT claims

	Total Beneficiaries Diagnosed with OUD or Received MAT	OUD Patients without MAT	% OUD Patients without MAT	Had Buprenorphine Prescription	Had Buprenorphine /Naloxone Prescription	Had Naltrexone Prescription
QIN	50,343	41,933	83.29%	9,936	2,760	540

Medicare FFS Community-Eligible Population of Beneficiaries Diagnosed with OUD, with MAT claims

	Had MAT Procedure Code Methadone	% Had MAT Procedure Code Methadone	Had MAT Procedure Code Buprenorphine	% Had MAT Procedure Code Buprenorphine
QIN	7,977	15.85%	454	0.90%



Medicare FFS Community- Eligible Population of Beneficiaries Diagnosed with OUD, without MAT claims

State	Total Beneficiaries Diagnosed with OUD or Received MAT	OUD Patients without MAT	% OUD Patients without MAT	Had Buprenorphine Prescription	Had Buprenorphine /Naloxone Prescription	Had Naltrexone Prescription
CT	2,483	1,939	78.09%	380	179	26
DC	582	495	85.05%	79	59	4
DE	2,486	2,369	95.29%	173	72	10
MA	8,795	6,827	77.62%	2,784	1,560	150
MD	9,512	7,474	78.57%	1,300	727	67
ME	1,529	1,216	79.53%	539	16	14
NH	2,012	1,649	81.96%	575	30	18
NJ	7,949	7,120	89.57%	962	11	56
OH	5,033	4,511	89.63%	916	16	74
RI	501	377	75.25%	133	5	4
VT	1,186	879	74.11%	488	15	11
NY	8,275	7,077	85.52%	1,607	70	106
QIN	**50,343**	**41,933**	**83.29%**	**9,936**	**2,760**	**540**

Data Source: Medicare Fee For Service (FFS) Parts A, B, and D claims, 10-1-22 through 9-30-23.

Medicare FFS Community- Eligible Beneficiaries Diagnosed with OUD with MAT claims

State	Had MAT Procedure Code Methadone	% Had MAT Procedure Code Methadone	Had MAT Procedure Code Buprenorphine	% Had MAT Procedure Code Buprenorphine
CT	543	21.87%	-	0.00%
DC	86	14.78%	1	0.17%
DE	108	4.34%	11	0.44%
MA	1,959	22.27%	3	0.03%
MD	1,931	20.30%	121	1.27%
ME	310	20.27%	3	0.20%
NH	357	17.74%	8	0.40%
NJ	801	10.08%	33	0.42%
OH	299	5.94%	219	4.35%
RI	109	21.76%	13	2.59%
VT	278	23.44%	33	2.78%
NY	1,196	14.45%	9	0.11%
QIN	**7,977**	**15.85%**	**454**	**0.90%**

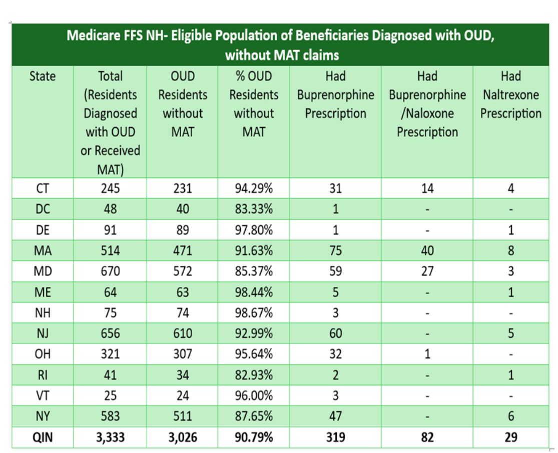
Data Claims Analysis: Nursing Home (NH) Beneficiaries Lacking MAT

Medicare FFS NH-Eligible Population of Beneficiaries Diagnosed with OUD, without MAT claims

	Total (Residents Diagnosed with OUD or Received MAT)	OUD Residents without MAT	% OUD Residents without MAT	Had Buprenorphine Prescription	Had Buprenorphine /Naloxone Prescription	Had Naltrexone Prescription
QIN	3,333	3,026	90.79%	319	82	29

Medicare FFS NH-Eligible Population of Beneficiaries Diagnosed with OUD, with MAT claims

	Had MAT Procedure Code Methadone	% Had MAT Procedure Code Methadone	Had MAT Procedure Code Buprenorphine	% Had MAT Procedure Code Buprenorphine
QIN	294	8.82%	15	0.45%



Medicare FFS NH- Eligible Population of Beneficiaries Diagnosed with OUD, without MAT claims

State	Total (Residents Diagnosed with OUD or Received MAT)	OUD Residents without MAT	% OUD Residents without MAT	Had Buprenorphine Prescription	Had Buprenorphine /Naloxone Prescription	Had Naltrexone Prescription
CT	245	231	94.29%	31	14	4
DC	48	40	83.33%	1	-	-
DE	91	89	97.80%	1	-	1
MA	514	471	91.63%	75	40	8
MD	670	572	85.37%	59	27	3
ME	64	63	98.44%	5	-	1
NH	75	74	98.67%	3	-	-
NJ	656	610	92.99%	60	-	5
OH	321	307	95.64%	32	1	-
RI	41	34	82.93%	2	-	1
VT	25	24	96.00%	3	-	-
NY	583	511	87.65%	47	-	6
QIN	**3,333**	**3,026**	**90.79%**	**319**	**82**	**29**

Data Source: Medicare Fee For Service (FFS) Parts A, B, and D claims, 10-1-22 through 9-30-23.

Medicare FFS NH- Eligible Beneficiaries Diagnosed with OUD with MAT claims

State	Had MAT Procedure Code Methadone	% Had MAT Procedure Code Methadone	Had MAT Procedure Code Buprenorphine	% Had MAT Procedure Code Buprenorphine
CT	14	5.71%	-	0.00%
DC	8	16.67%	-	0.00%
DE	2	2.20%	-	0.00%
MA	43	8.37%	-	0.00%
MD	91	13.58%	7	1.04%
ME	1	1.56%	-	0.00%
NH	1	1.33%	-	0.00%
NJ	46	7.01%	-	0.00%
OH	8	2.49%	6	1.87%
RI	5	12.20%	2	4.88%
VT	1	4.00%	-	0.00%
NY	74	12.69%	-	0.00%
QIN	**294**	**8.82%**	**15**	**0.45%**

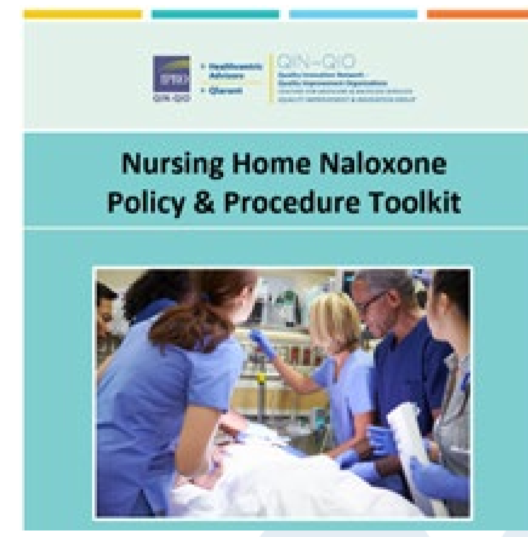
Disseminate Best Practice Resources and Call to Action

In 2023 IPRO convened PALTC stakeholders for action:

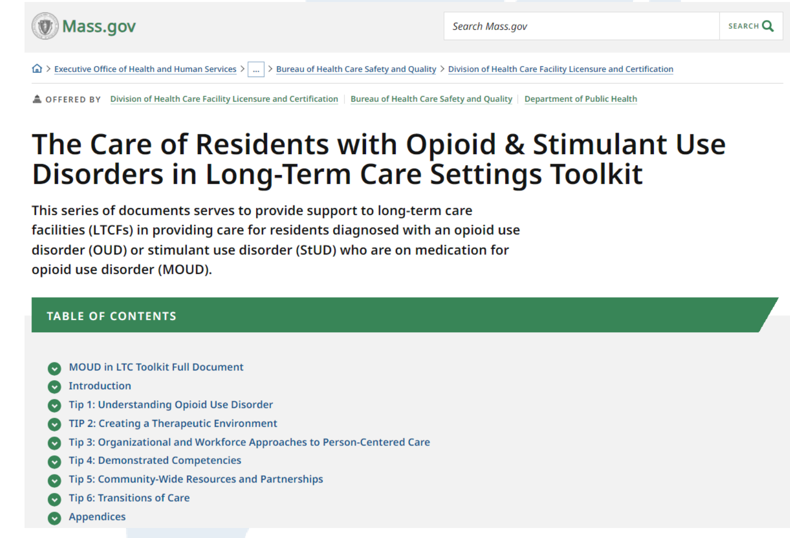
- Created Nursing Home Naloxone Toolkit.
- Resources provided on Medications for Opioid Use Disorder (MOUD) and for naloxone advocacy in the region.
- Included the NYS DOH, BNE, OASAS, provider associations and pharmacy organizations.

2024 plans include a webinar instructional series on the implementation of medications for OUD that meets the needs and concerns of SNF/PALTC facilities:

- Provide data-driven technical assistance to nursing homes emphasizing naloxone, medications for OUD, and alternatives to opioids.



Naloxone Nursing Home Policy & Procedure Toolkit



The Care of Residents with Opioid or Stimulant Use Disorders in Long Term Care Settings Toolkit

Abbreviations: QIN-QIO: Quality Innovation Network-Quality Improvement Organization; SNF: Skilled Nursing Facility; PALTC: Post-Acute Long-Term Care; NYS: New York State; DOH: Department of Health; BNE: Bureau of Narcotic Enforcement; OASAS: Office of Addiction Services and Support; OUD: Opioid Use Disorder

Opioid Treatment Policy Progress: Challenges and Opportunities

Karran Phillips, MD, MSc

Deputy Director, Center for Substance Abuse and Treatment

Substance Abuse and Mental Health Services Administration (SAMHSA)

US Department of Health and Human Services

Opioids are driving drug overdose deaths – more than 109,000 in 2022

Number of Deaths

100,000
80,000
60,000
40,000
20,000
0

Jan 2015 Jan 2016 Jan 2017 Jan 2018 Jan 2019 Jan 2020 Jan 2021 Jan 2022 Jan 2023

12-Month Ending Period

Legend for Drug or Drug Class

- Cocaine (T40.5)
- Heroin (T40.1)
- Methadone (T40.3)
- Natural & semi-synthetic opioids (T40.2)
- Opioids (T40.0-T40.4,T40.6)
- Psychostimulants with abuse potential (T43.6)
- Synthetic opioids, excl. methadone (T40.4)

---- Reported Value

O Predicted Value

A National Snapshot of Substance Use Disorders

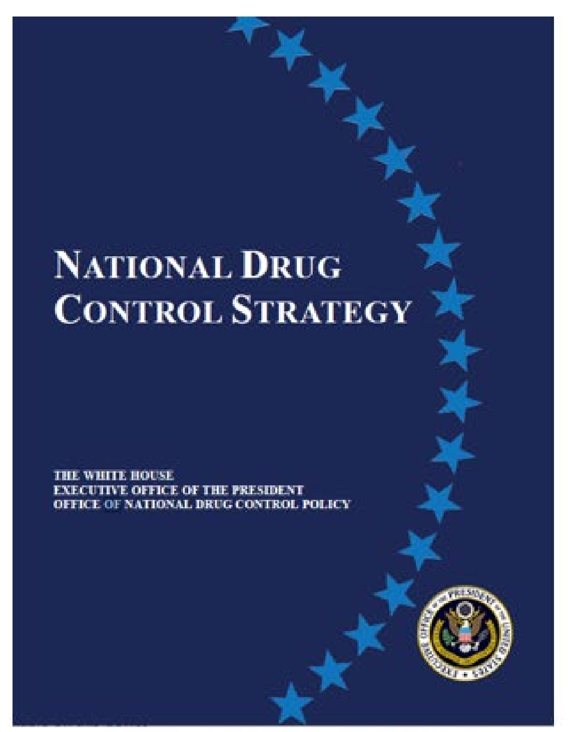
- **Overdose** remains a **leading cause** of injury-related death, with more than **109,000 lives lost (Jan. 2023).**
  - In 2022, provisional data found 68% of the 107,000 fatal overdoses involved synthetic opioids, primarily **illicitly manufactured fentanyl.**
  - **Xylazine** is an adulterant increasingly found in the illicit drug supply.
    - January–December 2021, a total of 5.3% of overdose deaths had xylazine detected on postmortem toxicology
    - Xylazine was listed as a cause of death in 79.0% of deaths in which it was detected
  - **Stimulants** are increasingly adulterated with illicitly manufactured fentanyl.
    - In 2021, 81.9% of deaths involved at least one opioid and 54.2% involved at least one stimulant
- Among people 12 or older in 2022, 59.8% (or 168.7 million people) used tobacco, alcohol, or an illicit drug in the past month. 16.5% (or 46.6 million people) reported use of an illicit drug.
- 19.4 percent of people 12 or older in 2022 (54.6 million) felt that they needed treatment.
- **72% of adults** who had a substance use problem considered themselves to be in recovery or recovering.

Guiding Federal Frameworks

HHS Overdose Prevention Strategy

https://www.hhs.gov/overdose-prevention/

White House Strategy



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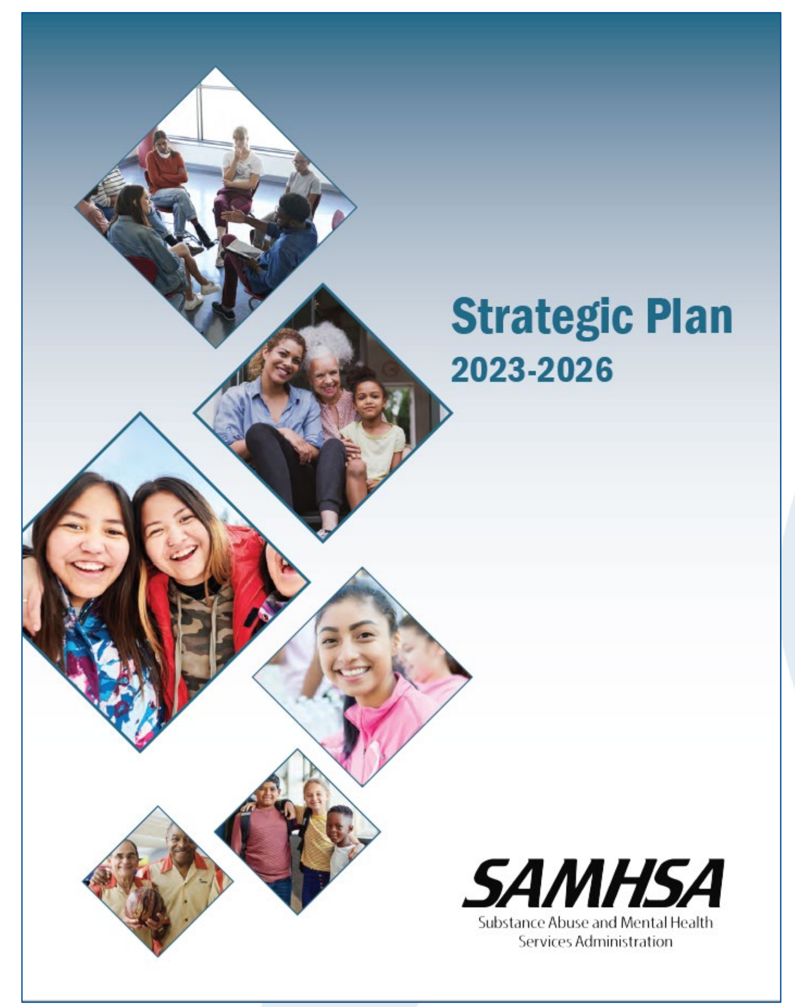
SAMHSA Priorities



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Addressing Overdose through Improved Policy: MAT and MATE Acts - 2023

- Policy changes are **presenting new opportunities**
- DEA temporarily extended the COVID-19 telemedicine flexibilities to prescribe controlled medications
- FDA approved **over-the-counter** naloxone nasal spray
- President Biden signed into law **H.R. 2617**, the "Consolidated Appropriations Act, 2023"

Mainstreaming Addiction Treatment (MAT) Act	Medication Access and Training Expansion Act (MATE)
Removes the DATA-2000 Waiver to prescribe buprenorphine	Requirement for a non-recurring, 8-hour training on SUD for practitioners applying for registration from the DEA
Lifts caps on number of patients who can be treated; removes counseling and reporting requirements	Met through addiction board certification, as part of or post-health care professional degree training

Implementation of MAT and MATE requires close collaboration and coordination between the Department of Justice/Drug Enforcement Administration, and Health and Human Services/SAMHSA

Addressing Overdose through Improved Policy: Changes to 42 CFR Part 8 – Published February 2nd, 2024

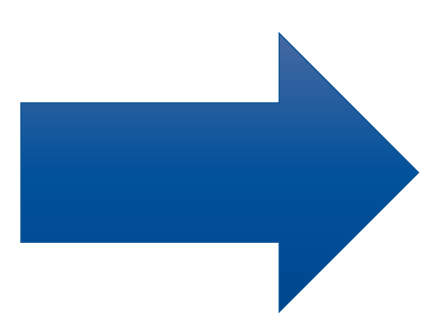
- In 2001, regulations governing methadone treatment for Opioid Use Disorder (OUD) shifted from FDA to SAMHSA
- SAMHSA reduced the scope of regulations that had been in place since 1972, but retained many original restrictions on methadone treatment
- These restrictions posed barriers to patient enrollment, but many factors precluded revisions
- The COVID-19 pandemic necessitated quickly creating regulatory flexibilities in key areas
  - Expanded parameters of take-home methadone dosing
  - Initiation of buprenorphine via telehealth
- The ongoing overdose crisis calls for patient-centered, accessible care
- Feedback from multiple stakeholder groups request and/or endorse continuation of the flexibilities and other changes to the rules

Ongoing Challenges: Eradicating Stigma

SUDs carry a high burden of stigma

- People with SUD are
  - less likely to seek treatment
  - more likely to drop out of treatment
- SUD is among the most stigmatized conditions in the US and around the world
- Health care providers treat patients who have SUDs differently
- People with a SUD who expect or experience stigma have poorer outcomes

Ongoing Challenges: Overcoming Provider Reluctance to Treat



Providers Clinical Support System (PCSS)

Providers Clinical Support System (PCSS) is a national training and clinical mentoring project developed in response to…

Provider's Clinical Support System-Universities (PCSS-Universities)

The purpose of this program is to expand/enhance access to medications for substance use disorder (SUD) services for…

Rural Opioid Technical Assistance Regional Centers (ROTA-R)

The purpose of the ROTA-R is to develop and disseminate training and technical assistance addressing opioid and…

Service Members, Veterans, and their Families Technical Assistance (SMVF TA) Center

SAMHSA's SMVF TA Center serves as a national resource to support states, territories, and local communities in…

SSI/SSDI Outreach, Access, and Recovery (SOAR)

SSI/SSDI Outreach, Access, and Recovery (SOAR) increases access to Social Security disability benefits for people…

State Opioid Response/Tribal Opioid Response Technical Assistance (SOR/TOR-TA)

The Substance Abuse and Mental Health Services Administration (SAMHSA) funded the State Opioid Response / Tribal Opioid…

Strategic Prevention Technical Assistance Center (SPTAC)

Suicide Prevention Resource Center (SPRC)

The Suicide Prevention Resource Center (SPRC)

Technology Transfer Centers (TTC) Program

The purpose of the Technology Transfer Centers (TTC)

https://www.samhsa.gov/practitioner-training

Opportunities

- Where reimbursement is appropriate, and easily obtained, practitioners are more likely to provide services, and expand access
- The OTPs may be concerned that the revised rules will impact their fiscal viability, given reduced take homes and removal of ability to require counseling, however, the rules foster coordination of care and collaboration with other services.
- How can CMS help:
  - Educate OTPs on ancillary billing codes available to them under both Medicare and Medicaid that will support collaboration and provision of primary medical care and behavioral health services
  - Expand education to reviewers to familiarize them with OTP services
  - Help standardize how Medicaid is applied across states vis-à-vis OTPs
  - Encourage State Medicaid Directors to
    - a) attend the planned webinars on Part 8 rollout
    - b) increase understanding of the needs of the OTPs in their states

Thank you!

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatment and supports to foster recovery while ensuring equitable access and better outcomes.

FindSupport.gov

FindTreatment.gov

988Lifeline.org

www.SAMHSA.gov

1-877-SAMHSA7 (1-877-726-4727)

1-800-487-4889 (TDD)

HRSA Federal Office of Rural Health Policy Resources for Rural Communities

Megan Meacham, MPH
Director, Rural Strategic Initiatives Division
Federal Office of Rural Health Policy
Health Resources and Services Administration (HRSA)
US Department of Health and Human Services

Health Resources and Services Administration

Mission: To improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs

TENS OF MILLIONS of Americans receive quality, affordable health care, and other services through HRSA's 90-PLUS PROGRAMS and more than 3,000 GRANTEES

CMS 2024 Quality Conference
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HRSA Program Areas

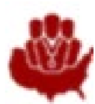
Health Centers

Maternal & Child Health

Provider Relief

Ryan White HIV/AIDS Program

Telehealth


Health Workforce

National Health Service Corps

Rural Health

Organ Donation & Transplantation

Behavioral Health Initiatives

In FY 23, HRSA invested over **$2 billion** for behavioral health initiatives that improves access to behavioral health services for individuals in underserved and rural communities across the nation.

As a result:

- HRSA awarded **$25 million** to **77 HRSA-funded health centers** to create new and expand existing school-based health centers, which for the first-time included support for these school health centers to provide mental health services in schools.
- Approximately **3,700 rural health clinicians** provide behavioral health services through the National Health Service Corps (NHSC)
- **21 Behavioral health workforce programs** provide education and training to the workforce
- **More than 8,700** behavioral health providers are supported by NHSC loan repayment programs
- **14 suicide prevention** and **40 overdose prevention** programs connect people to care and contribute to saving lives.

The Federal Office of Rural Health Policy

The Federal Office of Rural Health Policy collaborates with rural communities and partners to support community programs and shape policy that will improve health in rural America.

Activities:

- Align federal initiatives
- Build capacity
- Advise the Secretary of Health and Human Services

Newly Eligible Metro Counties
Previously Eligible Metro Counties and Census Tracts
Non Metro Counties

*Map last updated: 8/30/2021

CMS 2024 Quality Conference
Resilient and Ready Together

Rural Communities Opioid Response Program

One of 22 naloxone safety kits installed in libraries throughout MI's northern Lower Peninsula as part of MI Center for Rural Health's RCORP grant

Participants of a Mental Health First Aid training hosted by Bay Rivers Telehealth Alliance in VA

- The **Rural Communities Opioid Response Program** (RCORP) provides direct funding and technical assistance to rural communities to address **behavioral health workforce** and service delivery needs, including **SUD/OUD**.
- Through RCORP, grantees have served in **47 states** and **2 territories**, reaching **1,900+ rural counties.**
- RCORP grant recipients are providing direct services to more than **2 million rural patients per year.**
- RCORP programs continue to expand to more diverse and emerging areas.

Rural Communities Opioid Response Program
Rural Centers of Excellence on SUD

Recovery Center of Excellence

RCOE on Prevention: University of Rochester

- Reduce morbidity and mortality related to SUD by focusing on prevention activities
- Working to engage communities/ reduce stigma, save lives, and support primary care

RCOE on Treatment: University of Vermont

- Expanding evidence-based treatment and harm reduction for OUD and other SUDs via education, technical assistance, and resources
- Patient focused approaches serving the needs of rural populations through innovative technology and telehealth strategies

RCOE on Recovery: Fletcher Group

- Expansion of Recovery Housing Capacity & Quality
- Rural Recovery Ecosystem Support Services: Employment, Housing, Transportation
- Evidenced-Based Education & Training

Find us at:
recoverycenterofexcellence.org

Find us at:
www.uvmcora.org or cora@uvm.edu

Find us at:
www.fletchergroup.org

RCORP Funding Opportunities Forecast (Pending Appropriations)

Program	FY 2024	FY 2025
RCORP-Overdose Response		NOFO Available: Fall 2024/Winter 2025 Project Start Date: 9/1/2025
RCORP-Stimulant Support	NOFO Available: Spring 2024 Project Start Date: 9/1/2024	
RCORP-Impact	NOFO Available: Winter/Spring 2024 Project Start Date: 9/1/2024	

Rural Health Support – Assistance and Services

- Telehealth Centers of Excellence
  - www.telehealthcoe.org
- Telementoring Training Center
  - www.ruraltelementoring.org
- 3RNet – Rural Recruiting and Retention Network
  - www.3Rnet.org
- Rural Emergency Hospital National Technical Assistance Center
  - Rural Health Redesign Center - www.rhrco.org/reh-tac
- Partnerships
  - National Organizations of State Offices of Rural Health – www.nosorh.org
  - National Rural Health Association – www.ruralhealth.us

Rural Health Support – Free Resources

- Rural Health Information Hub – topic guides, data, maps, case studies, and toolkits
  - www.ruralhealthinfo.org
- Rural Research Gateway
  - www.ruralhealthresearch.org
- Rural Residency and Training Resources
  - www.RuralGME.org
  - www.rttcollaborative.net
- Rural Health Value – research and resources about value-based payment
  - ruralhealthvalue.public-health.uiowa.edu
- AgriSafe Resources – occupational and public health
  - www.agrisafe.org

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Federal Office of Rural Health Policy

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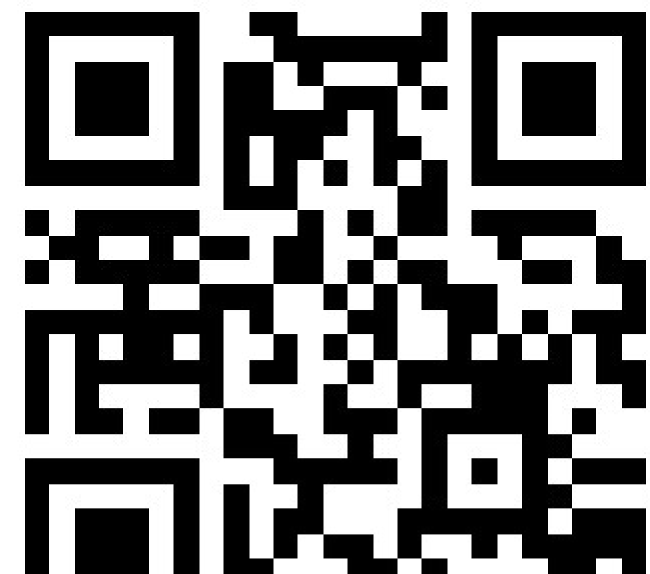
May 18, 2023

What's New

Funding Now Available for the Rural Maternity and Obstetrics Management Strategies Program. On Tuesday, HRSA announced that the Rural Maternity and Obstetrics Management Strategies Program (RMOMS) is accepting applications through **Friday, July 7**. Approximately $2 million is available to fund up to two health networks to preserve access to and continuity of maternal and obstetrics care in rural communities. For more information about the RMOMS program and current awardees, visit the RMOMS webpage.

Stigma and Opioid Use Disorder. More than 450 clinicians and counselors in rural New England were surveyed about stigma as a barrier to treating patients for opioid used disorder (OUD) as well as practitioners' beliefs about medications for OUD. Over half (55 percent)



https://www.hrsa.gov/about/organization/bureaus/forhp

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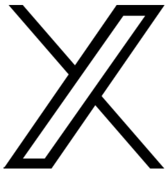

Medicare: Opioid Use Disorder Treatment

CDR Wanda Pamphile, PharmD, MPH
Outreach Specialist, Region 2 (New York)
Office of Program Operations and Local Engagement
Centers for Medicare and Medicaid Services (CMS)
US Department of Health and Human Services

Medicare Opioid Use Disorder Screening & Treatment

- Medicare pays for opioid use disorder (OUD) screenings performed by physicians and non-physician practitioners.
- Screening for OUD is a required element of Medicare's Initial Preventive Physical Exam and Annual Wellness Visit.
- During visits in physicians' offices and outpatient hospital settings, Medicare will pay for Screening, Brief Intervention, & Referral to Treatment (SBIRT) treatment services.

https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/opioid-use-disorder-screening-treatment

Medicare Opioid Use Disorder Treatment

- Medicare will pay for certain treatment services:
  - Evaluation & Management (E/M) visits for medication management

    You can use E/M visits to provide medication management to make sure patients take medications properly as part of their recovery process.

  - Office-based Substance Use Disorder (SUD) treatment services

    Medications prescribed as part of in-office treatment could include buprenorphine and naltrexone. If your patient has Medicare Part D coverage, these medications may be covered by their plan.

  - Opioid Treatment Program (OTP) (a more comprehensive treatment)

    OTPs provide medication-assisted treatment (MAT) for people diagnosed with an opioid use disorder (OUD). OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body.

https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/opioid-use-disorder-screening-treatment

Opioid Treatment Program (OTP) Services

- Medicare covers opioid use disorder (OUD) treatment services in opioid treatment programs (OTPs) through bundled OUD Medicare Part B treatment services payments.
- There's NO copayment for OTP services for Medicare patients, but the Part B deductible does apply.
- The services include:
  - FDA-approved opioid agonist and antagonist medications for opioid use disorders (MOUD) including methadone, buprenorphine, and naltrexone and their administration (if applicable)
  - Dispensing and administering MOUD medications FDA-approved opioid antagonist medications, specifically naloxone, for emergency treatments of opioid overdose, as well as overdose education provided in conjunction with opioid antagonist medication
  - Substance use counseling
  - Individual and group therapy
  - Toxicology testing
  - Intake activities
  - Periodic assessments that OTPs may conduct via two-way interactive audio-video communication technology

https://www.cms.gov/medicare/payment/opioid-treatment-program/billing-payment

Telehealth Services for Opioid Use Disorder (OUD) Treatment

- During the public health emergency, CMS covered telehealth-based OUD treatment at the same rates as in-person service.
- CMS permanently extended some telehealth policies for mental health and OUD:
  - Medicare covers video or audio-based treatment that people receive in their homes and other locations
  - For people who cannot use video, CMS will pay for audio-only mental health services (including those for OUD)
- Fiscal Year (FY) 2023 Medicare Physician Fee Schedule (MPFS) final rule allowed the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine
- Also allowed periodic assessments to be furnished audio-only when video is not available for the duration of Calendar Year (CY) 2023
- FY 2024 MPFS proposed rule proposes to extend flexibilities through CY 2024

https://www.cms.gov/medicare/payment/opioid-treatment-program/billing-payment

Contact Information

CDR Wanda Pamphile, PharmD, MPH

26 Federal Plaza, 18th Floor

New York, NY 10278

Email: wanda.pamphile1@cms.hhs.gov

Feedback

Thank you for attending today's session. We appreciate your time. We are always trying to improve our level of service to our customers and stakeholders. You can help us do that by providing your feedback on today's session. Please take a few moments to complete this brief evaluation via link or QR code. Thank you very much.

Please use this name for the CMS Activity:

April 9, 2024 – HHS' Call to Action on Opioid Use Disorder Treatment

- https://cmsgov.force.com/act/Evaluation