ALLIANT HEALTH SOLUTIONS®

GA FLEX Quality Improvement Project

Monthly Meeting

November 24, 2026



Agenda

- Welcome
- Kick-off New Cycle Year (September 2026-August 2027)
- National Rural Health Day 2026
- RQITA Workbook
- Composite Measure 5 CY 2025 Data
- Q&A/Wrap Up



GA FLEX Improvement Project Lead

Melody has more than 45 years of healthcare experience, including extensive service in diverse roles at Alliant Health Solutions. She currently leads and supports projects with hospitals, nursing homes, and physician practices, focusing on quality improvement, performance optimization, and the implementation of evidence-based interventions that improve clinical outcomes and patient-centered care.



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Alliant Health Solutions Website



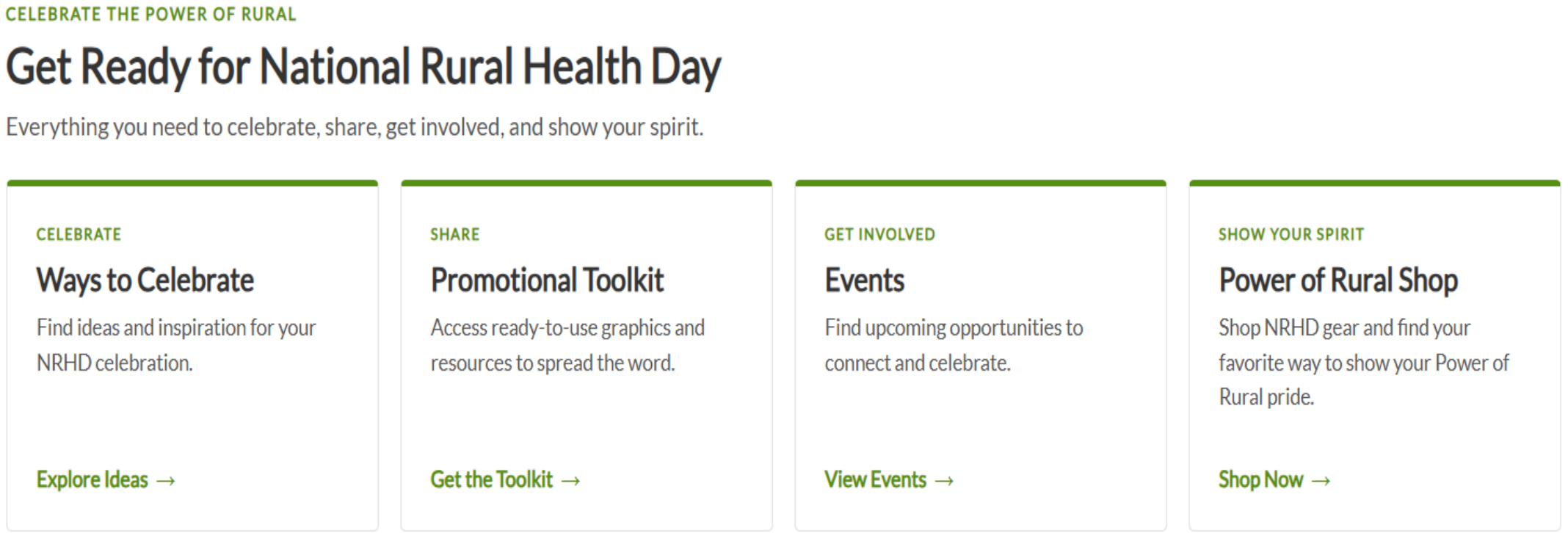
https://quality.alliantheath.org/ga-flex/

2026 National Rural Health Day



https://powerofrural.org/

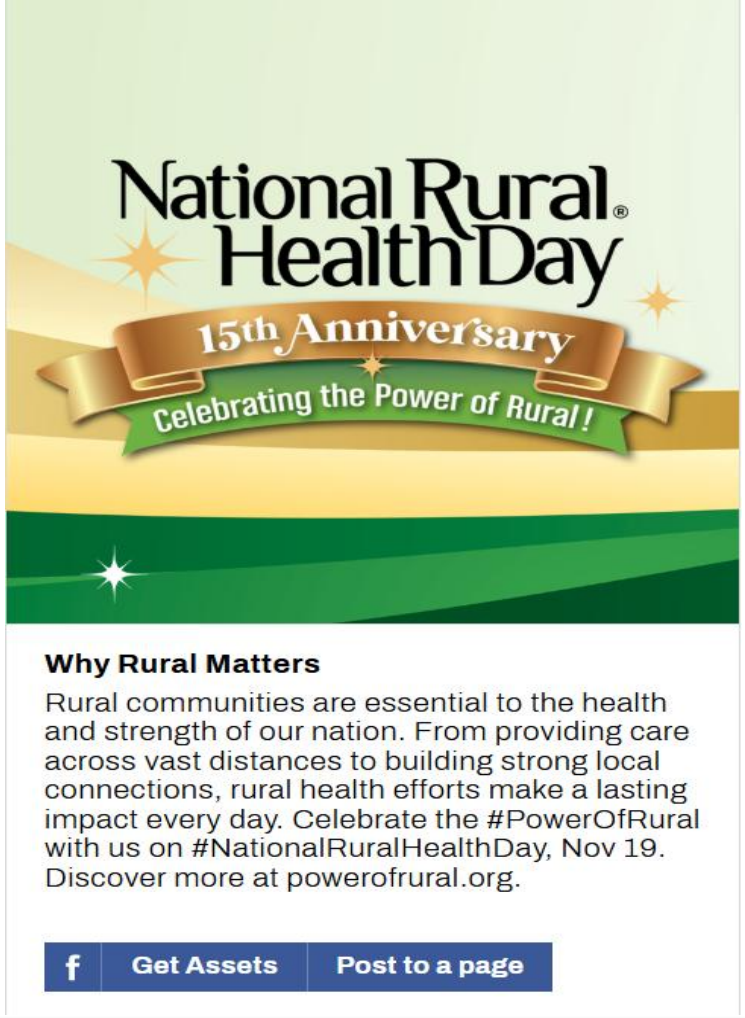
Rural Health Day Resources



https://powerofrural.org/

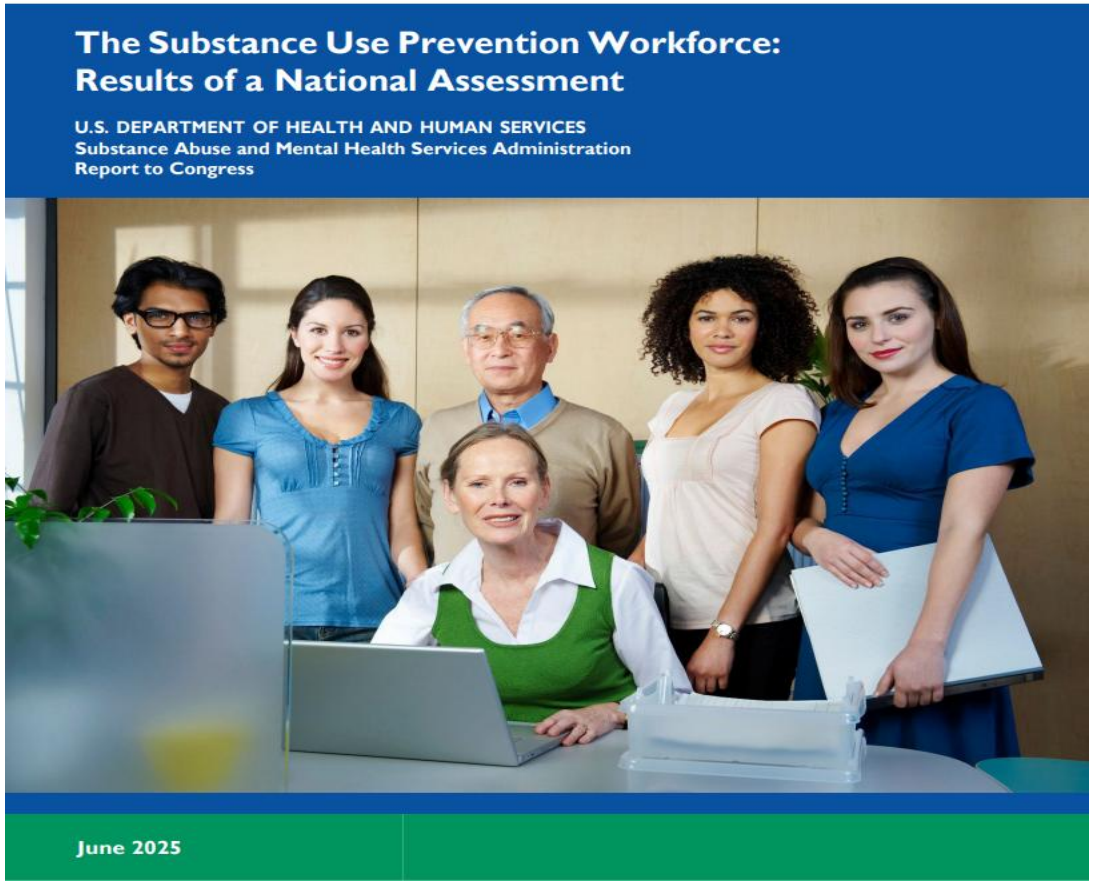
Toolkit Resource Examples





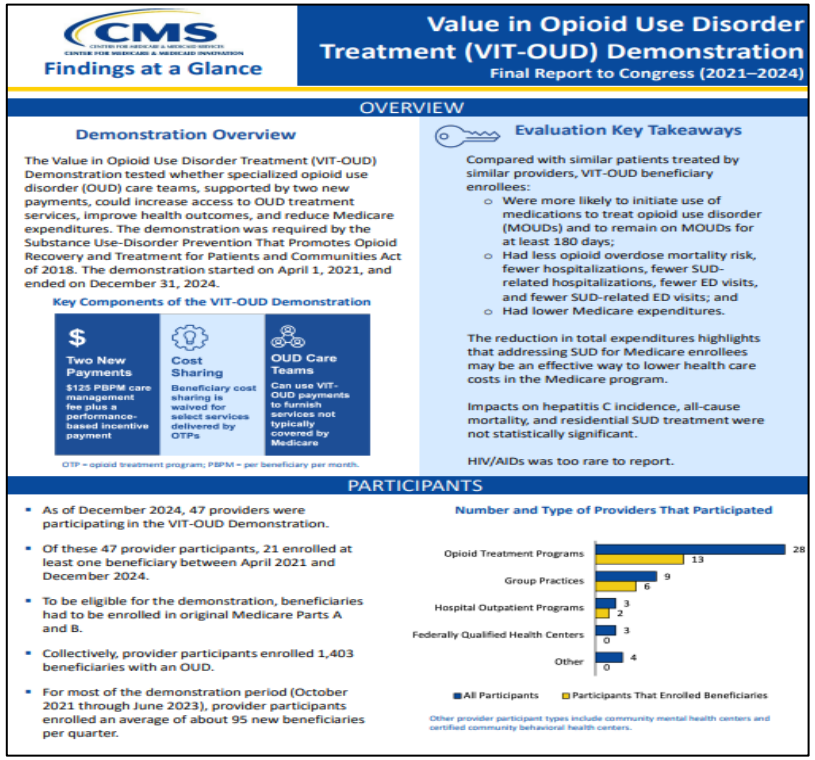


SAMHSA



https://library.samhsa.gov/sites/default/files/substance-use-prevention-workforce-results-national-assessment-pep26-03-004.pdf

Value in Opioid Use Disorder Treatment (VIT-OUD) Demonstration



CMS Findings at a Glance

Value in Opioid Use Disorder Treatment (VIT-OUD) Demonstration
Final Report to Congress (2021–2024)

OVERVIEW

Demonstration Overview

The Value in Opioid Use Disorder Treatment (VIT-OUD) Demonstration tested whether specialized opioid use disorder (OUD) care teams, supported by two new payments, could increase access to OUD treatment services, improve health outcomes, and reduce Medicare expenditures. The demonstration was required by the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018. The demonstration started on April 1, 2021, and ended on December 31, 2024.

Key Components of the VIT-OUD Demonstration

- **Two New Payments**: $125 PBPM care management fee plus a performance-based incentive payment
- **Cost Sharing**: Beneficiary cost sharing is waived for select services delivered by OTPs
- **OUD Care Teams**: Can use VIT-OUD payments to furnish services not typically covered by Medicare

OTP = opioid treatment program; PBPM = per beneficiary per month.

Evaluation Key Takeaways

Compared with similar patients treated by similar providers, VIT-OUD beneficiary enrollees:

- Were more likely to initiate use of medications to treat opioid use disorder (MOUDs) and to remain on MOUDs for at least 180 days;
- Had less opioid overdose mortality risk, fewer hospitalizations, fewer SUD-related hospitalizations, fewer ED visits, and fewer SUD-related ED visits; and
- Had lower Medicare expenditures.

The reduction in total expenditures highlights that addressing SUD for Medicare enrollees may be an effective way to lower health care costs in the Medicare program.

Impacts on hepatitis C incidence, all-cause mortality, and residential SUD treatment were not statistically significant.

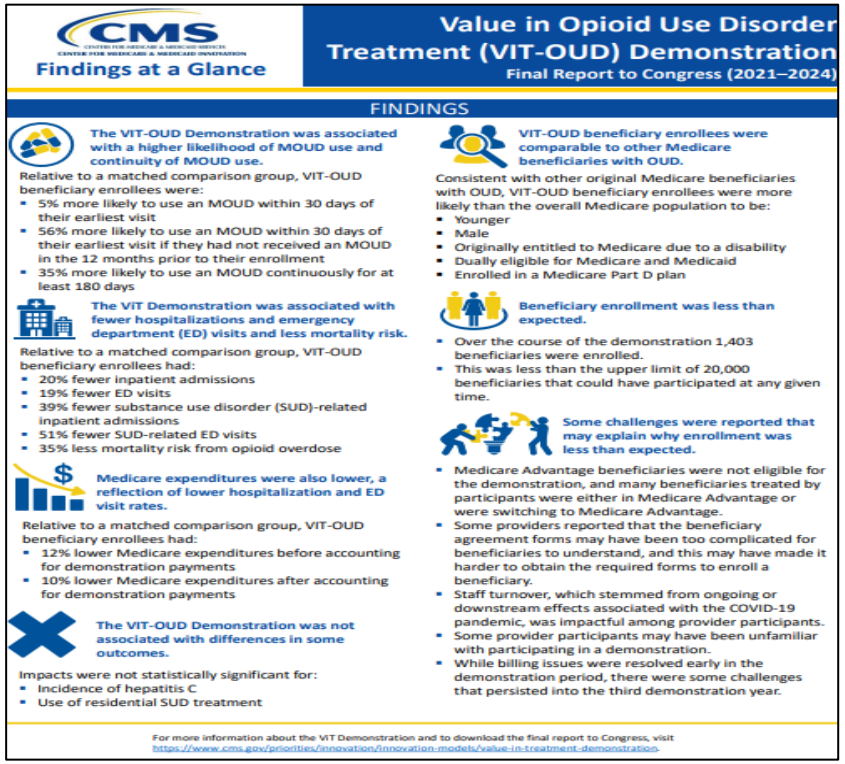
HIV/AIDs was too rare to report.

PARTICIPANTS

- As of December 2024, 47 providers were participating in the VIT-OUD Demonstration.
- Of these 47 provider participants, 21 enrolled at least one beneficiary between April 2021 and December 2024.
- To be eligible for the demonstration, beneficiaries had to be enrolled in original Medicare Parts A and B.
- Collectively, provider participants enrolled 1,403 beneficiaries with an OUD.
- For most of the demonstration period (October 2021 through June 2023), provider participants enrolled an average of about 95 new beneficiaries per quarter.

Number and Type of Providers That Participated

Other provider participant types include community mental health centers and certified community behavioral health centers.



CMS Findings at a Glance

Value in Opioid Use Disorder Treatment (VIT-OUD) Demonstration
Final Report to Congress (2021–2024)

FINDINGS

The VIT-OUD Demonstration was associated with a higher likelihood of MOUD use and continuity of MOUD use.

Relative to a matched comparison group, VIT-OUD beneficiary enrollees were:

- 5% more likely to use an MOUD within 30 days of their earliest visit
- 56% more likely to use an MOUD within 30 days of their earliest visit if they had not received an MOUD in the 12 months prior to their enrollment
- 35% more likely to use an MOUD continuously for at least 180 days

The ViT Demonstration was associated with fewer hospitalizations and emergency department (ED) visits and less mortality risk.

Relative to a matched comparison group, VIT-OUD beneficiary enrollees had:

- 20% fewer inpatient admissions
- 19% fewer ED visits
- 39% fewer substance use disorder (SUD)-related inpatient admissions
- 51% fewer SUD-related ED visits
- 35% less mortality risk from opioid overdose

Medicare expenditures were also lower, a reflection of lower hospitalization and ED visit rates.

Relative to a matched comparison group, VIT-OUD beneficiary enrollees had:

- 12% lower Medicare expenditures before accounting for demonstration payments
- 10% lower Medicare expenditures after accounting for demonstration payments

The VIT-OUD Demonstration was not associated with differences in some outcomes.

Impacts were not statistically significant for:

- Incidence of hepatitis C
- Use of residential SUD treatment

VIT-OUD beneficiary enrollees were comparable to other Medicare beneficiaries with OUD.

Consistent with other original Medicare beneficiaries with OUD, VIT-OUD beneficiary enrollees were more likely than the overall Medicare population to be:

- Younger
- Male
- Originally entitled to Medicare due to a disability
- Dually eligible for Medicare and Medicaid
- Enrolled in a Medicare Part D plan

Beneficiary enrollment was less than expected.

- Over the course of the demonstration 1,403 beneficiaries were enrolled.
- This was less than the upper limit of 20,000 beneficiaries that could have participated at any given time.

Some challenges were reported that may explain why enrollment was less than expected.

- Medicare Advantage beneficiaries were not eligible for the demonstration, and many beneficiaries treated by participants were either in Medicare Advantage or were switching to Medicare Advantage.
- Some providers reported that the beneficiary agreement forms may have been too complicated for beneficiaries to understand, and this may have made it harder to obtain the required forms to enroll a beneficiary.
- Staff turnover, which stemmed from ongoing or downstream effects associated with the COVID-19 pandemic, was impactful among provider participants.
- Some provider participants may have been unfamiliar with participating in a demonstration.
- While billing issues were resolved early in the demonstration period, there were some challenges that persisted into the third demonstration year.

For more information about the VIT Demonstration and to download the final report to Congress, visit https://www.cms.gov/priorities/innovation/innovation-models/value-in-treatment-demonstration.

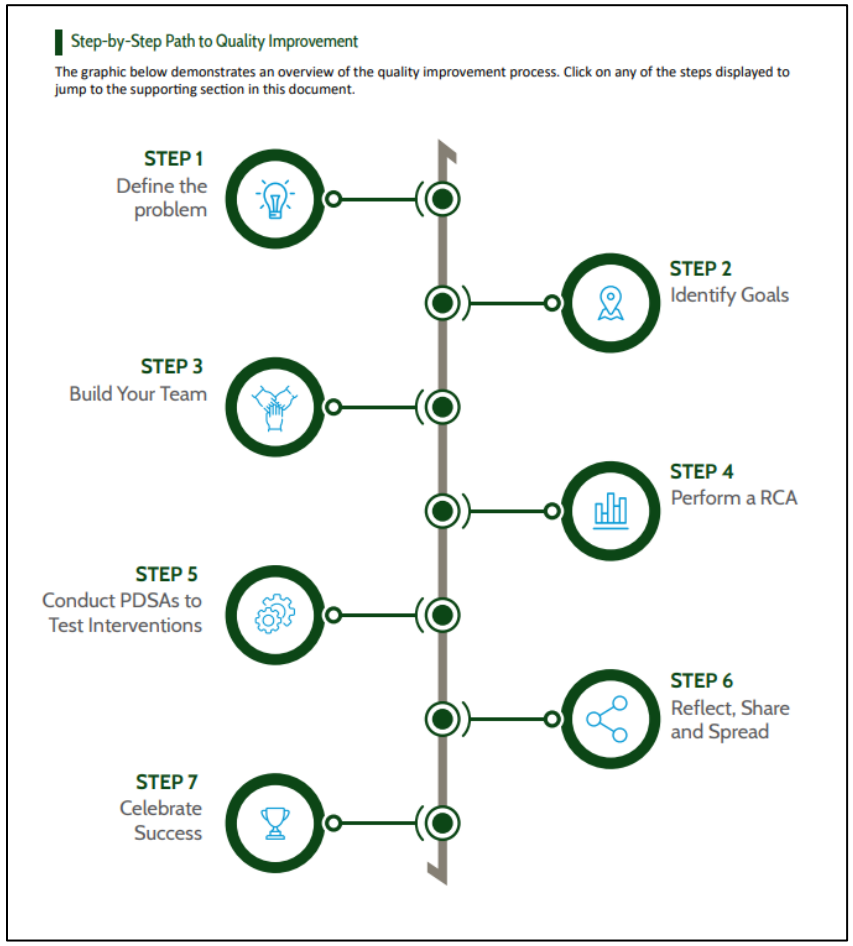
https://www.cms.gov/priorities/innovation/data-and-reports/2026/vit-final-rtc-aag

RQITA Workbook



https://www.telligen.com/wp-content/uploads/2025/03/QI-Workbook_RQITA_508.pdf

RQITA Workbook Examples



Step-by-Step Path to Quality Improvement

The graphic below demonstrates an overview of the quality improvement process. Click on any of the steps displayed to jump to the supporting section in this document.

STEP 1 Define the problem

STEP 2 Identify Goals

STEP 3 Build Your Team

STEP 4 Perform a RCA

STEP 5 Conduct PDSAs to Test Interventions

STEP 6 Reflect, Share and Spread

STEP 7 Celebrate Success



Develop Your Own Quality Improvement Goal Statement

Use the following template to create your own statement for your quality improvement project.

By Select Date, the Select a Team/Department at _____ will implement _____ to improve Select a Problem/Issue by _____ to benefit Select who will benefit.

Calendar Date | *Team/Department* | *Organization* | *Intervention* | *Problem/Issue* | *How Much* | *Whom*

MBQIP Data Submission Deadlines

Updated September 2026

Medicare Beneficiary Quality Improvement Project (MBQIP) Current MBQIP Core Measure Set

Data Submission Deadlines[1,2]

Measure ID	Description	MBQIP Domain	Reported To	Encounter Period & Due Date			
				Q2 / 2026 Apr 1 – Jun 30	Q3 / 2026 Jul 1 – Sep 30	Q4 / 2026 Oct 1 – Dec 31	Q1 / 2027 Jan 1 – Mar 31
HCP/IMM-3[3]	Influenza vaccination coverage among health care personnel	Patient Safety	NHSN	N/A	N/A	May 17, 2027 (Q4 2026 - Q1 2027 data aggregate) anticipated	
Antibiotic Stewardship	CDC NHSN Annual Facility Survey	Patient Safety	NHSN	March 1, 2027[4] (CY 2026 data)			March 1, 2028[4] (CY 2027 data)
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	Patient Experience	HQR - HCAHPS	October 14, 2026	January 13, 2027	April 14, 2027	July 14, 2027
EDTC[5]	Emergency Department Transfer Communication	Emergency Department	Submission process directed by State Flex Program	July 31, 2026	November 2, 2026	February 1, 2027	April 30, 2027
OP-18	Median time from ED arrival to ED departure for discharged ED patients	Emergency Department	HQR - Outpatient Chart Abstracted	November 2, 2026	February 1, 2027	May 3, 2027	August 2, 2027 (anticipated)
OP-22	Patient left without being seen	Emergency Department	HQR – Outpatient Web-Based	May 17, 2027 (CY 2026 data aggregate)			May 15, 2028 (CY 2027 data aggregate) anticipated

1. Based on currently available information. Submissions dates are subject to change.
2. Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable except for Antibiotic Stewardship which will remain March 1 regardless of when that date occurs.
3. The encounter period for HCP/IMM-3 is limited to Q4 and Q1.
4. Hospitals must complete the NHSN Annual Facility Survey by March 1 of each year for NHSN and MBQIP data reporting.
5. State Flex Programs must submit data to FMT by the 10th day of the month following the hospital deadline (e.g. Q3 2026 data due to FMT by Nov 10, 2026).

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $640,000 with 0% percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, visit HRSA.gov. As a technical assistance provider to rural healthcare organizations, Telligen provides access to a wide range of resources on relevant topics. Inclusion on the Telligen webpage or presentations does not imply endorsement of, or agreement with, the contents by Telligen or the Health Resources and Services Administration.

https://www.telligen.com/wp-content/uploads/2026/09/MonthlyMBQIPDataSubmissionDeadlines_202609_508.pdf

Data Submission

MBQIP Current Core Measure Set—Continued

Data Submission Deadlines[1,2]

Measure ID	Description	MBQIP Domain	Reported To	Encounter Period & Due Date			
				Q1 / 2026 Jan 1 – Mar 31	Q2 / 2026 Apr 1- Jun 30	Q3 / 2026 Jul 1 – Sep 30	Q4 / 2026 Oct 1- Dec 31
N/A	CAH Quality Infrastructure	Global Measures	FMT via Qualtrics	National CAH Quality Inventory and Assessment Continues Submission window September 8, 2026-November 20, 2026			
Safe Use of Opioids	Safe Use of Opioids-Concurrent Prescribing	Patient Safety	HQR -eCQM File Upload	Submission Deadline March 1, 2027[6] (CY 2026 data) anticipated			
Hybrid HWR	Hybrid Hospital-Wide Readmission	Care Coordination	HQR -Hybrid	MBQIP Core Measure starting with this measurement period Submission Deadline October 1, 2026 (Q3 2025 - Q2 2026 data)		Submission Deadline October 1, 2027 (Q3 2026 - Q2 2027 data) anticipated	

1. Based on currently available information. Submissions dates are subject to change.
2. Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable except for Antibiotic Stewardship which will remain March 1 regardless of when that date occurs.
3. The encounter period for HCP/IMM-3 is limited to Q4 and Q1.
4. Hospitals must complete the NHSN Annual Facility Survey by March 1 of each year for NHSN and MBQIP data reporting.
5. State Flex Programs must submit data to FMT by the 10th day of the month following the hospital deadline (e.g. Q3 2026 data due to FMT by Nov 10, 2026).
6. The Safe Use of Opioids-Concurrent Prescribing measure is required as part of the Promoting Interoperability Program. Hardship exemption applications are available for the Medicare Promoting Interoperability Program and are available during the yearly hardship application period May-July.

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September 2026 Upcoming MBQIP Deadlines

October 1, 2026

- Hybrid Hospital-Wide Readmission (Hybrid HWR) Q3 2025 - Q2 2026 encounters (7/1/2025-6/30/2026) is due October 1, 2026. Submission is through the HQR Secure Portal-Hybrid Measures. CMS eCQM ID specifications CMS529v5

October 14, 2026

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Q2 2026 encounters (4/1/26-6/30/26) is due **October 14, 2026**. Submission is through the HQR Secure Portal-Vendor. Quality Assurance Guidelines V.19.0

November 2, 2026

- Reporting Median time from ED arrival to ED departure (OP-18) Q2 2026 encounters (4/1/2026-6/30/2026) is due **November 2, 2026**. Submission is through the HQR Secure Portal-Outpatient Chart Abstracted. Previous CART users may enter abstractions into the HQR abstraction tool. Outpatient Quality Reporting Specifications version 19.0a
- Emergency Department Transfer Communication (EDTC) Q3 2026 encounters (7/1/26-9/30/26) is due **November 2, 2026.** Connect with your State Flex Program for submission process details.

For more information, review the MBQIP Navigator for understanding the measure reporting process for the MBQIP core measures.

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Composite Measure 5

HCAHPS Survey Questions (beginning with October 2026 refresh):

https://www.hcahpsonline.org/globalassets/hcahps/updated-hcahps-survey/crosswalk-of-updated-hcahps-survey-questions-to-sub-measures-.pdf

Questions specific to Composite Measure 5

Communication about Medicines

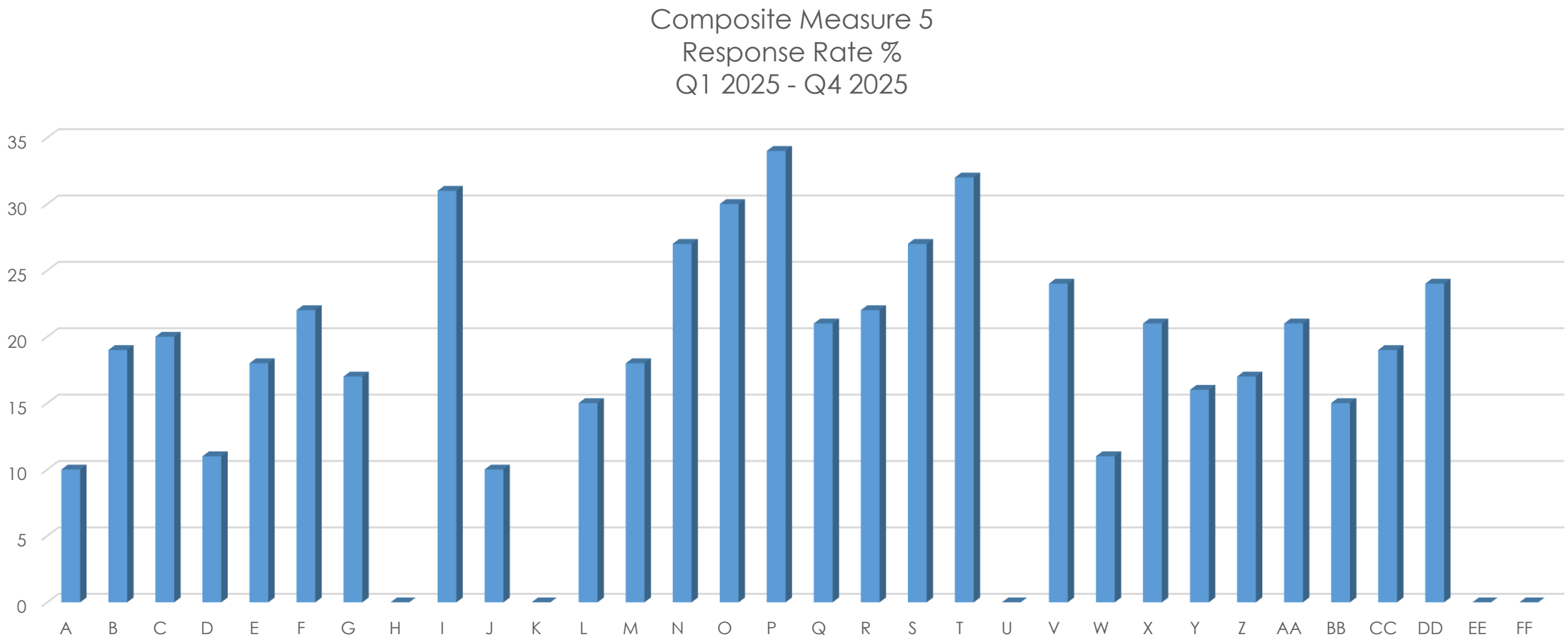
16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?	**Communication About Medicines**
17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?	**Communication About Medicines**

Composite Measure 5

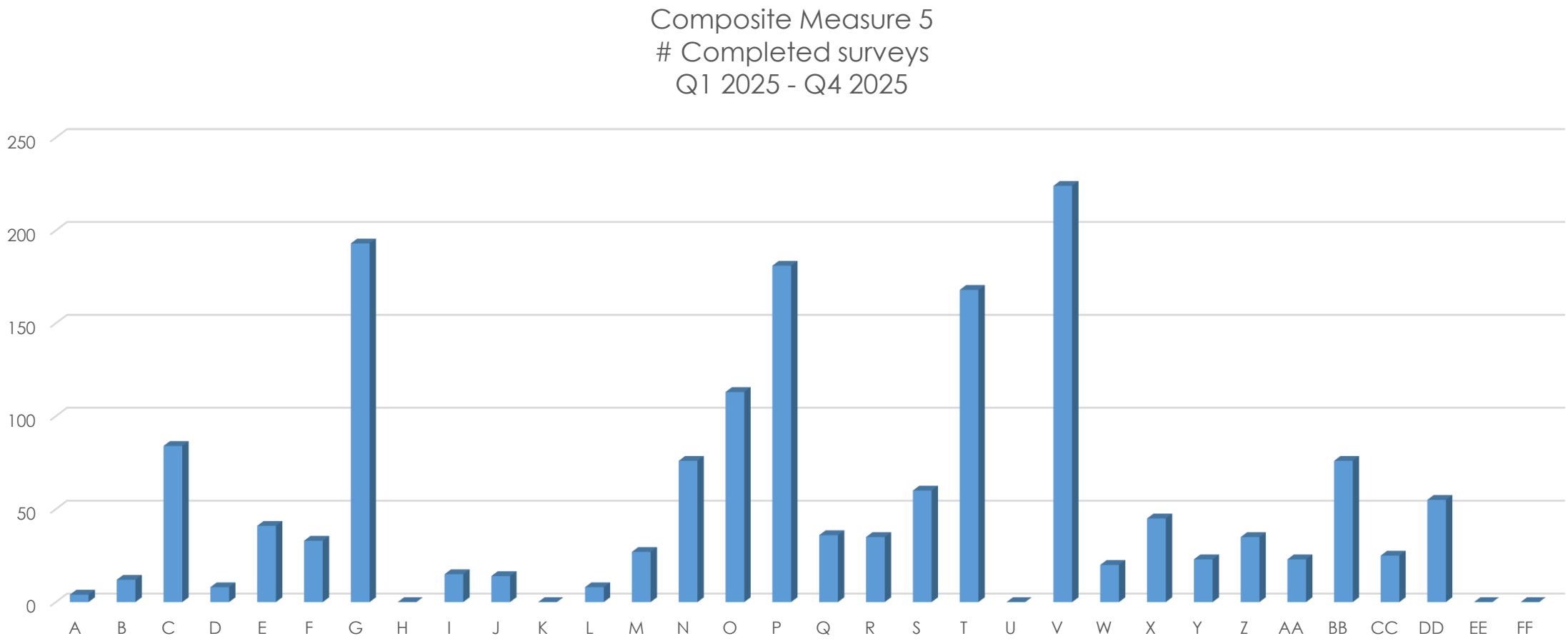
High-performing organizations typically focus on:

- Explaining the purpose of every new medication before administration.
- Discussing common side effects in plain language.
- Using teach-back to confirm patient understanding.
- Providing medication education consistently across all shifts.

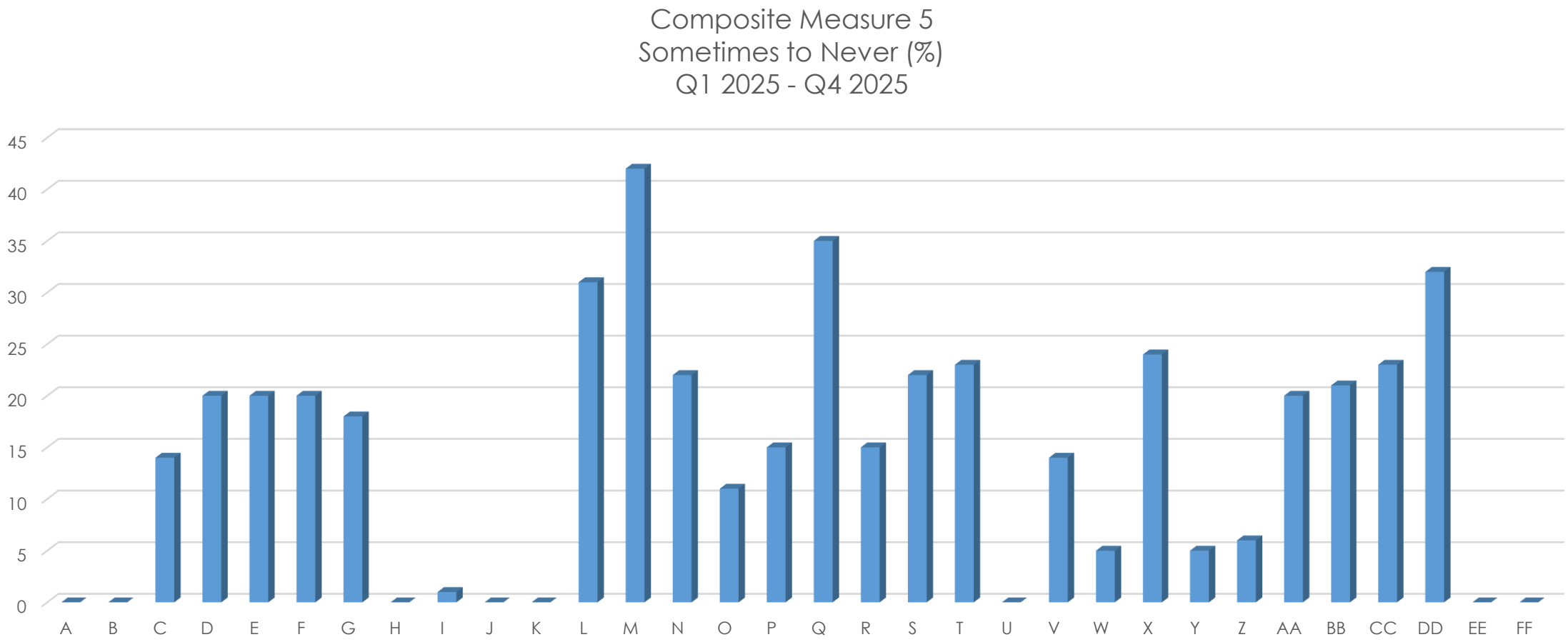
Composite Measure 5 Response Rate



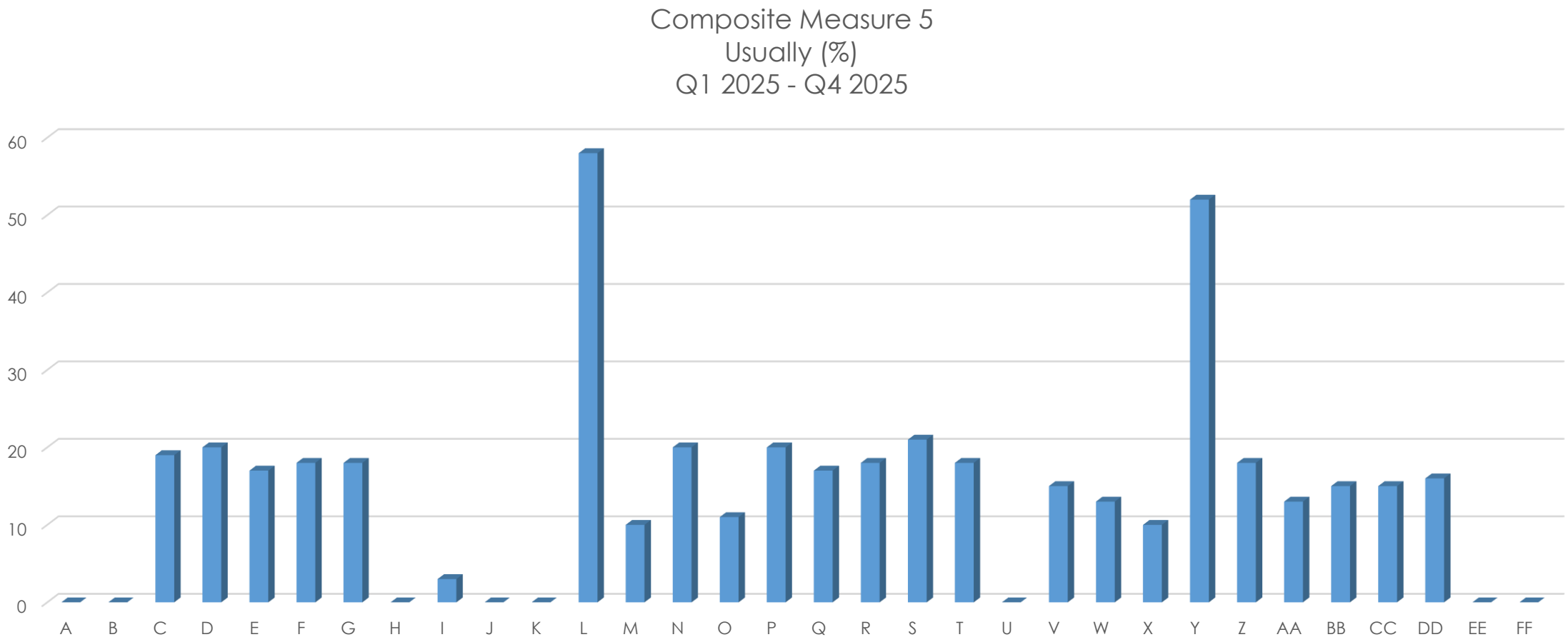
Composite Measure 5 # Completed Surveys



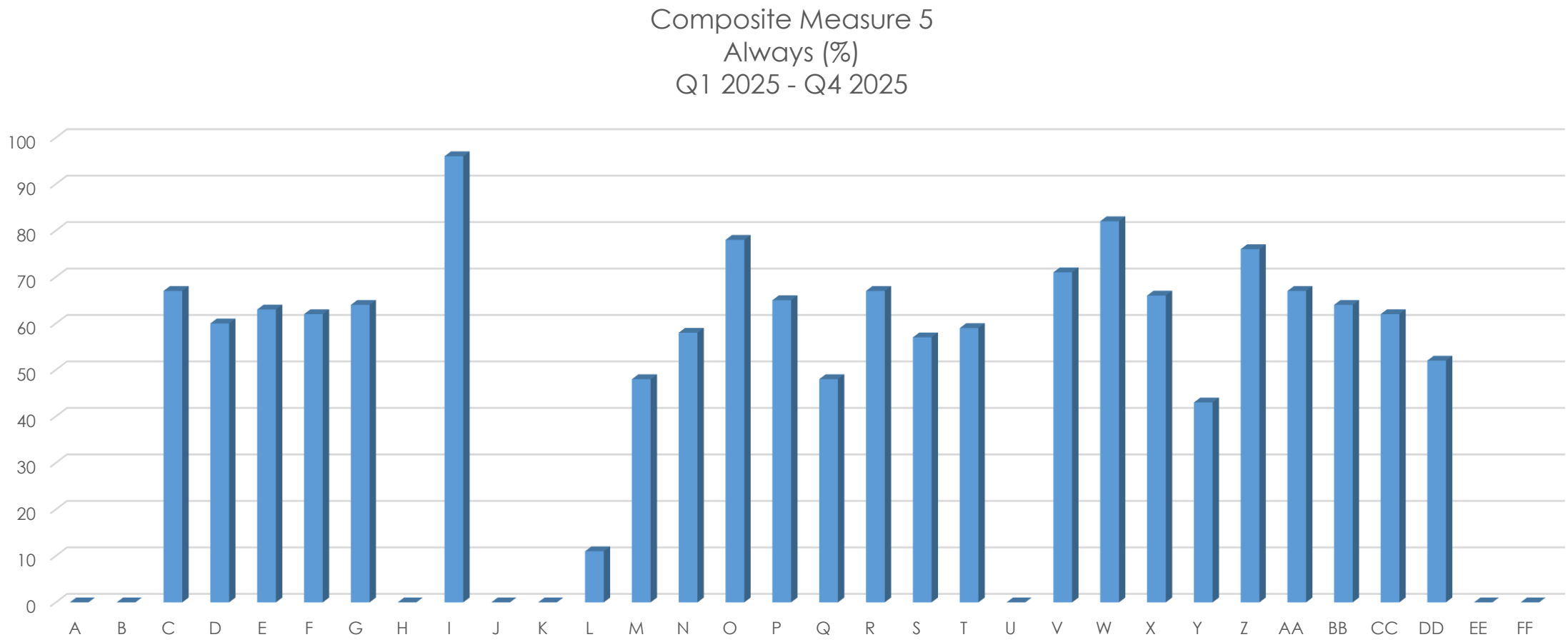
Composite Measure 5



Composite Measure 5

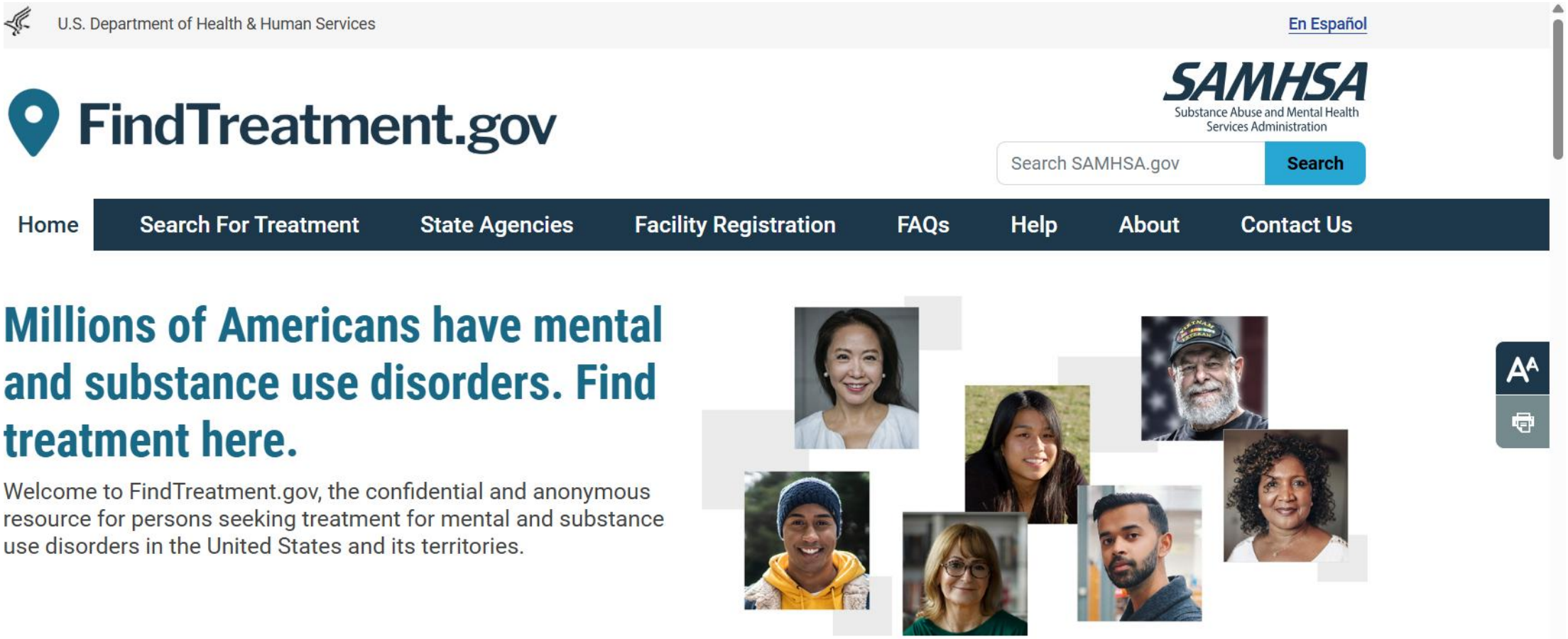


Composite Measure 5

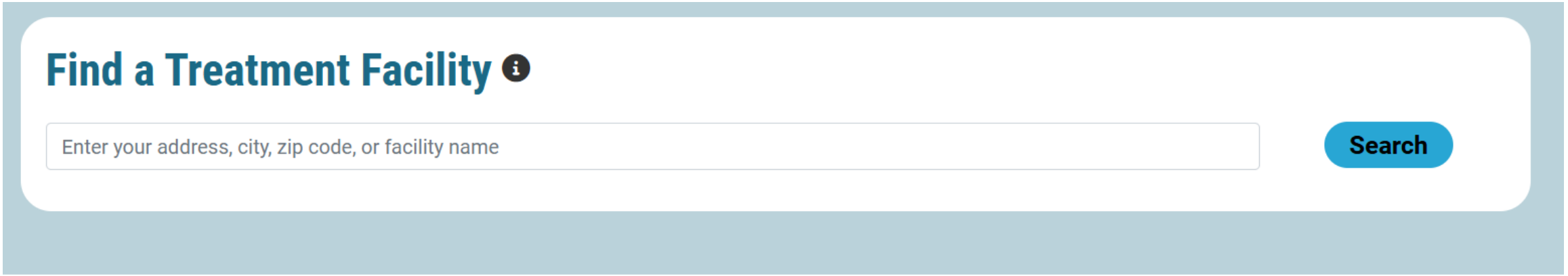


Find Treatment

https://findtreatment.gov/



Find Treatment



Help Resources

988 Suicide & Crisis Lifeline

Free and confidential support for people in distress, 24/7.

Call or text 988

National Helpline

Treatment referral and information, 24/7.

1-800-662-HELP (4357)

Disaster Distress Helpline

Immediate crisis counseling related to disasters, 24/7.

1-800-985-5990

Project Timeline

Date	To-Do List
4th Tuesday of each month 10 a.m. EST	□ Monthly calls



Email melody.brown@allianthealth.org to schedule a meeting.

Resources

1. The Rural Quality Improvement Technical Assistance (RQITA) Resource Center: https://www.telligen.com/rqita/

2. Rural Health Information Hub website: https://www.ruralhealthinfo.org/

3. Rural Health Research Gateway: https://www.ruralcenter.org/

Questions?


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