



March 23, 2018

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member Neal:

We greatly appreciate the opportunity to respond to the Ways and Means Committee Request for Information regarding the opioid crisis. The American College of Physicians is strongly committed to doing what we can to end the epidemic, including supporting better access to substance use disorder treatment.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Internists are uniquely suited to treat individuals with opioid and substance use disorders as they are often the first point of contact into the health system for patients with chronic pain. Our physicians have an ethical obligation to manage and relieve pain in a manner that reflects the best available clinical evidence. The challenge for physicians and public policymakers is how to deter prescription drug abuse while maintaining patient access to appropriate treatment.

Over the last several years, ACP has published a series of policy papers on this topic that provide our prescription for policy reforms to curb the abuse of prescription drugs including: [The Integration of Care for Mental Health, Substance Abuse, and other Behavioral Health Conditions into Primary Care, Prescription Drug Abuse](#), and [Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs](#). These policy papers inform some of the answers to your questions below and provide a resource for you as you examine policies on this topic.

Our feedback on your questions below provide additional guidance and detail about our policies regarding OUDs and SUDs and we look forward to working with you to enact these measures as Congress considers ways to stem the rising tide of opioid use.

Perverse Incentives in Medicare

ACP is committed to identifying policies that may result in unintended consequences for patients seeking relief from pain. In 2016, ACP expressed its concern to the Joint Commission and the Centers for Medicare and Medicaid Services about the use of pain screening standards and recommended actions toward the goal of limiting the unnecessary, and potentially harmful, practice of routinely screening for patient pain within the outpatient, primary care setting. The College also expressed support for removing pain scale questions from the Hospital Consumer Assessment of Healthcare Providers and Systems survey, alleviating potential pressure that physicians may feel to overprescribe opioids and we appreciate that this matter has since been addressed.

ACP supports team-based care models that financially incentivize cooperation and coordination among physicians and other health care professionals engaged in the treatment of their patient's pain. However, the fragmented nature of fee-for-service Medicare does little to incentivize such coordination. We recommend that Medicare develop alternative models to deliver holistic, nonpharmacologic pain management and encourage coordination among the patient's care team. Further, physicians are forced to work within the constraints of the typical 15-minute primary care visit which allows little time to conduct comprehensive pain management. This issue is discussed further under the heading "Alternative Options for the Treatment of Pain."

Second-Fill Limits

According to the [Center for Disease Control and Prevention](#) (CDC), "most people who abuse prescription drugs get them free from a friend or relative." Partial fill limits are promoted as a way to reduce diversion. ACP [policy](#) notes that defined maximum dosage (i.e., morphine equivalent) and duration of therapy limitations are not applicable to every clinical encounter and favors establishment of evidence-based, nonbinding guidelines regarding recommended maximum dosage and duration of therapy that a patient taking controlled substance medications may receive.

Arbitrary partial fill limits that are not based on evidence or practice protocol may place a substantial burden on seniors, patients in rural or medically-underserved areas, and those recovering from surgery that may not be able to travel to receive a refill. ACP is concerned that establishing mandatory partial fill limits without an exception process or opportunity to re-evaluate whether a patient needs additional medication could place a serious burden on patients and physicians alike. ACP expressed similar [concerns](#) to the CDC regarding its Draft Guideline for the Use of Opioids for Chronic Pain and noted the proposed 3-day limit without modification can too easily be rigidly and inappropriately applied by payers.

Electronic Prior Authorization

Prior authorization and other administrative burdens consume a massive amount of physician and staff time and contribute to physician [burnout](#) and [medical errors](#). To facilitate the elimination, reduction, alignment, and streamlining of administrative tasks, all key stakeholders should collaborate in better utilizing existing health information technologies, as well as developing more innovative approaches. Restructuring digital approaches to collecting, sharing, and reporting information and responding to requests should be a top priority of key stakeholders and implemented in a manner that involves direct input from frontline physicians and patients to ensure that these approaches are affordable and truly

meet their needs. ACP recommends that all stakeholders must work to ensure that reporting requirements are modified and standardized to take full advantage of the capabilities inherent in electronic health records (EHR) technology. Reporting burdens would be reduced dramatically if all stakeholders agreed to use the same data and structure definitions. Decision rules could be programmed into EHR systems to eliminate the need for prior authorizations.

When a patient expresses the desire to begin treatment for a substance use disorder, they should promptly be referred to the appropriate physician or health care professional to begin development of a treatment plan and receive the care they need. However, administrative hurdles can stall the initiation of treatment. ACP [recommends](#) that public and private insurers should remove onerous limits on medications for overdose prevention and medication-assisted treatment, including burdensome prior authorization rules.

Prescription Drug Monitoring Programs (PDMP)

ACP supports the establishment of a national PDMP. Until such a program is implemented, ACP endorses efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting program. ACP strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy.

Although PDMPs have been an effective tool in reducing the rate of unnecessary opioid prescriptions and have reduced opioid-related overdose deaths, the usage of PDMPs has also been linked to increased administrative burdens for physicians. Several policies must be pursued to reduce administrative burdens associated with PDMPs, including ensuring interoperability with electronic health record systems. According to a recent report from the [Pew Charitable Trust](#), the integration of PDMP data into a patient's health IT record would save the physician time and reduce administrative hassle associated with this task. The report notes that "integration with health IT makes PDMP data available to prescribers as part of their workflow without the need for multiple user accounts, log-ons, or user interfaces, thus saving prescribers time and effort. One study, involving focus groups of 35 prescribers from nine states, identified time spent accessing a report as a barrier to PDMP use and recommended integration with health IT as part of the solution." The Substance Abuse and Mental Health Services Administration and other federal agencies have initiated pilot projects and provided funding to states to encourage interoperability of PDMPs, but more needs to be done to enhance user friendliness.

Another solution would be to allow health care team members other than the physician to consult PDMPs. This would allow the physician to have a record of patient usage of opioids readily available to him or her before a decision is made on the type of medication to prescribe to the patient.

Prescriber Notification and Education

ACP firmly believes that physicians are obligated by the standards of medical ethics and professionalism to practice evidence-based, conscientious pain management that prevents illness, reduces patient risk, and promotes health. The College recommends that physicians must become

familiar with, and follow as appropriate, clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologic and nonpharmacologic interventions. The College has organized a collection of resources under the featured heading “Opioid Epidemic” as part of our [Online Learning Center](#), aimed at helping physicians to better treat patients with pain and/or opioid use disorder. The resources cover opioid therapy, pain management, behavioral health, and substance use disorder. Since 2015, over 2,000 physicians have attended live seminars provided by ACP at regional and national meetings. ACP’s online Safe Opioid Prescribing educational modules have been accessed by over 30,000 unique viewers, and hundreds have viewed our patient education support resources for management of chronic pain and opioids. Nearly 7,000 physicians have studied safe opioid prescribing principles using ACP’s Risk Evaluation and Mitigation Strategy courses.

ACP believes that training in screening and treatment of substance use disorders should be embedded in the continuum of medical education and continuing medical education providers should offer courses to train physicians in addiction medicine, medication-assisted therapy, evidence-based prescribing, and identification and treatment of substance use disorders. To encourage physicians to participate in CME related to pain management or proper prescribing of opioids, ACP has supported a recommendation that the DEA registration fee be waived for those who complete voluntary courses on pain management and substance use disorders. This policy will ensure that physicians and other health care professionals have the flexibility to engage with educational topics and materials that best suit their learning needs, including in-depth courses relating to specific areas of clinical practice.

Opioid Treatment Programs (OTPs), Medication Assisted Treatment (MAT), and Reimbursement

Medicare should support and reimburse medication assisted treatment by lifting barriers to MAT (such as prior authorization); covering FDA-approved medications such as buprenorphine, naltrexone, and methadone therapies; and developing new ways to access MAT through telemedicine. Hub and spoke systems can connect patients in remote areas to MAT.

Many physicians are not waivered to prescribe buprenorphine in part because they may not feel they have the support to deliver care to patients with SUD. To address this, pre- and post-buprenorphine training support and education resources should be made available and widely disseminated to assist physicians in their treatment efforts. Medicare should also support physician support initiatives, such as mentor programs (like Project Extension for Community Healthcare Outcome for Opioid Therapies [ECHO]), shadowing experienced physicians and other health care professionals, and telemedicine that can help the delivery of substance use treatment.

The College [strongly supports](#) reforming Medicare and Medicaid payment policies to better integrate behavioral health, including screening, referral and treatment of opioid and substance use disorders, into the primary care setting. Primary care is the appropriate platform to care for these patients as it is often the first point of contact of care for patients with these disorders. Many patients with chronic pain present co-morbid behavioral health conditions, including anxiety and depression, that can have an effect on pain management. Unfortunately, many barriers to the seamless integration of behavioral and primary care exist in the physician payment structures of Medicare and Medicaid. Behavioral and physical health care clinicians have a long history of operating in different care silos and

reimbursement policies have not always incentivized integrated, team-based care. Recently, Medicare has developed new payment codes for certain integration models, such as the Psychiatric Collaborative Care Model (CoCM).

While the CoCM model is well-established, there are many other integration models and approaches that may be more scalable and appropriate for different practice settings and capabilities. Payment incentives in Medicare and Medicaid can be designed to continue to support the Patient Centered Medical Home and the Patient-Centered Specialty Practice [model](#), with its emphasis on whole person primary care, care coordination, and delivery of care by a team of professionals, as an excellent foundation for the integration of behavioral and primary care to manage pain and treat patients with OUD or SUDs. Its bundled monthly pay components also provide a means to financially support the required infrastructure and clinical resources necessary for effective integration.

Alternative Options for the Treatment of Pain

CMS should continue to test team-based, coordinated care models that are designed to treat the whole patient, including the patient's pain management needs, in a manner that emphasizes use of evidence-based non-opioid pharmacologic and non-pharmacologic pain management interventions.

One model of care that provides additional Medicare payment for non-pharmacological interventions is the Medicare Diabetes Prevention Program (MDPP). In this care setting, rather than treating patients at risk for type 2 diabetes with prescription drugs, Medicare provides beneficiaries with an approved Centers for Disease Control and Prevention (CDC) curriculum of classes that provide practical training in long-term dietary change, increased physical activities, and behavior changes in weight control. A study of MDPP found that behavior changes resulting in modest weight loss sharply reduced the development of type 2 diabetes.

Although patients with type 2 diabetes face different challenges on the path to wellness than those with chronic pain, it may be beneficial for CMS to consider additional Medicare payment for non-pharmacological interventions for evidence-based treatment programs such as cognitive behavior therapy and physical therapies that treat these disorders.

Again, ACP appreciates the opportunity to offer solutions to ending the opioid epidemic.

Sincerely,

A handwritten signature in black ink, appearing to read "Jack Ende", with a stylized flourish at the end.

Jack Ende, MD, MACP
President