American Hospital Association

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March 15, 2018

The Honorable Kevin Brady, Chairman
The Honorable Richard Neal, Ranking Member
The Honorable Peter J. Roskam, Chairman, Subcommittee on Health
The Honorable Sander Levin, Ranking Member, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Transmitted via email: WMOpioidSubmissions@mail.house.gov

Re: Request for Recommendations for Policy Actions to Address the Opioid Epidemic

Dear Chairmen Brady and Roskam and Ranking Members Neal and Levin:

As the nation continues to struggle with the devastating public health crisis created by the opioid epidemic, it is encouraging to see the Committee on Ways and Means take constructive action to understand how changes in public policy and the Medicare program can help in the fight. We appreciate your interest and commitment to action and welcome this opportunity to work with you. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers, the American Hospital Association (AHA) thanks you for your leadership in addressing the nation's opioid epidemic.

HOSPITALS AND HEALTH SYSTEMS ARE ALREADY TAKING ACTION

Every day, hospital staff witness the devastating effects of the opioid epidemic on the patients, families, and communities we serve. Prescription opioids can be a safe and necessary element of pain management for those who have experienced trauma, are suffering from cancer, sickle cell disease, or other diseases that cause debilitating pain. On the other hand, opioids carry significant risk for misuse, addiction, overdose and death, and they must be used judiciously.

To prevent addiction and misuse, hospitals are working to reduce patients' exposure to opioids by making other types of pain control readily available. They are implementing standard, evidence-based protocols for prescribing limited amounts of opioids to patients, and they are safeguarding prescription drugs from diversion. They are using state prescription drug monitoring programs and working to link them to their electronic health records (EHRs) to

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ensure a seamless and accurate flow of information regarding the patient's prescriptions is available.

When patients are diagnosed with substance use disorder (SUD), hospitals are offering treatment or referrals, as appropriate, and integrating physical and behavioral health care to ensure the whole patient is treated. They are training first responders to use naloxone and, in some cases, equipping them with this antidote.

However, hospitals are aware that this epidemic cannot be successfully dealt with by health care providers working independently. They are collaborating with their communities to create coordinated responses. They are forming partnerships with other health care providers, state and local departments of health, law enforcement, schools, community organizations, and others. Through these collaborations, we have seen hospitals engage recovery specialists to help patients admitted for drug overdose enter treatment, expand SUD treatment services, join with law enforcement to facilitate access to treatment, fund public education programs, educate community clinicians about prescribing practices, participating in drug take-back days, and more. But much remains to be done.

Following are our recommendations in the areas outlined in your letter of February 28.

OVERPRESCRIBING/DATA TRACKING

Perverse Incentives in Medicare: In the fiscal year (FY) 2018 Inpatient Prospective Payment System (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) finalized changes to the existing pain management-related questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in an attempt to reduce the inadvertent pressure on providers to prescribe opioid medications in order to receive better scores on this survey. We commend CMS for its responsiveness to our and other stakeholders' concerns about the previous pain-related questions, and wholeheartedly agreed with CMS's decision in 2016 to temporarily suspend these questions from calculations in the Hospital Value-Based Purchasing Program.

However, we believe that the agency should complete the multi-stakeholder, consensus-based review process for these questions and the measure informed by the scores on these questions before incorporating them into the HCAHPS survey and the Inpatient Quality Reporting Program. Although Congress envisioned a robust evaluation of measures before their inclusion in pay-for-reporting programs when these programs were created, the evaluation of the measure based upon the pain management questions has yet to occur due to the unavailability of testing data (as these questions have not yet been put into place). Without robust examination of how the questions will be perceived by patients and providers, whether the new questions could potentially have unintended consequences, and how the new questions compare to others that may have been tested, it is unclear whether the changes to the HCAHPS survey will actually result in reduced pressure to prescribe opioid medication.

We also draw your attention to quality measures that penalize hospitals when patients return to emergency departments (EDs) for additional treatment. Should stringent prescribing limits on opioids be imposed, some patients with chronic conditions, such as sickle cell disease, may need to return to the ED for additional medicine, and hospitals should not be penalized for those return visits.

As Congress considers ways to discourage the use of opioids, we urge the Committee to examine other quality measures, such as the recently removed Outpatient PPS measure Median Time to Pain Management for Long Bone Fracture, which may impose penalties on hospitals for providing alternative pain management strategies that take longer or are more complex to administer than opioids. We believe that the Inpatient, Outpatient, Ambulatory Surgery Center, and post-acute care quality reporting programs include measures that, while well intentioned, carry the unintended consequences that have led to overprescribing of opioid medications over other, non-opioid pain-management strategies.

Second-fill Limits: As the Committee considers prescribing limits, the AHA urges members to keep in mind the legitimate uses of opioids for patients with severe and chronic conditions. These patients should not be subjected to unnecessary and burdensome requirements to refill small-dose prescriptions frequently, nor should they be required to pay non-prorated cost-sharing amounts associated with refills for appropriate, warranted use of opioids.

Electronic Prior Authorization: The AHA supports moving toward industry-wide adoption of electronic prior authorization transactions based on existing national standards, which has the potential to streamline and improve the process for all stakeholders. Additionally, making prior authorization requirements and other formulary information electronically accessible to health care providers at the point-of-care in EHRs and pharmacy systems will improve process efficiencies, reduce time to treatment, and potentially result in fewer prior authorization requests because health care providers will have the coverage information they need when making treatment decisions. Technology adoption by all involved stakeholders, including health care providers, health plans, and their trading partners/vendors, is key to achieving widespread utilization of standard electronic prior authorization processes.

Prescription Drug Monitoring Programs (PDMPs): The AHA also supports efforts to ensure that PDMP information is shared across state lines. State PDMPs are an important tool in fighting the epidemic, and the nation. Congress should seek ways to maximize the capacity of this technology to help clinicians avoid unnecessary or potentially harmful opioid prescriptions. We understand that most PDMPs already engage in some level of information sharing, especially with their neighboring states. To enhancing these efforts, certified EHRs can be used to improve knowledge about a patient's active and prior medications. The best approach would be to ensure the inclusion of PDMP information in the certified EHR in a timely and efficient manner in the course of clinical workflow, which requires improved interoperability. We urge the Ways and Means Committee to consider additional funding to promote the improved interoperability between health care providers and PDMPs and among PDMPs in different states. We encourage the Committee to promote such interoperability so that should you extend CMS access to state PDMP data, this move would have the added virtue of ensuring that Medicare physicians can

review *all* states' data rather than only the data maintained by the state in which they practice and nearby states.

COMMUNICATION AND EDUCATION

Beneficiary Notification: We bring to your attention the attached patient education resource that the AHA developed in collaboration with the Centers for Disease Control and Prevention (CDC) and distributed to our member hospitals and health systems for dissemination to patients and families. We recommend that this resource be included in the *Medicare & You* booklet and on the CMS website to educate Medicare beneficiaries and their families.

Prescriber Notification and Education: The AHA strongly supports prescriber education through medical and dental school training, as well as continuing medical education, and it has worked to disseminate information to hospitals on opioid prescribing guidelines, such as the CDC guidelines for chronic pain. We also have committed to continue sharing successful hospital practices related to education, prescriber monitoring and alternatives to pain management. Last fall, we released a toolkit with additional information and resources for hospitals. While the AHA supports increased prescriber education initiatives, we caution that mandatory requirements can have unintended consequences.

TREATMENT

Opioid Treatment Programs (OTPs) and Medication Assisted Treatment (MAT): A recent report from the National Academies of Sciences, Engineering and Medicine underscores the gaps in availability of MAT in the U.S. The AHA supports the need to enhancing access to MAT, and we have previously supported efforts to increase patient limits for buprenorphine prescribing. The federal government should continue to incentivize adequate access to MAT, and that starts with having enough clinicians with specialized training. Medicare could incentivize clinicians to get this training by providing a small bump in payment to those who have the training or by recognizing the acquisition of such skills as a quality improvement activity under the Merit-based Incentive Payment (MIPs) System.

The importance of coordinated care for patients in treatment for opioid use disorder cannot be overstated. Congress must amend 42 CFR Part 2, which governs the confidentiality of SUD patient records and impedes the sharing of patient information necessary for delivering the most efficient and effective care. Clinicians in hospitals and health systems have to go to extraordinary lengths to comply with the requirements of 42CFR, Part 2. For example, we have heard from obstetricians who specialize in treating pregnant women with SUD diagnoses and other clinicians who treat both the physical and SUD diagnoses of patients. To ensure compliance with 42CFR, Part 2, as currently written, these clinicians must maintain two separate computers and two separate medical records. This adds burden and expense, but without benefit.

The AHA supports legislation to fully align the Part 2 regulation with the Health Insurance Portability and Accountability Act (HIPAA) regulation as the best way to eliminate these

barriers. Recent revisions made by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Part 2 regulations do little to eliminate existing barriers. In fact, complete alignment of Part 2 and HIPAA will require statutory changes, and we urge the Committee members to support legislation currently being considered by the Committee on Energy and Commerce, which is necessary to achieve this outcome. Applying the same requirements to all patient information − whether behavioral or medical − would support the appropriate information sharing essential for clinical care coordination and population health improvement, while safeguarding patient information from unwarranted disclosure.

Reimbursement: Medicare beneficiaries are currently limited to just 190 days of inpatient psychiatric hospital treatment in their lifetime. No other Medicare inpatient hospital service has this type of arbitrary cap on benefits. The 190-day lifetime limit is problematic for patients who may have SUD and mental illness, as they are especially at risk of exceeding this limit. The AHA supports eliminating the Medicare 190-day lifetime limit to equalize Medicare mental health coverage with private health insurance coverage, expand beneficiary choice of inpatient providers, and increase access to essential treatment for the most seriously ill.

Alternative Options for the Treatment of Pain: We urge the Committee to encourage further collaboration between the Center for Medicare and Medicaid Innovation and the National Institutes of Health to implement tested innovations in pain management. In addition, we reiterate our support for H.R. 5197, the Pascrell-McKinley legislation that would direct the Secretary of Health and Human Services to conduct a demonstration program to test alternative pain management protocols to limit the use of opioids in emergency departments.

Thank you for this opportunity to submit recommendations to the Committee. If you have questions or would like further information, please contact Priscilla A. Ross, Senior Associate Director, Federal Relations, at pross@aha.org or (202) 626-2677.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

Attachment

PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW

Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

receiving prescription opioids long term in a primary care setting struggles with addiction.

*Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

U.S. Department of Health and Human Services
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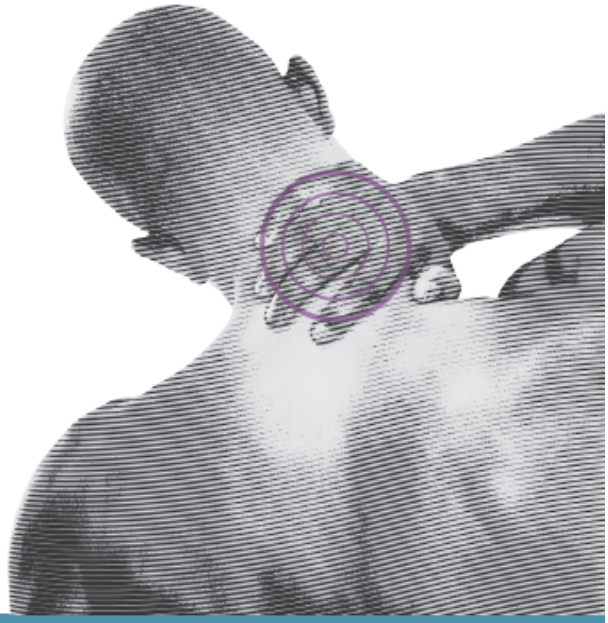
KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- Pain relievers such as acetaminophen, ibuprofen, and naproxen
- Some medications that are also used for depression or seizures
- Physical therapy and exercise
- Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- Never take opioids in greater amounts or more often than prescribed.
- Follow up with your primary health care provider within ___ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html