American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

February 16, 2018

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the American College of Emergency Physicians (ACEP) and our 38,000 members, thank you for your important efforts to address the nation's opioid epidemic and its impact on Americans who depend upon Medicare and Medicaid. Emergency physicians are on the front lines of the opioid and substance use disorder crisis, and every day we witness the effects of this epidemic on patients, their families, and our communities. We strongly agree that addressing this issue requires a thoughtful, bipartisan approach, and we are grateful for the opportunity to share our feedback with the Committee.

By the nature of our profession, many patients seeking care in the emergency department present with severe pain, which may be due to an acute or chronic condition. A primary goal of emergency care is to alleviate pain quickly, safely, effectively, and compassionately. As part of our efforts to help solve the opioid epidemic, emergency physicians rarely prescribe opioids for more than several days. Additionally, ACEP has worked to educate its members on safe prescribing guidelines for many years, and these efforts have shown great success. According to a 2015 American Journal of Preventive Medicine (AJPM) study, the largest percentage drop in opioid prescribing rates between 2007 and 2012 occurred in emergency medicine (-8.9%).

As we work together to develop effective solutions to the opioid epidemic, we believe it is important that our collective response is sufficient and appropriate to address the problem, while still ensuring that legislative responses do not overcorrect and that physicians still have access to effective options to treat pain. Opioids are an appropriate course of treatment for some patients, and the response to the epidemic should not unduly burden physicians and their patients for whom opioids may be a suitable treatment. At the same time, we encourage the development and use where possible of non-opioid alternatives to effectively treat patients and address the devastating impacts of the opioid epidemic on our country. Our responses to the questions posed by the Committee can be found on the following pages.

We are deeply appreciative of the Committee's continued attention to this critical public health issue, and emergency physicians throughout the country stand ready to help implement effective, bipartisan, and patient-centered solutions to improve the lives of our patients and their families.

Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP Senior Congressional Lobbyist, directly at (202) 370-9299 or at rmcbride@acep.org.

Sincerely,

Paul D. Kivela, MD, MBA, FACEP
ACEP President

WASHINGTON, DC OFFICE
2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
www.acep.org

1) **How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing Opioid Use Disorder (OUD) or other Substance Use Disorders (SUDs)?**

Emergency physicians see patients every day whose pain may be the result of an acute condition or due to one or more chronic conditions. Medicare and Medicaid policies should reflect the unique nature of managing pain in the emergency department and incentivize providers to follow evidence-based best practices and clinical guidelines. Pain treatment and prescribing guidelines should promote adequate pain control, health care access, and flexibility for the physician's clinical judgement. Medical specialties should be the primary sponsors of these guidelines. To this end, ACEP has been actively engaged in developing pain treatment guidelines along with the American Medical Association (AMA), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Office of the National Drug Control Policy (ONDCP), and many others. Creating additional federal work groups or task forces would be duplicative. Safe harbors should also exist for prescribers who follow pain treatment guidelines.

In 2017, the Centers for Medicare and Medicaid Services (CMS) issued regulations that revised how pain management is assessed as part of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Previously, the survey's questions on pain management were calculated as part of the total performance score under the Hospital Value-Based Purchasing (VBP) program, raising concerns that hospitals would be incentivized to prescribe more opioids to ensure higher HCAHPS scores. Under the changes issued by CMS that went into effect in 2018, the survey questions are now designed to solicit feedback on pain communication as opposed to management. Additionally, while the survey still gathers data on how a patient's pain was treated during their hospital stay, these responses are no longer factored into the total VBP performance score, removing potential incentives that could encourage greater opioid prescribing.

CMS is currently developing a similar survey focused on the emergency department, the Emergency Department Patient Experiences with Care (EDPEC) Survey. As this survey continues to be developed, we would encourage legislators and regulators to ensure that pain-related questions are approached similarly to those in the revised HCAHPS survey, and that the responses to these questions are not tied to payment calculations. Medicare and Medicaid payments must value the physician's best clinical judgement.

ACEP also supports expanded research into and manufacturing of opioids with abuse-deterrent properties. However, there remain significant challenges that may limit use of abuse-deterrent products as an alternative to opioids already on the market. Many of these products are significantly more expensive than their non-abuse-deterrent counterparts, and additional research is still needed to accurately determine their effectiveness compared to traditional opioids. Regardless, expanding access to abuse-deterrent opioid therapies is just one part of the solution and should occur in conjunction with expanded research and promotion of other evidence-based, non-opioid treatments and prevention strategies.

2) **What barriers to non-pharmaceutical therapies for chronic pain exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?**

For many patients, their first encounter with the health care system is through the emergency department, so emergency physicians also have a role in ensuring that patients do not go from a prescription to an addiction. Alternatives to opioid pain management must be easily accessible to Medicare and Medicaid beneficiaries and be adequately covered as options for the first line of pain treatment.

We encourage the Committee to promote successful programs like the emergency department-based Alternatives to Opiates (ALTO) program at St. Joseph's Hospital in Paterson, NJ. This program uses targeted non-opioid medications, trigger-point injections, nitrous oxide, and ultrasound-guided nerve

blocks to treat a variety of acute pain diagnoses, including headache, bone fractures, back pain, and many others. In many cases, these treatments are as effective or more effective than opioids as they are specifically tailored to the patient and the type of pain. Within five months, the ALTO program reduced opioid use in the emergency department by 38 percent, and nearly 75 percent of patients were successfully treated with non-opioid protocols. For those patients who are eventually treated with opioids, the emergency department ensures they are aware of the potential risks of opioid treatment and connects patients with providers who can help manage their pain symptoms, such as primary care physicians, pain management specialists, physical therapists, and psychiatrists.

3) **How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?**

ACEP supports physician prescribing of naloxone to at-risk patients, per recommendations of the Substance Abuse and Mental Health Services Administration (SAMHSA), and education of overdose recognition and safe naloxone administration by non-medical providers, such as family members. These efforts should be paired with legislation that would make health care providers and lay users of naloxone immune from liability for failure or misuse of bystander naloxone.

Cost and access to naloxone is a growing concern. The nationwide prevalence of the opioid epidemic and the increasing potency of heroin laced with fentanyl or carfentanil mean that overdoses now tend to require larger doses of naloxone to reverse. Further, necessary efforts at both the state and federal levels to increase the availability of naloxone have also contributed to rising prices for this drug. Ensuring affordable access to naloxone should continue to be a priority.

Access to Medication-Assisted Treatment (MAT) is also an integral component of responding to substance use disorder and starting patients on a path to rehabilitation. ACEP supports the expansion of MAT, including the increasing of the caps on how many patients may be treated by physicians and physician-led provider teams who are appropriately trained to dispense narcotics for maintenance and detoxification.

ACEP also supports partial filling of Schedule II controlled substances at the request of the prescriber or patient. We urge the Committee to ensure that patients are not burdened by financial disincentives (e.g., additional copays) for requesting partial fills.

4) **Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?**

In addition to potential changes to these programs, there are a number of ongoing efforts that can help inform the Committee's work. For example, ACEP supported provisions in the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198) that created pharmacy/physician "lock in" programs that also ensured appropriate access to needed medications for beneficiaries receiving emergency medical care. ACEP also largely supports the recent draft 2019 Contract Year rule for the Medicare Advantage Program and the Part D Prescription Benefit Program framework for Part D plan sponsors to voluntarily adopt drug management programs through which they can address potential overutilization of frequently abused drugs by identifying potential at-risk beneficiaries, conducting case management, and, if necessary, limiting access to coverage for such drugs through pharmacy or prescriber lock-in, as well as beneficiary-specific point-of-sale claim edit.

Any proposals should uphold the requirements of CARA to first conduct case management, including clinical contact, before coverage of any frequently abused drugs can be restricted. This can help ensure that

any eventual limitations are clinically appropriate and that beneficiaries can be ensured sufficient notice that coverage may be restricted.

5) How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

Emergency physicians are well-educated and trained in treating pain, including prescribing of opioids. ACEP supports voluntary efforts by physicians to complete continuing medical education (CME) regarding opioid prescribing. We urge caution in considering the addition of new federal requirements for mandatory CME on opioid prescribing, given the potential for significant overlap with existing requirements already imposed on physicians by their state or specialty board, as well as additional administrative burden.

High prescribing patterns are not by themselves an indicator of inappropriate prescribing patterns, and care should be taken to analyze health professionals based upon factors that reflect their specialty, the care provided, and the patient population they treat. Solutions should avoid a "one-size-fits-all" approach.

Prescribers should be notified on a regular basis on how their prescribing patterns compare to their peers in the same specialty, geographic region, and even, where possible, facility size or type. Using existing available data within these programs, priority should be placed on identifying outliers using statistically sound and relevant methods. Notifications should be frequent enough to ensure prescribers have an accurate picture of their prescribing patterns, but not so frequent that they become burdensome or ineffective. We would suggest quarterly notifications as a starting point. These efforts can also be informed by threshold reporting that already occurs at the state level.

6) What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?

ACEP supports effective, interoperable, and voluntary state prescription drug monitoring programs (PDMPs) that push prescription data to emergency department providers, rather than requiring them to separately sign into and pull the data from the PDMP. PDMP use can and should be seamlessly integrated into physician workflows, and to encourage greater adoption of these technologies, electronic health record (EHRs) products should be required to provide such capability before they are certified. Ideally, PDMP data should be available in real time to identify any potential patient risks and help inform the physician's clinical prescribing decisions.

Due to the current limitations and widely varying capabilities of state PDMPs, we caution against mandated use of these programs. This is due in part to limited optimization of and standardization between programs, and the lack of a mechanism to allow effective interstate communication. To help address some of the existing limitations of data sharing and coordination between PDMPs, Congress reauthorized the National All Schedules Prescription Electronic Reporting Act (NASPER) as part of CARA, and authorized additional funding through 2021. We urge Congress to ensure stable and adequate funding to promote the continued improvement of these programs. To the extent possible, Congress should incentivize the development of interstate, frequently updated, multiple-drug-schedule, easily accessible, and widely used PDMPs.

7) What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

Identifying at-risk patients is the first step in addressing the opioid epidemic. We urge the Committee to consider the successful and innovative programs that have been developed at the state and local levels to identify at-risk patients and help decrease opioid prescribing and use. Such initiatives include the state Emergency Department Information Exchange (EDIE) currently operating in more than a dozen states,

including Washington, Oregon, and California. EDIE is an automated tool that is directly integrated with a state's PDMP to improve care coordination. For example, in Washington, when a patient registers in an EDIE-connected emergency department, EDIE processes a patient-specific history and identifies any potential risk patterns, and within seconds automatically pushes this to information to the provider in an easily-digestible format. This ensures that relevant information is available to the provider the moment they need it, allowing them to make the most informed clinical decision about a patient's care.

EDIE looks for high utilizers – identified as individuals who present in the emergency department more than five times a year. Many of these patients have a concomitant mental health disorder, and many also have a substance use disorder or history of substance use disorder. These patients are primarily Medicaid beneficiaries, but similar patterns appear in other insured populations as well.

8) What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

ACEP supports the expanded use of drug treatment courts that balance supervision, support, and encouragement as an alternative to criminal incarceration. Incarceration will not solve the opioid epidemic and does not prevent or mitigate the impacts of substance use disorders on children, families, and communities. Treatment is necessary to put patients on a path toward recovery and rehabilitation.

ACEP also supports expanding the number of disposal sites for unwanted prescription medications and drug take-back programs. These programs are an essential part of an effective approach to reducing the abuse of controlled substances. Drug take-back programs should be available at no cost to patients, and there should be no legal sanctions against those who turn in unused controlled substances.