February 16, 2018

[Submitted electronically via opioids@finance.senate.gov]
The Honorable Orrin G. Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden:

ASHP (American Society of Health-System Pharmacists) thanks you for the opportunity to offer policy recommendations for identifying, preventing, and treating substance use and opioid use disorders. ASHP represents pharmacists who serve as patient care providers in acute and ambulatory settings. The organization's 45,000 members include pharmacists, student pharmacists, and pharmacy technicians. For more than 75 years, ASHP has been at the forefront of efforts to improve medication use and enhance patient safety.

ASHP shares the committee's commitment to combating the nation's opioid overdose and misuse epidemic. We believe that pharmacists, as the medication experts on the interprofessional healthcare team, play an essential leadership role in opioid and substance misuse prevention, education, and assistance. There are many patient care areas throughout hospitals and health systems that use opioids for pain and/or sedation needs. Such areas include, but are not limited to, the emergency department, intensive care units, oncology units, operating rooms, and recovery suites. Pharmacists practicing in these areas have been shown to have significant impact on patient care and improving patient care and outcomes. These pharmacists rely heavily on electronic tools to share patient data and to document interventions. One of these tools, specifically designed for opioids and controlled substances, is the prescription drug monitoring program (PDMP). ASHP has long prioritized efforts to address this public health crisis, engaging at the state level to strengthen PDMPs and at the federal level to increase funding for treatment and prevention initiatives.

Below, we offer our responses to the questions you posed in your February 2, 2018, letter:

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 OUDs or other SUDs?

When clinically appropriate, pain should be treated with non-opioid therapies. Medicare and Medicaid should cover both non-opioid and non-pharmacological treatments. For instance, in the hospital inpatient setting, treatment options would include intravenous (IV) acetaminophen or IV nonsteroidal anti-inflammatory drugs (NSAIDs). In all settings, federal payers should cover non-pharmacological treatments, including acupuncture, massage therapy, physical therapy, and ICE/cold therapy machines. Particularly for low-income patients, Medicare and Medicaid should consider methods to minimize any differential in out-of-pocket costs for opioids and alternative therapies to ensure patient access and uptake. While research does indicate that these treatments may reduce pain as effectively as opioids and without the associated health risks, additional research into alternative pain treatment modalities is needed.

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

Perhaps the two largest barriers to non-pharmaceutical therapies for chronic pain are 1) inconsistent coverage of the benefits under Medicaid and Medicare and 2) a general lack of awareness among both Medicare and Medicaid enrollees of the existence and availability of alternative therapies. Although most Medicaid programs cover at least one non-opioid treatment (i.e., physical therapy, occupational therapy, cognitive behavioral therapy, and chiropractic services), coverage of other alternative therapies (e.g., massage, acupuncture, etc.) is less common. Medicare Part B does not currently cover massage therapy or acupuncture and covers chiropractic services only in certain instances. Without supplemental insurance, Medicare beneficiaries pursuing these alternative treatments in lieu of an opioid regimen must cover the costs on their own.

Many of the Medicaid programs designed to promote non-pharmacologic therapies are in their infancy[1], and more provider and beneficiary education is needed to promote awareness and uptake. Furthermore, as programs roll out, their success will be heavily dependent on whether they are both financially and logistically feasible for patients. Unlike medication, alternative therapies will require beneficiaries to take time out of their day for treatment and may require travel to new sites of care. If therapies are co-located with existing services or if transportation support is offered, time and cost are less likely to become barriers to uptake.

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?

ASHP has consistently urged the U.S. Department of Health & Human Services and its agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), to better utilize pharmacists' services for pain management and SUD and OUD treatment. Studies have documented the positive impact of pharmacists in treating pain and mental health disorders, including substance abuse.[2] Despite this evidence, pharmacists are neither eligible to participate in Medicare Part B, nor are they required providers within accountable care organizations (ACOs). They are also currently ineligible for Drug Addiction Treatment Act (DATA) waivers required to provide medication-assisted treatment (MAT) for OUD. These statutory and regulatory barriers make it extremely difficult for pharmacists to fully integrate into certain practices, including SUD and OUD treatment. It has been reported by physicians, especially primary care providers, that gaining access to pain management or SUD and OUD treatment specialists is often difficult. Incorporating pharmacists, who are often underutilized as medication experts,

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1 *See* Hannah Dorr, Charles Townley, *Chronic Pain Management Therapies in Medicaid: Policy Considerations for Non-Pharmacological Alternatives to Opioids*, National Academy for State Health Policy (August 2016), *available at* https://nashp.org/wp-content/uploads/2016/09/Pain-Brief.pdf.

2 *See* A.B. Adolphe *et al*., *Provision of Pain Management by a Pharmacist with Prescribing Authori*ty, 64 Am. J. Health-Sys. Pharm. 85-9 (2007); *see also* P.R. Finley *et al*., *Impact of a Collaborative Pharmacy Practice Model on the Treatment of Depression in Primary Care*, 59 Am. J. Health-Sys. Pharm. 1518-26 (2002).

increases their ability to optimize opioid therapy and minimize risks for abuse by patients. Engaging pharmacists effectively, potentially through collaborative practice agreements, and telehealth treatment options, would give Medicare and Medicaid new resources to increase patient access and reduce OUD and SUD treatment gaps. ASHP recommends that Congress enact S. 109, the "Pharmacy and Medically Underserved Areas Enhancement Act," which would recognize pharmacists as providers under Part B of the Medicare program. This would help remove current barriers to increasing access to the pain management services of pharmacists.

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?

Payers, including a number of states, have begun to implement rules limiting initial opioid prescriptions for acute pain episodes to a maximum number of days. Medicare has recently proposed implementing a limit for Part D plans beginning in 2019[3]. CMS, with the input of physicians, nurses, pharmacists, and other patient care providers, should assess the risks and benefits to patient care of imposing limits on the maximum number of days. Regardless of whether these types of limits are imposed, pharmacists, in collaboration with the patient's physician and other members of the interprofessional team, are critical in transitioning patients to non-opioid treatment and/or may educate patients regarding potential warning signs of addiction. For chronic pain patients, there should be routine monitoring on a monthly basis to assess whether dosage adjustments are needed.

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

A national interoperable, real-time PDMP would significantly improve the ability of Medicare and Medicaid to recognize and address problematic prescribing and dispensing patterns. A robust PDMP would allow prescribers and pharmacists to track patient-specific opioid use to prevent overprescribing and potential misuse at the point of prescribing. Additionally, better use of existing systems could also have a positive impact on overprescribing. Further, a national PDMP would give Medicare and Medicaid a window into national prescribing trends, allowing it to identify and target problems more precisely, while controlling for practices that are inherently opioid heavy, such as oncology and palliative care. We recommend that Medicare and Medicaid evaluate initiatives to enhance existing PDMPs and to improve current use of PDMPs by both prescribers and dispensers.

6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as PDMPs?

To improve clinical data sharing among a patient's clinicians, ASHP recommends that patients receiving opioids have a tailored pain plan that is transmitted electronically through electronic health records and the PDMP. Pain plans should include a needs assessment for an opioid; the optimal agent, dosing, frequency, and amount upon

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[3] *See* U.S. Centers for Medicare & Medicaid Services (CMS), *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter* (February 2018), *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2019Part2.pdf

discharge; and a plan to discontinue the drug, taper the drug, or switch to a non-opioid drug. In addition, pain plans should include a risk assessment that indicates if the patient has risk factors for SUD or OUD and/or if the patient needs naloxone.

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?

In terms of clinical practice, ASHP recommends that Medicare and Medicaid review and consider current best practices from the Veterans Affairs (VA) system and Kaiser Permanente (KP). VA and KP have recognized the importance of engaging the pharmacist in pain management and have integrated pharmacists into OUD and SUD treatment. Specifically, KP and the VA have provided pharmacists with prescribing privileges through collaborative practice agreements and MAT protocols. These two health systems are examples of early adopters and have had experience with pain management models utilizing pharmacists for the last two to five years. Many other health systems have also implemented effective pain management strategies.

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?

SAMHSA's 2015 National Survey on Drug Use and Health found that the "majority of abused prescription drugs were obtained from family and friends, often from the home medicine cabinet."[4] Thus, improved education and awareness about the proper disposal of opioids and other prescription drugs may help curtail SUD and OUD. We encourage investment in and expansion of programs such as Up and Away[5], a federal partnership program, to assist patients in disposing of or safely storing medications. Additionally, increasing the number of Drug Enforcement Administration Drug Take Back Days and other similar events could keep unused prescription medications off the streets.[6]

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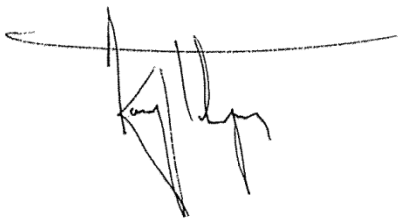
4 *See* Center for Behavioral Health Statistics and Quality, *2015 National Survey on Drug Use and Health: Detailed Tables* (September 2016), Substance Abuse and Mental Health Services Administration, Rockville, MD, *available at* https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf

5 http://www.upandaway.org/

6 The October 2017 National Take Back Day collected 912,305 pounds (456 tons) of prescription drugs at 5,321 sites across the United States. Details available at https://takebackday.dea.gov/sites/default/files/NTBI_XIV_Totals-Oct2017.pdf

Again, ASHP thanks the committee for the opportunity to provide our policy recommendations. As the committee continues its work, we encourage you to view ASHP as a resource on this critical issue. Please contact me with any questions, or have a member of your team contact Christopher Topoleski, Director of Federal Legislative Affairs, at 301-664-8806 or at ctopoleski@ashp.org.

Sincerely,



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