Society of Hospital Medicine

Empowering hospitalists.
Transforming patient care.

1500 Spring Garden Street
Suite 501 • Philadelphia, PA 19130
P: 800.843.3360 • F: 267.702.2690
www.hospitalmedicine.org

February 16, 2018

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

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

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the nation's hospitalists, the Society of Hospital Medicine (SHM) welcomes the opportunity to provide input to the Senate Committee on Finance on its approach to confronting the on-going opioid epidemic. This is a complex issue that requires interventions on multiple fronts. We applaud the Committee's efforts and attention to this urgent crisis.

Hospitalists are front-line healthcare providers in America's hospitals, caring for millions of hospitalized patients each year, including more than half of all hospitalized Medicare beneficiaries. As leaders of an interdisciplinary care team, they manage the inpatient medical needs of patients, including addressing their acute and chronic pain during the hospital stay and at discharge.

As part of our approach to addressing the opioid epidemic, SHM recently convened a workgroup of clinician experts to craft a consensus guidance statement on opioid prescribing during acute hospitalizations. This statement [to be published in the *Journal of Hospital Medicine*; embargoed until April 5, 2018] includes recommendations on when to prescribe opioids in the hospital and how to improve the safety of opioid prescribing during hospitalization and discharge. We believe these recommendations are useful steps for clinicians to implement in their practices as part of a comprehensive strategy for safe opioid prescribing.

We also believe there may be opportunities for policy changes in both the Medicare and Medicaid programs around opioid prescribing and access to opioid use disorder (OUD) treatment. We make several suggestions below for consideration, but note these are not mutually exclusive.

Prescription Drug Monitoring Programs

As of 2017, every state has some form of a Prescription Drug Monitoring Program (PDMP) (Missouri does not have a state-wide PDMP). Currently, there is no consistent data sharing across states, although a few states participate in a data-sharing hub. The ability to see nationwide data on opioid prescribing by patient would enable clinicians to

detect potential patterns of abuse and encourage patients to seek treatment. Legislation could establish or support efforts to develop a national PDMP or a national information sharing exchange.

The Committee could also explore requiring integration of PDMPs within electronic health records (EHRs). By having a second, separate login for providers, accessing PDMPs can be cumbersome and disruptive to provider workflow. By encouraging integration directly within EHRs, providers could seamlessly reconcile a patient's opioid prescription history with current medications and health needs.

Expanding Telehealth

We believe there are opportunities for screening, diagnosis and treatment for OUD through telehealth. One of the promises of telehealth is to improve access to healthcare services. Medicare currently has a narrowly defined field of telehealth, targeted on rural areas. We encourage the Committee to consider removing some of these restrictions to telehealth services, such as originating site and place of service restrictions and requirements for synchronous communication with an audio-visual interface, which would enable email and telephone-based encounters.

The Committee could also allow and increase reimbursement for telehealth mental health counseling, which would help address both the opioid and mental health crises.

Expand Access to Non-Opioid Treatment for Pain

One of the largest barriers for providers to discuss and implement non-opioid treatment is a lack of time and reimbursement. These discussions can be long, involve patients and their caregivers, and require educating patients about pain management and reasonable expectations for treatment. We strongly encourage increasing reimbursement for evaluation and management (E/M) codes and consultation codes, particularly to prioritize these discussions. Increasing reimbursement allows providers to create more time within their workday and signals the importance of shared decision making in the context of pain management. We also encourage the Committee to consider whether the non-opioid treatments, such as non-opioid medications, physical therapy, cognitive behavioral therapy, and transcutaneous electrical nerve stimulation (TENS) are adequately reimbursed and covered by Medicare and Medicaid. We also encourage the Committee to explore access for alternative and complementary services, such as massage or acupuncture, that may be beneficial for pain management.

Another lever for consideration is harmonizing quality measures and other federal performance assessment programs with the goal of expanded non-opioid treatment for pain. This may involve further adjustments to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) questions around pain management and ensuring that other measures throughout federal programs do not unintentionally encourage opioid prescribing.

Provider Education and Training

As evidenced by our opioid prescribing guidance statement, we believe providers can make changes to their practice to ensure judicious and safe use of opioids. Education and training is a critical element for culture change. As CMS has expansive reach, there are opportunities for the agency to drive and to support states in providing education about safe opioid prescribing and detecting and treating OUDs. Similar education requirements could also be placed on providers contracted with Medicare Advantage and Medicaid managed care plans. Some states

may already have educational requirements around opioid prescribing and OUD. The federal government may be able to bolster these efforts and encourage states without existing programs to prioritize education in this important clinical area.

Expanding Access to Buprenorphine

Buprenorphine is a partial opioid agonist that can be used to treat opioid addiction. It is an important tool in combatting OUDs, particularly when combined with counseling or behavioral therapy. To prescribe buprenorphine, physicians must submit to the requirements of the Drug Addiction Treatment Act of 2000, including applying for a waiver. We encourage the Committee to revisit the waiver requirements and deregulate prescribing or further streamline the process by which providers receive permission to prescribe buprenorphine. This should be coupled with increased education and training for providers in detecting and treating OUD.

Expanding Coverage for OUD Treatment and Mental Health Services

One significant barrier that patients face in seeking and sustaining treatment for OUD is lack of financial resources and healthcare coverage. This includes coverage for OUD treatment itself, and for mental health care which may be a concurrent or contributing factor in addiction. Some recent legislation, such as the 21st Century Cures Act, sought to address some of these challenges, but we urge the committee to include further coverage expansion as part of their solution. Coverage in this case means both that a health plan allows a patient to seek these services and that providers are adequately reimbursed. The Affordable Care Act essential health benefits requires exchange plans to cover these services. We encourage Medicare Advantage and Part D plans to have similar requirements.

We also encourage the Committee to reconsider the appropriateness of the 190-day lifetime limit on Medicare inpatient psychiatric hospitalizations. We would support a longer lifetime limit or the elimination of limits to remove barriers to care, including high financial liabilities for patients and families, caused by the existing policy.

Conclusion

SHM commends the Senate Committee on Finance for its leadership in addressing the opioid crisis facing the country. We believe thoughtful policy interventions in both the Medicare and Medicaid programs can be useful tools to help address the pressing needs of preventing and treating OUD.

Sincerely,

Ron Greeno, MD, FCCP, MHM
President, Society of Hospital Medicine