Society of Hospital Medicine

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March 15, 2018

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

The Honorable Peter Roskam
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady, Chairman Roskam, Ranking Member Neal, and Ranking Member Levin:

On behalf of our more than 16,000 hospitalist members, the Society of Hospital Medicine (SHM) welcomes the opportunity to provide input to the House Ways and Means Committee and the Committee's Subcommittee on Health on their approach to confronting the on-going opioid epidemic. This is a complex issue that requires interventions on multiple fronts. We applaud the Committee's and the Subcommittee'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 for providers 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, if implemented by clinicians in their practices, would be useful as part of a comprehensive strategy for safe opioid prescribing.

We also believe there may be opportunities for policy changes in the Medicare program 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.

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Overprescribing/Data Tracking

Prescription Drug Monitoring Program (PDMP)

As of 2017, every state has some form of a Prescription Drug Monitoring Program (PDMP), and while some states participate in a data-sharing hub, there is no consistent data sharing process across state lines. 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, thus ensuring more timely, accurate and actionable information is available to providers.

The Committee could also explore requiring integration of PDMPs within electronic health records (EHRs). Providers currently have two separate logins for EHR and for PDMP, which makes accessing PDMPs 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 healthcare needs.

Communication and Education

Beneficiary Notification

Discharge from the hospital is a crucial period for beneficiary education and notification. When a patient is discharged with a prescription for opioids, providers have an opportunity to provide both written and verbal education about the medication, its side effects, and how to appropriately use and store it. Discussions about expectations for pain management and different approaches for controlling pain can be lengthy and complicated. This scope and breadth of counseling may not be adequately reflected in the current Evaluation and Management (E/M) reimbursement schedule. The Committee should explore opportunities to bolster the discharge process by increasing reimbursement for discharge planning and discharge E/M codes and the expectations for what must occur at discharge. Relatedly, we note that CMS had considered changes to the Medicare Conditions of Participation for discharge planning in 2015-2016 (CMS-3317-P), but has not finalized any changes to regulations.

Prescriber Notification and Education

Education and training is a critical element to cultural change. As CMS has expansive reach, there are opportunities for the agency to support states in providing education about safe opioid prescribing, as well as detecting and treating OUDs. Similar education requirements could also be placed on providers contracted with Medicare Advantage and Medicaid managed care plans.

Professional societies, such as the Society of Hospital Medicine, are uniquely positioned to provide educational opportunities for healthcare providers. We encourage the Committee to consider how partnerships between the federal government and specialty societies could be leveraged to share resources and information on opioid prescribing and its impacts. We also believe specialty societies can take leadership roles in addressing the culture of prescribing and use of opioids. Our recent opioid prescribing guidance statement advocates for changes to hospitalist practice to ensure judicious and safe use of opioids. The Committee could encourage similar clinical guidelines and the harmonization of these efforts across specialties.

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Treatment

Expanding Telehealth

We believe there are opportunities for screening, diagnosis and treatment for OUD through telehealth services. One of the promises of telehealth is to improve access to healthcare services, particularly in underserved and rural areas. Medicare currently has a narrowly defined field of telehealth, targeted on rural areas. We encourage the Committee to consider removing some of these restrictions on 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 allow and increase reimbursement for telehealth mental health screening, diagnosis, and treatment including counseling, which would help address both the opioid and mental health crises.

Expanding Access to Non-Opioid Treatment for Pain

One of the largest barriers providers face in discussing and implementing non-opioid treatment, is a lack of time and reimbursement. These discussions can be long, involve multiple parties, including 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, to reinforce the prioritization of 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.

The Committee should also consider whether non-opioid treatments, such as non-opioid medications, physical therapy, cognitive behavioral therapy, transcutaneous electrical nerve stimulation (TENS), mindfulness-based stress reduction programs, and multidisciplinary pain management programs which emphasize non-opioid management of chronic pain are adequately reimbursed and covered by Medicare. Medicare coverage and reimbursement for alternative and complementary services, such as massage or acupuncture, that may be beneficial for pain management, should also be explored.

Another lever for consideration is the potential to harmonize quality measures and other federal assessments with the goal of expanding non-opioid treatment for pain. In 2016-2017, CMS enacted changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) questions over concerns we and other healthcare stakeholders raised about the potential for pain assessment questions to inadvertently encourage opioid prescribing. The HCAHPS pain management questions may require further study and adjustments, as we gain a greater understanding of how measures can drive prescribing behavior. Other measures throughout federal programs should also be reviewed to ensure they do not unintentionally encourage unnecessary prescribing.

Expanding Access to Buprenorphine

Buprenorphine is a partial opioid agonist that can be used to treat opioid addiction. It is an important tool, particularly when combined with counseling or behavioral therapy, in combatting OUDs. 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

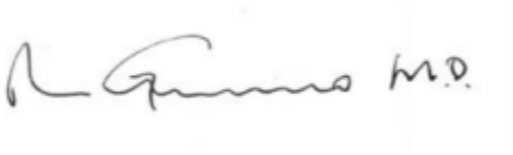
One significant barrier that patients face in seeking and sustaining treatment for OUD is a lack of financial resources and healthcare coverage. This includes coverage for OUD treatment itself, and for mental health care which may be a concurrent or contributing factor to opioid addiction. Recent legislation, such as the 21st Century Cures Act, sought to address some of these challenges, but we urge the committee to include further coverage expansion, including coverage for Medication-Assisted Treatment (MAT), as part of their solutions. 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's 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 Ways and Means Committee and its Subcommittee on Health for providing leadership in addressing the opioid crisis facing the country. We believe thoughtful policy interventions in the Medicare program 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