Oregon Association of Hospitals and Health Systems

February 15, 2018

The Honorable Orrin Hatch
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden,

The Oregon Association of Hospitals and Health Systems (OAHHS) appreciates the opportunity to respond to your questions about strategies for addressing the opioid epidemic. OAHHS is a statewide, nonprofit trade association representing all 62 acute care hospitals in Oregon.

Oregon has one of the highest rates of prescription opioid misuse in the nation according to the Oregon Health Authority; more drug poisoning deaths involve prescription opioids than any other type of drug, including alcohol, methamphetamines, heroin and cocaine. An average of three Oregonians dies every week from prescription opioid overdose, and many more develop opioid use disorder. Based on these facts and others, Governor Brown has rightfully declared substance abuse a public health crisis in Oregon. Below you will find our responses to your questions based on our hospitals' experiences with this ongoing public health crisis.

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 OUD or other SUDs?

We believe a best practice is to ensure that naloxone is a covered drug for Medicare and Medicaid recipients. A beneficiary should not have to see a health care provider for prior authorization or for a prescription. Ensuring Medicare and Medicaid benefits pay for naloxone will minimize deaths and empower people to help combat opioid misuse.

Second, the chronic care legislation included in the Bipartisan Budget Act of 2018 should present new opportunities to incorporate protocols that help minimize chronic pain while avoiding the risk of opioid abuse. For example, the bill calls for expanded benefits for Medicare Advantage enrollees – these could include measures that add pain management techniques that minimize the risk of opioid abuse. In general, CMS should incorporate awareness of potential opioid abuse into rules implementing this section of the budget legislation.

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?

Through implementing the chronic care provisions of the Bipartisan Budget Act of 2018, CMS should incorporate non-pharmaceutical therapies for payment for chronic pain, with a priority on those that have been shown to be effective. In general, Medicare and Medicaid should assess the adequacy of provider reimbursement for providing effective non-pharmaceutical therapies for chronic care pain, and potentially expand incentives in place today.

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

Providers in Oregon hospitals are approaching and treating pain management through more therapies than just prescriptions alone. With the next generation of prescribers beginning their education and/or careers, the federal government has the opportunity to evolve how health care practitioners learn and treat pain which may or may not include prescriptions. The paradigm of pain management needs to evolve and that could be best achieved through guidelines and training first. However, payment policies should also align to encourage evidence-based prevention, screening assessment and treatment. In addition, CMS should provide incentives for flow of information to and between providers to have the right information at the right time to reduce the opportunities for overuse of pharmaceutical therapies, supporting the efforts in this respect already underway in Oregon.

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?

The CDC stated that the likelihood of long-term opioid prescription drug use increases sharply after the third and fifth days of taking a prescription, and spikes again after the 31st day. According to the National Conference of State Legislatures, 17 states enacted limits on opioid prescription drugs, ranging from three days to two weeks, with seven days being the most common. Other states have legislation to authorize other entities to set prescribing limits of guidelines. With the probability of opioid abuse increasing as the numbers of pills for a prescription of opioids increases Medicare and Medicaid should encourage all providers to limit a patient's first opioid prescription to no more than 7 days while allowing for certain exceptions.

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

OAHHS supports expansion of the Oregon-based Prescription Drug Monitoring Program (PDMP) and its interface with Oregon's Emergency Department Information Exchange (EDIE). Using this

model, Medicare and Medicaid can provide incentives for providers as well as remove potential barriers for sharing information to better inform providers to have the right information at the time of care. In Oregon, OAHHS has developed a program to support rural Oregon hospitals in development of their Electronic Health Record (EHR) technology to allow for integration with EDIE and PDMP. The intent of the program is to transition hospitals from paper-based workflows and to integrated, electronic connections to EDIE and/or PDMP with their EHRs so that there is rapid access to patient information within normal workflows. Having access to the right information at the point of care is critical to reducing emergency department utilization and providing better patient assistance in managing prescriptions.

Thank you for your time and attention to this important issue not only facing Oregonians but the nation. We welcome any additional input or questions you have that we can help with.

Sincerely,

Sean Kolmer
Senior Vice President of Policy and Strategy

Oregon Association of Hospitals and Health Systems