February 16, 2018

The Honorable Orrin G. Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
United States Senate Committee on Finance
Washington, DC 20510-6200

RE: AANP Comments on Addressing the Opioid Epidemic.

Dear Chairman Hatch and Ranking Member Wyden:

The American Association of Nurse Practitioners (AANP) is the largest full-service national professional membership organization for nurse practitioners (NPs), which represents the more than 234,000 nurse practitioners across the country. We thank you for the opportunity to comment and look forward to working with the Senate Committee on Finance (the Committee) to combat the opioid epidemic.

As you may know, nurse practitioners are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment, ordering, performing, supervising and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment including prescribing medication (as well as non-pharmacologic treatments), coordination of care, counseling, and educating patients and their families and communities. They practice in nearly every health care setting including clinics, hospitals, VA and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health.

Nurse Practitioners (NPs) are educated in pharmacologic, pathophysiologic, psychologic and sociologic aspects of pain treatment that includes the diagnosis and treatment of patients with addictive diseases including those acquired from overdosing with opioids and other schedule drugs. The pharmacodynamics, therapeutics and management of controlled drugs including opioids is a part of both baccalaureate nursing education and graduate advanced practice nursing education. NPs hold prescriptive authority in all 50 states and the District of Columbia and have been providing high quality health care to patients for over half a century. With the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, nurse practitioners were authorized to prescribe medication-assisted treatment (MAT) after taking the necessary training and obtaining the required DEA waiver to do so. In that legislation, AANP was explicitly named as a provider of the MAT waiver training.

In this request for comment, the Committee asked for responses to eight questions. Our responses to five of those questions are below, and we look forward to continuing to work with the Committee to combat the opioid epidemic.

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 OUD or other SUDs?

As noted by the President's Commission on Combating Drug Addiction and the Opioid Crisis, Medicare and Medicaid reimbursement for substance abuse treatment services is lower than for other services. This has led to a shortage of qualified behavioral health and substance abuse providers.[1] Primary care providers face the same reimbursement issue; this is exacerbated for NPs who are only reimbursed at 85% of the physician fee schedule. It is critical that authorized providers fighting this opioid epidemic are reimbursed at a rate that allows them to accept Medicare and Medicaid patients. Current rates serve as a disincentive for new providers to enter those fields, and inhibit the ability of current providers to expand their practices and increase patient access to care. The Committee should consider increasing payment rates for qualified substance abuse providers and primary care providers in the Medicare and Medicaid programs.

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?

Currently, many non-pharmaceutical therapies for chronic pain are not covered by the Medicare and Medicaid programs. Treatments such as acupuncture and therapeutic massage should be available for patients who would like to seek non-opioid treatments for their chronic pain, but without Medicare or Medicaid coverage they cannot afford to obtain these treatments. The Committee can provide funding for these treatments by authorizing new benefits in the Medicare and Medicaid programs, or through funding demonstration models that utilize these treatments for patients with chronic pain or who are at risk for opioid abuse. Any new benefits or demonstration models should be inclusive of all qualified providers, including nurse practitioners.

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?

Medication-Assisted Treatment: MAT has been proven to be an important component of any treatment regimen and has been proven to decrease opioid use, opioid related deaths, criminal activity and infectious disease transmission.[2] As previously mentioned, with the passage of CARA in 2016, NPs were authorized to provide MAT after taking the necessary training and obtaining a DEA waiver. Since CARA passed, AANP has provided MAT training to over 4,500 NPs and the DEA has reported that almost 5,000 NPs and PAs have obtained a MAT waiver. This demonstrates that NPs are committed to using MAT to assist their patients suffering from opioid abuse, and granting NPs the authority to obtain MAT waivers has been a success. However, CARA only authorized NPs and PAs to obtain these waivers for a period of five years.

[1] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf, page 70.
[2] https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction.

It is critical that the Committee act to make this authorization permanent so that NPs and PAs are able to continue the fight against the opioid epidemic and work to prevent future epidemics. Current bills in both the Senate and House (S. 2317 and H.R. 3692), the Addiction Treatment Access Improvement Act of 2017/2018[3], would make this authorization permanent.

Additionally, while CARA removed barriers for NPs to provide MAT to their patients, in states that require collaborative or supervisory agreements with physicians, the NP must have an agreement with a physician who also has a MAT waiver for the NP to provide MAT. This has proven to be a significant barrier, especially in rural and underserved areas, because very few physicians have obtained MAT waivers. NPs in these states, many of which are the most impacted by the opioid epidemic, have reported that despite going through the training and obtaining a MAT waiver they are still unable to provide MAT because they cannot locate a physician who also has a MAT waiver. The Committee should recommend revising this requirement so that NPs who have completed the training and obtained their waiver can provide this medically necessary treatment without having to also locate a physician who has obtained the waiver.

Home Health: Barriers also continue to exist within the Medicare and Medicaid programs that inhibit an NPs ability to provide the most timely care to their patients. Delays in care can be detrimental to patients at-risk of or suffering from opioid or substance abuse, and removing these barriers will improve access to the high-quality timely care that these patients require. Currently, NPs with patients who need home health care services must locate a physician who will document the nurse practitioner's assessment and provide a plan of care. Further, while NPs are authorized to perform a required face-to-face assessment of the patient's needs, the Affordable Care Act also requires that a physician document that the encounter has taken place. For patients in need of MAT this delay can lead to severe consequences. Patients suffering from substance abuse have complex needs and qualified providers need to be able to adapt quickly to provide treatment and drug diversion. Under the current system NPs need to locate a physician to order home health services and certify any deviations in the plan of care. This delays treatment and jeopardizes patient health. Current bills in both the Senate and House (S. 445 and H.R. 1825), the Home Health Care Planning Improvement Act of 2017[4], would remove these barriers for NPs and their patients.

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

Provider Education: AANP is a strong advocate for provider education. Since 2013 the organization has educated more than 24,000 nurse practitioners on the safe prescribing of opioids for pain management, which includes the CDC guidelines. To aid in the fight against the disease of addiction, AANP is a partner with the Collaborative on REMS Education (CO*RE), 11 interdisciplinary organizations working together to improve pain management and prevent adverse outcomes. AANP has collaborated with the American Society of Addiction Medicine (ASAM) to provide the required 24-hour education/training described in CARA authorizing NPs to prescribe buprenorphine and other medications for the treatment of Opioid Use Disorder (OUD). To date, AANP has provided this training to over 4,500 nurse practitioners.

[3] https://www.congress.gov/115/bills/s2317/BILLS-115s2317is.pdf; https://www.congress.gov/115/bills/hr3692/BILLS-115hr3692ih.pdf.
[4] https://www.congress.gov/115/bills/s445/BILLS-115s445is.pdf; https://www.congress.gov/115/bills/hr1825/BILLS-115hr1825ih.pdf.

AANP works closely with the Substance Abuse and Mental Health Services Administration (SAMHSA). In May 2016 AANP joined other state and national organizations as members of the Coalition to Stop Opioid Overdose, a coalition dedicated to advancing legislation and regulatory policies to address the opioid public health crisis. AANP has worked closely with the U.S. Surgeon General to discuss best practices in addressing the opioid epidemic and is currently participating in a grant from the National Institute on Drug Abuse to create and provide education on adolescent substance abuse.

In addition to working and collaborating with other organizations, AANP has provided many and varied resources to both members and nonmembers of our organization, totaling a reach of over 234,000 NPs, related to the safe treatment of pain and substance use disorder. The organization has focused on safe opioid prescribing and pain management by offering courses, workshops and seminars at all three of our annual conferences. Additionally, AANP has provided resources such as live webinars addressing the opioid epidemic, continuing education activities and online courses, including the 24-hour waiver course for NPs to prescribe Buprenorphine and other medications for opioid use disorders.

It is important that any content and educational requirements are consistent for all qualified providers, regardless of licensure. Collaboration with key stakeholders at the local, state and federal levels is important for developing consistency among educational programs to reduce duplication or conflicting requirements. The Committee should ensure that educational requirements can be met at no cost to the provider to lessen provider burden and promote widespread adoption of educational opportunities. It is essential that the Committee work with all stakeholders to develop adaptive learning options that allow providers to demonstrate existing knowledge and focus on areas where they have less knowledge or experience.

Prescribing Guidelines: Developing standardized prescribing guidelines can also be an effective way to educate qualified providers and improve prescribing patterns. When assessing the benefits and risk of opioids the Committee must consider how guidelines can be adapted for individual responses to pain and the varying pain thresholds that patients have. While abuse and misuse are very serious concerns, there is also the concern that guidelines that are too strict may prevent a non-abusing patient who needs opioid pain management from obtaining medically necessary medication. Clinicians who provide pain management to patients, including nurse practitioners, should be included in the development of any guidelines to strike this balance.

Guidelines should include considerations of opioid selection and adverse reaction, periodic review and monitoring of patients through screening tools such as SBIRT (Screening, Brief Intervention, and Referral to Treatment) and consultation with prescription-drug monitoring programs prior to prescribing. These recommendations should also include exceptions for certain chronic pain sufferers such as hospice patients and patients with cancer pain.

Prescribing guidelines should also include patient self-management and non-pharmacologic treatments of pain. As we have noted, many qualified providers have difficulty prescribing non-pharmacologic pain treatments due to a lack of available options. Since many insurers base their coverage criteria on FDA policies, incorporating alternatives to opioids such as acupuncture and therapeutic massage in prescription recommendations will help increase their availability.

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?

We cannot stress enough the importance of including all qualified providers and removing barriers that inhibit a provider's ability to provide the best care to their patients. The opioid epidemic requires an all hands-on deck response, and as the Committee develops legislation to combat the opioid epidemic it is important that the legislation is inclusive of all qualified providers, including nurse practitioners.

The Committee should continue funding public awareness campaigns focused on the scope of the opioid epidemic and the risk of taking opioids. Part of this campaign should involve educating the public on alternative pain management options. We also encourage the Committee to continue to take steps that allow for easier disposal of unused medications to facilitate the removal of excess opioids from circulation in the community.

As the Committee works to eradicate this epidemic, AANP must be actively involved. We look forward to working together to ensure our patients gain access to treatment they so desperately need. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer