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February 16, 2018

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), we would like to thank you for your leadership in addressing the opioid epidemic, which is impacting far too many of our communities. The use and abuse of both prescription and illicit drugs has increased dramatically in recent years and has become a major public health concern. The ACS is committed to working with Congress and the Administration to help address this problem.

The United States is in the midst of an epidemic of opioid abuse. According to the Centers for Disease Control and Prevention (CDC), the number of overdose deaths involving opioids, both prescription and heroin, has quadrupled since 1999. Coinciding with this, the sale of prescription opioids nearly quadrupled from 1999 to 2014 [1-3].

Policymakers on both the federal and state level are now dealing with the fallout of this increase in the use and abuse of opioids. The ACS appreciates the opportunity to partner with policymakers in efforts to reduce the abuse of prescription opioids, as well as continue research into non-opioid pain treatments and other alternative remedies to reduce the number of individuals who improperly or unnecessarily receive opioid prescriptions. Many of the policies being proposed or adopted will have a significant impact on the way surgeons and other physicians can manage pain in their patients and prescribe opioids moving forward.

It is now well established that a small percentage of surgical patients continue to use opioids beyond their immediate post-operative recovery.[4-6] While there are a number of screening tools with predictive value to specifically screen for risk of opioid misuse in the context of chronic pain treatment, more research is

needed for assessment of the surgical patient. Central to quality surgical patient care is the knowledge and skill necessary for pain management. This includes recognition of the degree of tissue damage during the operation as well as the characteristics and preferences of individual patients, who may be opioid naïve, opioid dependent, and/or opioid avoidant. There is increasing tension between the need to balance post-operative pain control with guarding against inappropriate opioid use and abuse.

A lot has contributed to the opioid epidemic and we need a multi-pronged approach to address this epidemic moving forward. The ACS has been extremely proactive in providing and evaluating surgeon-specific education regarding pain management techniques with minimal to no prescribed opioids along with patient and caregiver education on safe and effective pain control. The ACS is committed to addressing the societal imperative to avoid overprescribing through both patient and provider education, and we will work with Congress to consider the impact of policies on patient safety, pain, and suffering.

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?**

According to data from the 2012 National Health Interview Survey (NHIS), 11.2 percent of American adults (25.3 million people) have experienced some form of pain every day for the past three months. Recognizing that this population may also require surgery, the ACS encourages Medicare and Medicaid to support physician reimbursement for both opioid risk screening of patients and for presurgical pain control counseling for patients.

Reducing the risk in opioid prescribing involves not only an assessment of the risk but also accommodation of that risk into the peri-operative plan for pain control. The ACS recommends establishing new Healthcare Common Procedure Coding System (HCPCS) codes to appropriately reimburse surgical practitioners for the additional opioid risk screening. In addition, specialty-specific pre- and post-surgical monitoring and education related to low or no-opioid strategies need to be made available and appropriately reimbursed.

The ACS also supports the deployment of incentives espoused by Medicaid across Medicare and the private sector (i.e., other insurance companies) to encourage the use of non-opioid options, when medically appropriate. More consistent reimbursement for alternative pain management, such as massage

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therapy, physical therapy, and acupuncture should be part of the legislative agenda.

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-pharmacological therapies when clinically appropriate?**

Surgical teams have worked to advance multi-modal pain strategies that utilize local pain control and non-opioid options. These have been effective in reducing opioid use and optimizing recovery. The ACS encourages Congress to work with the Centers for Medicare and Medicaid Services (CMS) to re-evaluate pain control methods in certain bundled services. Some bundled surgical procedures include opioids as the pre-approved pain control method, when other non-opioid treatments relieve pain just as well with far fewer short and long-term side effects. Unbundling Medicare reimbursement for non-opioid medications and removing obstacles to multi-modal pain management techniques should be part of any legislative initiative.

Congress should also assist with detaching pain scores from reimbursement. In some cases, pain scores (e.g., the Hospital Consumer Assessment of Healthcare Providers and Systems or HCAHPS) have been used as a quality metric for payment or reimbursement. While there is conflicting evidence as to whether or not this has an impact on the opioid crisis, ACS believes this correlation is not an appropriate way to assess quality for payment purposes, and we therefore support detaching questions regarding pain management on patient satisfaction surveys from physician reimbursement.[7]

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?**

Besides the greater promotion and utilization of e-prescribing, additional changes could include specific codes for opioid-related patient counseling (similar to the codes provided for smoking cessation) as well as a stronger examination of the effects of bundled payments and the inherent incentives against non-opioid alternatives. Recommendations also include incentives for groups using patient decision aids, screening and fact sheets at the point of care.

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In addition, ACS encourages states to implement disposal programs to prevent misuse of an unfinished prescription.

4. **Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of OUD and SUDs while promoting efficient access to appropriate prescriptions?**

There has been wide variation in the limits and restrictions placed on prescribers. ACS believes that medical decisions should be left to the prescribing physician and that limits should not adversely impact patient care. Surgical patients are unique and while their pain may be acute, it is also often intense and can limit mobility, thereby restricting the accessibility to retrieving multiple prescriptions. The ACS also supports provisions allowing a patient, in consultation with their physician, to partially fill their prescription for an opioid.

- The ACS encourages state and federal guidelines on prescribing protocols to provide E-prescribing options for the postoperative and/or severely injured surgical patient who, in the professional opinion of the attending physician, is expected to require more than 7 days of postoperative pain relief necessitating opioids:
    a) To improve tracking and reduce opportunities for fraud.
    b) To limit episodes where patients in pain are without relief.
- The ACS supports exceptions from prescriber mandates for patients undergoing cancer treatment, cancer rehabilitation, and palliative care.
- The ACS is actively promoting educational materials on home care training for patients and caregivers consisting of, but not limited to:
    a. Self-assessment of pain based on function.
    b. Utilizing alternatives to opioids to manage pain.
    c. Engagement in a post-discharge wellness curriculum aimed at increasing patient competence in care once home as well as long-term maintenance of health.

These policies would ensure that patients continue to have access to medically necessary treatments to manage pain, while also limiting risk of abuse and diversion.

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

ACS has developed several educational guides and courses to assist with both patient and physician opioid-related education, and welcomes governmental assistance in helping to disseminate these materials and courses. Patient and physician education is key to ensuring patients receive the most appropriate pain management and appropriate doses of opioids and non-opioids. The ACS has been extremely active in developing ways to educate both patients and surgeons on the safe and appropriate use of opioids (e.g., Safe and Effective Pain Control After Surgery, attached). These educational venues will provide certified Continuing Medical Educational (CME) credits specific to the surgical team that should satisfy federal and state requirements.

We urge Congress to provide grant funding for medical education and awareness as well as specialty-specific and team-based CME on proper opioid prescribing protocols, non-opioid alternatives, and the warning signs of opioid addiction. While the prescribing guidelines provided by the CDC are a good first step, the guidelines were developed for primary care providers and focused on long-term, chronic pain and, as such, provide limited information on treating patients with acute pain. Surgical specialty societies should provide opioid and pain management CME relevant to their specialty. It is critical that professional society certified continuing medical education programs be permitted to satisfy all federal and state CME requirements.

Surgical education efforts will seek to inform practitioners on accurate patient assessment techniques (i.e., screening for OUD or SUD), utilizing perioperative multimodal analgesics, and best practices for patients who are: opioid-naïve, experiencing chronic pain, or who are opioid-dependent.

Recently, the Food and Drug Administration (FDA) announced plans to require that opioid manufactures provide training to prescribers regarding the impacts of opioids. The ACS strongly feels that any opioid related training or CME should come directly from medical specialty societies. The surgeon is the person ultimately responsible for the surgical and pain control options and is best able to craft an individualized pain control plan. Recognition of the impact of other disease state, genetic variations, other prescription, overall health status, and home support goes beyond specific drug education by a manufacturer. This will allow a holistic approach to patient pain management rather than just a list of

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drugs and their side effects. Furthermore, specialty societies can best monitor the outcomes from education either through self-assessment questions or through documentation of patient outcomes and will help to provide feedback as to the effectiveness of the educational interventions.

Aside from new content delivery, surgical teams, along with patients and caregivers, need technical training in opioid sparing, multi-modal management, and enhanced recovery methods. This includes things such as use of local anesthetics and block procedures by the surgical team and home management of local infusion catheters by patients and caregivers. The ACS recommends funding for workforce retraining and evaluation of these models to determine best practice for specific populations.

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

ACS supports the use of fully-functioning prescription drug monitoring programs (PDMPs) as a health care and research tool to assist physicians and prescribers. Currently, there is wide variability between the functionality and accuracy of PDMPs from state to state. ACS strongly supports the utilization of governmental grant funding to enhance these programs and make them accessible to appropriate members of the health care team. For example, in some states there are legislative restrictions on the PDMP login credentials to be accessed only by a physician. Not only do these parameters disrupt the day-to-day physician workflow, they restrict the availability and accessibility of PDMP information. When these programs are accessible by physicians and/or a physician's designee, this burden is decreased. As such, the ACS supports allowing physicians, licensed independent practitioners (LIPs), physicians' designated agents, and pharmacists to have access to the PDMP.

In addition, there must be interoperability across states in the data contained in PDMPs with electronic health records (EHRs) to streamline workflow and accessibility. Finally, ACS strongly believes that any PDMP use should be voluntary, not used for law enforcement purposes, and that PDMPs should operate with the most accurate up-to-date data in real time. This would be of use in particular with partial fill-prescriptions.

Identification of professionals who have high prescribing patterns may be performed by better utilizing data from the prescribing registry and tracking the

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number and frequency of opioid prescriptions, refills, and doses given to patients. It is hoped that efforts to better identify and educate high opioid prescribers will result in more appropriate, safe, and effective pain control for patients.

7. **What best practices employed by states through innovative Medicaid policies or private sector can be enhanced through Federal efforts or incorporated into Medicare?**

Patients may be incentivized to increase play an active role in their care by participating in preoperative education including (but not limited to) the use of postoperative home care or skills kits. Upon completion of patient skills training, patients could then receive a certificate of completion which could be submitted to the insurance company for patient reimbursement.

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?**

ACS supports the use of a patient outcomes database related to safe and effective pain control. Studies have shown that physicians who monitor their patient outcomes have patients with better outcomes.[8] ACS is in the initial stages of building a database that could be used by hospital systems or individual physicians to monitor patient outcomes.

In addition, ACS also supports patient safety legislation that includes the following:

- Exceptions from prescriber mandates for patients undergoing cancer treatment, cancer rehabilitation, or palliative care.
- Exemptions for the postoperative and/or injured surgical patient who are expected to require opioid analgesics for more than 7 days.
- E-prescribing of controlled substances to improve tracking, reduce opportunities for fraud, and limit episodes where patients in pain are without relief.
- Partial filling of opioid prescriptions to reduce left-over excessive pain pills in patient's medicine cabinets. This option would require up to date state PDMPs with real time data – otherwise if the patient went back to the pharmacy for the rest of the fill, the partial fill data may not be reflected.

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- Pill disposal programs to prevent misuse or diversion of an unfinished prescription.
- Patient contracts and support for counseling for any patients with pain over 30 days.

We look forward to working with you to end the opioid crisis and ensure that all patients receive the most appropriate and highest quality care.

Sincerely,

David B. Hoyt

David B. Hoyt, MD, FACS
Executive Director, American College of Surgeons

Attachment(s):
Safe and Effective Pain Control After Surgery

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