Kentucky Coalition of Nurse Practitioners & Nurse-Midwives

February 16, 2018

Senator Orrin G. Hatch & Senator Ron Wyden
Senate Finance Committee
United States Senate
Washington, DC 20510-6200

Dear Senators:

RE: Request for Recommendations on OUD and SUD

Senator McConnell forwarded your request for recommendations on OUD and SUD and we are pleased to offer our suggestions and thank you for the opportunity to comment. The Kentucky Coalition of Nurse Practitioners and Nurse-Midwives (KCNPNM) represents 6043 nurse practitioners (NPs) and nurse midwives (CNMs) who are licensed in Kentucky. As I'm sure you are aware, substance abuse is a significant problem in Kentucky and nurse practitioners and nurse midwives in our state are working with our legislators and policy makers to seek ways to combat the problem.

The American Association of Nurse Practitioners (AANP) has also submitted comments and our organization fully supports the recommendations offered by AANP. Additionally, we would like to offer our perspective from Kentucky.

How can Medicare and Medicaid payment incentives be used to promote evidence-based care that minimizes the risk of developing OUD or SUD?

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. Primary care providers face the same reimbursement issue, with reimbursement for NPs and CNMs at 85% of the physician fee schedule for Medicare and 75% of the physician fee schedule for Medicaid. These reimbursement rates make it difficult to keep the lights on, much less provide wages for staff and providers. 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.

What barriers to non-pharmaceutical therapies for chronic pain exist in Medicare or Medicaid?

Currently, the Medicare and Medicaid programs do not cover many non-pharmaceutical therapies for chronic pain. Utilizing non-opioid alternative pain management interventions and therapies to replace, decrease or minimize the need for opioid prescriptions should be a priority.

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. Kentucky is a rural state with a large Medicaid population. Licensed professionals who provide alternative treatments should be adequately reimbursed for their services in order to encourage them to locate or provide care in rural areas, where services are desperately needed. 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 NPs and CNMs.

How can Medicare and Medicaid payment incentives be used to remove barriers or to create incentives to improve patient outcomes?

Medication-Assisted Treatment: According to the National Institute on Drug Abuse, 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. 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.

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 2017/20183, would make this authorization permanent.

Additionally, while CARA removed barriers for NPs to provide MAT to their patients, in states like Kentucky, that require collaborative agreements with physicians, the NP who has obtained the additional training and obtained a waiver, 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 and many who do, will not sign an agreement with a NP. This is a major barrier in Kentucky, which has been significantly impacted by the opioid epidemic. When regulatory and/or fee schedule barriers exist to the level currently impacting NP and CNM practice these providers are completely blocked from participating in treatment programs of any sort. For instance, extended release injectable naltrexone, a non-opioid option for opioid and substance abuse, is a good option but cannot be a provider's only tool in the toolkit. NPs must be fully educated on the topic, must be able to adequately assess the patient and should be able to choose from a complete list of of medications and therapies in order to tailor the treatment to the patient. 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, and can do so within a program versed in complete, well rounded care

Home Health: Barriers also continue to exist within the Medicare and Medicaid programs that inhibit an NP's and CNM's 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 and CNMs with patients who need home health care services must locate a physician who will document theirassessment 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. Under the current system NPs and CNMs 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 20174, would remove these barriers for NPs and CNMs and their patients.

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

Provider Education: For the past 30 years, KCNPNM has provided education for NPs and CNMs at a large, nationally recognized annual regional educational conference. Additionally, the organization sponsors continuing education in smaller venues around the state several times a year. Since 2006, KCNPNM has provided education on opioid dependence and treatment of pain at the annual conferences and at its smaller venues.

KCNPNM supports the efforts of AANP on the national level to educate NPs. Educational programs sponsored by KCNPNM are approved by AANP for continuing education credit.

KCNPNM agrees with AANP that 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 of patients. 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 NPs and CNMs, 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.

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

In Kentucky, we are fortunate that our Medicaid Program and KASPER, our Prescription Drug Monitoring Program (PDMP) both reside in the KY Cabinet for Health and Family Services, facilitating the sharing of data between those programs. Our Medicaid Program Integrity unit currently utilizes PDMP data for reviews and investigations. In addition, we are currently working on projects to link the Medicaid and PDMP data to identify potentially inappropriate patient and prescriber behaviors, and to support more detailed analyses of drug overdose deaths. The Cabinet's Office of Inspector General (OIG) uses PDMP data to support reviews of potentially inappropriate or illegal controlled substance prescribing and to make referrals to the prescriber's licensure board for further investigation when appropriate.

Medicare does not currently have access to PDMP data in Kentucky, nor in most other states. A meeting or dialog between state and federal stakeholders to discuss possible collaboration, data sharing or recommendations for state legislation that could allow more integration between Medicare, the state PDMPs and the state prescriber licensure boards may be of value.

What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts of 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 NPs and CNMs.

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 on the federal level. KCNPNM is committed to combating the problem on the state level and supporting our national nursing organization. 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 feel free to contact our executive director or me.

Sincerely,

Dr. Jessica Estes DNP, APRN
President

Leila Faucette
Executive Director