Working to Reverse the Nation's Opioid Epidemic

The PA profession is committed to combatting the abuse, diversion, morbidity, and mortality associated with the misuse of opioids. Of the 123,000 practicing PAs in the United States, approximately 30,000 practice in addiction medicine or primary care, where they commonly work with patients who struggle with opioid use disorder (OUD). Another 45,000 PAs practicing in surgical specialties and emergency medicine may prescribe opioids to their patients for pain control or treat patients with OUD.

PAs in the United States have upwards of 400 million patient encounters annually, providing vital access to cost-effective, high quality care. The epidemic's devastation will not improve if all qualified healthcare providers are not fully utilized to ensure treatment is made available to all those suffering from addiction and putting them on the path to recovery.

Expanding Access to Treatment

The Comprehensive Addiction and Recovery Act (CARA) of 2016 allowed PAs and NPs to obtain a Drug Enforcement Agency (DEA) waiver to prescribe buprenorphine for the purpose of providing medication assisted treatment (MAT) mediation for the treatment of OUD. This waiver program contains several requirements which are limiting its impact on alleviating the crisis. AAPA supports removing non-evidence-based restrictions on MAT so that more providers can deliver this critical care. This includes:

- Make permanent the CARA-established waiver program allowing PAs/NPs to prescribe buprenorphine to treat OUD or eliminate the waiver requirement entirely to expand crucial access to this proven treatment.
- Remove barriers to treatment related to patient limits and training requirements.
    - All buprenorphine prescribers of buprenorphine for MAT should have the same training requirements. The first eight hours of training for PAs/NPs is the same module required for physicians, with no evidence supporting the additional 16 hours of training required for PAs/NPs.
    - If Congress maintains patient limits for waivered practitioners, PAs and NPs should be treated the same as physicians.
    - Waivered practitioners need to be able to treat more than 30 patients in the first year. Some PAs serving in areas impacted by the epidemic are hitting the 30-patient cap in the first year.
- Remove the requirement placed on PAs/NPs that their collaborating physician be waiver eligible.

Congress should support the expedited development and implementation of alternative payment models (APMs) for treatment of OUD. Alternative payment models are an important strategy for ensuring patient access to the most effective treatment available.

Prescriber Education

AAPA is a leader in providing educational content focusing on responsible opioid prescribing for PAs.

- The AAPA is a founding partner of the Collaborative on Risk Evaluation and Mitigation Strategy (REMS) Education (CO*RE).
- Since 2013, AAPA has provided more than 100 hours of free instructional content to more than 10,000 PAs. Education content includes pain management treatment guidelines, early detection of opioid addition, and the treatment and management of opioid dependent patients.

- Since the passage of CARA in 2016, AAPA has also collaborated with the American Society of Addiction Medicine to provide a free 24-hour training program enabling PAs to obtain waivers to prescribe buprenorphine. To date, more than 2,000 PAs have completed this 24-hour training program.

While AAPA supports efforts to expand educational opportunities for prescribers, educational requirements are best implemented at the state level to avoid practitioners having to navigate a confusing patchwork of state and federal requirements.

- Congress may want to consider proposals that foster new state-based resources for prescribers to consult when treating patients with pain and that assist in identifying signs of substance misuse and substance use disorder (SUD). As existing educational mandates have not been shown to result in lower morbidity or mortality rates, AAPA supports taking a more collaborative and innovative approach.
- AAPA supports adopting evidence-based guidelines in an unobtrusive manner within the prescribing workflow, this approach could provide a more effective and clinically appropriate tool than electronic prior authorization.
- Original Medicare and private Medicare plans sharing information with prescribers on how their prescribing patterns compare to their peers could offer helpful information to PAs and other clinicians and serve as an effective mechanism to spread best prescribing practices.
- Any legislation concerning educational initiatives for prescribers should include AAPA as a recognized source of education and training resources.

Balancing Treatment Options and Risk

Being able to adequately treat pain across all types of settings and in diverse populations, while also minimizing the potential risk for diversion and misuse, requires a delicate balance. While the majority of patients who use prescribed opioid medications to treat acute or chronic pain do so without incident, some develop OUD over time. AAPA believes a balance must be maintained between fighting opioid abuse and ensuring patients who need opioids for pain management are able to access them.

- Treatment of both pain and OUD require that healthcare providers spend adequate time with patients. This is often not incentivized in existing payment models and practice settings.
- Medicare could offer payment incentives to increase uptake of treatment and prevention, such as reducing or eliminating co-pays for screening and OUD/SUD treatment.
- AAPA is concerned about the unintended consequences of placing arbitrary limits on the duration of initial opioid pain medication prescriptions. Set limits of three, five or seven days for initial opioid pain medication prescriptions may be suitable for some patients, in other instances such limits may be inappropriately restrictive.
- Decisions regarding therapeutic options and management for pain should be determined using best practices and evidence-based guidelines on a case-by-case basis by qualified medical practitioners.
- AAPA does not believe there is enough scientific evidence to establish limits for second fills and is concerned of the ramifications such a policy could have on pain treatment for some patients.
- AAPA supports wide availability of naloxone to aid patients at risk of an opioid overdose.
- Prescription Drug Monitoring Programs (PDMPs) should be widely utilized and integrated into electronic health records and provider workflow in a meaningful, user-friendly manner.

AAPA is supportive of using non-pharmacologic treatments when it is medically indicated as a potential solution for a patient. But if mandated as the first line of treatment, problems can arise because in some communities these options may not exist, there are too few providers to adequately cover the population needing treatment or the costs to pursue non-pharmacologic therapies like physical therapy or home health is prohibitive for many patients.

- For these treatments to be more widely used, all Medicare Advantage and Part D plans should eliminate barriers to multimodal treatment for pain by covering non-opioid analgesics and non-pharmaceutical treatments for pain and eliminating yearly limits on treatments such as physical therapy, and prior authorization to delay or deny care.
- The Medicare program should be updated to allow PAs/NPs the ability to certify or order home healthcare for their patients. Qualified providers should to be able to order these services as part of the efforts to address alternative treatments for pain management.

