March 15, 2018

The Honorable Kevin Brady
Chairman
House Ways and Means Committee
Washington, DC 20515

The Honorable Richard E. Neal
Ranking Member
House Ways and Means Committee
Washington, DC 20515

The Honorable Peter J. Roskam
Chairman
Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Ways and Means Committee
Subcommittee on Health
Washington, DC 20515

Electronically submitted to WMOpioidSubmissions@mail.house.gov

Dear Chairmen Brady and Roskam and Ranking Members Neal and Levin:

On behalf of the more than 123,000 PAs (physician assistants) throughout the United States, the American Academy of PAs (AAPA) welcomes this opportunity to offer feedback to the House of Representatives Committee on Ways and Means in relation to addressing the opioid epidemic confronting our nation.

PAs are one of three types of healthcare professionals, including physicians and nurse practitioners, who provide primary medical care in the United States. As such, PAs frequently work with patients who struggle with opioid use disorder (OUD). PAs practice in every state and in every medical setting and specialty, improving healthcare access and quality. While some PAs specialize in addiction medicine, there are also approximately 30,000 PAs practicing as primary care providers on the "front lines" of patient care in hospitals, private practices, community health centers, rural health clinics, non-federally qualified public or community health clinics, prisons, behavioral healthcare facilities, and free clinics, where they commonly encounter patients who have or are at risk of OUD. PAs in the United States have upwards of 400 million patient encounters annually.

Appropriate Prescribing/Data Tracking

AAPA recognizes the need to both ensure that patients receive medically appropriate care to address both acute and chronic pain and that necessary steps are taken to minimize the risks of OUD and diversion. Treatment of both pain and OUD require that healthcare providers spend adequate time with patients and build trusting relationships that serve as the foundation to care. This is not possible in the current fee-for-service model or regulatory environment. PAs are

working in all communities, including rural and underserved areas, to meet the needs of patients struggling with pain and OUD. The current fee-for-service approach to payment should be modernized to incentivize clinicians to provide the most effective, evidence-based care available, rewarding comprehensive and continuous care.

AAPA is concerned about unintended consequences of placing arbitrary limits on the duration of initial opioid pain medication prescriptions. Set limits may be adequate for certain patients but fail to take into account individual needs and could unfairly deny pain treatment that is appropriate for some patients. In addition, it removes the ability for the healthcare provider to utilize their education and experience to provide personalized care, but rather forces all patients into a one size fits all box. This would also likely be the case for second-fill limits placed on prescriptions. 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 is supportive of using non-pharmacologic treatments when it is medically indicated as a potential solution for a patient. However, we have concerns in mandating this as the first line of treatment because in some communities these options may not exist or there are too few providers to adequately cover the population needing treatment. In addition, the cost to pursue non-pharmacologic therapies like physical therapy, home health, and alternative or complementary therapies is prohibitive for many patients. Further compounding their use, the Medicare program denies PAs the ability to certify or order home healthcare for their patients. In order for these treatments to be more widely used, Medicare coverage needs to be expanded and qualified providers need to be able to order or provide such services.

In relation to requiring electronic prior authorization for opioid prescriptions, AAPA supports adopting evidence-based guidelines within the prescribing workflow as this approach could provide a more effective and clinically appropriate tool than electronic prior authorization. In order to provide accurate, timely prescriber information, evidence-based clinical guidelines should be integrated within the prescribing workflow in an unobtrusive manner. This is because they are by necessity not personalized to the individual patient.

From 2014 to 2016 the number of healthcare providers registered to use state prescription drug monitoring programs (PDMPs) increased from 471,896 to 1,322,996. PDMP records were checked more than 136 million times in 2016. PAs support increasing the use of PDMPs and increasing the thoroughness of information included in PDMPs.

Communication and Education

The AAPA is a founding partner of the Collaborative on Risk Evaluation and Mitigation Strategy (REMS) Education (CO*RE). Through participation in CO*RE, AAPA has led a national quality improvement initiative for PAs focused on responsible opioid prescribing. AAPA has expanded these efforts to focus on all aspects of the opioid epidemic and the variety of ways PAs can be leaders in addressing the epidemic. Since 2013, AAPA has provided more than 100 hours of free instruction reaching more than 10,000 PAs on pain management treatment guidelines, early detection of opioid addition and the treatment and management of opioid dependent patients.

Since the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, AAPA has also collaborated with the American Society of Addiction Medicine to provide a free 24-hour training program allowing PAs to obtain medication-assisted treatment (MAT) waivers to prescribe buprenorphine. To date, more than 2,000 PAs have completed this 24-hour training program. In 2018, AAPA will be providing the first in-person MAT waiver training specifically designed for PAs. Now that we have a critical mass that has taken the training, we plan to survey them to find out if there are any barriers for them to go to the next level. We will keep the committee informed on what we discover.

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. 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. 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). CMS or Medicare private plans sharing information with prescribers on how their prescribing patterns compare to their peers could offer helpful information to PAs and other clinicians that may be useful in informing prescribing decisions.

Treatment

MAT, especially the use of buprenorphine, has proven effective in treating opioid addiction, but is underutilized. While CARA allowed PAs and nurse practitioners (NPs) to obtain a Drug Enforcement Agency (DEA) waiver to prescribe buprenorphine for the treatment of OUD, there are still nonevidence-based requirements in place that limit availability of providers and limit the number of patients that can be treated. PAs and NPs are required to have 24 hours of training to obtain a waiver, when physicians are only required to receive eight hours of training. The different training requirements are arbitrary and not evidence-based, and eight hours of training is sufficient to cover the necessary information. The first eight hours of training for PAs and NPs is the exact module required for physicians. The waivers that are in place for all prescribers also limit the number of patients that can be treated, with PAs and NPs only being allowed to treat 30 patients in the first year. AAPA agrees with the American Medical Association (AMA) that, "removing the federal waiver requirement will give many more patients new access to treatment from physicians and other qualified healthcare professionals." House and Senate committees with jurisdiction over the Medicare program should suspend the waiver requirement for physicians, PAs, and APRNs under Medicare.

In addition to expanding access to MAT by removing restrictions placed on providers, 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. Such a change could also support the appropriate co-prescribing of naloxone to patients at risk of experiencing an opioid overdose.

The opioid crisis is a serious health epidemic affecting families and communities across America. PAs stand ready to work as partners with other healthcare professionals, Congress,

states, community leaders, law enforcement, and our patients to address the many challenges and complexities arising from OUD/SUD.

AAPA appreciates the Committee's focus on this important issue and the opportunity to provide these comments. Please contact Tate Heuer, Vice President for Federal Advocacy, at (571) 319-4338 or theuer@aapa.org with any questions.

Sincerely,

Tillie Fowler
Senior Vice President, Advocacy & Government Relations