American Society of Anesthesiologists®

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March 15, 2018

via online submission: WMOpioidSubmissions@mail.house.gov

The Honorable Kevin Brady
Chairman
Committee on Ways and Means

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means

The Honorable Peter Roskam
Chairman
Subcommittee on Health

The Honorable Sander Levin
Ranking Member
Subcommittee on Health

1102 Longworth House Office Building
Washington, D.C.
20515

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

On behalf of the American Society of Anesthesiologists (ASA) and our 52,000 members, we are pleased to submit our response to the House Ways and Means Committee and the Subcommittee on Health's ("Committees") recent request for feedback on how the Committee can respond to the opioid crisis. ASA looks forward to serving as a resource for Committee members as these critical discussions ensue.

Physician Anesthesiologists' Role in Combating the Opioid Epidemic

Physician anesthesiologists' role in the delivery of care is integral to reducing opioid use throughout the perioperative period and upon discharge. These specialists not only have extensive experience with the intricacies of short-term pain management such as following a surgical procedure or minor injury, but they also focus on long-term pain management related to chronic conditions like arthritis or low back pain. While certain pain can be managed very effectively with non-opioid treatments, other types of pain requires the use of opioids. Physician anesthesiologists partner with patients and families to manage expectations around pain treatment, educate patients on the safe use, storage and disposal of opioids, and the prevention of opioid misuse and abuse post discharge.

ASA supports an integrated, multimodal and interdisciplinary approach to pain treatment and our recommendations are based on this concept. Patients experiencing pain should have timely access to patient-centered care that meets their needs, but appropriate prescribing and treatment behavior must be equally paramount.

Overprescribing of Opioids in Medicare

Under the current Medicare and Medicaid coverage polices, patients may receive a relatively low-cost opioid prescription as opposed to other effective treatment options because opioid products are typically covered by Medicare, Medicaid and most health plans. In ASA members' experience, Medicare and Medicaid are still denying many instances of non-opioid alternatives (e.g. chiropractic therapy, acupuncture, biofeedback, nerve blocks, and neuromodulation) when such care could provide benefit to these patients.

ASA supports increased patient access to multimodal, multi-disciplinary pain management, including safe and effective opioid prescribing. A comprehensive, patient-centered approach to pain management may also include interventional therapies (e.g. epidural steroid injections, radiofrequency ablation, and neuromodulation), which are key non-opioid therapies for the treatment of chronic pain and have been shown to reduce and eliminate pain, improve function, decrease reliance on opioids, and for some patients, eliminate the need for surgery. Our pain management experts have reported that when spinal neuromodulation is performed by physicians trained to perform these procedures, the average opioid reduction for chronic pain patients is approximately 70 percent after one year. **ASA recommends increased coverage for alternative therapies and interventional pain management.**

Further, as a multimodal approach to pain treatment becomes more prevalent, the utilization of interventional procedures will increase, and that utilization should not be considered as sole grounds for identifying the services as being potentially misvalued and subject to review and decreased valuation under the Medicare Physician Fee Schedule. ASA points out that the values associated with interlaminar epidural injections were significantly reduced in recent years. We would ask that the Centers for Medicare and Medicaid Services (CMS) be directed to reconsider its stance in regard to these services and take into account the savings they provide in overall spending - not only due to their effectiveness but also how their use can contribute to solving the opioid crisis.

Increased Funding for Pain Research and Non-Opioid Therapies

Congress recently recognized the importance of pain research by passing the Safe Treatments and Opportunities to Prevent ("STOP") Pain Act as Section 108 of the CARA legislation in the last Congress. That provision recognizes the work already underway through the Interagency Pain Research Coordinating Committee ("IPRCC") at NIH, the National Pain Strategy released last year, and the recently released Federal Pain Research Strategy, all which support prioritization of pain research studies. The essential next step is to provide adequate funding to NIH and these initiatives. While ASA recognizes this issue is not under the purview of the Committee, it is critical to highlight the importance of increased research funding for alternative therapies, including non-opioid treatments and interventional pain therapies. **We support the efforts of Congress to dedicate resources to pain research, including non-opioid alternatives.**

Importance of Clinical Guidelines and Appropriate Payment Incentives

Proper clinical guidelines along with appropriate payment incentives are key to reducing overprescribing and promoting desired behavior from health care providers. ASA urges the Committee to consider multiple approaches to align payment incentives with evidence-based care, including:

Utilization of MIPS and AAPMs

Utilization of the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs) implemented under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA's) Quality Payment Program (QPP) supports the provision of appropriate, high-quality treatment of pain for Medicare beneficiaries. Clinicians are investing significant resources to successfully participate in these programs, and the development of new incentives and performance measurement tools presents a unique opportunity to address the risks and concerns associated with opioid use. **ASA urges the Committee to leverage the existing infrastructure of these programs under MACRA to promote and encourage evidence-based care for patients with acute and chronic pain.** For example, CMS could focus on appropriate pain medicine and management practices with special attention to proper opioid prescribing and methods of minimizing opioid use in patients with pain conditions when assessing and approving quality measures, improvement activities and the use of health information technology objectives under MIPS.

Programs to Support Models of Care that Minimize Opioids

Physician anesthesiologists are already engaging in efforts to implement best practices for pain management and promote minimizing opioids in the perioperative period. Congress should leverage these efforts and build upon the work already being done. **ASA recommends that the Committee direct CMS to support innovative programs that encourage opioid sparing techniques in the hospital and surgical setting.**

One example of ASA's work in this area is the development of the Perioperative Surgical Home (PSH), which is a patient-centered, physician-led, interdisciplinary and team-based system of coordinated patient care. This encompasses the experience from decision of the need for any invasive procedure—surgical, diagnostic, or therapeutic—to discharge from the acute-care facility. PSH collaboratives currently function in almost 60 large and small health care systems across the country, where physician anesthesiologists and surgeons are partnering to carry out comprehensive perioperative analgesic plans that are tailored to the individual patient. Through work with the PSH, ASA has developed protocols to optimize the perioperative use of opioids by relying on multimodal, opioid-sparing analgesic regimens versus the traditional unimodal intravenous and/or oral opioids.[1] The PSH holds great potential for having an impact on patients by addressing risks for opioid misuse, abuse and addiction. A grant program would support these efforts on a wide-scale and enable implementation of safer pain management practices across the care continuum.

Another example of a project where physician anesthesiologists are already working to minimize opioids in the perioperative setting includes a collaborative with Premier, Inc. and their network of hospitals, the Safer Post-Operative Pain Management Reducing Opioid Related Harm Pilot. The six-month pilot runs through March 2018 and aims to reduce harm associated with the use of opioids in patients undergoing certain high-volume surgical procedures (hip, knee, and colectomy). The project, which is being executed through CMS' Hospital Improvement Innovation Networks (HIIN), involves implementing evidence-based pain management practices to measurably reduce opioid use during and after surgery. As part of the pilot, ASA physician-members are providing education to the participating hospitals on these practices, including multimodal approaches to pain management, with the goal of reducing the overall number of opioids prescribed to patients receiving these surgeries. **ASA requests that the Committee consider supporting additional initiatives to educate hospitals and physician practices on clinical guidelines**

[1] Vetter, Thomas; Kain, Zeev. (2017). *Role of the Perioperative Surgical Home in Optimizing the Perioperative Use of Opioids*. International Anesthesia Research Society; https://journals.lww.com/anesthesia-analgesia/Abstract/2017/11000/Role_of_the_Perioperative_Surgical_Home_in.33.aspx, accessed on 3/1/2018.

and best practices for opioid pain management. This approach encourages more responsible prescribing behavior in both hospitals and physician practices and can reduce the number of unused opioids in American communities and households.

Implement Quality Measure Development Funding Initiative

In May 2017, CMS announced that it will award up to $30 million in grant funding to clinical specialty societies, clinical professional organizations and independent research organizations to develop quality measures under MACRA. The application process for this funding has been delayed multiple times since the original announcement and the estimated project start date is now August 1, 2018, although applications have yet to be released. **ASA urges Congress to direct CMS to move forward with this important quality measure development funding initiative that will contribute to supporting the provision of evidence-based care for patients with chronic pain.** Quality measures seek to track the degree to which evidence-based treatment guidelines are followed, where indicated, and assess the results of that care. The use of quality measurement helps strengthen accountability and supports performance improvement initiatives at numerous levels. An increase in measures in this area will help support the provision of evidence-based care for pain management services.

ASA and the American Society of Regional Anesthesia and Pain Medicine (ASRA) partnered in 2017 to develop chronic and acute pain measures for physicians and their practices to use. These measures include Safe Opioid Prescribing Practices and Multimodal Pain Management and are available for eligible clinicians to report via our Qualified Clinical Data Registry (QCDR). We were disappointed that CMS did not accept our measure on patient education related to proper disposal of opioids. In the future, we hope that pain medicine physicians and others will use these measures to improve quality care and to effectively address the opioid crisis.

Best Practices and Policies to Modify Prescribing Patterns

ASA recommends that any policy or recommendation regarding opioid prescriptions be based on evidence-based guidelines; **we urge Congress to support the efforts of national professional and medical societies to develop these guidelines.** ASA welcomes the opportunity to work with the Department of Health and Human Services (HHS), the Food and Drug Administration (FDA), CMS and other stakeholders to develop educational materials and guidelines on opioid prescribing, non-opioid alternatives, pain management and substance abuse prevention and treatment. Specifically, a program or public-private partnership that supports collaboration and consensus among the medical specialties and societies would increase consistency in education, as well as medical and clinical practice.

ASA understands that the Committee is seeking input on how to modify prescribing patterns and prevent opioid abuse and misuse. We believe that the above outlined programs provide multiple options that would not only benefit patients but also incentivize physicians to adhere to safe prescribing and best practices for patient care.

ASA supports the Committee's efforts to curb overprescribing, but we also ask that in identifying solutions, the pendulum not be swung too far. Some patients suffering from chronic pain are well-managed on high doses of opioids under the proper care of a physician. **ASA recommends that all patients on high daily doses of opioids undergo evaluation by a board-certified pain physician with additional addictionology consultation if needed.**

Prescription Drug Monitoring Programs (PDMPs)

ASA members have seen the benefits of select state-based prescription drug monitoring programs (PDMPs) and **supports the implementation of a national PDMP under certain circumstances**. Such a program, if properly designed, could reduce unnecessary or inappropriate opioid prescribing as well as facilitate consistent reporting and tracking across the country. Almost every state has its own PDMP, but those programs tend to differ significantly from one state to another, and there are marked differences in how states set up agreements with other states to share the data. Another significant problem is a lack of physician access to information about what prescriptions patients have filled in other states, as data sharing across state lines is not always possible. Additionally, health care providers accessing PDMPs experience other challenges caused by slow or unstable technology and barriers created by multiple systems that do not work together. Currently, CMS does not have access to state PDMPs and a national PDMP would help facilitate greater data sharing.

A national PDMP, with providers participating in the Medicare and/or Medicaid programs to start, could address many of the shortcomings of inconsistent state PDMPs and eventually create a uniform resource that reduces gaps in care, enables prescribers to effectively monitor patients and help prevent substance use and abuse. However, the rollout of a national system should be carefully implemented to ensure that clinicians are not overburdened by reporting to both state and national systems. Over time, the national PDMP should either replace or incorporate state-based efforts to streamline reporting and effectiveness.

Communication and Education

ASA encourages support for educating health care providers, patients, caregivers and family members on safe storage and disposal, and the risks of misuse, abuse and addiction associated with opioid analgesics.

Physicians
Physician education on opioid prescribing and best practices for pain management, as well as on substance use and addiction can have a real, positive impact on addressing the opioid epidemic. A recent report by the American Medical Association (AMA) Opioid Task Force, of which ASA is a member, found that opioid prescriptions continue to decline nationwide. The report also notes that nearly all 50 states have naloxone access laws, more physicians are educated on safe opioid prescribing than ever before, use in PDMPs has increased, and the number of physicians certified to provide office-based medication-assisted treatment for opioid use disorders has also increased. These trends are a good sign of progress, but more work needs to be done.

As mentioned above, ASA supports the development of educational materials and guidelines by the national professional and medical societies. Educational initiatives that come from the specialties will be evidence-based and already have consensus and support behind them. **ASA requests that the Committee support educational efforts that come directly from the clinical experts.**

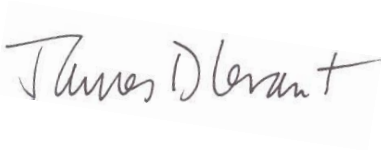
ASA also supports efforts by health care providers to evaluate their own practices and prescribing patterns. ASA is aware that many hospitals and practices are already analyzing their own data to identify outliers and analyze prescribing patterns in comparison to peers. **Any support the Committee can provide to bolster these initiatives is welcomed.**

Patients
ASA strongly supports the use of culturally sensitive and linguistically appropriate patient and caregiver education on safe storage and disposal of opioids and the risks of misuse, abuse and addiction associated with opioid analgesics. Effective patient education can be a powerful prevention tool and is especially important for extended or long-term prescriptions. Because they are suffering from pain, feeling anxious

or distracted, patients do not always hear the information correctly the first time they receive it. To address this issue, it's important for patients and their caretakers to receive this education at both the physician's office as well as again at the pharmacy. The FDA, Centers for Disease Control and Prevention (CDC) and other entities can be supportive in this area by participating in the ongoing validation of evidence-based guidelines and conducting research on the effectiveness of various types of interventions, communications and messaging. However, the most effective patient education efforts are undertaken at the local level, and Congress should refrain from being excessively prescriptive in this area. **Individual physicians and local health systems and pharmacies should be given the authority to implement educational initiatives that are appropriate for their own patient populations.**

Thank you for your leadership in addressing the opioid epidemic in communities across the nation. We appreciate the opportunity to provide our comments as the Committee on Ways & Means continues to work on this issue. Please do not hesitate to contact ASA Pain Medicine and Federal Affairs Manager, Ashley Walton, J.D. via email at a.walton@asahq.org or by telephone at (202) 289-2222 if we can be of further assistance.

Sincerely,



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