AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

March 14, 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

Sent to WMOpioidSubmissions@mail.house.gov

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

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to your February 27, 2018 letter requesting policy recommendations and feedback to inform the House Ways and Means Committee's deliberations on the opioid epidemic. We appreciate that the Committee is seeking input from the AAFP on how to address the root causes that lead to, or fail to prevent, opioid misuse and abuse.

The AAFP recognizes the intertwined public health issues of chronic pain management and the risks of opioid misuse. We understand that high levels of misuse and addiction persist with devastating consequences despite annual decreases in the number of opioids prescribed in the United States since 2010. To promote evidence-based care for patients with chronic pain while minimizing the risk of opioid and other substance use disorders (OUD/SUD), we must recognize that both pain management and dependence therapy require patient-centered, compassionate care as the foundation of treatment. These are attributes that family physicians uniquely bring to their relationships with patients. It is unfortunate that the payment and regulatory framework for physician practices has reduced face-to-face time with patients, making it more difficult for physicians and patients alike. Our current payment models, coupled with crippling regulatory structures, threaten access for millions of patients' to evidence-based pain care and OUD and SUD treatment from primary care physicians.

The fee-for-service (FFS) reimbursement model continues to undervalue evaluation and management services and fails to reward taking the time and effort necessary to provide the kind of comprehensive, continuous care patients need. In a volume over value FFS environment, it is easier and more economically viable to write a prescription than to explore alternative treatment options for chronic pain as outlined by the Centers for Disease Control and Prevention (CDC)

guidelines and affirmed by AAFP. Regrettably, barriers to non-pharmacologic therapies for chronic pain exist in public and private health insurance plans.

While we commend the Congress for permanently repealing the Medicare therapy caps in the recent *Bipartisan Budget Act* of 2018 (now Public Law 115-123,) geographic and other barriers such as inadequate providers of non-pharmacologic therapy hinder its universal use. Coverage of these therapies is also often lacking. The administrative burden for prescribing or referring patients for non-pharmacologic therapies like physical therapy, home health, etc., is a barrier to the use of non-pharmacological treatments. Steps the Committee may wish to consider should include incentivizing evidence-based non-pharmacologic therapies by reducing their associated administrative burden, decreasing or removing co-pays for nonpharmacological therapies, and increasing coverage for those services.

Family physicians are the most visited specialty—especially in underserved areas. Family physicians conduct approximately one in five of all office visits in the United States. This represents more than 192 million visits annually. Family physicians therefore find themselves at the crux of the issue, balancing care for patients with chronic pain and the challenges of managing the appropriate use of opioids, while always mindful of their misuse and abuse. In the face of opioid misuse, family physicians have a unique opportunity to be part of the solution. Effective pain management should be coordinated by a primary care physician who best knows the patient and integrated into continuous and comprehensive whole-patient care.

The AAFP opposes limiting patient access to any physician-prescribed pharmaceutical without cause, as well as any actions that limit physicians' ability to prescribe these products based on the physician's medical specialty. There is little scientific evidence on which to base limits on "second fills" or refills. Strict enforcement of prescribing limits fails to recognize the needs of individual pain patients and could unfairly deny appropriate pain treatment for some patients.

Medicare payment incentives could be used to reduce or remove co-pays for screening and treatment for OUD and SUD. Such incentives should also be used to support the appropriate co-prescribing of naloxone as the AAFP and the American Medical Association Opioid Task Force outline on the AAFP website. The Committee should also ensure coverage for medication-assisted treatment (MAT) and other evidence-based treatments for OUD. While the evidence is still evolving on the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for opioids, SBIRT is recommended by the Substance Abuse and Mental Health Services Administration and others and could be implemented like screening for tobacco and alcohol misuse. The AAFP has screening tools and other resources in our Chronic Pain Management Toolkit.

The AAFP supports embedding evidence-based guidelines within the prescribing workflow as a more effective 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. The online guidelines should be unobtrusive because they are necessarily not personalized to the individual patient.

Prior Authorization tops the list of physician complaints on administrative burden. In coalition with 16 other medical organizations, the AAFP has called for the reform of prior authorization and utilization management requirements that impede patient care in *Prior Authorization and Utilization Management Reform Principles* (www.ama-assn.org). In addition, the AAFP recently published *Principles for Administrative Simplification* calling for an immediate reduction in the regulatory and administrative requirements family physicians and practices must comply with on a daily basis.

The AAFP recognizes the importance of educating all health professionals including those with high prescribing patterns, and we recommend the Committee encourage an approach that recognizes team based care and promotes patients as stakeholders in their own care via shared decision making and collaborative physician-patient management plans. In addition, we support the development and use of effective patient education materials to support physicians in educating patients to help them overcome resistance to non-pharmacologic approaches to pain treatment.

Family physicians are deeply committed to fine-tuning their ability to prescribe opioids appropriately and effectively. AAFP members reported completing well more than 141,000 continuing medical education credits on this topic in 2016. To help address opioid abuse and addiction, the AAFP recognizes the need for evidence-based physician education to ensure safe and effective use of extended-release and long-acting opioids as well as short acting opioids. The AAFP continues to believe educating physicians is an important tool, but to be impactful, the education must be designed to address needs and gaps of the learners. “One size fits all” education is not optimal. Physician education should ideally be designed to address practice gaps which vary significantly.

The AAFP supports effective state prescription drug monitoring programs (PDMP) that facilitate the interstate exchange of registry information as called for under the *National All Schedules Prescription Electronic Reporting Act*. We advocate for physicians to use their state PDMP before prescribing any potentially abused pharmaceutical product. However, the success of such efforts depends on state reporting systems that are accessible, timely, interoperable, and comprehensive. We must work together to make prescription drug monitoring effective for the sake of the public’s health. The AAFP supports an interoperable secure national database to support a robust National PDMP. Until the United States has a National PDMP, the AAFP and our 54 chapters will continue working to encourage the use of state PDMPs and bring localized and state specific education to our members and their care teams. The AAFP calls for State PDMPs to use national standards to facilitate interfacing with users and urges them to be included in the Trusted Exchange Framework and Common Agreement. Inclusion in this work will allow queries to Qualified Health Information Networks to return information about controlled prescriptions. By using national standards, the PDMPs and their data can be integrated into electronic health records which would result in higher utilization as a result of reduced prescriber administrative burden. CMS would be able to use the same standards to access PDMP data if legally allowed.

We thank Congress for its effort to improve PDMPs by the enactment of the *VA Prescription Data Accountability Act* (Public Law 115-86) to require Veterans Health Administration (VHA) health professionals with the authority to prescribe controlled substances to provide data to their state PDMPs. The law applies to VHA prescriptions for both veteran and nonveteran patients.

The current opioid crisis is having an overwhelming impact on America’s overall health and well-being, which translates to increased trauma for children, families, and communities. Unfortunately, payment for primary care office visits with a mental health diagnosis code has traditionally been discounted or proscribed by private insurance, Medicaid, and Medicare as detailed in the AAFP’s Mental Health Care Services by Family Physicians (Position Paper). Many managed care plans do not pay family physicians for the provision of mental and behavioral health care, even though family physicians are frequently in the position to diagnose, treat and provide the needed care. We encourage the Committee to adequately pay for prevention programs and counseling/outreach programs to support children and families impacted by OUD and SUD. As a member of the Institute for Medicaid Innovation Workgroup on Opioid Use in Pregnant Women, the AAFP believes that MAT must be integrated into behavioral health services

available to pregnant women and that the health care system cannot adequately meet the needs of these patients unless care is integrated across multiple lines (e.g., insurance, employers, hospital/health system, pharmacies, public health and community agencies). Moreover, the health care system needs to reassess pain treatment in general and consider prescribing non-opioid pharmacologic therapy for chronic pain, as recommended in 2016 CDC guidelines.

Recognizing the current epidemic, late in 2016 the AAFP updated our "Chronic Pain Management and Opioid Misuse: A Public Health Concern" position paper to better equip members to combat the opioid abuse crisis while continuing to treat chronic pain.

We appreciate the opportunity to provide these comments. Please contact Teresa Baker, Senior Government Relations Representative, at 202-232-9033 or tbaker@aafp.org with any questions.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair

About Family Medicine
Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.