AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

April 25, 2018

Hon. Greg Walden
Chairman
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Hon. Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
United States House of Representative
Washington, DC 20515

Hon. Michael Burgess, MD
Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representative
Washington, DC 20515

Hon. Gene Green
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
United State House of Representative
Washington, DC 20515

Dear Chairman Walden and Ranking Member Pallone,

On behalf of more than 34,000 orthopaedic surgeons and residents, the American Association of Orthopaedic Surgeons (AAOS) commends the House Energy and Commerce Committee for taking up an unprecedented number of bills addressing the opioid epidemic that is devastating so many patients, families, and communities. The AAOS believes the reconciliation of the bills under consideration will significantly impact the scourge opioids that are causing across the United States. We urge the committee to thoughtfully consider each bill so as to avoid any negative unintended consequences.

To be successful, stakeholders need to work together to ensure all patients have access to the whole gamut of options that prevent and treat addiction. The AAOS supports increased access to evidence-based pain related treatment, including mental health and substance abuse treatment, research into innovative treatments, better prescription monitoring, and effective education for physicians and patients. To these ends, the AAOS is working on several initiatives – from public service announcements to a "pain relief toolkit" – to encourage AAOS members to practice safe and effective pain management and treatment.

Here we provide our comments on legislation recently addressed in hearings over the past two months.

CMS Action Plan

The AAOS believes the Action Plan to be developed by the Secretary of Health and Human Services, along with the Pain Management Best Practices Inter-Agency Task Force, will have a significant impact in mitigating the epidemic. By addressing issues such as enhanced coverage and reimbursement for multimodal pain management, care coordination, mental health and substance abuse screening, and education, we can improve care quality and coordination for patients with acute and chronic conditions.

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With many other work groups amongst the various federal agencies, (FDA, DEA, CMS, FBI, etc.) we call for central oversight to the regulatory processes to harmonize a unified federal approach.

The AAOS supports payment models that encourage and incentivize the incorporation of evidence-based care. Several AAOS clinical practices guidelines (CPGs) and appropriate use criteria (AUCs) make recommendations on better care coordination and multimodal pain management, all of which reduce patients' need for opioids and improve functional outcomes. Making evidence-based medicine, developed by medical and surgical specialties, a central part of Medicare and Medicaid programs will help mitigate patients' risk for opioid use disorder.

Coverage for pre-operative mental health and substance abuse screening has significant potential to reduce the odds of post-operative complications and addiction. Research has shown that surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery, suggesting the potential benefit of psychological and opioid screening with a multidisciplinary approach that includes weaning of opioid use in the preoperative period and close opioid monitoring postoperatively.

Regarding changes to both the Medicare inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS), physician fee schedule (PFS) and MACRA year 3 proposed rules, the AAOS supports eliminating the obstacles to care coordination. A lack of payment incentive has left care coordination fragmented. A specific example to orthopaedics includes hip fracture in the elderly, a patient population with a significant impact on Medicare. Strong evidence supports the use of interdisciplinary care programs. Patients with well-coordinated teams, including geriatric consultation, rehabilitation services, discharge planning, and post-hospital planning, achieved better functional outcomes. Proper reimbursement for these services will ensure better outcomes and creating more value-based models with this kind of coordination can help not only hip fracture patients, but countless other patients in the Medicare and Medicaid population. (https://www.aaos.org/Quality/)

The AAOS supports provider education as a means of ensuring appropriate and judicious opioid use. Physicians' enhanced understanding of opioid analgesics and alternative, multimodal pain management techniques would lead to better patient outcomes. Awareness of the risks and appropriate uses of opioid medications is critical and AAOS encourages development of effective education programs for physicians, caregivers, and patients. Periodic CME on opioid safety and alternative pain management strategies will help physicians reduce opioid use and misuse. Currently, provider requirements vary from state to state and different medical specialties require education tailored to meet the needs of their respective patients. A one-size-fits-all approach poses significant challenges and may have unintended consequences. AAOS believes that medical professional organizations are best positioned to provide relevant and meaningful education to its members and patients.

Postoperative Opioid Prevention Act of 2018
The AAOS supports the need to remove bundled cost conflicts that fostered an environment where it is more convenient to prescribe post-operative opioids than using other evidence-based treatments with a safer risk profile.

Several recommendations in our CPGs and AUCs support the use of non-pharmacological and non-opioid pharmacological treatment options that help patients effectively manage pain without relying solely on opioid narcotics. Multimodal examples that reduce pain as well as improve satisfaction, improve function, reduce complications, reduce nausea and vomiting, reduce delirium, decrease cardiovascular events, and reduce opiate utilization include: neurostimulation, local anesthetics, regional anesthetics, epidural anesthetics, relaxation, combination techniques, and various pain protocols. There are a large variety of techniques that result in modest but significant positive improvements in many clinical and patient-centered domains with minimal significant adverse outcomes. Using an array of pain management modalities is appropriate and should be encouraged and incentivized, such as the transitional pass-through payments for analgesics during the post-operative period. The AAOS recognizes that the available therapies alone will not solve the problem and supports additional research and increased funding for other non-narcotic and/or non-pharmaceutical, including nutritional, alternatives for pain management.

Additionally, it is imperative to identify patients pre-operatively who are at a greater risk of opioid misuse and abuse (e.g., using the opioid risk tool http://www.mdcalc.com/opioid-risk-tool-ort-fornarcoticabuse/). This includes patients with symptomatic depression and ineffective coping strategies. Physicians, the public, and policy makers should value interventions to lessen stress, improve coping strategies, and enhance support for patients recovering from injury or surgery.

Post-surgical Injections as an Opioid Alternative
The AAOS strongly supports reimbursement parity for services provided in ambulatory surgical centers. With procedures increasingly moving to the out-patient setting, it is crucial that services be adequately reimbursed. We have been supportive of making payments for services furnished in the physician office or the ASC equal to payments in the hospital outpatient setting.

With the recent removal of Total Knee Arthroplasty (TKA) and potentially several other orthopaedic procedures from the Inpatient Only List (IPO), patients' post-operative care coordination and delivery is changing rapidly, including physical therapy and pain management services. This makes designing reimbursement models, with the necessary care coordination components, especially important.

Pain Assessment Bill
The AAOS is concerned that requiring a pain assessment as part of the Medicare Welcome Examination, without accounting for a patient's function, is one factor that contributed to the situation in which we

find ourselves now. Payment incentives for higher scores on the Pain Management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey may have created the unintended consequence of overprescribing opioids in the inpatient setting. The AAOS cautions against creating another situation leading to the over-treatment of pain by not making pain evaluation mandatory. Rather pain should be included as part of a larger discussion between the physician and patient about function and quality of life, after which, if it is deemed necessary, the patient be referred to a pain management specialist.

Medicaid Partnership Act & Every Prescription Conveyed Securely Act

The AAOS believes that for the provisions in the Medicaid Partnership Act to be successful, it is necessary for the provisions of the "Monitoring and Obtaining Needed Information to Track Opioids Responsibly Act of 2017" or the "MONITOR Act of 2017" to be put into place. The legislation mandates that PMDPs must meet a uniform electronic format for reporting, increase sharing and disclosing of information, meet minimum standards for interoperability, and make information available to physicians on a timely basis. Several states with high-functioning and interoperable systems have demonstrated significant reductions in opioid prescriptions, overdoses, and opioid-related mortality. A robust interoperable and integrated PDMP network is necessary to have the desired impact on opioid prescribing. With the Medicaid Partnership Act and the Monitor Act, this stands the considerable chance of becoming a reality.

The AAOS is highly supportive of the provision to integrate the PDMP into clinicians' workflow, specifically into the Electronic Medical Record. Providers would face a significant burden if these systems were to remain separate. The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) recently released a report on its PDMP Electronic Health Records (EHRs) Integration and Interoperability Expansion (PEHRIIE) program, the goal of which was to increase PDMP use and effectively reduce prescription opioid misuse and overdose. The study noted that a serious obstacle to effective PDMP use was poor integration into health information technology (HIT) systems at the point of care, inefficient workflow, and limited data sharing across state lines. The program was successful in reducing these obstacles in several states:

- Illinois achieved PDMP integration into EHRs at a local hospital, where over a two-year period, opioid prescriptions decreased 22% and saw a 41% decrease in the number of patients who received at least one prescription over the same period. The data remained hosted within the PDMP, but direct linkages from the PDMP to EHRs were established so that end users could request data through a portal within their EHRs or directly via the web.
- Washington's PDMP became interoperable with OneHealthPort, a statewide Health Information Exchange (HIE), enabling integration with the Emergency Department Information Exchange (EDIE), a hub connecting hospital emergency departments, in late November 2014. In calendar

year 2014, the PDMP provided 26,546 solicited reports to prescribers via EDIE. This number increased more than 80-fold to 2,222,446 EDIE reports in calendar year 2015.

- Some states connected their PDMPs to hubs to help facilitate interstate PDMP data sharing. Florida, Illinois, Kansas, and West Virginia created PDMP/EHR and PDS integration by connecting the state to a PDMP hub (e.g., PMPi, RxCheck).
- Other important lessons learned in the study included:
    - Learn from the field
    - Start small, then expand
    - Consider state context
    - Engage stakeholders early and often

Electronic prescribing of medications promotes patient safety and e-prescriptions for all opioids would help not only appropriate use and patient convenience, they would also provide data in a format that could provide better surveillance of excessive, inappropriate, and non-therapeutic prescribing. *Every Prescription Conveyed Securely Act* would aid orthopaedic surgeons in addressing this issue by requiring electronic prescriptions for controlled substances. By requiring prescribers to use an online database where prescriptions are easily monitored and tracked, this bill could help eliminate doctor shopping and duplicative or fraudulent handwritten prescriptions that fuel the opioid epidemic. All federal agencies (VA, DOD, Coast Guard and Indian Health Service) should be required to participate in the state PDMP programs. It is essential that regional access to bordering states, federal health facilities such as military and Indian health services be available to all bordering physicians to combat "doctor shopping" across jurisdictional lines.

Mandatory Lock-in (Medicare) & Medicaid Pharmacy Home Act of 2018

AAOS believes opioid use is best coordinated with a limited number of prescribers and dispensers, especially for patients dealing with ongoing/chronic pain issues. Locking-in patients to a limited number of prescribers and pharmacies will help reduce misuse and abuse. The appropriate number of prescribers will vary from patient to patient, depending on their health status, comorbidities, geographic location, etc. Putting too strict a limit on the number of prescribers or pharmacies could inadvertently create a situation in which a patient's access could be limited, for instance dual residence retirees. The AAOS advises carefully considering, with the input from a broad group of stakeholders, how lock-in rules are determined.

Standardized Electronic Prior Authorization for Safe Prescribing Act

AAOS strongly supports standardizing the electronic prior authorization (ePA) process. Many plan sponsors have implemented their own policies as to when and which treatments would require a review and have created challenges for providers and staff in securing ePA, including long wait times with customer service and, at times, lack of timely follow-up. These situations have at times delayed treatment and/or limited patient access to care. There are many third-party vendors providing an ePA

service between plan sponsors and providers that has added to the confusion, as providers have to learn several different systems based on practice setting (clinic, hospital, etc.). Standardizing this process will save time for providers and other healthcare staff and ensure patients receive high quality, timely care.

Prescriber Notification & Prescriber Education

AAOS believes that medical professional organizations are best situated to provide relevant and meaningful education to its members and patients, helping avoid a situation of adding another requirement that may do little to enhance patient care. Recognizing the urgency of this public health problem and the important roles that physicians have in controlling appropriate use of opioid medications, the AAOS believes that Continuing Medical Education (CME) on opioid safety and optimal pain management strategies will help physicians reduce inappropriate opioid use and misuse, while still providing high quality musculoskeletal care.

It is important to be mindful of the fact that provider education requirements vary considerably from state to state. Developing and implementing provider education can be challenging when trying to adhere to and meet the varied requirements of each individual state. But, it is also equally important to recognize that different medical specialties require education tailored to meet the needs of their respective patients and a one-size-fits-all approach poses its own significant challenges.

Again, the AAOS commends the committee for taking steps to address the opioid epidemic. Please feel free to contact Catherine Hayes, AAOS Senior Manager of Government Relations (hayes@aaos.org), if you have any questions or if the AAOS can serve as a resource to you.

Sincerely,

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