American College of Physicians
Leading Internal Medicine, Improving Lives

April 10, 2018

The Honorable Rob Portman
United States Senate
Washington, DC 20510

Dear Senator Portman:

On behalf of the American College of Physicians (ACP), I would like to express our appreciation for your continued effort to improve treatment for individuals with opioid and substance use disorders. These disorders have reached an epidemic level and represent a threat to the public health of our nation. Congress has taken positive steps to address the opioid crisis with the passage and enactment of the Comprehensive Addiction and Recovery Act (CARA) in 2016, but a greater sustained effort is needed to fulfill the unmet needs of individuals who need treatment for drug addiction. To that end, we are pleased to offer our support for your legislation, S. 2456, the Comprehensive Addiction and Recovery Act (CARA) 2.0 of 2018, a comprehensive bill that would increase funding, improve treatment, and enhance first-responder training to care for individuals with substance use disorders. We also would like to provide you with several recommendations to help improve the legislation and hope that you will incorporate these suggestions in the bill as it moves through the legislative process.

The ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Continued Funding for CARA

The CARA 2.0 Act builds on legislation that was signed into law in 2016, by reauthorizing CARA for five additional years with increased funding to strengthen the federal government's response to the opioid crisis. ACP supported the initial CARA legislation that provides funding for public education on the risks of opioid misuse and substance abuse, evidence-based treatment and recovery programs, and additional tools for law enforcement officers to reverse overdoses. The initial CARA bill authorized $267 million in funding to combat the opioid crisis in 2017, with an additional $6 billion in related funding provided as part of the recently-enacted Bipartisan Budget Act of 2018, which we were pleased to support. CARA 2.0 authorizes $1 billion in dedicated funding to evidence-based prevention, enforcement, and treatment programs to address the opioid crisis.

Opioid Prescribing

Internists are uniquely suited to treat individuals with opioid and substance use disorders as they are often the first point of contact into the health system for patients with chronic pain. Our physicians have an ethical obligation to manage and relieve pain in a manner that reflects the best available clinical evidence. The challenge for physicians and public policymakers is how to deter prescription drug abuse while maintaining patient access to appropriate treatment.

Physicians are obligated by the standards of medical ethics and professionalism to practice evidence-based, conscientious pain management that prevents illness, reduces patient risk, and promotes health. ACP strongly believes that physicians must become familiar with, and follow as appropriate, clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologics and nonpharmacologic interventions.

The CARA 2.0 Act would limit initial prescriptions for opioids to 3 days while exempting chronic care, care for cancer, hospice or end-of-life care, and pain being treated as part of palliative care. This provision is generally reflective of the Centers for Disease Control and Prevention's (CDC) Guideline for Prescribing Opioids for Chronic Pain, which ACP supported. ACP policy notes that defined maximum dosage (i.e., morphine equivalent) and duration-of-therapy limitations are not applicable to every clinical encounter and favors establishment of evidence-based, nonbinding guidelines regarding recommended maximum dosage and duration of therapy that a patient taking controlled substance medications may receive.

While we are supportive of the CDC guidelines for prescribing opioids, they are intended to guide prescribers, not act as prescribing standards. The guideline states "The recommendations in the guideline are voluntary, rather than prescriptive standards. They are based on emerging evidence, including observational studies or randomized clinical trials with notable limitations. Clinicians should consider the circumstances and unique needs of each patient when providing care." We believe guidelines should not be used to make coverage decisions that may impair access to needed medications since patients have individual care needs that may not be reflected in the guidelines. We caution that such thresholds should not be rigidly applied and that there must be some flexibility to allow adjustments in determining duration of therapy reflecting physician judgment. If overutilization controls are to be implemented, they must be applied in a way that provides ample flexibility to deliver the appropriate care for patients with complex care needs and do not create an undue burden on patients.

Prescription Drug Monitoring Programs

S. 2456 would also require a prescriber or their designee to consult their state prescription drug monitoring programs (PDMP) before initiating treatment with a prescription for a controlled substance and every 3 months thereafter as long as the treatment continues. State PDMPs must also make their PDMP data available to other states. We strongly urge prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing

and filling prescriptions for medications containing controlled substances and support the sharing of PDMP data from one state to another. We also support allowing a prescriber's qualified designee to consult the PDMP. However, we believe that policies should be implemented to reduce administrative burdens associated with their use, including ensuring interoperability with electronic health systems. According to a recent report from the Pew Charitable Trust, the integration of PDMP data into a patient's health IT record would save the physician time and reduce administrative hassle associated with this task. The report notes that "integration with health IT makes PDMP data available to prescribers as part of their workflow without the need for multiple user accounts, log-ons, or user interfaces, thus saving prescribers time and effort. One study, involving focus groups of 35 prescribers from nine states, identified time spent accessing a report as a barrier to PDMP use and recommended integration with health IT as part of the solution." The Substance Abuse and Mental Health Services Administration and other federal agencies have initiated pilot projects and provided funding to states to encourage interoperability of PDMPs, but more needs to be done to enhance user friendliness.

Education, Treatment, and Recovery

ACP supports all appropriate and effective efforts to reduce substance use disorders. These include educational, prevention, diagnostic, and treatment efforts. We support a provision in the CARA 2.0 bill that authorizes $10 million to fund a national drug awareness campaign that will bring greater awareness to the association between prescription opioid misuse and heroin use, and will emphasize their similar effects on the human body, and educate the public about the lethality of fentanyl, particularly when it is mixed with other drugs.

We also support additional funding to expand access to naloxone in the community and through co-prescribing. The CARA 2.0 Act will authorize $300 million annually to make naloxone available to first responders to train and provide resources for carrying and administering naloxone, and establish mechanisms for referrals to treatment. Funds may also be used to provide resources to first responders on safety around fentanyl and how to respond after exposure.

S. 2456 will also expand activities related to the treatment for substance use disorders, including the availability of medication assisted treatment (MAT). It would provide grants to state substance abuse agencies, units of local governments, nonprofit organizations, and Indian tribes or tribal organizations that have a high rate or rapid increase in the use of opioids or heroin. ACP is supportive of this provision of the bill as we encourage the expansion of medication assisted treatment to prevent opioid and substance use disorders. We promote the expansion of coverage of MAT in Medicare and Medicaid and are concerned that 14 state Medicaid programs do not cover the full array of MAT (including the buprenorphine/naloxone formulation), naltrexone, and methadone.

We are also pleased that the CARA 2.0 Act will authorize $200 million annually to build communities of recovery that would build connections between recovery support services and networks, including treatment programs, mental health providers, treatment systems and

other recovery support. We urge that this funding should be used to enhance the integration of behavioral health, including screening, referral and treatment of opioid and substance use disorders into the primary care setting. Primary care is the appropriate platform to care for these patients as it is often the first point of contact of care for patients with these disorders.

We are pleased S. 2456 will expand medication assisted treatment for recovery from addiction by waiving the limit on the number of patients physicians can treat with buprenorphine so long as they follow evidence-based guidelines. ACP policy supports lifting the cap on the number of patients who can receive buprenorphine if a physician has been trained in proper prescribing practices. We also believe that public and private insurers should remove onerous limits on medications for overdose prevention and medication assisted treatment, including burdensome prior authorization rules or lifetime limits on buprenorphine that prevent medically necessary care.

In closing, we would like to again thank you for introducing this legislation and appreciate the opportunity to offer our feedback and recommendations on this important issue. Please do not hesitate to contact ACP if we can be of further assistance in this effort to reduce the rate of opioid and drug addiction in our country. Please contact Brian Buckley at 202-261-4543 or bbuckley@acponline.org with any questions regarding this letter.

Sincerely,

Jack Ende, MD, MACP
President

CC: Senators Whitehouse, Capito, Klobuchar, Sullivan, Hassan, Cassidy, Cantwell