



The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

The Honorable Ron L. Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

Re: Hatch-Wyden Opioid Input Solicitation Letter

Dear Chairman Hatch and Ranking Member Wyden:

The National Partnership for Hospice Innovation (NPHI) is a collaborative of over 50 of the nation's most innovative, community-integrated not-for-profit hospice and palliative care providers that serve as a critical safety net in communities across the United States. By coming together, we identify, enhance, and spread the best practices in which our members are engaging. The members of NPHI have decades of demonstrated experience in providing the highest-quality hospice and palliative care to those facing the final stage of their life. Of the 4,199 hospice providers in the United States, only 30% are not-for-profit; the number of for-profit hospices grew by 5% in 2015 while the number of non-profit hospices declined by 1% (the number of hospice providers grew overall by 2.6% continuing a 10 year trend of industry growth).¹ Our programs serve the sickest and most vulnerable patients in our communities and refuse to turn away any patient regardless of their terminal condition or ability to pay, while still providing a comprehensive scope of care to meet patients' goals, values, and wishes during their last stage of life.

We are writing today in response to the Committee's request for input on the opioid epidemic and its impact on the Medicare and Medicaid programs. We want to support the Committee's efforts to look at the epidemic but also want to caution that until we get a much better handle on pain care in this country, we will continue to have "spill-over" effects with problematic opioid use---and the converse, *a reluctance to treat pain when indicated*. The critical importance of well-informed, well-supported, well-monitored, and well-managed pain management (especially chronic pain of all etiologies) cannot be overlooked—especially in the Medicaid and Medicare populations—in any plan to reduce, no less eliminate, opioid-related morbidity and mortality in our country.

As an organization that represents not only high-quality hospice and palliative care providers, but also many of the legacy hospice organizations, we want to point out that hospice is a pioneer in end-of-life (EOL) care and pain management. Hospice & palliative medical professionals are leaders in pain management, goal setting, resource allocation, global care management, and conservation of resources as well as responsible providers of opioid medications for our patients. Our message needs to reflect the commitment we make to improve the health care of Americans, the quality of life for our patients and their families, and the unwavering vigilance for safe and responsible prescribing with an eye toward taking care of the pain of our patients.

¹http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch12.pdf?sfvrsn=0

As opioid utilization moves toward more regulation, we want to emphasize the need for more education and higher practice standards. There is also a need to delineate the types of patients that require opioids. Providers should understand the risk individuals face for opioid/substance use disorder (OUD/SUD) when battling pain, whether it is non-malignant, malignant, chronic, as well as pain and suffering from a progressive serious illness and condition with a high risk of morbidity or mortality. Identifying where individuals fall in the progression of their illness is paramount just as much so as appreciating the progression of an aged population where many have serious chronic conditions that contribute to a lessening of functionality and at some point contributes to an eventual death.

The Congress need to recognize the inherent differences in these patient populations that are served. We hope that lawmakers would have a better understanding of the unique needs that palliative care and hospice patients present with and the need for these patients to be carved out.

Overall Recommendations

- Hospice and cancer patients should be carved out from any opioid or other narcotic restrictions in the Medicare and Medicaid programs to avoid any under-treatment of pain;
- Providing financial support for programs and personnel that are often provided by community-based hospice and palliative care programs like chaplains, social workers, and community-grief programs that are critical resources for people with OUD, SUD, and their families;
- Continue to fund research into means to treat chronic pain –through both non-pharmaceutical or pharmaceutical means.

Specific Responses

1. **How can Medicare and payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing opioid use disorder (OUD) or other substance use disorders (SUD)?**
 - a. Monitoring of function to justify the use of opioids would be beneficial. Clearly the regulators, payors, and enforcement bodies want to see justification (patients continue to work/ maintain independent living) for interventions and are ok when adequate documentation is in place. Utilizing function scales in place of or in combination with pain scales in the palliative setting (upstream from the hospice where the function may no longer be possible) is externally important.
 - b. The importance of utilizing non-opioid pain adjuvants and multi-modal therapy should align with reimbursement policies to help to deemphasize opioid use in chronic pain. The use of a biopsychosocial approach to pain² (which is the backbone of the palliative care philosophy) has been shown to improve outcomes in pain management.

²<https://www.apa.org/pubs/journals/releases/amp-a0035514.pdf>



- c. Reimbursement or funding support for specialty training in palliative medicine and end of life care often is focused in the acute care arena and large educational health systems and doesn't reach into the post-acute arena, where much of the palliative care support, training, and education occurs.
 - d. Improving payment models for supportive resources and addressing social determinants needs, i.e., chaplains, social workers, for individuals need palliative care or with life-limiting illness would:
 - i. Prevent OUD by identifying and addressing spiritual pain/mental/psychosocial pain, and
 - ii. Recognize SUD and then improve engagement with community resources. Some programs are just not large enough to offset the costs of having these talented individuals on their multidisciplinary team.
 - e. Having a better understanding of the use technology brings to this area, especially to see the benefit of opioids therapy. It appears that often providers just prescribe opioids and assume that the intended effect will be achieved. Using remote symptom assessment tools along with monitoring the pain score and functional status (using step counters/sleep monitoring devices) can provide more objective data to show that opioids can improve a person's function and overall quality of life.
- 2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?**
- a. CMS should create more palliative care support and reimbursement codes for the use and inclusion of appropriate referrals to community palliative care practices. Promoting the benefit of the community palliative medicine providers as a collaborator in the care of individuals with serious illness who would benefit from opioids as an adjunct to their treatment is a strong example of where this expertise would improve patient outcomes. The development of these codes could also help CMS to monitor which patients and providers might benefit from a carve-out like what we recommend for hospice patients.
 - b. Improved access and coverage for compounded topical therapies.
 - c. Improved access and coverage for the continuing use of non-pharmaceutical therapies.
 - i. Ease barriers to access or provide payment for non-pharmaceutical treatments in Medicare and Medicaid that have show efficacy in pain management such as: physical/occupational therapy, osteopathic manipulative therapy, massage therapy, music therapy, therapeutic exercise, acupuncture, and relaxation techniques.
- 3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment,**

and treatment for OUD and other SUDs to improve patient outcomes?

- a. First, stakeholders should agree on a common definition of “evidence-based.” While many non-pharmaceutical therapies have shown positive outcomes and improved functioning, these therapies are often not approved for reimbursement or treatment choices.
 - b. If non-pharmaceutical therapies are approved the sequence of services are limited without continuing to show a high degree of need. Just as the treatment is beginning to improve function and reduce pain, the individual doesn’t meet the initial criteria because they aren’t “as sick” as they were originally. Yet, they haven’t reached their full potential recovery, and the lack of ongoing therapy degrades earlier successes and slows healing.
 - c. Allow less restrictive access and coverage for primary functional treatments to include physical/occupational therapy, osteopathic manipulative therapy, massage therapy, music therapy, and therapeutic exercise.
 - d. Improving payment models for supportive resources in care, i.e., chaplains, social workers, addiction specialists in individuals on prolonged opioid therapy, including those with life-limiting illness which in our opinion would:
 - i. Prevent OUD if possible (spiritual pain/mental/psychosocial pain identification); and
 - ii. Recognize SUD and then improve engagement with community resources. Some programs are just not large enough to offset the costs of having these talented individuals on their multidisciplinary team.
- 4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?**
- a. CMS should support funding for initiatives to encourage states to develop interactive and functional Prescription Drug Monitoring Programs (PDMPs). Identifying basic parameters around what data elements PDMPs should collect would help create interoperability standards between programs that exist in most states already.
 - b. Identify and determine what data elements should be shared on a national, regional, and state basis. Open the data to researchers that could assist in educating providers on utilization and improved use.
 - c. Promote collaborative practices of sharing data between states, particularly between those states that border one another, if not already occurring.



5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

- a. There need to be better ways to identify the practice setting and what patients are being served and why to better identify and educate around high prescribing patterns of prescribing. For example, patients with serious illnesses that have a high morbidity or mortality risk describe palliative care and hospice type patients, as well as cancer patients. These types of patients often use controlled substance in some situations that are not prescribed in the same manner as in other patient populations. It is important for policymakers, CMS, and others to determine how to define a palliative care patient and assuring that these patients are prescribed the level of medication needed without overly burdensome scrutiny regardless of where the patient is on the trajectory of their illness, therefore improving access to good pain management.
 - i. For example, in regard to end-of-life narcotic use - not only are opioids used for pain but also for shortness of breath. It's not uncommon to see uncontrolled shortness of breath with end-stage cancer, COPD, heart disease, muscular disorders (ALS, muscular dystrophy, etc.), patients with aspiration (CVA, dementia, Parkinson's), patients with end-stage coronary artery disease having acute MI, and heart failure patients. This list covers the majority of terminal patients. In these cases, the use of morphine goes beyond pain management and is used for symptom management (i.e. shortness of breath).
 - ii. Also, as patients are dying, they often lose the ability to swallow. When patients have trouble swallowing they can't take their nonnarcotic pain and comfort medications by mouth. At this time Roxanol or Methadone are easily given sublingually to control symptoms and allow patients to be comfortable and be cared for at home. When patients can no longer tolerate oral medications, there are limited options to provide comfort meaning access to medication in other forms is critical and allows for lower doses and a lower cost of care at home.
- b. Incentivize earlier and clearer pathways to palliative care with improved funding for palliative care services for inpatient, facility and home care. These services have demonstrated lower ER visits and hospital admissions, reducing cost and improving quality of life.
- c. Provide, develop, and implement more opportunities and support to improve and demonstrate the value of pain and palliative medicine education at the undergraduate and post graduate level as well as for community prescribers in making physicians better pain managers.



- d. There are needs for physicians and payers to understand the physiology of pain and its effect on the patient and family unit.
 - e. Additional funding for specialty training in palliative medicine would help to alleviate the lack of understanding around pain management in addition to addressing issues around the current workforce shortage in the field.
 - f. As the health care system moves to address the social determinants of health, as well as treating the patient and family as a unit of care, it is critical to understand the importance of an interdisciplinary team approach to pain management including team access to and funding for specialty level psychological and PharmD expertise on the team.
 - g. For those health care providers who prescribe controlled substances, it is important to educate the patient and family on the need to be a partner and identify the patient's and family's responsibility for medication safety and stewardship to the community.
- 6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?**
- a. There should be support for state initiatives to develop and enhance interactive functionality between Prescription Drug Monitoring Programs.
 - b. There should be some central mechanism to identify basic parameters around what data elements Prescription Drug Monitoring Programs should collect.
 - c. Promote collaborative practices of sharing data between states, particularly those that border one another, if not already occurring.
- 7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?**
- a. Addressing pain and suffering through a comprehensive program has many benefits. Using an opioid risk assessment, a medication agreement, , as well an agreement with the patient to initially accept lower potent prescriptions, allows for closer evaluations to document efficacy and/or aberrant behavior. This also provides more time to implement a clear and easy to follow disposal policy when care is completed. These actions help to ideally shift some of the responsibility and incentives, as well as consequences to the patient.



- b. Promote the development of well-designed organizational policies and procedures on medication management and drug disposal which enable staff to work effectively and with more job satisfaction.
 - c. Support the relaxation of laws that govern the direction of medications moving into a patient's estate when that individual dies and support more drug disposal drop-off sites and other mechanisms of disposal. Encourage similar programs in other states that allow oversight of the destruction of medications through appropriate mechanisms, similar to the practice of hospices in Ohio and a 2018 state law taking effect in Kentucky.
 - d. In addition, these types of programs should be explored to supplement other efforts to destroy dangerous medications in the home. For example, other healthcare providers that work in the patient's home environment could educate and assist clients in the destruction of dangerous medications in the home. Additionally, primary physicians should routinely educate patient and families on their responsibility to destroy medications that are no longer used.
 - e. The responsibility of prescribers and healthcare providers to take an active voice in national and state opioid policy should be addressed in the basic education and training.
 - f. Pain management is critical to keep members of society participating in the workforce and community. More work needs to occur to demonstrate support for identifying the value of utilizing measurement tools that focus on improving function rather than just reducing a number on the pain scale for upstream patients.
- 8. What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?**
- a. One response to address issues related to treating adults and children affected by an unintended overdose death is the utilization of grief and bereavement counseling and support by community-based not-for-profit hospices.
 - b. Many of our programs who have developed strong community support programs around the nation and distinguish us from our counterparts in our communities, report a growing population of participants seeking these services – both children and adults. Since these programs are funded by philanthropy, the efforts to serve this population stretch the abilities of the programs to continue these services without addressing the impact and viability of the maintaining services at this level. The services they provide give tremendous support and guidance for individuals often living in an otherwise destructive environment. Providing funding for these programs would mitigate the impact of OUD and SUD on children and families by allowing more people to access these programs

- c. Expanding funding for other behavioral health services to address the root causes of SUD disorders and to treat the co-morbid conditions that might be present.
- d. Funding for addiction medicine and treatment that can be given in conjunction with pain management.
- e. Some states have policies with unintended consequences for patients on hospice. Nevada, for example, recently implemented a law where even for patients on hospice, every patient who will be prescribed an opioid must be looked up and found in a state database. Then a patient risk assessment must be performed in order for the narcotic to be prescribed. While a patient risk assessment is appropriate and recommended for screening patients prescribed opioids in most circumstances, patients are often referred to hospice late in their disease trajectory and in a pain crisis. Delay in relief of symptoms is detrimental to that patient and to his or her family's last days. This is an example at an attempt at good policy that needs some adjustments.
- f. Hospice providers have concerns about leaving extra drugs in the home given the increasing rates of family addiction. One policy that would mitigate this would be if pharmacists have discretion over breaking up doses of medications, for example oral morphine. As noted earlier, at the end of life, patients often cannot swallow and are prescribed oral morphine. In some states, for example Texas, the pharmacy cannot break up the dose in smaller quantities.

We believe these are critically important issues and we thank you for your consideration and we would be happy to assist the Committee and the Congress with these issues in any way that we can going forward.

Please contact Mollie Gurian, Chief Strategy Officer, at mgurian@hospiceinnovations.org with any questions or comments.