



**Association of
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President and Chief Executive Officer

March 19, 2018

The Honorable Kevin Brady
Chair
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Peter Roskam
Chair
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Brady, Ranking Member Neal, Chairman Roskam, and Ranking Member Levin:

On behalf of the Association of American Medical Colleges (AAMC), thank you for your February 28, 2018, letter requesting input on strategies to respond to the nation's opioid epidemic and for your ongoing efforts to help curb this public health crisis. As you know, the epidemic is devastating communities across the country, and our member medical schools and teaching hospitals are actively working to prevent and address its impact every day.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

While AAMC-member teaching hospitals represent only five percent of all hospitals, they account for a much larger share of care delivered nationally – including 23 percent of all hospital inpatient days, 20 percent of all Medicare inpatient days, and 24 percent of all Medicaid hospitalizations – and disproportionately care for the nation's under- and uninsured patients, accounting for 33 percent of charity care. Major teaching hospitals also offer vital services that often cannot be accessed elsewhere in the community. Over half of AAMC-member teaching hospitals offer outpatient substance use services, and over three-quarters operate crisis

prevention programs. AAMC-member hospitals also account for 19 percent of the nation's alcohol unit beds and 22 percent of inpatient psychiatric unit beds. The vast majority of our member teaching hospitals provide child psychiatry services or outpatient psychiatric care. These institutions serve on the front lines of the country's safety net, investing in a wide scope of mental and behavioral health services, including treatment and recovery support for substance use disorders.

In concert with their communities, academic medical centers are leveraging their three missions of research, education, and patient care to advance comprehensive approaches to better prevent, identify, and treat pain and addiction. Scientists at medical schools and teaching hospitals are conducting approximately half of the research supported by the National Institutes of Health (NIH) on pain, substance use, narcotics, and opioids, as we strive to improve our understanding of pain and addiction and to develop new and more effective treatments. Medical educators are preparing the next generation of physicians by enhancing existing content on pain and substance use disorders (SUDs) with additional classroom, hands-on, and interprofessional experiences integrated throughout the educational continuum. And clinicians at major teaching hospitals are implementing new and refined pain management protocols and connecting patients to behavioral health and substance use services, often filling gaps by providing care and recovery support that is not accessible elsewhere in the community. The AAMC highlighted just a few examples of academic medicine's multifaceted response to the opioid epidemic in a [recent publication](#), and we continue to support our members in their work by offering opportunities to share information through conferences, webinars, an online database of peer-reviewed curricular resources, and other venues summarized on our website at www.aamc.org/opioidresponse.

Despite these efforts and the work of numerous other stakeholders, the opioid epidemic alarmingly continues to take a toll on communities across the country. The latest data from the Centers for Disease Control and Prevention (CDC) revealed that between 2016 and 2017, the number of overdoses seen in hospital emergency rooms increased by a staggering 30 percent nationwide, with particularly steep increases in large central metropolitan areas and across all age groups (including a 32 percent increase in overdose rates among adults over the age of 55).¹ While the report does not specify the exact drivers of the rising overdose numbers, there has been a dramatic rise in opioid overdose deaths attributed to other and more potent synthetic opioids such as fentanyl and heroin.

The rapidly growing and highly dynamic nature of the epidemic brings to light some of the challenges health care providers face in mitigating its impact. These challenges are amplified because this crisis is layered on top of existing public health and social services deficits, further straining the health care and public health infrastructure. Thus, any effective response will require a collective effort across multiple sectors and attention to systemic barriers to progress. Consistent with their mission, the nation's academic medical centers are committed to redoubling their ongoing efforts to meet their communities' changing needs to the extent they are able. The enactment of agile and forward-thinking public policies holds the potential to greatly

¹ Vivolo-Kantor AM, Seth P, Gladden RM, et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses — United States, July 2016–September 2017. *MMWR Morb Mortal Wkly Rep* 2018;67:279–285. DOI: <http://dx.doi.org/10.15585/mmwr.mm6709e1>.

facilitate and maximize this work, especially given the power of Medicare policy to drive changes in the private sector.

To that end, the AAMC commends the Committee's interest in identifying specific policy solutions and welcomes the opportunity to provide the recommendations that follow. While we recognize that some of the proposed strategies may fall outside the Committee's jurisdiction, we include them because we believe a comprehensive approach will be necessary to address the many factors associated with this challenge. For example, the experiences in other agencies, such as innovations implemented by the Department of Veterans Affairs, may be informative to the Committee's efforts. Additionally, though the Committee has focused its inquiry on addressing the opioid epidemic specifically, we note that efforts to develop solutions for the current crisis simultaneously present an opportunity to address existing and looming challenges with respect to preventing and treating substance use disorders more broadly.

Improve coverage and payment for non-opioid alternatives to treat pain. In addition to addressing the consequences of the current epidemic, any comprehensive strategy also should take steps to prevent further growth of the epidemic. Experts have suggested that non-opioid and non-pharmaceutical alternatives to prescription pain medication for some patients may be just as or more effective than opioids. However, payment barriers in the Medicare program (as well as Medicaid and private insurance plans) may be hindering greater use of such therapies. Ensuring coverage of these treatments, and appropriate payment, could help provide patients and providers with additional options for managing pain beyond opioids. Such an approach will be increasingly important as research supported by NIH and other agencies helps to improve our understanding of existing treatments and to advance the development of new and more effective alternatives to opioid analgesics.

Additionally, we appreciate that the Centers for Medicare and Medicaid Services (CMS) temporarily suspended the inclusion of pain-management related questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in the Hospital Value-Based Purchasing Program to help relieve the unintentional pressure providers felt to prescribe opioids. However, we share the concern of other provider organizations that simply reincorporating revised questions into HCAHPS and quality programs would be shortsighted. We believe that before these measures are reinstated, the measures need to be tested and verified to ensure the measures do not fall victim to the same pressures that originally led to their suspension.

Enhance the usability of Prescription Drug Monitoring Programs (PDMPs). PDMPs serve as a valuable state-level tool in informing providers' prescribing based on a patient's history of controlled substance prescriptions. Integrating PDMPs more effectively with electronic health records and more seamlessly into clinical workflow would help promote greater use and could help facilitate greater data sharing across states. These enhancements would be especially useful for academic medical centers, who often treat patients from an entire region or across the country. Improving interoperability of PDMPs across settings and states and avoiding increased administrative burden on physicians will help avert barriers to their use.

Reduce access challenges by addressing physician shortages. There remains a substantial gap between the number of Americans needing treatment for substance use disorders and those who

receive it. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2016, approximately 21 million people needed substance use treatment, but only 3.8 million received any treatment.² Though there are many reasons for the gap, existing and looming shortages of physicians only exacerbate other potential access issues. The AAMC projects that by 2030, the demand for physicians in both primary and specialty care will outpace supply by up to 105,000 physicians, primarily as a result of an aging, growing population with increasing health care needs. Though medical schools have expanded their class sizes to address shortages, residency positions for graduates to complete their training have not grown at the same pace, in part due to a two-decade cap on Medicare support for physician training. The AAMC strongly supports bipartisan legislation introduced in both the House (H.R. 2267) and Senate (S. 1301) to raise these caps and enable teaching hospitals to expand their residency programs. These bills appropriately target additional support to shortage specialties, allowing teaching hospitals to help meet local and national workforce needs, including the wide range of disciplines needed to address the opioid epidemic.

Support efforts to promote Medication Assisted Treatment (MAT). Beyond general access issues, even patients who are successful in seeking care may have difficulty accessing treatment options that reflect the most current science. Studies have shown the effectiveness of buprenorphine in safely treating opioid use disorder, but a federal waiver is required to prescribe it. To help minimize the hurdles for qualified clinicians to provide evidence-based MAT, the AAMC supports suspending the waiver requirement.

While we are pleased that recent efforts have eased limitations on the number of patients waived prescribers can treat with buprenorphine, patients continue to face challenges in finding clinicians who provide MAT. The data shows that even among waived physicians, few are prescribing at capacity,³ suggesting that additional barriers beyond the waiver process itself could be limiting greater uptake. Patients undergoing MAT often have complex clinical and psychosocial needs that are best served by a multidisciplinary and interprofessional team, span across multiple care delivery settings, and require services beyond just direct clinical care; however, current payment models do not adequately support such an approach. To help build the support system necessary to encourage more providers to co-manage patients who would benefit from MAT, the AAMC suggests offering incentives such as increased payment for such clinicians. Leveraging the flexibility of the Center for Medicare and Medicaid Innovation to test comprehensive models addressing these challenges may offer additional insights for developing a more robust approach over the long term.

Additionally, ensuring coverage of these well-documented, effective treatments for opioid use disorder also will be critical in helping to connect more patients with the care they require. The November 2017 report of the President's Commission on Combating Drug Addiction and the Opioid Crisis identified a number of barriers within the Medicare program (among other payers) in reimbursement for MAT, including that methadone is only covered under Medicare Part D

² Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>

³ Stein BD, Sorbero M, Dick AW, Pacula RL, Burns RM, Gordon AJ. Physician Capacity to Treat Opioid Use Disorder With Buprenorphine-Assisted Treatment. *JAMA*. 2016;316(11):1211–1212.

when prescribed for pain, but not for treatment of opioid use disorder. The AAMC supports efforts to remove reimbursement barriers to MAT.

Enforce parity. Despite enactment of the Mental Health Parity and Addiction Equity Act and subsequent legislation, additional efforts are needed to ensure that benefits for behavioral health and substance use disorders will be comparable to physical health coverage. Reliable, comprehensive insurance coverage – including through the Medicare and Medicaid programs, the health insurance exchanges, and other commercial plans – plays a fundamental role in providing patients access to vital services and improving their health. For Medicare, the AAMC urges elimination of the Medicare policy that limits inpatient psychiatric hospital treatment to 190 days over the course of the beneficiary’s lifetime. In a similar vein, while we recognize that Medicaid is outside the Committee’s scope, the AAMC notes the need to eliminate the Institutions for Mental Disease (IMD) exclusion, which prohibits Medicaid from covering care delivered at inpatient psychiatric hospitals.

Allow providers to access the information they need. Despite recent revisions by SAMHSA, well-intentioned privacy regulations continue to hamper provider efforts to treat patients with substance use disorders. The regulations under 42 CFR Part 2 require written consent from a patient before clinicians can access information on the patient’s substance use disorder and treatment plan, even if the treatment facility is within a larger health system. As a result, providers treating a patient’s other ailments do not have complete access to the patient’s medical history, leaving the provider ill-equipped to avoid adverse drug interactions or opioid prescriptions for patients with opioid use disorder. The AAMC supports alignment of 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule to help providers better safeguard their patients’ health without abandoning rigorous privacy protections.

Invest in research. While we continue to make progress, there is still much to study to better understand – and therefore better prevent, identify, and treat – pain and addiction. For example, pain remains a relatively subjective experience, leaving physicians few objective markers to assess patients’ pain and identify the most effective treatments. It will be important for the community to continue to build and refine the evidence to support treatment and clinical decision-making. Ensuring robust, sustainable, and reliable growth for the NIH is a key element in that endeavor by supporting fundamental science that can be used broadly and targeted efforts to identify new and better treatments for overdose reversal, long term recovery, and pain. In addition to investments in other public health agencies like CDC, strengthening funding for the Agency for Healthcare Research and Quality ([AHRQ](#)) will complement the investment in NIH by supporting health services research on care delivery. We strongly support Congress’s continued commitment to the nation’s irreplaceable federal research and public health infrastructure.

The Patient-Centered Outcomes Research Institute (PCORI), an independent nonprofit organization authorized by Congress in 2010, also is an [asset in the country’s efforts to address the opioid epidemic](#). As the largest public research funder primarily focused on comparative clinical effectiveness research (CER), the institute is actively filling evidence gaps in opioid research through studies that span the care continuum and making that research accessible to the general public. PCORI’s mandate is to help patients, providers, payers, and others better understand the various treatment and health care options that may work best under a patient’s

circumstances and preferences. As of November 2017, the institute has funded 65 CER studies related to noncancer pain and 13 CER studies related to opioid use.

For example, early results from a recent PCORI study show that pain clinics that have implemented opioid risk-reduction programs are able to successfully decrease patients' average opioid dose. Another study demonstrated the effectiveness of cognitive behavioral therapy and simplified pain education in decreasing intensity for patients with chronic pain. Other studies underway are assessing the effectiveness of state-based initiatives to improve pain management and reduce high-risk opioid prescribing; determining whether opioid use disorder treatment that is integrated into primary care is more effective than referring patients to off-site addiction treatment settings; evaluating the most effective methods of reducing opioid dose for patients with long-term opioid use; and comparing different models of MAT delivery to pregnant women with opioid use disorder, among others.

PCORI holds great potential to help patients, providers, and other stakeholders better navigate the science to identify the treatments and other health care options that work best for them. However, the authorization for PCORI is scheduled to expire at the end of FY 2019. The AAMC strongly supports reauthorizing PCORI and the related Patient Centered Outcomes Research Trust Fund to avoid taking the nation backwards in our efforts to help integrate the outcomes of discovery more effectively into practice. We encourage the Committee to leverage PCORI as a resource in its efforts to address the epidemic and other endeavors.

Support grants to enhance provider and patient education. Medical education programs nationwide are actively enhancing existing coursework and clinical experiences related to pain and substance use disorders. These efforts are integrated and reinforced throughout the educational continuum to be maximally effective, rather than gauged based on an arbitrary number of hours. The AAMC is working to support our members in their efforts, including through an [open call for peer-reviewed curricular resources](#) to populate MedEdPORTAL, the AAMC's open-access digital journal of teaching and assessment resources in the health professions. It is also important to note that the effectiveness of any educational interventions largely will be influenced by the success of clinical interventions. As clinical practice changes, so too will the educational environment in which trainees learn. The AAMC also is working through the Conjoint Committee on Continuing Education to explore the potential for adaptive learning tools, accredited by multiple professions, that will aim to help tailor a practicing health professional's individualized continuing education more effectively. Grant funding through the Health Resources and Services Administration (HRSA), SAMHSA, or other agencies would help advance these efforts, which we believe would yield more effective outcomes than imposing mandates. Such resources also could be useful in supporting patient education efforts, to help ease the challenges providers may face with respect to patient expectations.

Be mindful of unintended consequences. The AAMC lauds the Committee's attention to this public health emergency and for seeking input from a wide range of stakeholders on policy strategies to address it. As the Committee moves forward, we encourage you to consider the potential wide-spanning effects of proposed solutions and potential unintended consequences. For example, proposals to limit opioid prescription levels by dose or time handcuff qualified clinicians from exercising their clinical judgment to meet their patient's needs. Additionally, such proposals could impose unnecessary burdens on patients. For some patients in rural or

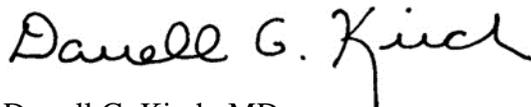
other underserved communities, multiple trips to the pharmacy may be impractical, while other patients may be concerned with such an approach if it will result in multiple co-pays. These and other policies could have the unintentional effect of exacerbating existing disparities in racial and ethnic populations who historically have been undertreated for pain. Likewise, we are hearing reports of hospitals facing critical shortages of a number of injectable opioid medications, which frequently are used in managing patients' pain associated with cancer; in the intensive care unit for major surgical procedures, trauma, or burns; and for patients for whom it is not clinically appropriate to use oral opioids. The challenge the shortages are posing for patients and providers alike is a reminder that the judicious and measured use of opioids has a place on the full spectrum of pain management options.

Ultimately, our shared goal is to achieve the right balance between limiting excess in opioid prescribing without hindering access to pain medications when clinically appropriate. To the extent possible, the AAMC encourages the Committee to prioritize policies that give providers the tools and flexibility they need to assess and respond to their patients' unique needs.

Conclusion

We recognize that reversing this public health crisis will require a multifaceted and multidisciplinary response, and, for our part, we are committed to equipping physicians and scientists with skills to make a positive impact. Thank you again for working tirelessly to address opioid addiction in the U.S., and we look forward to working with you and the full spectrum of stakeholders to continue strengthening our nation's health.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive, slightly slanted style.

Darrell G. Kirch, MD
President and Chief Executive Officer