Opioid Epidemic - Physicians Financially Incentivized to Prescribe?  
(Part One of a Three-Part Series)

In recent years, the rate of prescription opioid abuse has been increasing at an alarming pace.\textsuperscript{1} Since 1999, drug overdose deaths have nearly tripled in the U.S., of which approximately 61 percent were opioid related.\textsuperscript{2} In 2015, 33,091 deaths were attributed to opioid related overdoses, of which about half involved prescription opioids.\textsuperscript{3} An estimated two million Americans suffer from opioid use disorder (i.e., addiction) related to prescription drugs, resulting in an annual economic loss of roughly $78.5 billion.\textsuperscript{4}

A robust understanding of this public health emergency necessitates a review of: the reimbursement models that previously incentivized the prescription use of opioids; current legislative and regulatory actions underway to combat the opioid epidemic; and, the estimated economic ramifications of opioid misuse. This first installment of the three-part series on the opioid epidemic will discuss past and present provider reimbursement models related to pain management.

The main method for provider reimbursement is fee-for-service (FFS), under which providers are reimbursed separately for each service they provide.\textsuperscript{5} In an attempt to shift from this type of volume-based reimbursement to reimbursement based on the value of care provided, the 2010 Patient Protection and Affordable Care Act (ACA) introduced the Hospital Value-Based Purchasing Program (VBP Program), which reimburses providers based on their satisfaction of certain patient care metrics.\textsuperscript{6} Starting in fiscal year 2013, “patient experience” accounted for 30 percent of a hospital’s performance score;\textsuperscript{7} beginning in 2015, it was reduced to 25 percent of the score.\textsuperscript{8} In the 2013 initial VBP Program, “pain management” was one of eight measures (subjectively reported by patients) that composed the “patient experience” portion of the performance score.\textsuperscript{9}

Although the ACA has partially implemented value-based reimbursement measures, FFS is still the most common form of healthcare provider reimbursement.\textsuperscript{10} The FFS reimbursement model is a potentially contributing factor to the over-prescription of opioids to treat pain.\textsuperscript{11} Because primary care physicians, in particular, are in high demand,\textsuperscript{12} and visits are commonly scheduled for only 15-minute intervals, physicians often feel rushed when treating patients.\textsuperscript{13} Therefore, because other pain management options, such as physical therapy, may take more time and knowledge to discuss, recommend, and prescribe, than simply writing a prescription for opioids, clinicians are not financially incentivized to dedicate the time required to evaluate other pain management options.\textsuperscript{14} Additionally, physicians may be disincentivized to allocate time to discuss the negative effects of opioids with patients, which discussions may serve to prevent misuse and abuse.\textsuperscript{15} Through their Opioid Misuse Strategy 2016, the Centers for Medicare and Medicaid Services (CMS) has distributed publications on evidence-based non-pharmacologic therapies to clinicians for their use in treating patients.\textsuperscript{16}

Because pain was measured and monitored for the VBP Program, providers often called pain the “fifth vital sign.”\textsuperscript{17} The measure of patient pain and structure of the VBP Program created a financial incentive for some physicians to err on the side of overprescribing pain medications in an effort to eradicate a patient’s pain and obtain the full incentive payment.\textsuperscript{18} This, in addition to physicians’ alleged lack of knowledge in the 1990s as to the extent of the addictive properties of opioids,\textsuperscript{19} aided in the rapid increase of prescriptions for opioid (measured in morphine milligram equivalents) such that, as of 2015, the amount of opioids prescribed to patients was nearly four times that of Europe, per capita.\textsuperscript{20} As of 2017, it has been estimated that one in five patients with non-cancer related pain is prescribed opioids.\textsuperscript{21} Several states and federal agencies have taken specific actions related to provider reimbursement to combat the opioid epidemic. In particular, CMS received and considered comments from physicians regarding their incentives to prescribe opioids, and, as of January 2017, removed pain management from the reimbursement subject to incentive payments under the VBP Program.\textsuperscript{22} It is important to note that, although the pain management questions have been removed from reimbursement measures, these questions are still being administered via the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) Survey (i.e., patients still answer the same pain management questions, but those answers do not impact the reimbursement level of the hospital).\textsuperscript{23} Because CMS still views pain management as an important aspect of patient care, they are currently developing new pain management questions for the collection of patient pain data that would remove

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any ambiguity or misconception related to CMS financially incentivizing the prescription of opioids.24 Many physicians support CMS’s decision to remove pain management from the VBP Program, because it relieves them of any financial pressure to prescribe opioids that could, in turn, potentially expose physicians to malpractice lawsuits. The American Hospital Association (AHA) stated that the pain management questions utilized in the determination of the level of reimbursement under the VBP Program may be viewed by clinicians as CMS’s encouragement of physicians to provide pain medications to patients.25 The American Society of Health-System Pharmacists and other healthcare-related advocacy groups petitioned for the pain management questions to be removed and replaced with better questions more tailored to provider-patient communication regarding pain management.26 For example, the question “During this hospital stay, how often was your pain well controlled?” would be replaced by a question such as “During your hospital stay, how often did the hospital staff ask about the level of pain you were experiencing?” Although no data have been reported regarding opioid misuse rates since 2015, CMS removed pain management from the incentive-based reimbursement portion of the VBP Program, separating the management of pain from provider reimbursement may serve to decrease the number of patients suffering from opioid use disorder, benefiting physicians, patients, and public health generally. The next two installments of this Health Capital Topics series will further analyze the opioid epidemic through a review of regulations and legislation related to opioids, as well as an examination of the estimated economic ramifications of the opioid epidemic.

3 Ibid.
4 Schuchat, July 6, 2017.
7 Ibid.
10 Cimasi, 2014.
14 Fodeman, MD, MBA, p. 6.
15 Ibid.
21 Centers for Medicare and Medicaid, January 5, 2017. Note: These ongoing lawsuits will be analyzed in the August edition of Health Capital Topics.
23 Ibid.
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