VOICES FOR NON-OPIOID CHOICES

March 1, 2019

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor and Pensions
Washington, DC 20510 – 6300

Dear Chairman Alexander,

Thank you for your commitment to reducing health care costs. We are eager to work with you to ensure that the US health care system works better, and more efficiently, for all Americans.

As you know well from the impacts on your home state of Tennessee, the opioid epidemic is taking a devastating toll on our country, including in an economic sense. The scope of the epidemic can often seem staggering -- the President's Council of Economic Advisers estimated that the crisis cost our country $504 billion in 2015 alone, and costs continue to mount[1]. These costs include the economic productivity foregone with lives lost, criminal justice burdens, and provision of treatment for opioid use disorder. However, we'd like to focus on an often-overlooked cost stemming from the overuse of opioids – opioid-related adverse drug events (ORADEs), especially in the surgical setting.

Numerous research studies demonstrate the impact of these medical errors. A study of a large integrated health care delivery system found that adjusted risks for absolute mortality were 2.9% higher in individuals experiencing ORADEs, were associated with higher hospitalization costs (an additional $8,225), and longer hospital stays (a 1.6 day increase).[2] In a study of postsurgical pain control in another large health system, patients with an ORADE had a 55% longer length of stay, 47% higher costs of care ($14,291 vs $21,012), 36% increased risk of 30-day readmission, and 3.4 times higher risk of inpatient mortality than did patients who did not experience an ORADE.[3] Finally, a retrospective study of a large, national hospital database, examining outcomes in patients undergoing a small set of procedures known to require significant

[1] Council of Economic Advisers. The Underestimated Cost of the Opioid Crisis. Nov 2017. Available online, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf.

[2] Shafi S, Collinsworth AW, Copeland LA. Association of opioid-related adverse drug events with clinical and cost outcomes among surgical patients in a large integrated health care delivery system. JAMA Surg. 2018;153(8):757-763.

[3] Kessler ER, Shah M, Gruschkus SK, Raju A. Cost and quality implications of opioid-based postsurgical pain control using administrative claims data from a large health system: opioid-related adverse events and their impact on clinical and economic outcomes. Pharmacotherapy. 2013 Apr;33(4):383-91. doi: 10.1002/phar.1223.

postoperative pain management, found that costs for cases with ORADE were $1,614 higher with a .70 day increase in length of stay.[4]

Studies have estimated an ORADE rate between 10 and 20 percent of surgical patients, but the Medicare population, who frequently have comorbidities (e.g., obesity, sleep apnea, respiratory disease, urinary disorders) may be particularly vulnerable to experiencing one or more ORADE(s).[5] With 51 million surgeries performed in the United States annually[6], there are hundreds of thousands of patients every year experiencing unwanted and potentially life-threatening ORADEs. Based on the average cost and error rate found in the literature, this could add up to over $42 billion in added costs every year. With Medicare serving as a payer for 43% of surgeries[7], that's potentially $18 billion of annual waste in this taxpayer funded program that is costing us money and seriously threatening patient health.

However, we do not have to accept this status quo for our country's surgical patients. There is a growing class of health care professionals – surgeons, physicians, nurses, anesthesiologists – implementing multimodal pain management programs for surgical patients designed to minimize the use of opioids and reduce ORADEs. These protocols utilize a combination of different classes of medications to provide acute postsurgical pain relief. For example, a systemic NSAID could be combined with a long-acting local anesthetic, to alleviate pain following an extensive surgery such as total knee replacement. In a recent study, patients given liposomal bupivacaine in combination with other non-opioid medications after knee replacement procedures consumed 78% less opioid medication compared to patients receiving standard of care. Reducing or eliminating the use of opioids significantly reduces the risk of ORADEs, generating cost savings for the hospital and the Medicare program.

Unfortunately, use of multimodal therapies is limited by two specific Medicare policies that have limited access to non-opioid treatments for postsurgical pain:

1. The outpatient hospital surgical supply packaging policy, which eliminates separate payment for drugs used to treat postsurgical pain; and
2. The outpatient hospital comprehensive APC policy, which also bundles payment for non-opioid pain management treatments into the Medicare payment for the surgical procedure.

Hospitals receive the same payment from Medicare regardless of whether the health care professional prescribes an opioid medication for pain management or provides a non-opioid option. Without appropriate reimbursement, hospitals cannot justify the additional expense to purchase and administer non-opioid options. Instead, hospitals rely on opioids, which are typically dispensed by a pharmacy at little to no additional cost to the hospital, either during the

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[4] Odera GM, Gan TJ, Johnson BH, Robinson SB. Effect of opioid-related adverse events on outcomes in selected surgical patients. J Pain Palliat Care Pharmacother. 2013 Mar;27(1):62-70.

[5] Oderda GM. Challenges in the management of acute postsurgical pain. Pharmacotherapy [01 Sep 2012, 32(9 Suppl):6S-11S]

[6] National Quality Forum, Surgery 2015-2017 Final Report. Accessed online: https://www.qualityforum.org/Publications/2017/04/Surgery_2015-2017_Final_Report.aspx

[7] Steiner CA et al. Surgeries in Hospital-Based Ambulatory Surgery and Hospital Inpatient Settings, 2014. HCUP Statistical Brief #223. May 2017. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb223-Ambulatory-Inpatient-Surgeries-2014.pdf.

hospital stay or upon discharge. And in many cases, they pass on the cost of additional health care services to treat ORADEs to payers, including the Medicare program.

Therefore, in order to lower health care costs, Congress must revise these payment policies for the treatment of surgical pain. This would dramatically improve hospitals' ability to employ multimodal pain techniques and reduce the rate of ORADEs, which would lower the cost of surgical care, improve patient outcomes, and help patients have access to a wider array of pain management options. Congress must direct CMS to make these changes as part of their prospective payment systems in both the inpatient and outpatient setting.

We do not see potential shortcomings in these steps, as a payment policy change would merely increase the choices available to patients, physicians and hospital administrators to reduce the unnecessary use of opioids and their associated adverse events.

We appreciate your consideration of our submission and would be glad to discuss further. Please contact Tyler Roberts, Director of Federal Affairs at tyler@nonopoioidchoices.org.

Sincerely,

Chris Fox
Executive Director