March 1, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-2018-01154: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter

Dear Administrator Verma:

Thank you for the opportunity to provide our comments to the recently released guidance related to Medicare Advantage (MA) plans' coverage of non-opioid pain management therapies as found in the 2020 draft call letter released on January 30, 2019.

Voices for Non-Opioid Choices ("Voices") strongly applauds the effort to encourage coverage of medically relevant, evidence-based approaches to pain management. We believe such coverage can accomplish three laudable goals: significantly lower the number of opioid pills prescribed to patients, improve patient outcomes by reducing the number of opioid-related adverse events, and reduce health care resource utilization in acute pain patients.

Voices is a non-partisan coalition dedicated to advancing patient choice in acute pain management. Unfortunately, the vast majority of acute pain patients in the United States lack options when it comes to managing their pain, as the default protocol of pain management is still a simple opioid prescription. Voices works to change this status quo, and increase patient choice, by facilitating access to all medically relevant pain management therapies, including pharmacologic and non-pharmacologic approaches.

Many patients receive their first exposure to opioids to help manage postsurgical pain;[i] nearly 9 in 10 surgical patients in the United States receive a prescription for opioids. Unfortunately, every year, 3 million surgical patients go on to be persistent opioid users, meaning they are still taking opioids three to six months after their operation[ii]. In addition, many of these patients receive hundreds of opioid pills following their surgical procedure[iii]

and, according to recent research published in *JAMA*, more than two-thirds of patients have unused medication leftover from these postsurgical prescriptions.[iv] These pills are then available for diversion in our communities. Providing patients access to non-opioid approaches would significantly lower the amount of opioids available for diversion, misuse or abuse.

There are significant structural hurdles in place that unfortunately make it difficult for patients to access non-opioid pain management options. Most of these hurdles are economic – with health systems opting for what they perceive to be the more economical approach in the short term (opioids) rather than a more comprehensive approach that is better for patients and ultimately less expensive. Because of this, millions of Americans, including approximately 8 million Medicare beneficiaries lack access to non-opioid therapies after a surgical procedure[v].

Comprehensive, multimodal approaches to acute pain management utilize multiple non-opioid medications to help patients manage their pain with a reduced reliance on opioids. Such approaches have documented benefits, including reducing opioid consumption by as much as 69 percent[vi], improving patient outcomes following surgery[vii,viiiix], and reducing overall health system costs, including by as much as $4,216[x] per patient treated due to shorter hospital stays.[xi]

We also recognize the benefits of medically-approved non-pharmacologic treatments for chronic and acute pain patients, some of whom may be in recovery from opioid use disorder and in need of comprehensive options. These options include: peer support services, chiropractic services, acupuncture, and therapeutic massage – all of which have been demonstrated to be effective not just in helping patients manage their pain but also reducing the rate of opioid use disorder.

The draft guidance, by encouraging MA plans to cover recommended non-opioid treatment plans for patients, recognizes the need to put patients in change of these critical health care decisions. In doing so, we believe that more and more patients will opt for appropriate non-opioid approaches, which will ultimately improve patient outcomes and save money.

Thank you for your consideration of these comments. Voices stands ready to work together to continue to promote patient choice in non-opioid pain management and, in doing so, working to curb our nation's opioid epidemic.

Sincerely,

Chris Fox
Executive Director

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[ii] Choices Matter: Exposing a Silent Gateway to Persistent Opioid Use. October 2018; Available at: https://www.planagainstpain.com/wp-content/uploads/2018/10/ChoicesMatter_Report_2018.pdf

[iii] Ibid.

[iv] JAMA Surg. Published online August 2, 2017. Doi:10.1001/jamasurg.2017.0831

[v] Hall, MJ, Schwartzman A, Zang J. Lui X. Ambulatory Surgery Data from Hospitals and Ambulatory Surgery Centers: United States, 201. Natl. Health Stat Report. 2017 Fe;(102) 1-15.

[vi] Emerson et al. Comparison of Local Infiltration Analgesia to Bupivacaine Wound Infiltration as a Part of a Multimodal Pain Program in Total Hip Replacement. Journal of Surgical Orthopaedic Advances. Vol 24 No 4. Winter 2015.

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[viii] Afonso A, Oskar S, Tan KS, Disa JJ, Mehrara BJ, Ceyhan J, et al. Is Enhanced Recovery the New Standard of Care in Microsurgical Breast Reconstruction? Plast Reconstr Surg. 2017.

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[x] Asche CV, Ren J, Kim M, Gordon K, McWhirter M, Kirkness CS, et al. Local infiltration for postsurgical analgesia following total hip arthroplasty: a comparison of liposomal bupivacaine to traditional bupivacaine. *Curr Med Res Opin.* 2017;33(7):1283-90.

[xi] Wang MY, Chang HK, Grossman J. Reduced Acute Care Costs with the ERAS Minimally Invasive Transforaminal Lumber Interbody Fusion Compared With Conventional Minimally Invasive Transforaminal Lumber Interbody Fusion. *Neurosurgery*. 2017.