April 19, 2019

The Honorable Mick Mulvaney
Director
White House Office of Management and Budget (OMB)
725 17t Street, NW
Washington, DC 20503

Dear Director Mulvaney:

We appreciate and applaud your work to combat the opioid epidemic in this country. Unfortunately, with 130 Americans dying every day[1] from an opioid overdose, we still have more to do. Accordingly, we encourage the Administration to continue to utilize all available avenues to address this epidemic, including by reducing unnecessary opioid prescribing and increasing the availability of medically appropriate non-opioid pain management approaches.

Specifically, we write to ask the Centers for Medicare and Medicaid Services (CMS) to provide for separate reimbursement for non-opioid pain management approaches in the hospital outpatient setting in the 2020 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) rule.

We represent providers and patients eager for choices that allow us to manage pain without opioids – and we strongly believe that this policy change would significantly increase access to these options for the health care community.

In our experience, the decision of how to manage postsurgical pain is often made neither by the clinician nor the patient. Today, when Medicare-eligible patients have surgeries, Medicare pays a flat fee to the hospital for the procedure, which include non-opioid pain management approaches. As the cost of such pain relief alternatives exceed generic opioids, it can be challenging for hospitals operating with razor-thin margins to recoup their costs. Conversely, Medicare provides ample coverage for oral prescription drugs, so providers can write patients a prescription for opioid medications at no cost to the hospital.

We believe these decisions should not be based solely on these short-term cost considerations. Instead, we believe that CMS should allow for separate reimbursement, and shift decision criteria to include our primary concerns: maximizing patient outcomes, accommodating patient and provider preference, lowering long-term systemic costs, and ultimately reducing the risk of severe downstream consequences, including dependence or addiction.

When looking to do what is best for patients, we see robust evidence documenting the improved outcomes associated with utilization of opioid-sparing multimodal approaches to pain management. Such approaches utilize multiple non-opioid medications and therapies to help patients manage their pain with a reduced reliance on opioids. In a study of pain management in total knee replacements, a non-opioid treatment regimen decreased postsurgical opioid consumption by 78% in patients through 72 hours post surgery. Within 12 hours of surgery, 43% of patients were discharge-ready, and at 24 hours, patients had a 91% reduction in opioid use as

[1] Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC. National Center for Health Statistics: 2017. Available at: http://wonder.cdc.gov

compared to the patients treated with a traditional protocol.[2] In data presented at this year's American Academy of Orthopaedic Surgeons annual meeting, researchers found that an enhanced recovery after surgery (ERAS) protocol, which prioritizes non-opioid use, allowed the vast majority of patients to limit their opioid use to a 7-day prescription following discharge.[3] Nationally, 38% of knee replacement patients are still taking opioids 2 months after surgery. In addition, 84% of patients treated with this protocol were discharged to home on the same day of surgery.

Further, research shows that utilizing multimodal approaches to acute pain management can reduce overall per capita healthcare spending. Specifically, because patients who receive multimodal pain management treatment often recover function more quickly, they are able to return home more quickly following surgery.[4] Accordingly, because these patients are spending less time in the hospital, they reduce overall health system costs by as much as $4,216 per patient.[5] Research shows that psychological factors contribute substantially to surgical outcomes, and that pain catastrophizing is a significant predictor of disability, pain intensity, and prolonged opioid use after surgery.[6]

Finally, we know that opioid exposure during a surgical procedure puts a patient at increased risk of opioid use disorder – especially those already at risk. Evidence shows that approximately 6% of patients in the U.S. who use opioids to manage postsurgical pain continue with long-term opioid use after the surgical procedure (defined as opioid prescription fulfillment between 90 and 180 days post surgery). [7] Given the correlation between postsurgical opioid prescriptions and long-term opioid use, and the potential for non-opioid protocols to reduce opioid exposure, expanded adoption will ultimately reduce the number of patients and Medicare beneficiaries suffering from opioid use disorder.

In the upcoming Outpatient Prospective Payment System Rule, please consider the opportunity presented to allow more providers, and more patients, be a part of the solution to today's persistent opioid crisis.

We appreciate your consideration of these comments.

Sincerely,
Voices for Non-Opioid Choices
American Association of Orthopaedic Surgeons
American Association of Nurse Anesthetists

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[2]Mont MA, Beaver WB, Dysart SH, Barrington JW, Del Gaizo DJ. Local Infiltration Analgesia With Liposomal Bupivacaine Improves Pain Scores and Reduces Opioid Use After Total Knee Arthroplasty: Results of a Randomized Controlled Trial. The Journal of Arthroplasty. 2017.

[3] Van Horne, J. 2019, "*Enhanced Recovery After Surgery Pathway for Total Knee and Hip Arthroplasty in a Medicare Population: Implications for a Transition to Ambulatory Surgery Centers*," presented to the annual meeting of the American Academy of Orthopaedic Surgeons, March 12, 2019.

[4] 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.

[5] 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.

[6] Darnall, B. D. (2016). Pain psychology and pain catastrophizing in the perioperative setting: a review of impacts, interventions and unmet needs. *Hand clinics*, *32*(1), 33.

[7] Brummett et al., New Persistent Opioid Use After Minor and Major Surgical Procedures in US Adults, JAMA SURGERY (Apr. 12, 2017).

American Psychological Association
Center on Addiction
Cover2 Resources
Crohn's and Colitis Young Adult's Network
National Hispanic Medical Association
National Safety Council
National Transitions of Care Coalition
RetireSafe
Students for Opioid Solutions
The Society for Opioid Free Anesthesia