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March 12, 2019

To: Members of the Oregon Health Authority Health Evidence Review Commission

Re: Value-based Benefits Subcommittee: Chronic Pain Task Force Proposal and Health Evidence Review Commission Staff Suggested Revisions

Dear Members of the Health Evidence Review Commission:

We write in response to the above-mentioned proposal regarding its biannual recommendations for Medicaid coverage of chronic pain treatment in Oregon.[1]

We appreciate HERC's revisions of its original proposal which will better balance the need for appropriate opioid stewardship with patient-centered care. Nevertheless, we have grave concerns with the goals of the current proposal: its call for non-consensual tapering off opioid analgesics.

Objections to forced opioid tapering

We have seen documented concerns from broad stakeholders and professionals in pain/addiction regarding forced opioid tapering. One example is the International Stakeholder's letter, signed by 130 experts which opposed forced prescription opioid tapering due to the risks posed to patients.

We urge HERC to reference the December 4, 2018[2] letter submitted by experts, which underscored that HERC's proposal contradicts all of the relevant North American and Oregon guidelines for opioid prescribing.[3,4,5,6,7] We posit that the current proposal violates the very

[1] *Health Evidence Review Commission's Value-based Benefits Subcommittee Jan 17, 2019.* Oregon Health Authority, www.oregon.gov/oha/HPA/DSI-HERC/MeetingDocuments/VbBS-Materials-1-17-2019.pdf Accessed 13 Feb 2019

[2] Mackey, Sean MD, PhD. Oregon Chronic Pain Task Force Revised Proposal Regarding Opioids. 8 Dec 2018, https://drseanmackey.com/s/Oregon-Letter-Governor-Kate-Brown-120418-final.pdf

[3] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1– 49. Accessed 13 Feb 2019

[4] Jason W. Busse, Samantha Craigie, David N. Juurlink. "The Canadian Guideline for Opioid Therapy and Chronic Noncancer Pain." *cmaj*, 8 May 2017, www.cmaj.ca/content/189/18/E659

[5] VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain. Version 3.0 2017. *U.S. VA Department of Veterans Affairs*

[6] Oregon Medical Board Chronic Opioid Prescribing Guidelines, https://www.oregon.gov/omb/Topics-of-Interest/Documents/Chronic-Opioid-Prescribing-Guidelines.pdf pp.7-9 Accessed February 18, 2019

[7] 2019 Medicare Advantage and Part D Rate Announcement and Call Letter." *Centers for Medicare and Medicaid Services*, www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter. Accessed 13 Feb 2019

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principles of patient-centered pain care that HERC itself declared foundational to pain treatment in Oregon.

We are concerned that HERC's broadly drawn policies for forced opioid tapering lack evidence of benefit or safety and entail significant risks of harm. The evidence review HERC commissioned as a basis for its tapering policies uncovered *no evidence* that forced, nonconsensual opioid tapers are safe or effective.

We are cognizant that the revisions of the January 17, 2019 proposal permit a slower pace of taper, with the option to "pause" if patients are harmed. However, the present proposal still demands "taper to zero" in a "unidirectional" manner.[8] We also note that many of the harms (including death) that we have observed following forced tapers occurred in tapers that were slow, not fast.

We are also aware of at least four comprehensive studies of opioid discontinuation currently in progress. The findings of these studies will become available this year or next and are likely to significantly alter our present understanding of the consequences of opioid stoppage.

Objections to mandating forced tapering to patient subgroups designated by diagnosis

HERC specifically selected persons diagnosed with fibromyalgia or one or more of 170 specific spine, back, and neck conditions for forced opioid tapering.

Only a single statement in HERC's record suggests that opioids result in unique harms in fibromyalgia patients, which was based on "***expert input***".[9] We cannot evaluate the accuracy of this statement without knowing identity of the expert or the basis of their opinion. Similarly, we cannot locate the basis of the single fibromyalgia-specific statement in the January 2019 "Chronic Pain Task Force Proposal for Review by VbBS"[10] with regard to tramadol treatment for fibromyalgia. While a single trial would not justify designating tramadol as a first- or even second-line therapy for fibromyalgia, it raises questions about the evidentiary basis of a policy that prohibits all opioids and mandates forced opioid tapering to this specific population.

In our own careful review of the existing literature, we found no high-quality evidence that ties the use of opioids to specific harm in patients with fibromyalgia or conditions affecting

[8] Chronic Pain Task Force, January 17, 2019, p. 80, 82, 98

[9] *Id.*

[10] *Id.*

the neck, back, or spine – any more so than the inherent risks of taking opioids with any medical condition.

Concerns regarding replacement treatment in patients undergoing tapering

Expanding access to integrative and complementary treatment options is helpful. However, embracing a policy that broadly substitutes integrative and complementary approaches for—and specifically excludes—pharmacological treatment is not.

An exhaustive analysis conducted by the Agency for Healthcare Research Quality[11] found the quality of evidence supporting most complementary and integrated services to be low or moderate. Few studies reported a likelihood of a clinically significant improvement. Thus, we are far from being able to draw conclusions as to how any replacement treatment will impact forced opioid tapering in a large population.

Conclusions

The ultimate test of policy change in health care is not whether prescription use can be reduced (as is now the case in every state), but how we can ensure safety and functioning of the people whose lives are affected.

To summarize our findings, across all domains of assessment HERC's proposed policy in Oregon provides:

- No evidence to support the diagnostic code selections applied;
- No evidence to support the practice of large-scale forced prescription opioid tapering;
- No evidence to assure absence of patient harms in forced prescription opioid tapering;
- No evidence for 'replacement' of established long-term opioids with behavioral and integrative approaches within the context of mandatory opioid tapering;
- No evidence to suggest patients across the state of Oregon and in rural settings will have meaningful and sustained access to covered behavioral treatments;
- No evidence that Oregon has established *and tested* accessible and meaningful prescriber and patient infrastructure to allow for careful monitoring and risk mitigation in patients who may be the subject of an opioid taper;
- No evidence to support patient safety from medical and psychological destabilization that has been reported nationally with forced opioid tapering.

[11] Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review. *AHRQ.* 11 June 2018, effectivehealthcare.ahrq.gov/sites/default/files/pdf/nonpharma-chronic-pain-cer-209.pdf Accessed 15 Feb 2018

We fear that HERC's proposal is, in essence, a large-scale experiment on vulnerable Oregonians. We implore Governor Brown not to conflate concerns regarding prescription opioids with the dangers of illicit opioids, for which Oregon has seen a troubling increase in related deaths in recent years.[12] It is well recognized that these are largely separate public health issues - each requiring different actions.

Oregon also lacks any statewide infrastructure that would ensure careful symptom monitoring of patients to identify and address iatrogenic patient harms caused by a forced taper. HERC's proposal will also place physicians in the untenable position of choosing between violating the tenets of their oaths and licenses - to do no harm - or complying with Oregon's mandates.

HERC's attention to these concerns is greatly appreciated. As the policies set by Oregon officials are likely to reverberate nationally, they are of immense concern to people with pain, professionals, and the media.

Sincerely,

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[12] Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017 MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. DOI: http://dx.doi.org/10.15585/mmwr.mm675152e1

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