July 30, 2018

Dear Members of VbVS and HERC:

We are a group of concerned practitioners and scientists specializing in pain, addiction and epidemiology, and experts in public health law and policy. We recently learned of efforts by the Oregon Medicaid Pain Task Force to deny coverage of opioids beyond 90 days for most chronic pain conditions and, effectively, to mandate the taper of current patients receiving opioid therapy. We believe that such efforts risk doing substantially more harm than good.

The Oregon proposal is the most restrictive in the country and is unsupported by current treatment guidelines related to opioid prescribing, including those issued by the Centers for Medicare and Medicaid Services (CDC) in 2016, Canada in 2017, the U.S. Veteran’s Administration, and professional medical associations.[[1]](#footnote-1) While the CDC and Canadian guidelines ask practitioners to consider tapering patients to lower dosages, both expressly require a risk/benefit assessment. According to Tamara Haegerich of the CDC, the guideline does not provide “support for involuntary or precipitous tapering. Such practice could be associated with withdrawal symptoms, damage to the clinician–patient relationship, and patients obtaining opioids from other sources.” [[2]](#footnote-2) Under both guidelines, for patients with managed risks who experience a loss of function or an escalation in pain, tapering should cease.

Concerns regarding a Center for Medicare and Medicaid Services (CMS) proposal to permit denial of coverage of long-term opioid therapy above 90 MME—a proposal that is far less drastic than Oregon’s, which would taper patients to 0—prompted strong objection from architects of the 2016 CDC guidelines and leading experts in addiction and pain medicine.[[3]](#footnote-3) Among their objections was the lack of evidence of benefit from compelled tapering and considerable anecdotal evidence of harm, ranging from medical decline to suicide[[4]](#footnote-4). In addition, the petition highlighted unintended consequences of recent regulatory limits on opioid prescribing, including the curtailed capacity of physicians to meet their ethical and legal obligations to patients and outright patient abandonment.[[5]](#footnote-5) Oregon is a state that has sanctioned physicians for failure adequately to treat pain, including with opioids.[[6]](#footnote-6) Well-intended regulations have resulted in over-reach to cancer patients and end-of-life care.[[7]](#footnote-7) Recognizing these potential harms, CMS declined to go ahead with a hard edit at 90 MME.

Although the proposed coverage of modalities from CBT to aquatic therapy to acupuncture is laudable, such services should be offered alongside medication and procedures. Integrated care is the gold standard of pain treatment. According to the Academy of Integrative Pain Medicine, “For some patients, access to opioid medications to manage their daily pain is necessary; for others, nonpharmacological methods alone provide sufficient relief; and, for many, it’s a combination of both.”[[8]](#footnote-8) No single modality is a “magic pill” for all patients. An across-the-board denial of opioid therapy for the huge umbrella category of chronic pain is as destructive as is liberally prescribing opioids for all types of chronic pain. While there is a paucity of longitudinal studies on the efficacy of opioids for chronic pain, your hearings recognize that the evidentiary basis for the alternatives you propose is no stronger. By contrast, there is a considerable clinical basis for an integrative approach that provides access to both options.

The denial of coverage to the Medicaid population, in particular, is likely to have a disproportionate impact on individuals with disabilities, on the sickest patients and those with multiple chronic conditions.[[9]](#footnote-9)

Finally, curtailed opioid prescribing has not correlated with a reduction in drug-overdose deaths. Although prescribing has dropped every year since 2012, drug overdose deaths during the same period have skyrocketed as the crisis has evolved to feature heroin and illicitly manufactured fentanyl and its analogs.[[10]](#footnote-10) Even most deaths that involve a prescription opioid are polypharmacy[[11]](#footnote-11) – often including illicit drugs, benzodiazepines and other CNS depressants, and alcohol – and most misuse is non-medical.[[12]](#footnote-12) Until these realities are reckoned with, we will continue to see a rise in harmful effects. In conclusion, we believe that there is insufficient scientific evidentiary basis for the Oregon proposal and that denying pain relief to those who suffer most is likely to cause harm even with the best of intentions.

Sincerely,

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1. See,e.g, Joint Guidelines of the American Academy of Pain Medicine and the American Pain Society, <http://americanpainsociety.org/uploads/education/guidelines/prescribing-opioid-pain-drugs.pdf>; Academy of Integrative Pain Medicine, <https://www.integrativepainmanagement.org/page/OpioidPositioning>. [↑](#footnote-ref-1)
2. <http://annals.org/aim/article-abstract/2643843/changing-conversation-about-opioid-tapering>, Dowell, Deborah, MD, MPH & Haegerich, Tamara, PhD, “Changing the Conversation About Opioid Tapering,” *Annals of Internal Medicine*, 167 (3), August 2017. [↑](#footnote-ref-2)
3. Attached petition. Among its 220 signatories were persons who played significant roles in developing the CDC guidelines and faculty at major medical centers with expertise in opioid safety, addiction, pain, primary and palliative care. [↑](#footnote-ref-3)
4. A VA abstract concluded that opioid tapering did not result in a drop in overdose mortality but a rise in suicide mortality. <https://www.wjhl.com/news/va-reps-to-discuss-impact-of-opioid-reduction-on-suicides-during-summit_20180123093420242/934066782>. [↑](#footnote-ref-4)
5. “Physicians prescribe fewer opioids despite their belief that they are causing patient harm,” <https://www.bostonglobe.com/metro/2017/01/02/doctors-curtail-opioids-but-many-see-harm-pain-patients/z4Ci68TePafcD9AcORs04J/story.html>. As indicated in a related submission to your Task Force, a recent survey of 1985 patients with multiple chronic conditions conducted by Dr. Terri Lewis revealed harms of suicide and patient abandonment in Oregon. In recognition of patient harm, British Columbia recently revised its mandatory prescribing guidelines on opioids to require that physicians continue to treat chronic pain patients who use opioids, <https://www.theglobeandmail.com/canada/article-bc-doctors-cant-limit-opioids-or-discriminate-against-pain-patients-2/>. [↑](#footnote-ref-5)
6. Complications in Regional Anesthesia and Pain Medicine, 2d ed. [↑](#footnote-ref-6)
7. *See* “Opioid limits hit hospice, cancer patients,” <https://www.bendbulletin.com/localstate/6033839-151/opioid-limits-hit-hospice-cancer-patients>; “Opioid Stigma is keeping many cancer patients from getting the pain control they need,” <https://www.statnews.com/2018/07/06/cancer-patients-pain-opioid-stigma/>. [↑](#footnote-ref-7)
8. <https://www.integrativepainmanagement.org/page/OpioidPositioning>. [↑](#footnote-ref-8)
9. *See* National Council on Independent Living, Pain and Opioid Task Force, Statement of Principles, <https://www.ncil.org/wp-content/uploads/2018/07/7-20-18-Statement-of-Principles-on-Chronnic-Pain-and-Opioids.pdf>. [↑](#footnote-ref-9)
10. *See* [*https://www.aafp.org/news/health-of-the-public/20180425opioidstudy.html*](https://www.aafp.org/news/health-of-the-public/20180425opioidstudy.html)*;* Dasgupta, PhD, MPH, Beletsky, JD, MPH, Ciccarone, MD, MPH, “Opioid Crisis: No Easy Fix to Its Social and Economic Determinants, American Journal of Public Health, v. 108, n. 2, p. 183. [↑](#footnote-ref-10)
11. Schatman, Michael, PhD, and Ziegler, Stephen, JD, PhD, “Pain Management, prescription opioid mortality and the CDC, is the devil in the data?” Journal of Pain Research. 2017; 10: 2489–2495, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5659223/>. [↑](#footnote-ref-11)
12. 2013-2014 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration (SAMHSA), <https://www.samhsa.gov/atod/opioids>. [↑](#footnote-ref-12)