



December 5, 2018

Ariel Smits, MD, MPH
Members of the Chronic Pain Task Force

Re: Health Evidence Review Commission Chronic Pain Task Force Revised Proposal

The Oregon Medical Association (OMA) and the American Medical Association (AMA) would like to thank the HERC Chronic Pain Task Force for the time and effort invested in creating the proposed recommendations. The misuse and overuse of opioids has created a multifaceted problem; as a result, many varied tools are necessary to combat it. Over the past five years, our physicians have been on the front lines working to turn the tide.

The Oregon Medical Association is a professional society engaging in advocacy, community-building, and networking opportunities for the healthcare community in our state. The association's primary aim is to serve and support our nearly 8,000 physician, physician assistant, and student members in their efforts to improve the health of Oregonians.

The American Medical Association is the premier national organization providing timely, essential resources to empower physicians, residents, and medical students to succeed at every phase of their medical lives. Physicians have entrusted the AMA to advance the art and science of medicine and the betterment of public health on behalf of patients for more than 170 years.

In Oregon, enhancing the Prescription Drug Monitoring Program, providing education to our members, and assisting in the development of prescribing guidelines are just a few of the methods necessary to ensure that opioids are used in an appropriate manner. As one measure of the efforts physicians have made in Oregon, opioid prescribing has decreased by 25.5 percent between 2013 and 2017, according to data provided by IQVIA, a health information company.

Nationally, opioid prescribing has decreased 22.2 percent—a sign of progress, but one that must be tempered by two facts: the opioid epidemic now is being fueled by heroin and illicit fentanyl overdoses, and we are acutely aware that patients with pain often

have extreme difficulty accessing comprehensive, multimodal pain care, including non-opioid pain care alternatives. Ensuring access to this care is one of the main recommendations of the AMA Opioid Task Force—a multistate, multispecialty group of which the OMA is a proud member.

We appreciate the emphasis on maintaining the integrity of the provider-patient relationship. It is paramount that the physician or physician assistant be able to make lifestyle recommendations and prescribe other medications and therapies that are individualized to the specific history and needs of each patient. It is also important that treatment plans for opioid use, including tapering, are discussed and carried out in a way that preserves the provider-patient relationship. We request that recommendations be written with an acknowledgment of the fact that there may be patients who never reach zero use due to medical complexities and diagnosis, among other factors. And we further request inclusion of language stating that neither patients nor physicians should ever be forced into nonconsensual tapering protocols by payers or the state that contravene the treatment plan prescribed by the provider.

We also want to ensure that we use the best evidence with regard to any tapering policy. There seems to be a lack of solid evidence that a blanket approach to taper all patients is the least harmful. Although the task force recommendations as drafted currently suggest goals to achieve, it is our hope that the Oregon Health Authority monitor how Coordinated Care Organizations (CCOs) interpret any recommendations that are adopted. For example, we recognize that a 5-10% monthly tapering goal is just that, a goal. But as noted above, it may not be a realistic or healthy approach for some patients. Our concern is that this type of guidance may be utilized as a measurable metric by CCOs or payers and result in additional layers of burdensome administrative oversight, specifically regarding prior authorization. Although this sort of firm metric would indeed offer some benefits to the prior authorization process, it would also offer the possibility of additional burden to both patient and provider that could result in delays or denials of pain care, leaving the patient suffering because of a one-size-fits-all policy.

There are some metrics that also cause concern. For instance, the requirements for continued use of opioids for chronic pain syndrome include initial functional improvement of at least 30% during the prescribing period. We request that the HERC better describe the justification for and implementation of this measure. And if the evidence does not support this proposed metric, we recommend its deletion.

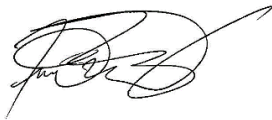
To summarize, we request the following considerations:

- Maintain the integrity of the provider-patient relationship by ensuring that the physician or physician assistant may continue to prescribe based on the individual history and needs of each particular patient;
- Utilize evidence-based practices in the development of tapering recommendations;

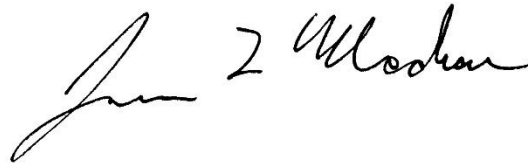
- Where specific goals are identified, ensure that language supports those goals as a target to work towards, not a hard and fast metric that could have unintended, harmful consequences; and
- Ensure that quantitative goals are measurable and not utilized by payers to increase the administrative burden on patients and providers, specifically through the prior authorization process.

Thank you for your attention and for the opportunity to provide comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Fred Williams", written in a cursive style.

Fred C. Williams, MD
President
Oregon Medical Association

A handwritten signature in black ink, appearing to read "James L. Madara", written in a cursive style.

James L. Madara, MD
CEO and Executive Vice President
American Medical Association