ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005
Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net
John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

January 13, 2016

Dr. Thomas R. Frieden
Director, Center for Disease Control and Prevention
Center for Disease Control and Prevention
4770 Buford Highway NE., Mailstop F63
Atlanta, GA 20241

Submitted electronically via: http://www.regulations.gov

Attn: Docket CDC-2015-0112

Dear Dr. Frieden,

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to respond to the Centers for Disease Control and Prevention's (CDC), "CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016," released Monday, December 14, 2015.

ACAP is an association of 60 nonprofit and community-based Safety Net Health Plans. Our member plans, located in 24 states, provide coverage to more than 15 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans (QHPs). ACAP plans currently serve approximately one-third of Medicaid and CHIP enrollees who receive coverage through risk-based managed care, including approximately one-third of all enrollees in the Medicaid-Medicare demonstrations. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon the Medicaid and CHIP programs.

ACAP believes that those suffering from chronic pain should have access to appropriate, high quality care to help manage their condition. In addition, we recognize the toll opioid abuse and addiction is taking on communities throughout the country. For the past two years, thirteen ACAP plans participated in a grant-funded collaborative aimed at addressing prescription drug abuse among their members. Their strategies and lessons learned are documented in a toolkit.[1] One thing that became apparent throughout the course of the collaborative, is the lack of a comprehensive set of opioid prescribing guidelines. We applaud the CDC for the development of national guidelines, however, we have several comments on areas that we believe could be strengthened or improved upon.

[1] Association of Community Affiliated Plans. Strategies to Reduce Prescription Drug Abuse: Lessons Learned from the ACAP SUD Collaborative (April 2015). http://bit.ly/1njknIu

Summary of ACAP's Comments

Our positions summarized below are explained in greater detail later in the letter.

- **Format of the Guideline:** ACAP recommends that the CDC add an executive summary to the onset of the guidelines.
- **Establishing Treatment Goals:** ACAP encourages the CDC to promote the use of written agreements to a greater extent in Recommendation 2.
- **Dosage:** ACAP believes that federal agencies, states, and quality organizations need to use the same level of MME for identifying patients as "at risk" for overdose.
- **Telemedicine:** ACAP believes the guidelines should recognize that while in-person visits should occur, they may not be feasible in all markets for both the initial prescription and follow-up assessments and that other alternative approaches may be utilized.
- **Prescription Drug Monitoring Programs:** ACAP recommends Recommendation 9 be strengthened by suggesting providers check the PDMP prior to writing a prescription for an opioid every time. We also believe that PDMPs should calculate the MME for each individual, as applicable.
- **Urine Drug Screenings:** ACAP requests that Recommendation 10, related to urine drug screenings, should be made more detailed.
- **Additional Research:** ACAP requests that the CDC, or some other federal agency, conduct additional research related to the effectiveness of risk assessments and the impact on outcomes of requiring providers to check the PDMP prior to writing an opioid prescription.

Expanded Comments

ACAP's comments are expanded below, with additional background.

<u>Format of the Guideline</u>

ACAP appreciates the CDC's efforts to put these guidelines together. We think they are an important first step in standardizing provider practices related to opioid prescribing across the country. With that said, the guidelines are very long and would benefit from an executive summary. We believe that an executive summary would aide in the approachability of the guidelines for both providers and insurers.

ACAP recommends that the CDC add an executive summary to the onset of the regulations as well as the development of easy to read, supportive infographics.

Recommendation 2: Establishing Treatment Goals

Recommendation 2 encourages providers to establish treatment goals with all patients. One thing that is touched on, but not emphasized enough, are written agreements and treatment plans. ACAP believes that completing written agreements facilitates the discussion about treatment goals and provides a tool that can be referred back to when determining whether or not to continue opioid therapy. Agreements can provide a mechanism of reinforcement; this may be particularly important in instances in which providers are accused of patient abandonment because of their refusal to continue to prescribe opioids. We would like to see written agreements completed with all patients prior to initiating a long-term opioid therapy.

ACAP encourages the CDC to promote the use of written agreements to a greater extent in Recommendation 2.

Recommendation 5: Dosage

Recommendation 5 states that the additional precautions should be taken when increasing dosage beyond 50 MME per day and increasing the dosage beyond 90 MME per day should be generally avoided. Some states, such as California, and the Medicare program use 120 MME per day in certain quality metrics to identify members as "at risk." ACAP requests that there be consistency between programs and quality metrics to alleviate confusion.

ACAP believes that federal agencies, states, and quality organizations need to use the same level of MME for identifying patients as "at risk" for overdose.

Recommendation 7: Telemedicine

ACAP believes the initial prescription of opioids should be based on an in-person visit in most instances. In addition, as stated in Recommendation 7, we believe seeing a patient on long-term opioid therapy in-person at least once a year is ideal. However, we recognize that this may not be feasible in all markets, especially where there are not a sufficient number of providers within the geographic area with expertise in prescribing and managing opioid therapy. ACAP would encourage the CDC to acknowledge this reality for both the initial prescription and follow-up assessments in the guidelines and offer alternatives. For example, the telemedicine provider should have a documented consult with the individual's primary care physician in lieu of an in-person visit.

ACAP believes the guidelines should recognize that while in-person visits should occur, they may not be feasible in all markets for both the initial prescription and follow-up assessments and that other alternative approaches may be utilized.

Recommendation 9: Prescription Drug Monitoring Programs

Recommendation 9 suggests that providers review prescription drug monitoring program (PDMP) data prior to initiating and periodically during opioid therapy, ranging from every prescription written to every three months. ACAP plans did not feel this recommendation was strong enough and would advocate that the PDMP be checked prior to writing a prescription for opioids every time. States such as Kentucky, New York, and Connecticut that currently mandate providers check the PDMP prior to each opioid prescription, have shown promising results related in decreases to both the total number of opioids prescribed as well as morphine milligram equivalents (MME).[2]

In addition, although this may be outside of the scope of these recommendations, we suggest that PDMPs calculate and provide the MME for each individual, as applicable. We heard from our plans that having this feature as part of their states' PDMP alleviates the burden on providers and makes the data more actionable.

ACAP recommends Recommendation 9 be strengthened by suggesting providers check the PDMP prior to writing a prescription for an opioid every time. We also believe that PDMPs should calculate the MME for each individual, as applicable.

Recommendation 10: Urine Drug Screenings

Recommendation 10 outlines utilizing urine drug screenings prior to initiating an opioid therapy as well as at least annually. ACAP requests that the CDC make this guideline more specific, as both plans and providers struggle with developing a policy and procedure for urine screenings. We suggest the guidelines include a more thorough discussion of the composition of the most effective urine drug testing panels to detect misuse, diversion, and the presence of other controlled substances. Also, we request additional details about the ideal duration between screenings as well as effective strategies for randomizing the screenings so patients aren't expecting them.

ACAP requests that Recommendation 10, related to urine drug screenings, should be made more detailed.

Additional Research

In several areas the CDC expressed that there was currently insufficient evidence to make a recommendation. ACAP would encourage the CDC, as well as other agencies, to conduct

[2] Prescription Drug Monitoring Program Center of Excellence at Brandeis. Mandating PDMP participation by medical providers: current status and experience in selected states (October 2014). http://bit.ly/1mWDCHm

research to better inform treatment guidelines, and ultimately provider practices, in the future. In particular, below are a few areas where we would advocate be prioritized:

- **Risk Assessments:** The CDC acknowledged that the research is insufficient on the effectiveness of risk assessment tools. We believe that assessing for risk may be an important component in engaging patients about risky behaviors. We recognize that existing tools may not adequately assess for risk; if this is found to be the case, we would advocate for the development of a new tool based on the evidence found.
- **PDMPs:** As stated earlier, we believe PDMPs can play an important part in ensuring opioid therapy is not inappropriately initiated when a patient is being prescribed controlled substances by another provider and to ensure that care is properly coordinated. The CDC mentions that although there is evidence showing that requiring providers to check PDMPs prior prescribing a controlled substance may decrease the number and levels of opioids being prescribed, there is inadequate evidence on the impact on outcomes. We would encourage the CDC to conduct this research.

ACAP requests that the CDC, or some other federal agency, conduct additional research related to the effectiveness of risk assessments and the impact on outcomes of requiring providers to check the PDMP prior to writing an opioid prescription.

Conclusion

ACAP thanks the CDC for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Deborah Kilstein (202-341-4101 or dkilstein@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer
ACAP