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April 11, 2022

Angela K. Oliver
Executive Secretary
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway NE
Mailstop S107-9
Atlanta, GA 30341

Re: Docket No. CDC-202-0024

Comments submitted via regulations.gov

Dear Ms. Oliver,

Every American deserves affordable, comprehensive coverage that allows them to access equitable and high-quality care. Americans should have the personalized health care information they need to make better, more informed decisions before seeking and receiving care. With this shared commitment in mind, AHIP appreciates the opportunity to provide comments on the *Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids.*

The opioid crisis is devastating for its victims, their families, and communities across the country. Unfortunately, opioid overdose deaths continue to rise. In order to make progress and reverse this devastating trend, the opioid crisis must be addressed in a comprehensive way, with everyone working together. This includes local governments, law enforcement and the justice system, social services agencies, community housing programs, Medicaid programs, physicians and other health care providers, pharmacists, health insurance providers, and pharmaceutical companies. Health insurance providers have long been part of the solution by working closely with clinicians and other stakeholders and embracing a comprehensive and evidence-based approach encompassing prevention, early intervention, and substance use disorder treatment and recovery.

Increased flexibility

We support the goals of the Guideline to improve communication between clinicians and patients, and to empower them to make informed, person-centered decisions related to pain care. We appreciate the clarifications made in the new Guideline, regarding which providers should use the clinical guidelines for which patients and conditions, and the acknowledgment that there is no "one-size-fits all" approach to managing pain. Clearly there is no single dosage that is always safe, nor is there a formula which would indicate when a dosage is always unsafe. While guidance and recommended parameters continue to be important, we agree with the de-emphasis

of rigid thresholds for opioid prescribing and tapering, and we appreciate the discussion of coordinated and team-based care to address whole-person health, including both physical and behavioral health needs.

Established goals of pain management
We especially appreciate the increased emphasis on a patient's needs and goals of treatment. In many discussions regarding opioid use, health insurance providers have stressed the importance of evaluating what outcomes a patient seeks to achieve from pain treatment, considering non-pharmaceutical and non-opioid options, and appropriately communicating with patients about what can and cannot be accomplished through a prescription for opioids. Insurance providers provide their members with access to a variety of non-opioid and nonpharmacological pain treatment options, like physical therapy, NSAIDs, topical pain relief options, and acupuncture, to address members' need for pain relief while avoiding the risks of opioids. We support the proposed inclusion of social and other non-clinical factors in the new Guideline, as well as the attention to issues of equity.

Continue to build the evidence base
Finally, we support the calls for further research to close knowledge gaps associated with opioid prescribing, dosages, and risk factors; multidiscipinary pain management models; alternative therapies and the evaluation of non-pain outcomes; diagnostics; transitions of care; and impacts of stigma. AHIP and its members agree that there is a need for research to enhance existing risk assessment tools and to inform future evidence-based clinical guidelines on dosing and treatment options to manage various types of pain.

Recommendations to further strengthen the Guideline
We also recommend additional clarifications and considerations be incorporated into the Guideline. Specifically:

- Recommendation 5 discusses patients who are already receiving higher opioid dosages. Though the continuous use of high-dose opioids is certainly not ideal, there is a small subset of patients for whom such a treatment may be appropriate. We encourage CDC to modify the Guideline to recommend that treating providers engage with their patients to conduct ongoing risk/benefit analyses for pain management options and increased monitoring for side effects and diversion.
- Addressing tapering in Recommendation 5, we agree that it is inappropriate to abruptly discontinue medications and that opioids must be properly tapered. We believe that CDC should consider recommending co-prescribing naloxone for those patients who are undergoing tapering or for those who may be at risk of overdose, given the potential for a patient to turn to diversion and/or street drugs. Naloxone is an important "tool in the toolbox" and CDC should further evaluate the circumstances in which co-prescribing naloxone is most appropriate, even beyond circumstances where a person is taking high doses of opioids or is tapering.

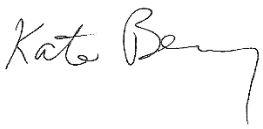
- In Recommendation 6, providers are given more autonomy in determining how long "the expected duration of pain requiring opioids" will last. While we support giving providers flexibility to address patients' individual needs, we support the inclusion of language advising against prescribing a large supply of opioids distributed at once, such as 15-30 day supply. The previous guidance supported a 7-day limit on initial prescriptions; while we support providing flexibility and encouraging providers to prescribe responsibly given the risks of overdose and diversion, a strict limit in this specific circumstance may be appropriate. Some states have limits on the days' supply given to a patient who is new to taking opioids, and CDC should consider similar guidance.
- In Recommendation 10, CDC should indicate that toxicology assessments are only one tool in ensuring patients are compliant with agreed-upon treatment plans. We concur that such testing should not be used to dismiss or abandon patients, but providers must be encouraged to conduct unannounced - but judicious - toxicology (and other) screenings when there is suspicion of drug misuse to ensure continued patient compliance.
- CDC should work to align this new Guideline with other relevant government guidance. For example, the Centers for Medicare & Medicaid Services (CMS) requires that Part D sponsors have an Opioid Drug Management Program to address members that are at risk for abuse or misuse of Frequently Abused Drugs. Those at risk of opioid overdose include patients who take more than 90 MME and those who have a history of opioid-related overdose and currently have at least one Part D Prescription for opioids. Providers and patients alike would benefit from having aligned guidelines on what constitutes risk and where it may be appropriate to co-prescribe naloxone due to risk of overdose, for example.
- Moreover, performance measures assessing opioid prescribing should be based on these aligned guidelines. Organizations such as the Pharmacy Quality Alliance (PQA) and the National Committee for Quality Assurance (NCQA) have developed mulitple measures to assess opioid prescribing practices including the use of opioids at high doses, from multiple providers, and concurrent prescribing. These measures are used in a number of programs to assess health plan performance including HEDIS, the Adult Medicaid Core Set, the Health Insurance Exchange Quality Rating System, and the Medicare Part C and D performance data display measures. Given the widespread use of these measures, CDC should work with measure developers and CMS to ensure performance measures are based on aligned guidelines.

We encourage CDC and other stakeholders to empower health insurance providers, as well as clinicians and other stakeholders, to help coordinate and collaborate on appropriate care for patients experiencing pain and those who may be prescribed opioids. While the revised Guideline increases inclusion of multi-stakeholder teams, policymakers and other authorities can further detail which groups can be effective in promoting evidence-based care and in which circumstances.

Health insurance providers will continue to work to combat the opioid crisis and will collaborate with other stakeholders to protect patient safety and improve outcomes. The strategies and challenges outlined in the Guideline provide a constructive shift towards person-centered, evidence-based care, and we support CDC's conclusions.

Thank you for the opportunity to provide these comments. We look forward to further efforts that recognize broad stakeholder engagement, and we stand ready to assist CDC in its efforts to promote appropriate access to pain care and prevent opioid addiction.

Sincerely,



Kate Berry
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