



April 11, 2022

Rochelle P. Walensky, MD, MPH
Director
Centers for Disease Control and Prevention
4770 Buford Highway NE
Atlanta, GA 30341

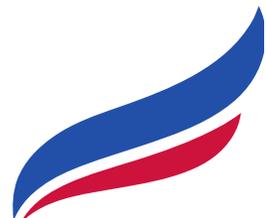
Re: CDC–2022–0024 – Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids

Dear Director Walensky:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on CDC’s proposed 2022 Clinical Practice Guideline for Prescribing Opioids. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society’s nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

Pain is one of the most feared symptoms for cancer patients and survivors. Data from our recent survey of cancer survivors shows that 59% of respondents experience pain that limits work, time with family, or social activities.¹ While we recognize that as a nation, we must take steps to identify balanced solutions that address the opioid epidemic, opioid-related deaths are uncommon in cancer survivors compared to the general population.² Therefore, it is crucial that policy solutions do not impede access to pain treatment – including opioid medications – for cancer patients, cancer survivors, and others with serious illness.

While we support some of the changes CDC has made to its proposed 2022 Clinical Practice Guideline for Prescribing Opioids (heretofore referred to as “proposed 2022 Guideline”) and believe the document more clearly states how patients being treated for cancer-related pain are exempt, we continue to have concerns about the language and evidence used in the proposed 2022 Guideline, as well as the likely misinterpretation and misapplication of the Guideline by policymakers and other stakeholders. We believe there is a lot that can be learned from some of the problems with the earlier 2016 CDC Guideline for Prescribing Opioids for Chronic Pain³ (referred heretofore as ‘2016 Guideline’) and opportunities to avoid those issues in the new proposed guidelines.



Problems with the 2016 Guideline

ACS CAN raised serious concerns about the 2016 Guideline, which we expressed during multiple comment periods.^{4, 5} One of our main concerns was that the 2016 Guideline would be used to set limits on access to pain treatment that would harm cancer patients and survivors. We anticipated this would be the case, even though the 2016 Guideline was not intended to dictate policy or apply to cancer patients.

Unfortunately, our concerns were validated in the following years. ACS CAN surveys in 2018⁶ and 2019⁷ showed that after the CDC released its 2016 Guideline, cancer patients and survivors saw a significant increase in barriers to pain treatment – driven by changes in prescribing requirements, insurance coverage and pharmacy policies.

In October-November 2021, ACS CAN again surveyed individuals with a history of cancer through its Survivor Views project.⁸ The findings of this survey⁹ make it clear that following the release of the 2016 Guidelines 1) many cancer patients and survivors continue to experience pain and find difficulty treating it, and 2) these patients continue to experience barriers to accessing recommended treatments. The survey found:

- **Many cancer patients and survivors experience pain.** Fifty-nine percent of cancer patients and survivors surveyed experienced pain that limits work, time with family, or social activities.
- **Some cancer patients and survivors are not able to find adequate treatments for their pain.** Only 27% believed their options for managing the pain associated with their cancer met their needs very well. The plurality, 44% said their pain management options met their needs only somewhat well, and another 26% said their options did not meet their needs very well or at all. These findings are consistent across those treating their pain with non-opioid medications (comprising 58% of respondents), those taking an opioid (43%), those employing a non-medication treatment such as physical therapy (27%), and those not treating their pain at all (12%). The primary reason for dissatisfaction with the options available for pain management came from patients who didn't want to take an opioid pain medication but had not found an effective alternative (44%). Over one-third (35%) said the treatments they'd tried didn't work well enough to manage their pain, and 24% said there were no effective treatments for their pain.
- **Cancer patients and survivors continue to encounter access barriers to their prescribed opioid medications, even though most opioid limits are not intended for cancer patients.** Among those who had been prescribed an opioid pain medication within the past year, 30% reported that their doctor had indicated treatment options for their pain were limited by laws, guidelines, or their insurance coverage.
- **Cancer patients and survivors do not experience access barriers equitably.** Lower income earners were much more likely to report access challenges, with 40% of those earning under \$70,000 in annual household income and 56% of those under \$35,000 per year saying their doctor had indicated such limitations, compared to just 14% of those in households earning over \$70,000.

- ***A larger share of cancer patients and survivors enrolled in plans that are subject to state laws/regulation reported challenges, despite most of these laws having exceptions for cancer patients.*** Over threequarters of Medicaid recipients reported their doctor indicating these limitations (78%), and those enrolled in privately purchased plans were also twice as likely as those on employer provided plans (40% vs. 20%) to say their doctor had indicated limits to their pain management options due to laws, guidelines, or coverage policies.
- ***Cancer patients and survivors have to jump through many ‘hoops’ to get their opioid prescriptions.*** One-in-five reported their pharmacy providing only a portion of the opioid medication written by their doctor (such as seven days instead of a prescribed thirty) and being told they had to call their doctor if more was needed. Another 20% said their doctor had informed them that prior authorization was required before they could prescribe a pain medication. Eleven percent said their insurance provider has required them to try an alternative pain medication before they could access the treatment prescribed by their doctor.
- ***Access challenges and barriers to pain treatment have real, negative impacts on cancer patients and survivors.*** Nearly half (47%) of those who had experienced difficulties filling an opioid pain prescription reduced their use of it regardless of their need for it, and 42% were unable to complete daily tasks or participate in work, family, or social events due to uncontrolled pain.
- ***This situation leads to worry and stress for patients.*** Fifty-five percent of cancer patients and survivors were concerned about having access to needed pain treatment for the pain associated with their cancer in the future.

These data show that policies drawn from the 2016 Guideline continue to limit access to opioids for cancer patients and survivors – even though the Guideline was never meant to apply to these patients – and that these access barriers have led to negative outcomes. CDC acknowledges this as well in its introduction to the proposed 2022 Guideline,¹⁰ and includes many citations to published research detailing these impacts.^{11,12} While we and the patients we represent appreciate this validation, CDC must take other actions to ensure that its 2022 Guideline is not “misapplied” in these same ways – as well as take action to ensure that policymakers at every level do not continue to misuse the previous version of the Guideline to create policy.

ACS CAN Comments on the Proposed 2022 Guideline

Summary Box: This clinical practice guideline is.. [and] This clinical practice guideline is not...

On the second page of the proposed 2022 Guideline, CDC includes a text box highlighting how the guideline is intended to be used and the providers and patients to which it applies. It also includes clear language about how the guideline is NOT to be used, and what patient types are exempt – including patients receiving pain treatment for sickle cell disease-related pain; cancer pain; palliative care; or end-of-life care.¹³

ACS CAN supports this language, particularly its inclusion of cancer pain, and its placement of prominence in the Guideline. We strongly encourage CDC to proactively promote the information in this box in its dissemination activities and other actions. Including this statement is not enough to ensure the 2022 Guideline is not misapplied.

Definition of cancer pain

The proposed 2022 Guideline makes it fairly clear that the Guideline does not apply to cancer pain. However, this cancer exemption is worded differently in various locations in the text:

- Most references are to patients receiving treatment for or management of “cancer pain.”¹⁴ It is unclear what qualifies as “cancer pain” – does this include pain caused by cancer treatment (for example, pain caused by chemotherapy or cancer surgery), as opposed to an actual tumor or the presence of cancer? Does this include pain that an individual experiences after they have completed active cancer treatment (and if so, how is active cancer treatment defined)?
- Several references to cancer leave it unclear whether the proposed 2022 Guideline applies to cancer survivors who are in remission or not undergoing active treatment, but still experiencing pain related to their cancer or as a sequelae of cancer treatments:
 - Pg. 7: refers to “individuals with cancer.”
 - Pg. 12: references the misapplication of the 2016 Guideline to the “cancer patient population.”
 - Pg. 19: “This clinical practice guideline does not apply to patients undergoing cancer treatment...”
 - Pg. 164: “...applying recommendations to populations that are not a focus of the clinical practice guideline such as patients with cancer...”
- One reference to cancer does appear to include any pain associated with cancer, presumably including pain experienced by a cancer survivor. On pg. 18, the authors state, “While some principles in this clinical practice guideline might be helpful in the management of pain in sickle cell disease, cancer, palliative care, and end-of-life care, some recommendations might not be relevant for patients with these conditions and receiving care in these settings. Thus, this clinical practice guideline does not apply to patients experiencing pain associated with these conditions or settings.” [emphasis added]

ACS CAN urges the proposed 2022 Guideline authors to clearly define the term ‘cancer pain’ and how it applies to cancer patients and cancer survivors. We also urge the authors to be consistent in their terminology regarding cancer throughout the Guideline. Since the publication of the 2016 CDC Guideline, we have been particularly concerned about cancer survivors’ access to pain treatment, as many of the laws and rules enacted after this guideline include exemptions for “patients in active cancer treatment.” These poorly worded exemptions are not inclusive of many individuals who have or had cancer, are not undergoing active treatment at the moment, but still experience debilitating levels of pain due to their cancer or side effects of their previous treatment.

ACS CAN strongly recommends a clear definition that explicitly includes all individuals receiving cancer treatment or managing “cancer-related pain”, or “cancer-associated pain,” because that includes individuals not in active cancer treatment. The Guideline authors can accomplish this by referring to “cancer-related pain” or “cancer-associated pain” throughout the document, or by adding an explicit

definition of “cancer pain” that clarifies the definition includes all pain related to cancer including pain experienced by those not actively being treated for cancer.

Guideline elements particularly vulnerable for misapplication

While ACS CAN agrees with the proposed 2022 Guideline that individuals being treated for cancer or cancer-related pain should not be impacted by the recommendations, we note that some of these individuals are likely to be impacted regardless of their ‘exempt’ status. Our survey data show that this was the exact case after the 2016 Guideline. The proposed 2022 Guideline includes an accurate summary of how the 2016 Guideline was misapplied: “includes extension of the 2016 Guideline to patient populations not covered in the 2016 Guideline (e.g. cancer and palliative care), opioid tapers and abrupt discontinuation without collaboration with patients, rigid application of opioid dosage thresholds...duration limits by insurers and by pharmacies, and patient dismissal and abandonment.”¹⁵

We are particularly concerned that the proposed 2022 Guideline will be misapplied in regard to references to specific Morphine Milligram Equivalents (MME). While the proposed 2022 Guideline does not explicitly list a maximum dosage limit for pain treatment, we note that 50 MME is mentioned several times in such a way that it could be inferred as the new maximum limit. For example, see pg. 96: “Many patients do not experience benefit in pain or function from increasing opioid dosages to ≥ 50 MME/day but are exposed to progressive increases in risk as dosage increases.” and “Additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further.”

ACS CAN is concerned that policymakers, insurance companies or pharmacy benefit managers will use this language as a rationale to restrict opioid doses to 50 MME in all patients, regardless of whether the Guideline is intended to apply. We are also concerned that, like with the 2016 Guideline, we will see a ‘chilling effect’ on all opioid prescribing above the limit suggested in the Guideline (even when prescribing over 50 MME is warranted), because clinicians will not want to be flagged as over-prescribers, and this chilling effect will restrict access to doses that cancer patients need.

We therefore strongly encourage CDC to remove any references to numerical dosing thresholds in the proposed 2022 Guideline’s Recommendations or Implementation Considerations that could be misinterpreted and perceived as limits to guide dosing decisions. CDC should also make clear that evidence pertaining to the use of doses or quantities to establish a prescribing threshold is categorized as low-quality (see section below on “Quality of Evidence”), and therefore any doses or quantities referenced in the proposed Guideline should not serve as the basis for any laws or policies. We also strongly encourage CDC to monitor for inappropriate application of the Guideline and proactively work to combat this outcome, including working with other state and federal agencies to ensure that clinicians who prescribe higher doses of opioids when medically appropriate do not get penalized for doing so.

Quality of evidence

When CDC published its 2016 Guideline, ACS CAN noted we were very troubled that CDC was making recommendations with far-reaching impacts based on what the Guideline authors themselves

considered to be low-quality evidence. We remain concerned that recommendations are made in the proposed 2022 Guideline based on evidence that is ranked as low quality. The proposed 2022 Guideline uses four categories of evidence, stating that a recommendation with type 3 evidence is based on “observational studies or randomized clinical trials with notable limitations.”¹⁶ Recommendations with type 4 evidence are based on “clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.”¹⁷

We note that out of 12 total recommendations in the proposed 2022 Guideline, three recommendations are categorized as type 3 (this includes recommendation #4, which as stated above, is likely to be misapplied as a de facto or actual maximum dosage limit), and 7 as type 4. CDC has once again made a majority of its recommendations – that will have far-reaching consequences on patients needing pain treatment – based on evidence it characterizes as having ‘notable’ or ‘major’ limitations. We remain concerned about the impacts of this proposed 2022 Guideline in light of its basis in research with such defects.

Application to Certain Clinician Specialties

Pages 15-20 of the proposed 2022 Guideline discuss the scope of the Guideline, and the patients and clinician types/specialties to which it applies. We note that it is unclear whether and how the Guideline and its recommendations apply to anesthesiologists – a clinician type that is not at all mentioned in the Guideline. We note that some anesthesiology services do occur in outpatient and other settings within the scope of this Guideline. Additionally, while pain management specialists are discussed on pg. 17, it is unclear if patients being treated by these specialists are automatically exempt from the Guideline simply because of the type of clinician treating them. We recommend CDC clarify whether and how the Guideline is intended to apply in these situations.

Potential Impacts of 2022 Guideline

On pgs. 164-165, CDC details its promotion efforts of the 2016 Guideline, and states that it will “update existing resources to align with the new clinical practice guideline and develop new tools and resources for clinicians, health systems, patients, and others on the use of opioid and non-opioid pain treatments — including resources supporting health equity.”

It is crucial that CDC recognize its important role in promoting the 2022 Guideline when it is finalized, and ACS CAN supports CDC’s efforts. We urge the agency to take this task seriously. CDC should ensure that any webpage or publication under its control that contains content from the 2016 Guideline contains clear notations that the 2016 Guideline is outdated, and link to the 2022 Guideline. CDC should proactively reach out to stakeholders to suggest they do the same on any websites or in publications that reference the 2016 Guideline.

CDC must ensure that clinicians, insurers/payers, and pharmacies are not only aware of the new 2022 Guideline but related how it has changed from the 2016 Guideline. CDC should be clear in communicating who is exempt from the Guideline, how the Guideline should NOT be used, and which Guideline clinicians should refer to for cancer patients and survivors. CDC should push stakeholders to remove, rescind, and/or re-write any policies, guidance or other documents/resources that use

information from the previous Guideline – particularly policies that include dosage or duration limits that are based on the previous Guideline. Lastly, we strongly urge CDC to track the effects of the 2022 Guideline on providers and patients – including on providers and patients for whom the Guideline is not intended to apply. This should include published quantitative and qualitative research, so that CDC and all interested parties can monitor the effects of the Guideline and continue to make course corrections in the future.

To that end, when the final 2022 Guideline is published, ACS CAN and its partners will renew our own efforts to evaluate improper limitations placed on opioid prescribing at the federal, state, insurance plan, and pharmacy benefit manager levels; and engage in advocacy efforts to rescind limits that misapply the 2016 Guideline and inappropriately limit access to pain treatment. We strongly urge CDC to be an active partner in these and similar efforts.

Thank you for considering our comments regarding the Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids. If you have any questions, please feel free to contact my staff at 202-839-3531 or Jennifer.Hoque@cancer.org.

Sincerely,



Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network

¹ ACS CAN. Survivor Views: Affordability, Prescription Drugs, & Pain; December 2021 Survey Findings Summary. https://www.fightcancer.org/sites/default/files/national_documents/survey3_polling_summary.pdf

² Chino F, Kamal A, Chino J. Incidence of Opioid-Associated Deaths in Cancer Survivors in the United States, 2006-2016: A Population Study of the Opioid Epidemic. *JAMA Oncol.* 2020;6(7):1100–1102. doi:10.1001/jamaoncol.2020.0799

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. DOI: <http://dx.doi.org/10.15585/mmwr.rr6501e1>

⁴ ACS CAN. Letter from President Chris Hansen to Dr. Tom Frieden, October 1, 2015. https://www.fightcancer.org/sites/default/files/ACSCAN_Comments_CDC_Opioid_Guidelines_Final.pdf

⁵ ACS CAN. Letter from President Chris Hansen to Dr. Tom Frieden, January 12, 2016. https://www.fightcancer.org/sites/default/files/National%20Documents/ACSCAN_Comments_CDC_Revised_Opioid_Guidelines_Final.pdf

⁶ Public Opinion Strategies, prepared for ACS CAN and Patient Quality of Life Coalition. Key Findings Summary: Opioid Access Research Project. 2018.

<https://www.fightcancer.org/sites/default/files/ACS%20CAN%20PQLC%20Opioid%20Research%20Project%20Key%20Findings%20Summary%20Memo%20FINAL.pdf>

⁷ ACS CAN. Survivor Views: Pain and Palliative Care Survey Findings Summary. 2019.

https://www.fightcancer.org/sites/default/files/Survivor%20Views.Pain%20and%20Palliative%20Care%20Polling%20Memo.20191028_FINAL.pdf

⁸ For more information about Survivor Views, please visit <https://www.fightcancer.org/survivor-views>

⁹ Source for all data remaining in this section: ACS CAN. Survivor Views: Affordability, Prescription Drugs, & Pain December 2021 Survey Findings Summary.

https://www.fightcancer.org/sites/default/files/national_documents/survey3_polling_summary.pdf

¹⁰ Pg. 12, CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022, available at:

<https://www.federalregister.gov/documents/2022/02/10/2022-02802/proposed-2022-cdc-clinical-practice-guideline-for-prescribing-opioids>

¹¹ Dowell, D., Haegerich, T., & Chou, R. (2019). No Shortcuts to Safer Opioid Prescribing. *N Engl J Med*, 380(24), 2285-2287. doi:10.1056/NEJMp1904190

¹² Kroenke, K., Alford, D. P., Argoff, C., Canlas, B., Covington, E., Frank, J. W., . . . Sullivan, M. (2019). Challenges with Implementing the Centers for Disease Control and Prevention Opioid Guideline: A Consensus Panel Report. *Pain Med*, 20(4), 724-735. doi:10.1093/pm/pny307

¹³ Pg. 2, Ibid, CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022

¹⁴ See references to cancer on pgs. 2, 14, and subsequent mentions of cancer in proposed 2022 Guideline recommendations

¹⁵ Pg. 12, Ibid, CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022

¹⁶ Pg. 211, Ibid, CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022

¹⁷ Ibid.