



**Maryland Medicaid PDL Committee:
Testimony Representing Individuals Affected by Pain
Micke A. Brown BSN, RN**

As a pain management nurse for over 10 years, I come to you today as a voice for individuals affected by pain. I currently serve as the Chief Elected Officer for the American Society of Pain Management Nurses, a board member of the Maryland Pain Initiative and the Pain Management Advisor to the American Pain Foundation, whose home office is based in Baltimore. I am requesting that this committee make all long-acting opioids preferred drugs, such that prior authorization is not required for any patient to receive them when they are prescribed by their physician. I am not here to speak on behalf of any particular drug, but to speak on behalf of the thousands of Medicaid beneficiaries with pain, whose pain control would be threatened by restricting access to long-acting opioid analgesics. I have seven (7) key concerns to stress.

1. Pain is very prevalent in our country, and massively undertreated.
 - a. Surveys indicate that 50 to 70 million Americans are partially or totally disabled by chronic pain.
 - i. A 2002 survey of Maryland residents by the Maryland Pain Initiative and the American Pain Foundation found that 66% reported they or someone in their household suffers from pain on a monthly basis. Of those people, 46% reported pain occurs daily or several times per week and 68% report the pain is moderate to severe.
 - b. The National Institutes of Health estimate that the cost of uncontrolled pain to our economy (considering decreased productivity, disability payments, cost of care, etc.) is over \$110 billion every year.
 - c. Among cancer patients, in a cross-sectional study, up to 50% have significant pain.
 - d. Among patients with advanced metastatic cancer, up to 70-80% have pain.
2. We have made great strides over the past 15 years in removing barriers to good pain management.
 - a. There have been efforts within Maryland to improve the education of physicians and nurses by the work of our Medical Board of Quality Assurance and the Maryland Board of Nursing.
 - b. Due to legislation in 2002, all healthcare facilities are required to notify the public about their pain rights, not just those facilities who are seek accreditation from the Joint Commission of Accreditation for Healthcare Organizations (JCAHO). Also, the Maryland Pain Advisory Council was created and now in the middle of investigating the current problem of unrelieved pain in our state. Their report to the Governor is due in September 2004.
 - c. Compared to other states, we have managed to maintain a C+ rating over the past 4 years from the Pain and Policies Study Group. We need to identify opportunities to improve access to pain care rather than promote more barriers that will improve our grade.
3. Implementation of a PDL that does not include all long-acting opioids will reverse this positive trend by erecting a new barrier that will prevent access to care for the most vulnerable of all our pain patients. These patients are doubly vulnerable:

- a. They are economically disadvantaged and/or old and/or disabled; all of these groups are at documented risk for poor pain management. Because of the economic issues, they have virtually no recourse if access to a medication they and their physician prefer is restricted.
 - b. They also have chronic pain. Chronic pain patients, especially those with chronic non-cancer pain, are known to be very under-treated.
4. In most states, the laws that allow the establishment of PDLs specifically exclude “mental health drugs” or “central nervous system” (CNS) drugs:
 - a. In part, this is because we have such a rudimentary understanding of the CNS and the ways in which specific drugs work in the CNS.
 - b. As a result of this, we have great difficulty predicting which medications will be the right ones for which patients, considering both the positive effects and the undesirable side effects.
 - c. The same is true of opioids:
 - i. Opioids work almost exclusively in the CNS.
 - ii. Research by Pasternak has established that we have at least 19 sub-types of the mu opiate receptor.
 - iii. It is believed that the great inter-individual differences in responses to various opioids may be due to the interaction between the specific receptor affinities of these medications and the specific receptor array found in each individual (and probably determined by genetic factors).
 - d. As is the case with, for example, antidepressants all have the same overall effectiveness rates. However, we don’t just choose medications for specific patients at random; we try to assess what we do know about the patient and the medication, and make our best guess as to what will work. The same is true for opioids; making only one available without going through the prior approval process will mean that the vast majority of patients will have to either go through the PA process or rely only on short-acting drugs. Our best guess as to what is the most appropriate drug is frequently wrong.
5. Choosing a preferred opioid on the basis of cost alone is not appropriate, given the extreme clinical variation among these medications. To do this is akin to saying that, because all automobiles will move you from one place to another, we should all drive Yugos because they are the cheapest cars available. The cheapest is not necessarily the best for everyone.
6. Restricting access to some long-acting opioids may save Medicaid money in its drug acquisition budget, but it may end up costing even more in other parts of the budget, such as payments for physician visits, ER visits, hospitalizations, and nursing home stays.
 - a. Dr. Bob Robinson, an epidemiologist who formerly worked for CDC, was commissioned to do a study of this possibility by the National Foundation for Women Legislators. In a retrospective study of California Medicaid (MediCal), assessing the effects of restricting access to OxyContin, he found the following:
 - i. Patients taking OxyContin, vs. other long-acting opioids, had more than twice the number of serious medical diagnoses, meaning that they are significantly more medically ill, and suggesting that these patients tolerate OxyContin better than other long-acting opioids
 - ii. These same patients did account, on a per capita basis, for a larger proportion of the drug acquisition budget for Medicaid.
 - iii. When cost for patients of illness with similar severity were compared, those taking other Schedule II opioids had an overall health care cost that average **\$24,000 more than** those taking OxyContin due to higher hospital and nursing facility costs. Even though the average drug cost averaged \$1700/patient less than the OxyContin patient population. Additional information about this study is available in a separate attachment.

- iv. Thus, the bottom line is that restricting availability to certain long-acting opioids may result in a net loss to Medicaid; such an approach is an example of “short term gain for long term pain”.
7. Finally, consider the additional burden that would be imposed on physicians and patients by requiring PA for most long-acting opioids:
- a. Physicians would have a huge increase in paperwork, since it is very unlikely that any single long-acting opioid is going to account for more than a third of the total market share, meaning they would have to complete PA paperwork on two-thirds of patients or run the risk that they will not respond well to the drug to which they are changed.
 - b. Patients could face up to a 24-hour delay in getting their prescriptions filled, leaving them with poor pain control or intolerable side effects for an additional day, and necessitating a return trip to the pharmacy to pick up the prescription.

In summary, for the good of Medicaid beneficiaries with pain, and for sound medical and perhaps economic reasons, the most prudent course is for all long-acting opioids to be placed on the preferred list. I thank you for your attention and thoughtful consideration.

Respectfully,

Micke A. Brown BSN, RN
President, ASPMN
Board of Directors, Maryland Pain Initiative
Pain Management Advisor, American Pain Foundation
22035 Holiday Drive
Smithsburg, Maryland 21783