



March 13, 2018

Chairman Kevin Brady
Chairman Peter J. Roskam
House Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20510

Dear Representatives Brady and Roskam,

On behalf of the Academy of Integrative Pain Management (formerly American Academy of Pain Management), the nation's largest pain management organization, and U.S. Pain Foundation, the nation's leading patient advocacy organization, we are pleased to respond to your request seeking policy recommendations for addressing the opioid crisis that would fall within the jurisdiction of the Committee on Ways and Means. Our organizations thank you for recognizing the complex challenges involved in addressing the intersection of three major public health crises—namely, ensuring adequate and appropriate treatment of pain, substance use disorders, and mental health conditions.

Chronic pain is the most prevalent, costly and disabling health condition in the United States. Because this extraordinarily common health condition is so intertwined with opioid analgesics, a long-term solution to the opioid crisis will only be achieved by addressing inadequately treated chronic pain.

Sadly, despite pain's prevalence and potential to devastate the lives of its victims, neglecting the widespread problem of chronic pain in both our civilian and veteran population has, in part, contributed to the opioid crisis we now find our nation embroiled in. Lack of investment in basic research in pain at the NIH has meant that we still do not understand the neurobiological basis of pain in the human body and have not discovered and developed new effective pharmacological alternatives to opioids for treating pain without their risks and side effects. Likewise, lack of investment in research to investigate the effectiveness of non-pharmacological treatments for pain has meant that insurers are reluctant to pay for these treatments as alternatives to opioid therapy. Although chronic pain is the leading cause of disability and the number one reason Americans visit their healthcare providers, doctors educated in American medical schools receive less than nine hours of pain management education in four years of training. Further, there is a dearth of physicians specialized in pain management – less than 1% of U.S. physicians are specialized in pain management. This has meant that the burden of care for the millions of Americans living with chronic pain has fallen on primary care providers who are ill-equipped to manage a disease as complex and misunderstood as chronic pain.

Successful management of chronic pain requires a combination of therapies that is highly specific to each individual. Consequently, this means that clinicians' time spent working with patients and coordinating their care leads to the most successful outcomes. Unfortunately, our system of reimbursement has forced physicians to reduce the amount of time spent with patients and virtually eliminate time spent coordinating care with other health care providers. It is easy to see why our system has unintentionally led healthcare providers to choose a quick pharmacological solution.

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While the issues of chronic pain, substance use disorders, and mental health all present numerous challenges, they also afford opportunities for government payers to implement innovative policy recommendations that have the potential to transform our current system of care for individuals living with these conditions into one that is safer, cost efficient, and most importantly, more effective.

We have broken down our recommendations so that they align with the questions posed in your letter dated February 27, 2018:

Treatment

The following recommendations are in response to the Committee's request for input related to (1) resource use and reimbursement issues that should be considered for the Medicare population when expanding treatment options, and (2) effectively addressing pain and ideas for innovative ways to encourage multimodal treatment of pain through payment reforms or benefit changes.

Reimburse Primary Care Providers and Pain Specialists for Longer Initial Visits and Frequent Follow-up Visits with Chronic Pain Patients.

These visits should require providers to develop an individualized plan of care for each patient that includes non-pharmacological treatments in combination with, or in place of, pharmacological treatments. These plans should be updated at each subsequent visit including which interventions have been tried and the effect of that intervention on patient functional abilities and pain severity. Providers should be paid for time spent coordinating care and conferring with other therapists about the patient's progress. The proper treatment of chronic pain is complex and requires frequent monitoring and care coordination. Providers should not be penalized for providing appropriate care with respect to the cost calculation in the Merit Based Incentive System. Instead, incentives should be in place to encourage providers to provide necessary, coordinated care. When patients are being managed on opioid therapy we want to be certain that the risk of developing a substance use disorder (SUD) is minimized. This requires frequent visits to monitor compliance measures as well as functional improvement. In the long run, the cost of this additional care will more than pay for itself in reduction of emergency room visits, outpatient visits, and hospitalizations, and duplicative tests and repeated visits to specialists in the hopes of finding someone and something to help reduce patients' pain, not to mention the expense of treating SUDs that will be prevented.

Address Additional Financial Barriers that Prevent Many Medicare and Medicaid Beneficiaries from Seeking Non-Pharmaceutical Treatments for Pain.

Nearly every recent effort to reduce prescriptions of opioid analgesic medications has been accompanied by a statement that urges the use of alternative treatments to treat pain. However, these treatments remain largely inaccessible due to lack of insurance coverage. The vast majority of Medicare and Medicaid beneficiaries living with chronic pain are on a fixed income or low income either due to retirement, disability, or inability to work part time (or work at all) because of their pain. Most non-pharmacological therapies that pain sufferers have reported to be beneficial are not covered by Medicare and Medicaid and the ones that are limit the number of visits or the type of treatments that can be used by practitioners.

CMS should allow a greater number of physical and occupational therapy sessions annually, and should allow patients to access physical and occupational therapy without first acquiring a referral or prior authorization.

Physical and occupational therapies

are effective at preventing and treating musculoskeletal pain syndromes, in particular, and chronic pain conditions in general. Medicare and Medicaid coverage for these therapies is inadequate in terms of the number of sessions covered, and requires that a physician serve as a gatekeeper. Physical and occupational therapists are highly-trained professionals who are capable of evaluating a patient's likelihood of benefitting from the treatments they offer. Requiring a gatekeeping appointment with a physician or a prior authorization process only drives up costs, delays a patient's access to treatment and, in some cases, may deny that patient access to an effective and cost-effective treatment that minimizes the need for opioid analgesics.

CMS should provide full coverage of chiropractic adjustments and osteopathic manipulations and other techniques and modalities and should allow a greater number of sessions annually.

Medicare only covers one very specific type of chiropractic manipulation for one specific type of pain syndrome – back pain. Chiropractic care, including a range of modalities (e.g., electrical stimulation) and techniques (e.g., Grasston), provides pain relief to many chronic pain sufferers. Further, chiropractic care is appropriate for many different types of musculoskeletal pain conditions and syndromes. These treatments should be fully covered by both Medicare and Medicaid.

CMS should provide full coverage for acupuncture, massage therapy, biofeedback, yoga and tai chi.

These integrative and complementary therapies are used successfully by many to manage chronic pain but are currently not covered by Medicare and Medicaid, outside of a few state Medicaid programs. These key treatments are recognized by the Department of Defense and the Veterans Health Administration as effective treatments for chronic pain, are included in the DoD/VHA pain management guidelines, and are covered services in DoD/VHA facilities.

CMS should provide coverage of behavioral health services for the prevention, treatment, or management of physical health problems.

Behavioral health care providers are well-equipped to teach patients skills and techniques in how to better manage and cope with pain including cognitive behavioral therapy, acceptance and commitment therapy, mindfulness meditation, relaxation therapy and others; however, these practitioners are often not reimbursed for their services when they use proper diagnoses and Current Procedural Terminology (CPT) codes. We urge that CMS be required to reimburse these practitioners for their services.

CMS should provide coverage of medical devices that are FDA-approved for the treatment of chronic pain.

There are a variety of stimulation devices such as TENS, spinal cord stimulators, low-level lasers, and others that have proven to be effective at reducing pain for certain types of chronic pain conditions. These should be covered by both Medicare and Medicaid.

Improve Pain Treatment by Funding Innovative Research and Demonstration Projects.

Fund Epidemiological Research, Analysis and Reporting of Chronic Pain in the Medicare and Medicaid Population.

A core responsibility of public health agencies is assessing the significance of health problems in the population they serve. We know that our aging population as they become eligible for Medicare are at increased risk of developing age-associated pain-producing conditions such as osteoarthritis, diabetic neuropathy and cancer. At present, neither CMS, nor CDC, to our knowledge, collects and reports data on the prevalence, onset, course, impact, and outcomes for common chronic pain conditions and syndromes. Without such data how can we

effectively develop, guide and refine

policies to reduce this burden? CMS must begin to track changes in chronic pain prevalence, impact and costs over time and longitudinally to enable evaluation of the effectiveness of interventions at the population health level.

Fund Long Term (greater than 12 weeks) Research Studies Evaluating the Effectiveness of Non-Pharmaceutical Treatments for Chronic Pain.

In order for private payers to cover the cost of non-pharmaceutical treatments, especially integrative and complementary therapies, they require valid research proving the effectiveness of these therapies for reducing pain and improving function. We lack a body of research on most of these therapies because no one will fund such research. CMS could help remove a barrier to utilization of the most promising non-pharmacological treatments for chronic pain by funding efficacy studies for a wide range of such therapies.

Fund (through the Center for Medicare & Medicaid Innovation) Innovative Demonstration Projects using Integrated, Non-Pharmacological Treatments for Chronic Pain Care.

A few Medicaid demonstration projects have been set up through Medicaid Waivers using non-pharmaceutical therapies for chronic pain. In most cases, these are small scale projects showing promise but need more substantial financial commitment to develop them and research their effectiveness.

Example projects include:

Colorado Medicaid Waiver for Spinal Cord Injury Pain

Since 2012, Health First Colorado (Medicaid) has offered a waiver for persons with Spinal Cord Injury (SCI Waiver Pilot Program) that provides participants with access to massage, acupuncture, and chiropractic care. There are signs of positive trends regarding cost-saving, but additional research and larger sample sizes are required to prove effectiveness in reducing pain and costs. Personal stories from participants include describing minimal use or complete abstinence from previously used medications for pain, due to the addition these three modalities.

Rhode Island Medicaid Pain Management Program

Originally started as an attempt to reduce ER visits among chronic pain sufferers with severe pain flares, eligible participants were given access to massage, acupuncture and chiropractic services. To our knowledge, there is currently a study underway evaluating the program.

Oregon Health Plan (Medicaid) Back Pain Services

Originally started as expanded services for Medicaid recipients with muscle weakness and nerve damage the plan has been expanded to those with chronic back pain. It covers acupuncture, chiropractic and osteopathic manipulation, cognitive behavioral therapy, physical therapy and occupational therapy.

Vermont Medicaid Acupuncture Pilot for Chronic Pain

The Vermont Legislature set aside \$200,000 for a pilot of acupuncture services for pain management.

We are aware of two other innovative state projects for improving pain management that could be aided, enhanced or expanded through federal efforts.

As stated earlier, the burden of caring for people with chronic pain falls largely on primary care providers who are not comfortable treating chronic pain. Over the past few years, as concern over opioid use disorder has intensified, physicians have gotten the message to cut opioid prescribing and they have responded accordingly.

Opioid prescribing is down by approximately 30%. There is a climate of fear amongst health care providers about treating people living with chronic pain.

Pain sufferers report feeling stigmatized and now many of them are being dropped from care entirely. Patient advocacy groups for people with living with chronic pain are all receiving a steady stream of calls and e-mails from patients seeking help finding doctors who will treat them. There is great concern amongst the pain community that this situation could lead to an increase in suicides, as was seen in the VA after it began reducing opioid doses. This is a sad and unintended consequence of policy makers' efforts to solve the opioid crisis.

One way to improve access to care for Americans living with devastating pain conditions is to provide specialized pain management consultation to PCP's to enable them to feel more comfortable treating chronic pain patients.

Project ECHO

One such innovative model of care that we believe has the potential to improve pain care if replicated in other locations is the Extension for Community Healthcare Outcomes (Project ECHO) pioneered by the University of New Mexico Medical School. Originally created by a hepatologist who was frustrated that so many New Mexicans with hepatitis C could not get the care they needed because there were no specialists where they lived, Project ECHO uses video technology to address the problem of providing access to specialty care for patients with complex chronic diseases who reside in areas where specialized services are remote or inaccessible, linking expert specialist teams at an academic medical center with primary care clinicians in local communities in order to share expertise. The program offers local healthcare providers the opportunity to co-manage complex patients while at the same time training them in the skills required to handle these complex chronic conditions themselves. Ultimately, these skills are transferred to the local setting which reduces or eliminates the need for costly specialty referrals and increases care coordination. ECHO has demonstrated lower costs and improved outcomes in the management of chronic diseases.

The DoD has adapted the ECHO program in remote sites to the treatment of chronic pain with considerable success. Further, Congress passed the ECHO Act in 2016 (sponsored by Senator Hatch), which requires specified federal agencies to study technology-enabled collaborative learning and capacity building models and the ability of those models to improve patient care and provider education. Essentially, the federal government has already mandated a study that analyzes ECHO programs from across the country to determine their effectiveness. We urge the Committee on Ways and Means to review this study's findings, as positive findings will support expansion of, and increased funding for, ECHO programs for chronic pain across the country.

MCPAP

Another innovative model of care that we believe could translate well to pain management is the Massachusetts Child Psychiatry Access Program or MCPAP. The goal of MCPAP is to increase access to behavioral health treatment by making child psychiatry services – a scarce resource – available to PCPs across the state. Each team is staffed with two full-time child and adolescent psychiatrists, independently licensed behavioral health clinicians, resource and referral specialists, and program coordinators. Through consultation and education MCPAP improves the PCP's competencies and comfort with screening, assessment, treating mild to moderate cases of behavioral health disorders and in making effective referrals and coordinating the care for patients who need community-based specialty services. MCPAP consultation is available to PCP's free of charge as the state pays for the program.

The Massachusetts legislature charged a Special Commission with determining whether the state should pilot a MCPAP model for pain management. The Commission has examined the issue and has made a positive recommendation to the legislature to pilot this program for pain management. Funds have not yet been appropriated for a pilot. We believe such a pilot with an Advisory Board and an evaluation component would benefit from federal support as a demonstration project.

Communication and Education

The following recommendations are in response to the Committee's request for input on the best methods for provider education on the adverse effects of prolonged opioid use, clinical guidelines for alternative pain treatments, and clinical guidelines for opioid prescribing.

Ensure Pain Education Mandates Require Balanced Information.

When teaching health care providers about treating pain, it is imperative that we not only teach them about safe opioid prescribing, but also about the wide variety of alternative pain treatments that are available and when those treatments (sometimes provided by other health care providers) are indicated for the patient's particular condition.

We often say in regard to opioids: when all you have is a hammer, every problem looks like a nail. By this, we mean that when we continually teach only opioids to our health care providers, they see pain as something that must be treated with opioids and that is inextricably linked to opioids. However, pain management often requires a multimodal approach, bringing together all appropriate therapeutic approaches to reduce pain and achieve optimal health and healing. If health care providers are to be expected to use a multimodal approach to pain management, we must teach them how to use more than just opioids to treat pain and when other treatments are indicated.

In order to encourage optimal pain management practices while decreasing the occurrence of addiction and overdose, we suggest a more focused approach to designing the curriculum. As advocates of optimal health care practices and policies, as well as a provider of continuing medical education, we strongly recommend that any education that you consider requiring include the following:

1. Best practices for pain management, including a thorough bio-psycho-social assessment with regular follow-up between provider and patient, an introduction to the approach and benefits of integrated pain care, alternatives to prescribing controlled substances, and evidence-based, non-pharmacological therapies for treating pain;
2. Safe opioid prescribing and identifying and mitigating risk factors associated with overdose;
3. Methods for diagnosing, treating, and managing a substance use disorder, and linking appropriate patients to evidence-based treatment for substance use disorders.

Ensure Pain Education Mandates Apply to All Relevant Health Care Providers.

If a pain education mandate is implemented, whether for students or for professionals, we strongly urge that requirement to be applied to all potential prescribers, not merely physicians. Again, because pain is best treated through a multimodal, multidisciplinary approach, it is imperative that other potential prescribers, including Nurse Practitioners, Physician Assistants, and Dentists, all receive adequate pain and opioid education.

Electronic Prior Authorization

The following recommendations are in response to the Committee's request for input on the value of standardizing the electronic prior authorization process and other improvements that could be made to improve coordination and prevent abuse.

Ensure Coverage of Medically Assisted Treatment (MAT) Without Prior Authorization

We strongly recommend that CMS not only cover MAT for the treatment of substance use disorders, but that they do so without prior authorization. Further, there are three forms of MAT that could be chosen, depending on the patient's needs and clinical judgment. In the face of an opioid overdose epidemic, patients should have access to whichever MAT treatment their health care provider believes is best indicated for their particular situation. They should also not have to await prior authorization while they seek treatment, as the delay could easily cause them to abandon treatment altogether. Therefore, CMS should ensure that all MAT options are available without prior authorization.

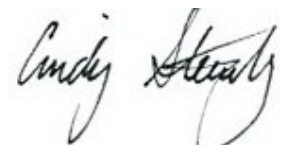
In closing, we sincerely thank the Committee for recognizing the urgent need to address the problem of chronic pain as part of a comprehensive strategy to curb the opioid epidemic. We are pleased to offer a range of policy recommendations that are within the jurisdiction of the Committee on Ways and Means.

If we can provide any additional information or assist the Committee's efforts in any way, please contact Katie Duensing at kduensing@integrativepain.org or by telephone at 209-425-0468.

Sincerely,



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About AIPM: The Academy of Integrative Pain Management is the premier organization for all clinicians who care for people with pain. It is the largest pain management organization in the nation and the only one that embraces, as part of its mission statement, an integrative model of care, which: is patient-centered; considers the whole person; encourages healthful lifestyle changes as part of the first line of treatment to restore wellness; is evidence-based; brings together all appropriate therapeutic approaches to reduce pain and achieve optimal health and healing; and, encourages a team approach.

About U.S. Pain Foundation: The mission of U.S. Pain Foundation is to educate, connect, inform and empower those living with pain while also advocating on behalf of the entire pain community. As a 501(c)(3) non-profit

organization dedicated to serving those who live with pain conditions and their care providers, U.S. Pain Foundation helps individuals find resources and inspiration.