

February, 20, 2017

Senator Orrin G. Hatch  
Senator Ron Wyden  
U.S. Senate Committee on Finance  
Washington, DC 20510

Dear Senators Hatch and Wyden,

We are pleased to respond to your request seeking policy recommendations for addressing the opioid crisis that would fall within the Finance Committee's jurisdiction. We thank you for recognizing the interrelationship of two public health crises our nation faces – chronic pain and opioid misuse. Chronic pain is the most prevalent, costly and disabling health condition in the U.S. A long-term solution to the opioid crisis will only be achieved by addressing inadequately treated chronic pain.

Sadly, despite its 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 PCP's 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 clinician's 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. It is easy to see why our system has unintentionally led healthcare providers to choose a quick pharmacological solution for which they have no incentive to follow-up with patients to ensure the success of their intervention.

We agree with the Committee's assessment that while these twin epidemics 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 chronic pain and those living with substance use disorder into one that is both more effective and more cost efficient.

Our recommendations relate specifically to three of the questions you have posed in your letter dated February 2, 2018:

*1. How can Medicare and Medicaid payment incentives be used to promote evidenced-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?*

**Reimburse PCP's and Pain Specialists for Longer Initial Visits and Frequent Follow-up Visits with Chronic Pain Patients.**

These visits should require doctors 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 as well as pain severity. Physicians 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. Physicians 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 physicians to provide necessary, coordinated care. When patients are being managed on opioid therapy we want to be certain that the risk of developing an OUD 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, 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 OUDs that will be prevented.

*2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of these non-pharmaceutical therapies when clinically appropriate?*

**Financial barriers prevent many Medicare and Medicaid beneficiaries from seeking non-pharmaceutical treatments for pain.**

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 in helping them manage chronic pain 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. Nearly every recent effort to reduce prescriptions of opioid analgesic

medications has been accompanied by a provision which urges the use of alternative treatments to treat pain. However, these treatments remain largely inaccessible due to lack of insurance coverage.

*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 grants to experienced pain patient organizations who have developed support group leader training that teaches self-management skills and provides on-going guidance to lay leaders.*

Chronic pain is a disease of the nervous system and brain for which there is no cure at present nor for the foreseeable future. Its effects over time, if not managed well, can be devastating and very costly leading to worsening of pain, development of multiple chronic pain conditions, isolation, depression, anxiety and even suicide. Like other chronic illnesses, patients need ongoing support services including skills to self-manage their conditions so they remain as healthy as possible. Long-term support groups have been shown to be extremely beneficial in keeping pain patients connected, educated about the latest methods of managing pain and engaged in better self-care. Investment in services like these is relatively inexpensive compared to costly procedures and surgeries that are usually covered by CMS and have been shown to be of limited value for chronic pain, especially in the long term.

*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.

**A key barrier to any progress in tackling the high prevalence of chronic pain with non-pharmaceutical options is the appalling lack of epidemiological data on any aspect of chronic pain including the number of chronic pain sufferers in the Medicaid and Medicare 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 longitudinally track changes in chronic pain prevalence, impact and costs to enable evaluation of the effectiveness of interventions at the population health level.

**Another barrier to the use of non-pharmaceutical treatments for chronic pain is the lack of long term (greater than 12 weeks) research studies evaluating their effectiveness.**

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.

*7. What best practices employed by states through innovative Medicaid policies or through the private sector can be enhanced through federal efforts or incorporated into Medicare?*

**CMS through the Center for Medicare & Medicaid Innovation (CMMI) should be required to set aside funds for more 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 PCP's 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 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 Finance Committee 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

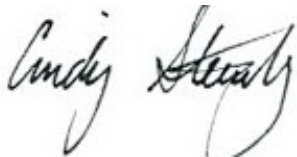
Another innovative model of care that we believe could translate well to pain management is the Massachusetts Child Psychiatry Access Program or MCPAP. The goal of MCPAP is to

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.

We 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 Finance Committee's jurisdiction. Please contact Cindy Steinberg by e-mail ([csteinberg@rcn.com](mailto:csteinberg@rcn.com)) or phone (781-652-0146) should we be able to provide additional information or assist the Committee's efforts in any way.

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Steinberg". The signature is fluid and cursive, with the first name "Cindy" and last name "Steinberg" clearly distinguishable.

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