September 13, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

The Alliance to Advance Comprehensive Integrative Pain Management (AACIPM) is respectfully submitting comments on CMS-1751-P, Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (the "PFS"). We will specifically be responding to "Comment Solicitation on Separate PFS Coding and Payment for Chronic Pain Management."

AACIPM is a multi-stakeholder collaborative comprised of more than 75 organizations representing people living with pain, public and private insurers, patient and caregiver advocates, researchers, purchasers of healthcare, policy experts, and 37 professional trade organizations representing the full spectrum of healthcare providers. These diverse experts are united in a shared interest to advance access to a value-based, person-centered model of integrative pain care focused on maximizing function and wellness that includes biomedical, psychosocial, complementary and integrative health, and spiritual care. It is with this unique perspective that the undersigned members of AACIPM respectfully offer the following comments in response to CMS' proposed PFS for CY 2022, and we are grateful for the opportunity to provide CMS with information to aid in improving coding design to improve the availability of safe, evidence-based, and cost-effective treatments to people living with pain.

AACIPM is pleased to see CMS' recognition that adequate treatment of pain is a significant public health challenge, along with its acknowledgement of HHS' 2019 Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations (PMTF Report) that focuses on the development of patient-centered pain treatment plans and emphasizes multi-modal, multi-disciplinary approaches and modalities for treating pain. While the PMTF Report urges clinicians to use a comprehensive, individualized, person-centered approach to the diagnosis and treatment of pain, **current coverage and reimbursement policies often make it difficult or impossible for patients to access many treatments and providers that are recommended in current guidelines for a comprehensive treatment plan.** We are pleased that CMS recognizes the need to update its coverage policies and codes in order to make comprehensive integrative pain management more widely available.

In our comments, we will answer a number of questions posed by CMS in the PFS, as well as offer recommendations, related to:

1. Healthcare settings and stages in which treatment transitions from prescribed opioids are occurring, as well as what types of practitioners furnish these services;
2. Resources involved in furnishing chronic pain management and opioid reduction; and,
3. New codes for medically necessary activities involved with chronic pain management and achieving safe and effective dose reduction of opioid medications when appropriate.

1. **Healthcare settings and stages in which treatment transitions from prescribed opioids are occurring, as well as what types of practitioners furnish these non-opioid and nonpharmacological services.**

Transitions from prescribed opioids to utilization of non-opioid treatments options for pain management occur in a wide variety of settings, and are provided by many different clinician types.

Settings include:

- Hospital Inpatient
- Hospital Outpatient
- Community Health Centers
- Private Health Clinics
- Comprehensive Pain Management Clinics (CPMPs, interdisciplinary, out-patient based)
- Integrated Pain Management Programs (IPMPs, primary care clinic- or health system-based)
- Acute and Post-Operative Settings outside hospitals
- Stand-alone clinics or office-based settings
- Rehabilitation Facilities

Comprehensive integrative pain management is delivered in varied settings. It is important that different payment structures with the flexibility to accommodate this variation are in place to provide optimal and cost-effective care. Unfortunately, current payment structures incentivize fee-for-service models, mainly reimbursing for individual unimodal therapy (i.e., PT, OT, behavioral medicine) and don't support the use of team-based and integrated care approaches. These payment structures do not work well in IPMPs and CPMPs outside of the hospital setting. Value-based care and outcome driven reimbursement rates, such as case rates and bundled rates, have found some success when used within the more fully-integrated IPMP and CPMP settings, but may not be cost-effective in standalone primary care or specialty clinics, or for certain provider types.

These issues, and how they may be addressed by improved codes, will be discussed in Section 3, below.

Practitioners include:

1. Physicians
2. Qualified Healthcare Practitioners
3. "Non-Qualified" Health Professionals

We have split these practitioner types into these three categories because they are representative of the way that healthcare providers are able to bill CMS.

Physicians[1] are able to bill CMS directly for pain management services, and include:

- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)
- Doctor of Podiatric Medicine (within limitations)
- Doctor of Optometry (within limitations)
- Doctor of Chiropractic (within narrow limitations)

[1] CMS. Medicare General Information, Eligibility, and Entitlement; Chapter 5 – Definitions. Rev. 120, 11-02-18. Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c05.pdf.

Qualified Healthcare Practitioners are non-Physicians who are able to bill CMS separately for pain management services, without having to bill through a Physician. These include:

- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Psychologists (PhDs, PsyDs)
- Nurse Practitioners (NP)
- Occupational Therapists (OT)
- Physical Therapists (PT, DPT)
- Physician Assistants (PA)
- Social Workers (LICSW)

"Non-Qualified" Health Professionals are not able to bill CMS for the pain management services that they provide. These include:

- Acupuncturists (unless billing under the license of a physician)
- Chiropractors (outside of CMS approved scope of practice)
- Heath Advocates
- Health Coaches
- Massage Therapists
- Naturopathic Doctors (ND)
- Nutritionists (non-CMS approved)
- Nurse Educators (PhD)
- Pharmacists
- Physical Therapy Aids (PTA)
- Yoga Therapists

CMS limitations on covered providers—even on those who are Qualified—are vast, and often impede patients' ability to access providers and treatments that are indicated for their pain.

Evidence shows that treatments such as acupuncture, chiropractic care, massage therapy, yoga and many treatments provided by "Non-Qualified" Health Professionals are effective non-opioid treatments for pain, and many guidelines, rules, and recommendations are calling for their use, including HHS' 2019 PMTF Report. **However, many of the health care providers qualified to provide the non-opioid pain care recommended by new guidelines across the nation are either not considered "qualified providers" under the Social Security Act or constrained by significant barriers to access under the CMS payment system. This misalignment between guideline-concordant care and payment policies must be addressed if CMS is committed to addressing pain management for its beneficiaries in a meaningful way.**

CMS limitations on covered providers cause a number of issues currently, including:

Group visits are underutilized, despite their cost-effectiveness and substantial role in improving access to quality care for people who are underserved.

Group visits have been shown to be effective in numerous pain related settings, helping patients to manage their pain, reducing cost to payers, and lessening the burden on an overwhelmed healthcare system that has a severe shortage of pain management specialists. Group visits–different from shared medical appointments or group medical visits–are used for various clinically-indicated treatments, such as acupuncture, nutrition

education, coping skills, and yoga therapy, and are only billable to CMS if a billable provider (MD, DO, NP, etc.) sees each patient individually on the same day as the group visit.

Group visits are particularly helpful when utilized in underserved communities, as they provide high-quality pain care to patients with less demand on a clinic's resources, which, if billed differently than currently required, would result in significant savings to CMS. As an example, innovative Federally Qualified Health Centers have used group visits with great success, but face challenges when it comes to billing CMS, despite the fact that this approach actually costs CMS less overall. There is confusion at CMS regarding group visits, which contributes to many FQHCs shying away from group visits, even though they can play an instrumental role in pain care. CMS regulations state that you cannot bill group visit E/M Codes in FQHCs (e.g. 99078). However, CMS has been very clear to say that it is allowable to use individual codes (e.g. 99212, 99213) as long as there is a medically necessary face-to-face visit with a billable provider (which, in FQHCs, include MDs, DOs, NPs, PAs, and CNMs), even if there are other patients present. For this reason, groups typically have a provider present, even though the real benefits of the group come from elsewhere, making the cost associated with the provider superfluous.

To fully embrace the benefits of group visits, providers require codes that enable them to bill CMS for this type of care. Group therapy billing for PT, OT, and behavioral health, for example, with the current codes, are often limited by non-coverage for structured programs that include multiple group sessions in the same day by same discipline (PT, OT, Behavioral Health) and/or individual and group session by same discipline in same day, limiting providers' ability to deliver these specialty-based self-management programs. Furthermore, after-care and maintenance classes, usually provided in group sessions, are rarely covered.

Health professionals are unable to provide "covered" pain care and guideline-recommended services they are trained to provide.

Patients are often unable to receive guideline-recommended care, even when that care is "covered" by CMS making evidence-based care frustratingly inaccessible.

In the case of acupuncture, for example, Medicare has implemented coverage of acupuncture for low back pain and has released brochures alerting patients of this coverage. However, LAcs are not listed as "recognized providers" in the Social Security Act.[2] For acupuncture to be covered by CMS, it must either be provided by a covered physician (who receives far less training in acupuncture than LAcs), or the services provided by the LAc will only be reimbursed when supervised by a covered provider. This has caused issues and confusion within hospitals and healthcare systems, with many patients being forced to sign paperwork for non-coverage because many Medicare contractors are ultimately denying coverage. Further, acupuncturists working in integrated settings consistently share that demand for acupuncture is extremely high, but they are unable to bill Medicare effectively. In addition, doctors of chiropractic, many of whom are certified to also provide acupuncture services, are not allowed to do so under the new CMS policy.

Doctors of Chiropractic provide another example of health professionals being unable to provide guideline-recommended care for which they have been trained. Current guidelines consistently recommend spinal manipulation for the treatment of back pain and more than 50% of patients with back pain have seen a Doctor of Chiropractic. However, CMS restricts coverage of chiropractic care to spinal manipulation even when

[2] Recognizing the need to address this issue, Rep. Judy Chu (CA) introduced HR 4803, the Acupuncture for Seniors Act, in July 2021. Passage of this bill would make the services of licensed acupuncturists (LAcs) available to all Medicare beneficiaries (over age 65, and children and others who are eligible, and the military treatment facilities and Tricare).

additional procedures in a chiropractor's scope of practice are indicated and helpful in reducing pain. In fact, Doctors of Chiropractic are the only CMS-qualified professionals who are not reimbursed for conducting a patient evaluation. Allowing these clinicians to provide the full range of evidence-based, guideline concordant services allowed under their scope of practice has the potential to significantly improve access to care and improve patient outcomes.

The above restrictions against qualified clinicians mean that patients are unable to receive evidence-based care in a timely manner due to supply and demand challenges. These issues, and how they may be addressed by improved codes, will be discussed in Section 3, below.

2. Resources involved in furnishing chronic pain management and opioid reduction

In the proposed PFS, CMS asked whether the resources involved in furnishing chronic pain management and opioid reduction are appropriately recognized in current coding and payment. What follows are resource challenges that CMS should address, relating to the list of resources included within the PFS that CMS already recognizes as resources which are necessary for the safe and effective delivery of a patient-centered pain management treatment plan.

Development and Maintenance of a Person-Centered Care Plan

Pain, especially chronic pain, is a very complex biopsychosocial phenomenon that is highly individuated. Much neuroscientific research is currently directed at this issue. "One size fits all" or "cookie cutter" approaches to pain management do not work. By their very design, comprehensive integrative pain management and person-centered care plans often include a variety of approaches to treating a patient's pain. One patient may be best served with a mix of physical therapy, yoga, neuromodulation, and non-opioid analgesics, while another may require a combination of acupuncture and chiropractic care, while another yet may require interventional procedures and low-dose opioids analgesics alongside massage and occupational therapy to best treat their pain. Each patient-centered plan will involve a unique mix of provider types and therapeutic approaches to most optimally manage the patient's pain in a timely and cost-effective manner.

Integrative, multidisciplinary, and person-centered pain care plans often best serve the patient when the patient is able to see multiple providers in one single visit to a hospital or clinic. Receiving multiple treatments in one day is not only time-effective for the patient; more importantly, it allows the benefits of the treatments to work alongside one another, ideally reducing the patient's pain more effectively than one treatment alone and, in many cases, encouraging healing to occur at an improved rate, thus reducing the patient's long-term need for costly pain care. However, patients and providers currently face numerous barriers in attempting to develop this type of care plan.

Different types of providers and health care models face different types of barriers to the development and maintenance of person-centered care plans in the current environment:

- Under certain rehabilitation models, multiple providers are allowed to bill CMS in one day, but reimbursement rates are low, often making the model unsustainable for providers.
- Patients want to see multiple providers in one day, and evidence-based care supports this, but current payment models result in multiple co-pays for these multiple visits, making quality integrated care an extreme financial burden for many patients, and therefore ultimately inaccessible in many cases.

- Within certain integrated pain management programs (IPMPs, CPMPs), bundled or case rates may allow patients to see multiple providers in one day, as those providers work together toward shared outcomes. However, even those programs face problems, as they are unable to bill CMS for crucial care team discussions (team conferences) that help to shape and modify treatment programs.

Patient Education and Self-Management

Teaching patients self-management skills and strategies is a key part of a whole person, comprehensive, integrative approach to pain management. Despite the demand for integrative and self-management strategies, including the need to teach patients these strategies, this approach to care is widely misunderstood and is often not covered by insurance, including CMS. Thus, it is imperative that CMS enable providers of healthcare to integrate the teaching of self-management skills in their practice by providing appropriate reimbursement for such services to a broad range of clinicians who are qualified to provide such services.

Self-management strategies are part of a broader integrated approach to healthcare and are already being utilized in employee assistance programs, worker's compensation, wellness benefits, behavioral health, and substance use disorder benefits. Given the success of these well-coordinated comprehensive integrative pain management programs (IPMPs, CPMPs), these models should be extended into a broader set of mainstream pain management programs and plan designs.

Patient Education and Self-Management could be improved by CMS in certain areas:

- **Group Visits** – Group visits are often used for teaching self-management techniques, such as relaxation training and mindfulness (clinical psychologist), nutrition classes (nutritionist, pain educator), pacing and ergonomics (OT), and prescribed therapeutic exercise and body movement (PT, Tai Chi, Yoga), which have been shown to be effective in managing pain. However, barriers related to billing exist in different ways, depending on the provider involved. As discussed above, many group visits are only billable to CMS if a billable provider (MD, DO, NP, etc.) sees each patient individually on the same day as the group visit. These barriers make group visits difficult to utilize in a way that is financially sustainable for providers and health systems.
- **"Non-Qualified" Health Professionals** – Many comprehensive care plans include recommendations that the patients access treatments for their pain such as yoga, massage therapy, and relaxation training. However, because the providers of these treatments are not covered providers under CMS, many patients end up accessing these treatments completely out-of-pocket, and in ways that are not coordinated with an overall treatment plan. This type of care would provide better outcomes for the patient if it were more fully integrated into their comprehensive care plan. To do so, there must be improved mechanisms for "Non-Qualified" Health Professionals to bill CMS for their services.
- **Community Health Workers** – These frontline public health workers are trusted members of the communities which they serve, and this trusting relationship enables them to serve as liaisons between their community members and health and social services, facilitating patient access to quality care. They also increase health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support and advocacy. However, they are unable to bill CMS, making it difficult for their roles to be sustainable within most healthcare systems.

These issues, and how they may be addressed by improved codes, will be discussed in Section 3, below.

3. New codes for medically necessary activities involved with chronic pain management and achieving safe and effective dose reduction of opioid medications when appropriate

As discussed above, comprehensive integrative pain management is provided in many varied settings which require varied payment structures in order to provide optimal and cost-effective pain management. Payment structures that work well in hospital settings, such as traditional fee-for-service models, will not work as well in integrated pain management programs. Conversely, value-based care and outcome driven reimbursement rates, such as case rates and bundled rates, work well in some integrated programs, but may not be cost-effective in primary care or specialty clinics, or for certain provider types. Therefore, **multiple types of codes (such as fee-for-service, time-based, value-based bundled and case rates) should be made available so that providers are able to craft individualized, patient-centered treatment plans** that utilize the best providers and settings for the patients' unique needs.

The Need for Chronic Pain Codes Separate from E/M Codes

AACIPM supports the creation of separate coding and payment for medically necessary activities involved with chronic pain management and achieving safe and effective dose reduction of opioid management. We do not believe that the resources involved in furnishing the full spectrum of comprehensive and integrative pain management services are appropriately recognized in current coding and payment.

Comprehensive integrative pain management is provided in many varied settings and by a plethora of healthcare providers, and many evidence-based and guideline-recommended services are provided in settings where no billable providers are present for each and every patient visit. Further, **because so many provider types are involved in a comprehensive pain care plan, connecting all care through a physician is highly problematic**. A patient's ability to access treatment from a licensed acupuncturist, or to receive evaluation and management services from a Doctor of Chiropractic, should not be dependent on a clinic's ability to have a supervising physician present for each LAc and DC visit. Similarly, a patient with a pain condition such as Crohn's Disease, that can be ameliorated through dietary changes, should be able to access a nutritionist without having to be seen by an MD in the same day, at the same facility. **These are arbitrary barriers to care that do not serve the patient's best interests, nor are they effective cost-saving mechanisms for CMS.**

Many treatments for pain, such as massage therapy, are best captured through a standalone code, as they are unlikely to be billed commensurate with an E/M visit. While some massage therapy is provided in a hospital setting, hospital-based services are primarily intended for acute pre-or post-operative pain. Most massage therapy intended to alleviate chronic pain conditions is provided in chiropractic offices, physical therapy offices, integrated medical centers, and other clinical settings. Some of these facilities may have a billable provider on staff and able to see the patient on the same day as the massage therapist, but many others will not, making it impossible for patients dependent upon CMS to access care at those facilities.

Furthermore, implementing **a standalone code will better enable CMS to determine quality, measurement, and outcomes**. Currently, when services such as acupuncture or massage therapy are billed "incident to" a Physician, CMS is unable to collect accurate data on which providers and treatments are proving the most effective for patients. With use of a standalone code, and by requiring providers to provide proper documentation to show who is providing the service, CMS will obtain far better outcomes data that can lead to more cost-effective policies.

Time-Based Pain Codes

AACIPM supports the creation of standalone time-based pain codes that will enable highly-skilled pain care providers to bill CMS for their services. We recommend that these codes be billable in 15-minute increments and be open to all clinicians designated by CMS as Physicians, Qualified Healthcare Practitioners, and "Non-Qualified" Health Professionals (to be determined by a CMS workgroup) that provide the pain care services included within HHS' 2019 PMTF Report, Section 2, Clinical Best Practices. Current time-based CPT codes for patient care, which include documentation of non-face-to-face time, coordinating care, reviewing tests, and other patient-related activity on the day of services, have helped to better reflect and accurately support the time necessary to provide comprehensive and patient-centered care.

In many pain care settings, particularly for ancillary services that are not easily billed under current E/M codes, time-based codes work well for delivering high-quality pain care in a cost-effective manner. These codes can be effective for delivering many evidence-based pain care services, such as acupuncture, physical therapy, occupational therapy, and massage therapy. In addition, time-based pain codes would be helpful in delivering lesser known, but very important, areas of pain care, such as team care conferences in which all providers come together to discuss a patient's case and care plan, or medication management, where a pharmacist, for example, reviews a patient's file to ensure there are no drug incompatibilities or other concerns related to adverse events and side effects.

Time-based pain codes open to a wide variety of health care providers will improve the availability of the full range of evidence-based pain treatments, therefore reducing reliance on opioid analgesics. These codes, paired with appropriate provider documentation (discussed above), will then be able to provide data that will show benefits to the Medicare population, including outcomes based on the type of integrative care being offered, as well as the cost-effectiveness of each type of care.

Value-Based Codes such as Case-Rates and Bundled-Rates

AACIPM supports the creation of value-based and outcome-driven pain codes, such as bundled rates and case rates, that will enable comprehensive and integrative pain care providers and programs (CPMPs and IPMPs) to bill CMS for their services.

The creation of value-based and outcome-driven pain codes is vital in order to provide truly integrated pain management in which a patient is able to receive a variety of pain care treatments from multiple provider types all working together as a team. These types of codes, in the form of bundled rates and case rates, enable integrated pain management programs to provide each patient with their own individualized mix of pain care options without the arbitrary barriers and burden of fitting those treatments within traditional E/M codes. Further, patients are able to more affordably access these treatments by avoiding the need to pay a co-pay for each and every practitioner from whom they receive treatment. Importantly, under value-based payment structures, which provide the opportunity for CMS to utilize outcome-driven reimbursement rates, providers are incentivized to reduce the cost of treating pain by working smarter—not harder—to provide cost-effective quality outcomes.

ICD-11 Pain Codes

AACIPM fully supports the adoption of the new ICD-11 pain codes by CMS. Approved by the World Health Assembly in May 2019, and taking effect January 2022, the revised 11th edition of the ICD (ICD-11) contains, for the first time in history, a coding and classification system for chronic pain.[3] The new pain codes in ICD-11 better enable clinicians to treat pain and bill for pain care services.

Chronic pain, as defined in ICD-11, is pain that recurs or persists longer than three months. Under the new classification, this type of pain will be coded using seven main codes, including the new code for "chronic primary pain," where the chronic pain itself is the disease. The other six main codes are for chronic secondary pain syndromes where the chronic pain was developed in the context of another disease, including cancer-related pain, post-surgical/post-traumatic pain, neuropathic pain, secondary headache or orofacial pain, secondary visceral pain, and secondary musculoskeletal pain. Finally, the World Health Organization included two additional codes to cover any pain conditions that do not fit within the seven primary codes, including one for "other specified chronic pain" (to be used only when a new set of diseases is recognized to cause chronic pain) and another for "chronic pain, unspecified" (when it is unclear whether the chronic pain is primary or secondary).

ICD-11's new pain codes include:

- MG30.0 Chronic primary pain
- MG30.1 Chronic cancer related pain
- MG30.2 Chronic postsurgical or post traumatic pain
- MG30.3 Chronic secondary musculoskeletal pain
- MG30.4 Chronic secondary visceral pain
- MG30.5 Chronic neuropathic pain
- MG30.6 Chronic secondary headache or orofacial pain
- MG30.Y Other specified chronic pain
- MG30.Z Chronic pain, unspecified

Once the new ICD-11 codes are implemented, they will ensure that it is simple and time-efficient for providers to apply the codes in any healthcare setting, allowing them to avoid older coding systems in which providers must code creatively as they attempt to fit pain conditions within existing symptom-based codes, diagnostic labels, or treatment-based codes. The new system will allow a patient's condition to be coded according to what the condition is (chronic postsurgical pain, for example) rather than how the condition is being treated (such as using the "opioids and related analgesics" code found in the ICD-10).

While AACIPM fully recognizes that the ICD-11 codes introduced by WHO are brand new, we strongly encourage CMS to adopt them as quickly as possible. While ICD-10 was originally introduced in 1990, the United States did not begin requiring its use until 2015. As the United States continues to face the dual epidemics of under-treated pain and opioid misuse, abuse, and overdose, we cannot afford to wait another 25 years to implement pain codes that will enable health care providers to better classify pain.

Finally, implementation of the ICD-11 codes will improve CMS' ability to measure the incidence, prevalence, and impact of chronic pain, which will then help to identify the human, financial, and educational needs

[3] WHO. ICD-11 for mortality and morbidity statistics (ICD-11 MMS). Available at: icd.who.int/browse11/l-m/en. Accessed September 4, 2021.

required to address chronic pain and improve efficient service delivery. This coding system will provide CMS with data that can help guide treatment provision and reimbursement, improve service delivery and timing, and enable comparison of changes across time and regions.

Final Recommendations

1. AACIPM supports the creation of standalone codes, both time-based and value-based, that will better describe the services provided by highly-skilled pain care providers, including certain "Non-Qualified" Health Professionals. The development of such codes will also aid CMS in reimbursing these clinicians for their services. While we acknowledge the need for an appropriate level of care coordination for pain management services, we encourage CMS to ensure that clinicians are able to provide services "at the top of their license or certification" by eliminating unnecessary direct supervision requirements and providing reimbursement for the full range of evidence-based, guideline concordant services that they provide.
2. AACIPM urges CMS to establish a multi-stakeholder working group to determine operational details and resource allocation of establishing payment for evidence-based pain management services, including which "Non-Qualified" Health Professionals should be eligible for reimbursement of pain management services without direct supervision.
3. AACIPM urges CMS to exercise its full regulatory authority to designate appropriate state licensed pain management providers—as well as providers authorized to provide pain management under Medicare Part C—with provider status under Medicare Part B.
4. AACIPM respectfully requests that CMS establish a pilot program for bundled and/or case rate comprehensive integrative pain management care compared to historical controls or current usual care controls, enabling the agency to determine the cost-effectiveness of treating pain using innovative payment methodologies.
5. AACIPM respectfully requests that CMS integrate the new ICD-11 pain codes into CMS coding and payment systems as quickly as possible.

AACIPM and its collaborators sincerely thank CMS for the steps it is taking to improve care for Americans living with pain conditions.

Thank you for considering our recommendations.

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