



October 11, 2019

Centers for Medicare & Medicaid Services (CMS)

**Comments on the Request for Information (RFI) on the Development of a CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment**

The U.S. Pain Foundation is pleased to respond to CMS's request for information to inform the development of a CMS Action plan to prevent opioid addiction and improve the treatment of acute and chronic pain. The U.S. Pain Foundation is the largest 501 (c) (3) organization for people who live with chronic pain from a myriad of diseases, conditions and serious injuries. Our mission is to connect, support, educate and advocate for those living with chronic pain, as well as their caregivers and healthcare providers.

Chronic pain is an enormous public health problem. The CDC and NIH have reported that 50 million Americans live with chronic pain and 19.6 million live with high-impact chronic pain that interferes with their ability to function on a daily basis.<sup>1</sup> That same study reported that of Americans over the age of 65, 13.5 million live with chronic pain and 5.4 million live with high-impact chronic pain. The Medicare population also includes disabled Americans younger than 65. Since pain is the number one cause of disability in the U.S., we can therefore assume that the number of Medicare beneficiaries living with pain is much higher than those reported numbers. Because many Americans living with high-impact chronic pain are unable to work or can only work part-time, many also depend on Medicaid.

There are currently very few highly effective treatments for many pain conditions. Managing pain is a matter of finding the right combination of treatments that allows pain sufferers to function and have some quality of life. We believe people with chronic pain should have access to a wide range of therapies and treatments because pain is very individual – what helps one person living with pain will not necessarily help another. Most people living with chronic pain spend years of trial and error searching for treatments that will help to reduce their pain, while struggling to manage their lives. This is extremely wasteful from a personal standpoint as well as an economic one.

We believe that when it comes to chronic pain, ***CMS's goal should be to get beneficiaries effective treatment sooner.*** Our recommendations for accomplishing this are as follows:

**1. Compensate physicians for time spent coordinating complex care**

Chronic pain patients require more time from their health care providers, because by its very nature, chronic pain is complex and challenging to treat. Doctors should be able to spend more time conducting a thorough pain assessment and developing a treatment plan at the first visit rather than

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<sup>1</sup> CDC. Prevalence of Chronic Pain and High Impact Chronic Pain Among Adult – U.S., 2016. MMWR Rep 2018;67:1001-6.



the fifth visit to the fifth doctor which is the current norm. Furthermore, because the cause, manifestations, and severity of chronic pain can vary so widely from person to person, there is no simple or uniform solution to managing it. Each patient is entirely unique and requires a unique treatment plan.

Individualized, multimodal, integrative care is widely understood to be the best and most effective approach to managing pain. But it requires time and resources to identify and try various modalities and coordinate this care. A traditional 10-minute appointment does not provide sufficient time for a provider to create and implement a multimodal treatment plan, and to continually reassess that plan as the individual's health and pain change over time.

The lack of reimbursement for coordinating care and managing complex care is perhaps one of the most significant impediments to proper pain care. It has resulted in an overuse of quick fixes—like a reliance on medication alone.

## **2. Reimburse for multimodal, multidisciplinary treatment**

Rehabilitation models of care, which emphasize integrated, multi-modal treatment, have been proven to be the most effective in reducing pain and improving function. Too often, pain management attempts to put a mere band-aid on pain levels, rather than address pain's effects on function and quality of life. Chronic pain is a biopsychosocial disease, meaning it affects every aspect of an individual's life, even more so when the individual lives with high-impact chronic pain. Thus, patients need and deserve care that addresses pain at multiple levels. For example, while medication and injections may help control pain, they do not give individuals tools for learning to live within their limitations. Restorative and complementary therapies, like physical therapy, occupational therapy, massage, yoga, and so on, are more suited to improving function and productivity and learning to live day-to-day with painful symptoms. Meanwhile, it is well-known that anxiety, depression, and other mental health conditions are common comorbidities of long-term pain. In fact, recent numbers from the CDC demonstrated that at least 10 percent of suicides in America involve someone living with pain. This vulnerable population needs earlier multimodal intervention that recognizes the full impact of pain on a person's life. Patients with pain—especially those with high-impact pain—should have access to psychosocial care, including psychological counseling and peer support groups that is tailored to their unique challenges.

Unfortunately, we have moved away from a bundled payment approach to this type of care, to the detriment of people with pain. It's vital we return to reimbursing for multimodal, multidisciplinary treatment..

## **3. Incentivize innovative value-based models of care that integrate multimodal treatment**

The cardiac care model, which incorporates exercise, nutrition and other modalities, is one innovative



approach that has been very successful and cost-effective at reducing the burden of heart disease. This is a model that takes into account that heart disease must be attacked from multiple angles, and that treatments and therapies work best in combination with one another.

This model also has proven that multidisciplinary, multimodal care can be cost-effective care. By investing health care dollars up front in managing heart disease and preventing cardiac events, we have saved millions of dollars in terms of reducing hospitalizations and emergency room visits. Beyond saving on direct healthcare costs, no price tag can account for the enormous reduction in suffering and lives lost.

Chronic pain is just as complex as heart disease. It similarly gets worse—and more expensive to treat—without comprehensive, multimodal early intervention. CMS should encourage and reimburse innovative integrated models of care for chronic pain.

#### **4. Remove access barriers to evidence-based non-opioid drugs and medical devices**

CMS should require that *at least* two medications in each class of non-opioid medications commonly used for pain—such as antidepressants (SSRIs, SNRIs, or tricyclics), anticonvulsants, corticosteroids, NSAIDs, muscle relaxers, triptans, calcium channel blockers, topicals and so on)—are in the lowest-cost tier in every Part D plan formulary.

It is vital to recognize that, again, each individual is unique, and what works for one person may not work for another. Patients must have access to various options to determine what reduces their pain levels. Unfortunately, many patients cannot afford the high copays on these medications, creating enormous and unnecessary barriers to safer, non-opioid medications. If CMS is committed to reducing opioid use, it must make alternative medications more affordable.

In addition, an increasing number of evidence-based medical devices for pain management are available, with more coming to market each year. These devices represent an important category of treatment, especially in that they often provide sustained relief and generally come with less side effects than many other interventions. CMS must work to improve access to these types of devices by reducing out-of-pocket costs and removing overburdensome prior authorization requirements. In particular, CMS should remove the requirement for a psychological evaluation prior to obtaining spinal cord stimulation devices. There is no such requirement for surgery, which is much riskier, or for other treatments for pain.

#### **5. Partner with NIH/NCCIH to continue to build the evidence base for complimentary treatments like acupuncture for chronic low back pain (ie. therapeutic massage, yoga, tai chi, aquatherapy)**

This is an area where data collection is essential to determining the value of these modalities for pain control. There is much anecdotal evidence that many complimentary techniques, especially gentle



exercise and mobility programs, are helpful in the ongoing management of chronic pain. These interventions can also be cost-effective, especially those that train patients on a program they can then practice at home. Exercise and mobility programs also do a lot to restore function, in addition to general pain reduction. But there is a lack of funding to do the randomized control trials that are necessary to prove their value. If we are truly committed to reducing opioid use, we must investigate and make available evidence-based alternatives for pain relief.

**6. Reimburse for promising treatments in specific conditions as evidence becomes available.**

The approach that CMS is using for chronic low back pain and acupuncture is an excellent model. In this instance, CMS is focusing on a narrow pain condition with one modality and a large subject population. This approach correctly recognizes that different modalities work differently for different types of pain—and must be studied accordingly. In particular, we commend CMS for covering treatment costs as part of this study. This reflects an understanding that cost is an enormous barrier to care, especially for the Medicare and Medicaid populations, who typically have limited ability to work. We would recommend using this approach simultaneously for other specific conditions.

**7. Encourage states to make more complementary and integrative care available through Medicaid**

A number of states have granted Medicaid waivers to cover complementary treatment for specific pain conditions and then studied the effect of these modalities on patients' pain levels and function. One such example we are aware of is a waiver in Colorado to cover complementary treatments for spinal cord injury. We urge CMS to support more states in offering this type of Medicaid coverage.

**8. Incentivize participation in pain management group programs, similar to Medicare Silver Sneaker Program for fitness club membership & Medicare's Diabetes Prevention Program**

These programs have proven track records of helping patients more effectively cope with and manage chronic illness. Educating patients about ways to engage in self-management of their condition, and then incentivizing such self-care, could have a similarly positive impact on the pain population. If patients were reimbursed for the cost of membership in these programs, it would help them maintain wellness and function.

**9. Reimburse for participation in chronic pain-specific patient education self-management and support group programs**

Similar to above, patient education on self-management and coping skills are key to living successfully with a chronic condition. These programs can be taught via support group models and provide essential information on topics such as: cognitive behavioral therapy; stress reduction techniques, like meditation; strategies for activity restriction and modification; and much more.

Isolation, stigma, and a sense of helplessness are enormous problems faced by the pain population, and create significant barriers to care. As mentioned before, people with chronic pain have



significantly higher incidences of mental health comorbidities, and are at greater risk of suicide. It is well-known that mood disorders and stress can increase pain levels, and vice versa, creating a vicious cycle. CMS has a vested interest in providing more comprehensive care, that treats the whole patient—mind and body. Creating opportunities for connection, community, and education is vitally important.

**10. Begin a serious effort to code for, collect, and analyze data on chronic pain in the Medicare and Medicaid population**

CMS does not collect nor analyze epidemiologic data on chronic pain in its beneficiaries. We do not know the incidence of chronic pain in general, the prevalence of various pain conditions, trends over time, subpopulations at risk, nor the health consequences of pain in terms of morbidity, mortality and disability. It is critical to have this data to understand the scope of the problem. It is also vital in order to assess whether the improvements in care and interventions CMS undertakes in the Action Plan are effective in reducing the enormous burden of chronic pain.

In Section 6032 of the SUPPORT Act, Congress has called on CMS to use its authority to improve access to care for the millions of Americans whose lives have been devastated by the dual public health crises of opioid use disorder and pain. We are hopeful that CMS will give serious consideration to the recommendations we and others, such as the HHS Pain Management Best Practices Task Force have proposed. Now is the time for CMS to take bold and innovative action to ameliorate the enormous burden of chronic pain in America.

Sincerely,

A handwritten signature in black ink that reads "Cindy Steinberg".

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