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# EXPANDING ACCESS TO NON-OPIOID MANAGEMENT OF CHRONIC PAIN

Considerations for Governors

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**Kirk Williamson**

Policy Analyst

**Shums Alikhan\***

Senior Policy Analyst

**Katie Greene**

Program Director

**Melinda Becker\***

Program Director

**Hemi Tewarson\***

Division Director

\*Shums Alikhan, Melinda Becker, and Hemi Tewarson's contributions to this publication were made during their tenure at NGA.

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## FOREWARD

**O**n January 31, 2020, the Secretary of Health and Human Services declared a public health emergency, in response to the novel coronavirus known as SARS-CoV-2 (“COVID-19”). Subsequently, the World Health Organization characterized the outbreak as a pandemic, as the rates of infection soared across the world and in the United States. On March 13, 2020, President Trump issued a national emergency declaration, acknowledging the dramatic upheaval to American lives and the pressing need to safeguard vulnerable populations.

The global pandemic has led to a significant increase in psychological stress and social isolation, with disruptions in access to healthcare services in ways that have compounded existing challenges for individuals with substance use disorders and chronic pain. Stay-at-home orders, the need to ensure adequate physical distancing, lack of personal protective equipment, postponement of elective procedures, and financial strains on providers have all contributed to disruptions in routine medical care and strained access to physical and behavioral therapies.

Addressing the biological, social, and psychological drivers of pain will require an integrated approach that incorporates physical and occupational therapy, behavioral health interventions or

integrative and complementary approaches. Several non-opioid therapies discussed throughout this report have demonstrated efficacy for managing chronic pain, with the potential for these services to be supported via telehealth. To support access to these critical services for individuals with chronic pain, many states have taken steps to increase the use of telehealth services by increasing the types of reimbursable covered services, reducing consumer costs, reducing participation requirements and barriers for providers, and increasing the modalities through which services may be offered.\*

This paper also addresses strategies for states to consider in expanding access to non-opioid pain management in their Medicaid programs. In the context of COVID-19, states are facing significant budget shortfalls while at the same time anticipating continued increases in Medicaid enrollment with higher unemployment. States will need to prioritize expanding access to new Medicaid services while they prepare for more limited state funding. Given continued barriers to care for individuals experiencing chronic pain, however, states should consider how to support access to critical non-opioid therapies as well as physical and behavioral health supports as part of an effort to improving outcomes for individuals with chronic pain while building on progress to address the opioid epidemic.

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\* For additional information on gubernatorial strategies to increase telehealth access during COVID-19, please see: <https://www.nga.org/wp-content/uploads/2020/03/COVID-19-Telehealth-Memo-20200320450pm.pdf>

## EXECUTIVE SUMMARY

The U.S. Centers for Disease Control and Prevention estimates that 70,980 Americans died of a drug-related overdose in 2019, an increase of 4.6% compared to 2018.<sup>1</sup> At the same time, nearly 100 million Americans experience chronic pain and are often prescribed opioid painkillers. There is little evidence to support the long-term use of prescription opioids for noncancer-related chronic pain. In addition, long-term opioid therapy has known risks, such as opioid use disorder and overdose, particularly with high doses.<sup>2</sup> Further, evidence exists that non-opioid therapies can be effective with less harm.<sup>3</sup> Given the clear risks that opioids pose, reducing unnecessary prescriptions and increasing access to effective non-opioid\* forms of pain management are important strategies states can use to confront the opioid overdose epidemic.

Governors are well situated to establish a vision for changes to pain management. They can direct their public health and Medicaid agencies to collaborate and design an approach to expand access to therapies such as physical and occupational therapy, behavioral health interventions or integrative and complementary approaches to manage common musculoskeletal conditions, such as low back pain, alongside prescription opioids. For patients with more complex, high-impact pain, scaling coordinated, interdisciplinary care management delivery models can promote cost-effective management of the biological, social and psychological drivers of pain.

To help states advance these approaches, in June 2018, the National Governors Association Center for Best Practices Health Division convened an expert roundtable with five states (**Arizona, Delaware, Indiana, Oregon and Washington**), federal officials, industry representatives and national pain specialists to discuss the opportunities for and challenges in improving access to non-opioid pain management through the Medicaid program.

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Drawing on insights from the roundtable and extensive interviews with states, industry and national experts, this report is a resource for governors looking to prioritize access to non-opioid therapies. Governors and their staff can consider the following strategies:

- ▶ **Examine current evidence, coverage and access for non-opioid therapies**, and nonpharmacologic interventions such as physical therapy, acupuncture and spinal manipulation for common musculoskeletal conditions such as low back pain.
- ▶ **Explore innovative, coordinated, interdisciplinary care delivery models** that function as best practice models for patients experiencing complex, high-impact chronic pain.
- ▶ **Consider state Medicaid strategies for expanding access to chronic pain management services** that can be used to increase access to therapies and improve care for patients with chronic pain.
- ▶ **Identify additional state strategies to improve access to pain management** for cross-sector collaboration to support expanded access to care.

*NOTE: This report should not be construed as clinical guidance. It should not be used in place of professional clinical judgment.*

\* "Non-opioid therapies" refers to both nonpharmacologic therapies (e.g., physical and occupational therapy, acupuncture, spinal manipulation) and non-opioid pharmacologic therapies (e.g., nonsteroidal anti-inflammatory drugs).



## BACKGROUND

Little evidence exists to support the long-term use of prescription opioids for noncancer-related chronic pain. In addition, long-term opioid therapy has known risks, such as opioid use disorder (OUD) and overdose, particularly at high doses.<sup>4</sup> Further, evidence shows that non-opioid therapies can be effective and cause less harm.<sup>5</sup> Given the clear risks that opioids pose, reducing unnecessary prescriptions and increasing access to effective non-opioid pain management are important strategies for states working to confront the opioid overdose epidemic.

Deliberate federal action, beginning with the U.S. Department of Health and Human Services National Pain Strategy and extending beyond the 2016 “CDC Guideline for Prescribing Opioids for Chronic Pain” (CDC Guideline), has helped redirect the long-term management of chronic pain from an approach that favored opioid pharmacotherapy to a biopsychosocial approach that emphasizes multidisciplinary management of the complex aspects of pain through medications; restorative movement therapies, such as physical and occupational therapy; minimally invasive interventional approaches; behavioral health interventions; and integrative and complementary approaches, such as tai chi and yoga.<sup>6,7</sup> The CDC Guideline, which is a voluntary resource for primary care providers treating pain not related to cancer, palliative care or end-of-life care, recommends that they first consider non-opioid therapies such as physical therapy, acupuncture and other nonpharmacologic therapies as first-line treatment; weigh the risks and benefits of opioid therapy prior to prescribing it for patients with chronic pain; and adopt a “start low, go slow” approach to opioid

dosing while monitoring and screening patients for risk of opioid use disorder (OUD). Many states have also sought to place prescribing limits on dosage or duration to reduce the risk of potential harm from opioid use, with at least 33 states enacting limits, guidance or requirements according to the National Conference of State Legislatures.<sup>8,9</sup>

Aided by the CDC Guideline, state initiatives and increased provider awareness of the risks posed by prescription opioids, overall opioid prescribing decreased nearly 22% between 2012 and 2017.<sup>10</sup> However, patients still received more than 191 million opioid prescriptions in 2017.<sup>11</sup> As an unintended consequence of efforts to reduce opioid prescribing, health care providers and members of the pain management community continue to raise concerns that patients with chronic pain dependent on opioid therapy face increased barriers to appropriate pain management, putting them at risk for adverse consequences such as transition to illicit opioids, overdose or death by suicide.<sup>12</sup>

As states continue to monitor and regulate opioid prescribing, it is essential that policymakers promote access to effective pain management, including use of physical, psychological and multimodal pain treatments, as well as non-opioid pharmacologic therapies. According to the 2017 National Survey on Drug Use and Health, the most commonly cited reason for misuse of prescription pain relievers was to relieve physical pain.<sup>13</sup> Reducing risky and inappropriate opioid prescribing will be key to turning the tide of the opioid overdose epidemic, but state leaders must also focus on promoting policies to address the burden of untreated chronic pain.

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# EXAMINE CURRENT EVIDENCE, COVERAGE, AND ACCESS FOR NON-OPIOID THERAPIES

As states tighten regulatory control over opioid prescribing and health care providers decrease their reliance on opioid therapies to manage chronic pain, states face considerable pressure from their pain management communities to coordinate and ensure access to non-opioid therapies to fill this gap in pain care. One area in which states are beginning to examine coverage of nonpharmacologic therapies is for the treatment of mild to moderate musculoskeletal pain, such as low back pain. In the United States, low back pain is one of the most common reasons people see their physician. It is also the most common cause of job-related disability and is a leading cause of workplace absenteeism.<sup>14,15,16</sup>

To address an issue that affects more than one-quarter of Americans annually, the American College of Physicians developed a guideline recommending noninvasive, nonpharmacologic therapies as first-line treatment for low back pain.<sup>17</sup> Such approaches include behavioral therapies (cognitive behavioral therapy [CBT], mindfulness-based stress reduction), exercise therapies (physical therapy, occupational therapy, yoga) or manual therapies (chiropractic manipulation, acupuncture, massage therapy).<sup>\*</sup> Many providers of these nonpharmacologic approaches have traditionally operated outside Medicaid and health care provider networks, even though they may have evidence to support the effectiveness of their approaches for long-term pain management. Lack of coverage of these services among Medicaid and private payers — and with few provider networks offering these services — has limited patient access.

For states that want to expand coverage and access to nonpharmacologic therapies for management of mild to moderate chronic pain, coverage decisions should be based on best available evidence and the availability of resources and providers. Currently, the literature on the effectiveness of non-

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opioid or nonpharmacologic pain management approaches to chronic pain management is mixed. Recent systematic reviews and clinical practice guidelines for treating low back pain suggest that some therapies have demonstrated mild to moderate effectiveness on pain-related patient outcomes, showing, for example, decreases in pain medication use, increases in physical functioning and additional understanding and correction of cognitive patterns for low back pain.<sup>18,19,20</sup>

Recent systematic reviews have also suggested that several behavioral, exercise and manual therapies are associated with slightly greater effects on low back pain and function compared with usual care<sup>\*\*</sup> by a health care provider (Table 1). The Agency for Healthcare Research and Quality (AHRQ) found that active exercise therapies led to improvement in function or pain for at least one month when used for low back pain of mild to moderate severity.<sup>21</sup> Furthermore, the AHRQ study builds on the Institute for Clinical and Economic Review systematic review, which found that yoga has a moderate effect on function and pain control for low back pain compared with usual care or combined with physical therapy and education.<sup>22</sup> Other therapies, such as chiropractic services and

<sup>\*</sup> See Appendix A for more information about forms of nonpharmacologic pain management.

<sup>\*\*</sup> A majority of trials reviewed in this study compared nonpharmacologic interventions with usual care, waitlist, no treatment, attention control or placebo/sham. Only rarely did these trials use pharmacologic treatments or exercise as comparators.



**TABLE 1. Summary of AHRQ pain and function-related effects of nonpharmacologic interventions for chronic low back pain compared with usual care, placebo, sham, attention control or waitlist**

Intervention	Short-term function	Long-term function	Short-term pain	Long-term pain
Exercise	Slight	None	Slight	Moderate
Cognitive behavioral therapy (CBT)	Slight	Slight	Slight	Slight
Chiropractic services	Slight	No evidence	None	No evidence
Massage	Slight	No evidence	Slight	No evidence
Mindfulness-based stress relief	None	None	Slight	None
Yoga	Slight	No evidence	Moderate	No evidence
Acupuncture	Slight	None	Slight	Slight
Multidisciplinary rehabilitation	Slight	None	Slight	None

CBT, had a slight effect on short-term function. Table 1 shows the effects on function by intervention.

Less well-known is the effectiveness of these therapies for centralized pain conditions resulting from damage to or dysfunction of the central nervous system (e.g. fibromyalgia). This is a pressing concern for states seeking to expand non-opioid therapies for neuropathic pain (that is, pain that results from damage to the brain, spinal cord or nerves of the arms or legs [peripheral nerves]) and nociceptive pain (that is, pain caused by ongoing tissue damage). Still, experts note that prior to opioid initiation for neuropathic pain, providers can consider prescribing non-opioid pharmacotherapies such as serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants or gabapentin. State officials may benefit from continued research into the pain-related outcomes of treating centralized pain

conditions with nonpharmacologic therapies that would support expanding coverage of conditions for which the evidence is limited but holds promise.

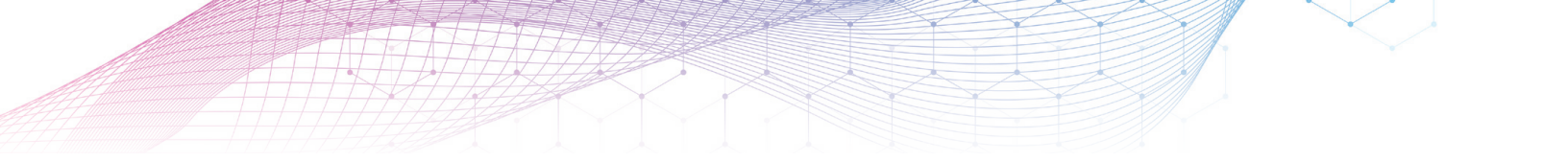
### Implications of Current Evidence on Coverage of Non-Opioid, Nonpharmacologic Management of Chronic Pain

AHRQ’s assessment of nonpharmacologic interventions for low back pain suggests that interventions such as exercise therapy for acute and chronic pain caused by musculoskeletal conditions may offer relief while avoiding the risks of opioid therapy. Although research comparing the efficacy and cost-effectiveness of nonpharmacologic therapies continues to emerge, coverage of such services may be limited. Most states cover these types of services under Medicaid, but considerable variation exists in how states manage their use (Table 2).

**TABLE 2. Coverage of nonpharmacologic therapies reported by state Medicaid agencies**

	Covered benefit	Copay required	Limit on services
Chiropractic services	24	13	18
Physical therapy	41	13	25
Occupational therapy	40	13	24
Rehabilitation services (specialty mental health and substance use)	42	7	22

Source: Kaiser Family Foundation. (n.d.). Medicaid & CHIP indicators. <https://www.kff.org/state-category/medicaid-chip/medicaid-benefits>



A 2016 National Academy for State Health Policy survey of state Medicaid agencies found that while most states have taken action to limit inappropriate opioid prescribing, only 12 of 41 responding states indicated they had implemented programs or policies to encourage or require the use of non-opioid pain management therapies.<sup>23</sup> For mild to moderate pain that can be appropriately addressed through nonpharmacologic means, increased Medicaid coverage of such services is key to expanding access. States will also have to address other significant barriers to access, including ensuring adequate provider networks, and practical barriers such as copays and other challenges that may create barriers for patients.

### Shared Challenges to Expanding Access to Non-Opioid Pain Management

Common and substantial challenges exist that must be carefully considered when implementing any policy or program that expands access to non-opioid therapies. Notably, states interviewed about the systemic challenges associated with implementing non-opioid and nonpharmacologic pain management policies or programs frequently mentioned three key issues:

- ▶ **Lack of ongoing provider education.** Primary care providers do not receive extensive training in pain management and often feel overwhelmed by the complexity of chronic pain cases or do not have the information they need to make an informed referral to practitioners of nonpharmacologic approaches.
- ▶ **Shortage of skilled workers.** Behavioral health care providers are often in short supply and may not be trained in chronic pain management strategies.
- ▶ **Substantial geographic variation.** Access to behavioral health providers, acupuncturists and chiropractic services differs significantly based on locality.

These circumstances highlight the need for states to assess the availability of qualified providers in their network to furnish non-opioid therapies and ensure that such services are reimbursed at a rate that is sustainable at the provider level.

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## EXPLORE INNOVATIVE, COORDINATED, INTERDISCIPLINARY CARE DELIVERY MODELS

**B**eyond mild to moderate pain that can be managed by using modest interventions, multimodal approaches may be needed for patients experiencing more chronic pain. During interviews with clinical pain management experts, pain was routinely described as a sensory and emotional experience best understood using the biopsychosocial model. This framework views pain as a dynamic interaction among and within biological, psychological and social factors that requires an individualized treatment plan to address the causes of pain and to manage pain during the course of treatment.<sup>24</sup> In brief, patients must be able to access a range of non-opioid therapy options to determine the most effective combination of services that improves their pain-related function and quality of life. Recent studies reinforce the notion that therapies for patients with chronic pain should primarily be based on the underlying types of pain present and the patient's psychosocial profile.

Interviews with pain management specialists suggest that the best approach to functional improvement for people with significant high-impact pain or multiple health conditions is an interdisciplinary, coordinated pain management program that teaches patients how to (1) improve their physical function, (2) address stress and trauma that may lie at the root of the pain experience and (3) access services that may provide temporary pain relief. Coordinated, interdisciplinary care\* is widely considered a gold standard in health care delivery because it has a demonstrated return on investment (ROI) and improves a range of comorbidities associated with chronic pain, such as depression.<sup>25</sup> Chronic pain and depression are two of the most commonly reported conditions in primary care, with a 30% to 50% co-occurrence that is associated with adverse effects on treatment, disability and health care costs.<sup>26,27</sup> Better strategies to address these conditions through a coordinated

### COMPONENTS OF COORDINATED, INTERDISCIPLINARY CARE

Models for coordinated care vary, but common elements include:



- A physician-led multidisciplinary care team consisting of primary care providers, behavioral health professionals, pain management specialists and other providers.
- Comprehensive pain assessment and coordination for the patient's care plan.
- Care that incorporates multiple modalities, such as pharmacologic and nonpharmacologic options, manual therapies, exercise, physical and occupational therapy and self-management.

approach can have a significant impact on patient outcomes and treatment cost.

Studies examining the long-term effectiveness of interdisciplinary pain management programs have found that patients reported improved outcomes across a range of domains (e.g., pain severity, interference of pain with function) maintained at one-year follow-up.<sup>28</sup> During the NGA Center roundtable, representatives from pain management programs stressed that any successful model must apply the biopsychosocial framework to the treatment of this population in the primary care setting to achieve cost savings and clinical effectiveness.

However, participants also raised challenges to the widespread implementation of coordinated care models. As with any attempt at delivery reform, significant upfront costs may be required. States that lack programs or policies to incentivize coordinated care in the primary care setting have expressed a willingness to partner with their

\* "Interdisciplinary care" refers to a comprehensive care delivery program in which a care manager coordinates services. An essential component of interdisciplinary care is frequent communication among providers, care managers and patients.

flagship universities, managed care organizations (MCOs) or health systems to replicate one or more of the following evidence-based interdisciplinary pain management delivery models. Consistent among these models is an explicit focus on function, a coordinated and multidisciplinary team-based approach to managing an individual's pain and associated comorbidities and applicability across practice settings.

### Outcome-Driven Approaches: Functional Rehabilitation

According to the American Chronic Pain Association, successful treatment of a person with noncancer-related chronic pain occurs when that person has learned how to independently self-manage his or her condition in a way that maximizes participation in everyday life, minimizes discomfort and side effects and avoids unintended consequences of treatment.<sup>29</sup> In this way, one best practice for the successful treatment of noncancer-related chronic pain is to focus on long-term functional rehabilitation rather than alleviating pain in the near term.

#### A PAIN MANAGEMENT DELIVERY SYSTEM THAT FOCUSES ON FUNCTION

The **Structured Functional Restoration Program** (SFRP) operates out of the Swedish Hospital System in Seattle, Washington. SFRP takes an interdisciplinary approach to helping patients better manage and understand their chronic pain by using pharmacologic and nonpharmacologic approaches such as exercise therapies, behavioral therapies and pain education by a nurse educator. The program draws patients' awareness to their pain so that they can better understand and independently manage it without opioids. At the initial visit, patients are assessed by both a pain management specialist and a pain psychologist to develop a four-week treatment plan, known as a "pain boot camp."



"Functional rehabilitation" refers to the combination of strength, flexibility and agility training that is coordinated and provided to patients so that they can return to their desired level of functioning. Functional rehabilitation programs have a long history of operation in the United States, beginning with workers' compensation programs that focused on restoring people's functional ability so that they could return to work. Programs in **Colorado** and **Washington** were models for these multidisciplinary rehabilitation programs. They showed positive results by returning workers to an adequate level of function following an injury. Participants at the NGA Center roundtable noted that these programs yielded positive outcomes for years until a multifactorial, national shift in medical practice and industry coverage occurred in the mid-1990s favoring opioid pharmacotherapy over multidisciplinary pain management to treat chronic pain.

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## CONSIDER STATE MEDICAID STRATEGIES FOR EXPANDING ACCESS TO NON-OPIOID CHRONIC PAIN MANAGEMENT

As a result of the COVID-19 pandemic, states are experiencing significant budget shortfalls, resulting in a reduction in state revenue alongside a significant increase in the number of Medicaid beneficiaries. As states consider how to prioritize services for their Medicaid populations, they may consider how to effectively address SUD including providing alternatives to opioids for pain management.

Although the NGA Center Roundtable happened before COVID-19, the roundtable discussion provided important insights for how states may consider expanding access to non-opioid chronic pain management. Senior state officials, federal officials, national pain management experts and representatives from managed care plans discussed coordinated, multidisciplinary models of pain management and how these approaches may be instructive for other states looking to increase the use of non-opioid therapies and help reduce the occurrence of serious adverse events such as OUD and overdose when treating chronic pain.<sup>30,31,32</sup>

### Taking a Staged Approach to Expansion of Covered Services for Non-opioid and Nonpharmacologic Therapies

As stewards of public programs, governors face considerable budgetary constraints and are often concerned about the potential for overutilization when new Medicaid benefits are made available. In cases where the effectiveness or cost-effectiveness of non-opioid therapies is emerging, taking a staged approach that incrementally expands access to treatment benefits may be more feasible than covering a broad spectrum of nontraditional benefits. This gradual approach gives relevant agencies time to conduct a thorough analysis of cost, quality and utilization that they can then use to justify sustainable funding of nonpharmacologic treatments for specific chronic pain conditions. The process suggested by roundtable participants, outlined below, reflects the variability in clinical opinion while also addressing the pressing need

to appropriately manage chronic pain among Medicaid enrollees:

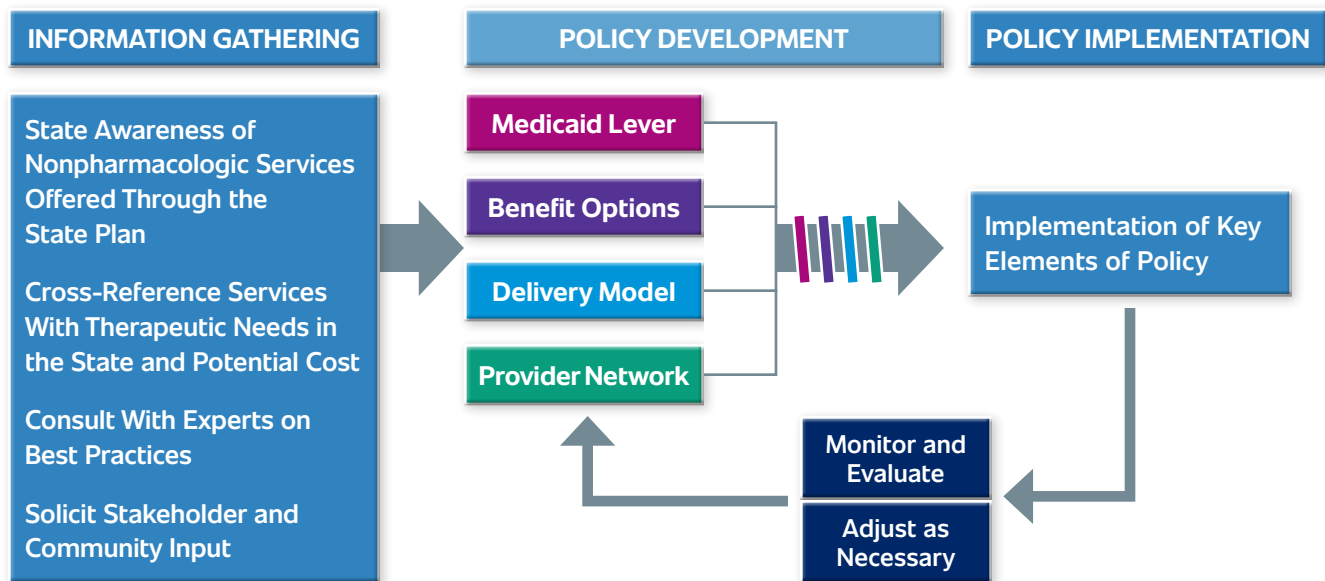
- ▶ Consider a narrow set of nonpharmacologic therapies (e.g., chiropractic and acupuncture services) that are covered in similarly situated states and have a robust evidence base.
- ▶ Identify the Medicaid lever (e.g., state plan amendment, waiver), and implement the policy. Partner with providers and health plans (if relevant) to ensure adequate provider networks.
- ▶ Assess effects on cost, utilization and pain-related health outcomes to determine which services — for defined populations and conditions — are generating the greatest ROI.
- ▶ Use data gathered to inform decisions regarding sustaining or changing policy; adding nonpharmacologic therapies; and pursuing more robust, interdisciplinary models of pain management.

As shown in Figure 1, a useful framework for policy development includes rigorous information gathering, a transparent policy-development process and policy implementation, with continuous monitoring and evaluation to inform course corrections. Such a framework can guide policymakers through a transparent and deliberate process to make policy determinations that mitigate risk as governors seek to provide meaningful access to non-opioid therapies and manage the burden of chronic pain among Medicaid enrollees.

### Incremental Expansion of Benefits Through State Medicaid Plans

Several states have incrementally expanded access to nonpharmacologic therapies through state plan amendments (SPAs). **Ohio**, for example, used flexibility under what is known as the “Other Licensed Practitioner Services” benefit to reimburse acupuncturists for covered services. Under this

**FIGURE 1. State policy development framework**



benefit, states have flexibility to define which types of providers can provide certain services, within the scope of state licensing and practice laws, making a broader group of providers eligible for Medicaid reimbursement.<sup>33</sup> This benefit option may be especially relevant for states that have a large rural population and face significant provider shortages, resulting in limited access to non-opioid treatment.

Other states have expanded access to nonpharmacologic options by enhancing physical therapy benefits offered under the Physical Therapy and Related Services benefit.<sup>34</sup> Most states already cover physical therapy in their Medicaid programs,<sup>35</sup> but states like **Colorado** have increased payment rates and removed limitations on the duration of physical therapy services, increasing the number of physical therapy providers available to treat Medicaid enrollees who experience chronic pain.

In a 2019 informational bulletin on Medicaid strategies for covering non-opioid pharmacologic and nonpharmacologic pain management, the Centers for Medicare & Medicaid Services (CMS) noted that states can consider covering biofeedback,

CBT, occupational therapy and physical therapy through the Rehabilitation Services benefit (Rehab option).<sup>36</sup> Traditionally, states have used this option to provide a range of mental health and substance use disorder services, including clinical services and recovery-oriented services such as supported employment, home-based services, psychosocial rehabilitation and peer support services.\* As of

### BUILDING PROVIDER CAPACITY USING A STATE PLAN AMENDMENT

In 2017, **Ohio** received approval of its State Plan Amendment (SPA) to cover acupuncture and chiropractic services when performed by a qualified chiropractor within their scope of practice for either low back pain or migraine. The state chose to limit this benefit to low back pain and migraine after an internal review of the evidence and assessment of network adequacy. Ohio has since broadened its rules to cover the practice when performed by licensed acupuncturists.



\* Unlike Medicaid benefits that must be provided in an inpatient or outpatient setting, the Rehab option can be provided in a variety of settings, such as community-based settings. In addition, these services can be furnished by a broader range of medical professionals (e.g., community paraprofessionals and peer specialists) than services in other benefit categories.



2018, 42 states and the District of Columbia had offered psychotherapy services, and all states except one offered some type of therapy, such as CBT.<sup>37</sup> To address concerns over potential overutilization, states can consider targeting this benefit to specific conditions or defining its medical necessity.

## Using Medicaid Managed Care Partnerships

Partnerships with Medicaid MCOs also emerged as a key strategy for incrementally expanding access to covered services while supporting and expanding a nontraditional provider network. (MCOs can also be integral to more comprehensive and multidisciplinary pain management approaches, as highlighted by the **Rhode Island** example discussed later.) With 81% of Medicaid beneficiaries enrolled in some type of managed care arrangement, states with managed care should consider partnering with their MCOs to expand access to non-opioid pain management services for those patient populations.<sup>38</sup> Discussions with states and MCOs have highlighted several important considerations and strategies available to increase access to non-opioid therapies for their members.

For Medicaid managed care states considering one or more SPA options, MCOs are federally required to cover those same benefits, if approved by CMS. Although MCOs can choose to impose

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their own utilization management criteria (such as prior authorization and narrowly defined medical necessity) — which cannot be more restrictive than state requirements — states can opt to require their managed care plans to follow a uniform protocol of coverage.

Alternatively, if states do not opt to cover non-opioid therapies for management of chronic pain, MCOs can cover those services on their own. States may consider engaging with MCOs to determine the extent to which the plans may be interested in expanding treatment options and under what circumstances. One option is for MCOs to make the specific treatment an “in lieu of” service. Generally, “in lieu of” services must be medically necessary and a cost-effective substitute for an otherwise covered service included in the MCO contract. It should be stressed that the MCO may not require the enrollee to use the service, though it may offer such services to provide appropriate care in a cost-effective manner that reduces opioid misuse and promotes the self-management of chronic pain.

Some MCO medical directors expressed significant hesitation over being the first out the gate to cover pain management therapies beyond what is traditionally covered by the state plan or other MCOs within a state, noting the increased likelihood for adverse selection.\* To address this issue, **Maryland** convened an opioid working group with its Medicaid MCOs and state pharmacy staff to examine coverage of non-opioid pharmaceuticals. To standardize the coverage of non-opioid pharmaceuticals across MCOs and avoid member churning, the working group decided to remove prior authorizations for nonsteroidal anti-inflammatory drugs and place prior authorization on opioid prescriptions that exceed 90 morphine milligram equivalents.<sup>39</sup>

At the NGA Center roundtable, Medicaid directors from smaller states with fewer competing MCOs generally expressed a preference for acting as a “neutral convener,” bringing all parties to the table to chart a way forward. In contrast, state officials

\* Adverse selection in health insurance occurs whenever people make insurance purchasing decisions based on their own knowledge of their insurability or likelihood of making a claim on the insurance coverage in question. For example, a chronic pain population may self-select into a more comprehensive plan that offers more robust non-opioid therapies, in turn raising the cost for all members covered under the plan.

from larger states with several MCOs indicated that they have had greater success using the contracting process to enhance pain management benefits and scale corresponding evidence-based delivery programs.

### Pathways for Promoting Coordinated, Interdisciplinary Care for Beneficiaries With Complex Health Needs

Beyond expanding the range of covered non-opioid and nonpharmacologic services, states are taking advantage of the flexibility in Medicaid to cover coordination of services for patients with multiple chronic conditions and more complex health care needs. One significant area of care delivery reform states are adopting is collaborative care models. The collaborative care model was pioneered by the University of Washington Advancing Integrated Mental Health Solutions Center and is designed to treat common mental health conditions in primary care and other clinical settings. Since its inception, more than 80 randomized controlled trials have shown that collaborative care is more clinically effective and cost-effective than the usual care for common psychological factors, such as depression, contributing to the experience of chronic pain.<sup>40</sup> This model uses a primary care provider in conjunction with a care manager (often a nurse care manager) and a psychiatric care consultant to address the ongoing chronic pain needs of a patient. States have pursued coordinated care for chronic pain in several ways, including the use of Medicaid health homes and waiver demonstrations.

### Integrating Physical and Behavioral Care Through Medicaid Health Homes

Established as a state plan option under the Patient Protection and Affordable Care Act, health homes are one vehicle for implementing collaborative care in Medicaid.<sup>41</sup> Health homes allow states to reimburse for centralized care coordination to support integration of physical and behavioral health services (both mental health and substance abuse) as well as long-term services and support for individuals with specified chronic conditions, including chronic pain.

## A PROMISING MODEL FOR A CHRONIC PAIN HEALTH HOME

In 2011, **South Dakota** partnered with a physician working group to address chronic pain among its Medicaid population. One idea was to build a health home that included musculoskeletal conditions as a qualifying condition for eligibility. The program takes a tiered payment approach in which increasing tiers are associated with individuals who have more chronic conditions and so often incur higher costs. Currently, 119 health homes are serving 123 locations, with a total enrollment of 5,809 recipients. An initial evaluation of the program demonstrated \$5.6 million in savings during state fiscal year 2016. State officials attribute the program's success to the high level of stakeholder involvement, including buy-in from behavioral and mental health providers.



To date, no state has designed a health home exclusively for individuals with chronic pain. However, at least three states (**North Carolina**, **South Dakota** and **Washington**) provide health home services to Medicaid beneficiaries with musculoskeletal neck and back pain disorders as one of several qualifying chronic conditions.<sup>42</sup> In **North Carolina**, health home services are coordinated through a preexisting care management program for Medicaid enrollees, where wraparound clinical services are provided for a variety of conditions, including chronic pain. **Washington's** health homes serve Medicaid beneficiaries with a range of chronic conditions, including musculoskeletal conditions. The state relies on regional Accountable Communities of Health to administer the program and subcontract with community-based organizations to provide services.<sup>43</sup>

### Supporting Coordinated Care Through Medicaid Waivers

States have long used Medicaid waivers to customize their Medicaid programs and implement



## LEVERAGING OF 1915(C) WAIVER FOR PAIN MANAGEMENT

**Montana's** 1915(c) waiver for Adults With Severe Disabling Mental Illness (SDMI Waiver) is based on rehabilitation and recovery. It enables individuals with SDMI to receive long-term care services in the community rather than in an institutional setting, such as a nursing home, if that is the patient's preference. The pain management component allows for the provision of traditional and nontraditional methods of pain management, including acupuncture, massage therapy, mind-body therapies such as biofeedback and chiropractic therapy for individuals with physical disability aged birth through 64 years.



new policies that may not otherwise be permitted under federal law. For some states, waivers may provide the flexibility needed to establish pain management delivery systems that incentivize care coordination among provider types and expand access to a more generous package of nonpharmacologic benefits.

Through 1915(c) Home & Community-Based Services (HCBS) waivers, states can provide an array of services, including comprehensive pain management, that promote community living for specific Medicaid populations. Such services can include case management, homemaker services, home health aide services, personal care services, adult day health services, habilitation (both day and residential) and respite care. **Montana**, for example, uses a 1915(c) HCBS waiver to provide nontraditional pain management therapies for adults with severe disabling mental illness as part of

a long-term care benefit offered in both community and institutional settings. Under a 1915(c) HCBS waiver, states can also offer services that divert or transition individuals from institutional settings into their homes and communities.<sup>44</sup> Transitional care is an important component in addressing an individual's chronic pain and can help patients regain strength and resume ADL.

At least three states (**California, Rhode Island and Oregon**) have included pain management initiatives in their broader Section 1115 Medicaid demonstrations. Section 1115 Medicaid demonstration waivers give states the flexibility to test new approaches that would otherwise not be permitted under federal rules. In **Oregon**, coordinated care organizations that provide community-based, integrated care to Medicaid enrollees are expected to participate in a statewide performance improvement project to reduce chronic opioid use and promote evidence-based non-opioid therapies. Some of the therapies offered include chiropractic therapy, acupuncture, yoga, CBT and interdisciplinary rehabilitation. Through the Public Hospital Redesign and Incentives in Medi-Cal program, **California's** Medicaid program, the state is incentivizing improvements in the delivery of care for chronic pain by making up to \$3.7 billion available to participating hospitals for their performance in a variety of clinical improvement projects, including one focused on pain management.

### Looking Ahead Toward Value-Based Payment for Comprehensive Pain Management

Collaborative care models have been shown to be more efficacious and cost-effective than usual care for common mental health disorders, but traditional

Through 1915(c) Home & Community-Based Services waivers, states can provide an array of services, including comprehensive pain management, that promote community living for specific Medicaid populations.

fee-for-service payment approaches can be a barrier to widespread implementation. Accordingly, some states and provider groups have expressed interest in advancing alternative value-based payment models in Medicaid programs that can support these coordinated models.

In an effort to drive value and build a sustainable, integrated pain management delivery system, health care organizations, pain management specialists and collaborative care programs during the NGA Center roundtable discussed the possibility of value-based purchasing arrangements, such as an episode of care or bundled payments for a set time and a core set of services related to the management and treatment of a chronic pain condition, such as musculoskeletal conditions. Although value-based payment models could be advanced through the health homes program, states could also integrate such payments and shared risk into contracts with accountable care organizations or MCOs or through demonstration waivers, giving states significant flexibility to support alternative payment and delivery models.

## LEVERAGING MEDICAID MANAGED CARE RELATIONSHIPS

Under a Medicaid Section 1115 waiver approved in 2014, **Rhode Island** developed the Communities of Care program, an initiative designed to help beneficiaries address comprehensive health needs as a means of improving health outcomes and avoiding more costly emergency care. For qualifying beneficiaries, managed care organizations (MCOs) provided access to complementary and alternative medicine (CAM) services, including access to chiropractic care, acupuncture and massage, along with nurse case management focused on developing self-management skills and coordinating care.<sup>45</sup> Although the demonstration has ended, the state continues to partner with MCOs to retain the pain management benefit, citing cost savings from decreased emergency department (ED) visits and pain-related hospitalizations. Using participation criteria developed by the MCOs, the state provides CAM service referrals to enrollees who visit the ED four or more times in a 12-month period.



Collaborative care models have been shown to be more efficacious and cost-effective than usual care for common mental health disorders, but traditional fee-for-service payment approaches can be a barrier to widespread implementation.





# IDENTIFY ADDITIONAL STATE STRATEGIES TO IMPROVE ACCESS TO PAIN MANAGEMENT

In addition to the ability to support expanded user coverage and coordination through state Medicaid programs, governors can use their role as convenors to promote cross-sector collaboration and support greater access to care. Medicaid partnerships and support for telehealth initiatives such as Project Extension for Community Healthcare Outcomes and engaging other state programs to support pain management and rehabilitation are strategies that states raised as a crucial part of their efforts to ensure adequate provider networks and access to services to improve functional outcomes for people with chronic pain.

## Using Telehealth to Increase the Available Workforce and Provide Alternative Sites of Care

Telemedicine is another way in which states can partner with providers to facilitate interdisciplinary care, especially for patients in rural areas or who face transportation barriers. The Stepped Care to Optimize Pain Care Effectiveness (SCOPE) trial, developed by the U.S. Department of Veterans Affairs, followed a collaborative care model for patients with chronic pain but used a telecare model for care coordination. The telecare model enabled coordinators to serve a greater number of patients.<sup>46</sup> The team for that model consisted of a nurse care manager assisting a primary care provider through telephonic engagement with members.

A later iteration of the model, the Strategies for Prescribing Analgesics Comparative Effectiveness (SPACE) trial, used a pharmacist care manager in a similar telecare role because they more easily provide the medication management important for patients on high-dose opioids undergoing

### EXPANDING ACCESS TO PAIN MANAGEMENT VIA TELEMEDICINE

In 2008, the Project ECHO pain management program was created as an avenue to teach primary care providers across the country about chronic pain and to increase their confidence in their pain management skills. The program teaches the providers within the Project ECHO pain network how to treat their patients with medication-assisted treatment. This work is critical in rural areas of the United States, which often have a shortage of Drug Addiction Treatment Act of 2000-waivered physicians to prescribe buprenorphine and a high saturation of patients on long-term opioids.



the tapering process. Both models produced promising results, with 52% reporting improvement in function in the SCOPE trial and 60% reporting improvement in the SPACE trial.<sup>47</sup>

## Engaging State Labor and Workforce Agencies

Governors are broadening the scope of their initiatives beyond Medicaid by providing access to non-opioid therapies for pain management for individuals across public programs, such as state employees. One leading example is **Washington** and its Department of Labor and Industries' Work Hardening program. The goal of the program is to assist the individual with getting back to work following a work-related incident that results in chronic pain and subsequent loss of function.<sup>48</sup>



## CONCLUSION

With growing evidence to support the use of non-opioid therapies and multimodal approaches to manage chronic pain, expanding access to high-quality pain management is a key strategy governors can use to reduce the potential harms of opioids. As governors and state officials address the twin challenges of reducing opioid-related overdose deaths and addressing the burden of untreated pain, expanding the use of non-opioid therapies and multimodal approaches can help prevent the adverse consequences of inappropriate opioid prescribing while advancing reforms to help patients manage chronic pain. This report does not present an exhaustive list of pain treatment options nor the complete mechanisms to implement them, but it does give state leaders the tools they need about how best to implement strategies that help individuals regain function, manage their chronic pain independently, and participate in daily living activities. Such conversations hold the promise of striking a balance between preventing adverse consequences by reducing inappropriate opioid prescriptions and instituting reforms to help patients manage their chronic pain.

As governors and state officials address the twin challenges of reducing opioid-related overdose deaths and addressing the burden of untreated pain, **expanding the use of non-opioid therapies** and multimodal approaches can help prevent the adverse consequences of inappropriate opioid prescribing while advancing reforms to **help patients manage chronic pain.**

# APPENDIX A

## Behavioral Therapies



Behavioral therapies identify and help change potentially self-destructive or harmful behaviors or teach new ways to manage stress and pain.

These therapies are guided by the philosophy that all behaviors are learned, and therefore unhelpful behaviors can be changed or unlearned. Through these treatment modalities, clinicians help patients identify current problems and find solutions to change them. Examples of behavioral therapies include the following:

- ▶ **Cognitive behavioral therapy (CBT).** CBT focuses on how someone's thoughts and beliefs influence their actions and moods. The long-term goal is to change a person's thinking and behavioral patterns into healthier ones.
- ▶ **Mindfulness-based stress reduction (MBSR).** MBSR takes a patient-centered educational approach focused on mindfulness meditation to teach people how to take better care of themselves and live healthier, more adaptive lifestyles.<sup>49</sup> The evidence base supporting this modality is like that for CBT, where many of the trials and meta-analyses confirmed small to moderate improvements in both function and pain for patients with chronic low back pain compared with usual care.<sup>50</sup>

## Exercise Therapies



Exercise therapies include programs that require patients to carry out repeated movements to stretch or strengthen key regions of the body, the goal being to relieve pain and restore function.<sup>51</sup> Exercise therapies include the following:<sup>52,53,54,55</sup>

- ▶ **Physical therapy.** Physical therapy involves a therapist working with a patient within a defined period to prescribe exercises tailored to the individual's needs. The U.S. Centers for Disease

Control and Prevention's "CDC Guideline for Prescribing Opioids for Chronic Pain" states that there is "high-quality evidence" that exercise therapy (a primary modality in physical therapy) for hip or knee arthritis reduces pain and improves function after treatment.

- ▶ **Occupational therapy.** This treatment is similar to physical therapy but focuses specifically on rebuilding skills to return to activities of daily living. A 2015 systematic review of the evidence for occupational therapy concluded that there was strong evidence for the use of occupational therapy broadly but that more research was needed on how it should be modified for patients with chronic pain.
- ▶ **Yoga.** Yoga is a mind-body and exercise practice that combines breath control, meditation and stretches.

## Manual Therapies



Manual therapies are techniques carried out by skilled practitioners who manipulate the body to produce a range of effects, including improvements in motion, increased relaxation and reduced inflammation in joints and tissues. Manual therapies include the following:<sup>56,57</sup>

- ▶ **Chiropractic manipulation.** This treatment uses spinal manipulation to relieve pain and improve function.
- ▶ **Acupuncture.** This traditional Chinese practice of medicine involves the insertion of thin needles into the skin to stimulate nerves, muscles and connective tissues throughout the body.
- ▶ **Massage therapy.** This treatment relieves muscle and tissue pain and tension to restore function. Many types of massage therapy are practiced, including Swedish massage, sports massage, and myofascial trigger point therapy.

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