October 14, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid
7500 Security Boulevard
Baltimore, MD 21244

Re: Input on the Dr. Todd Graham Pain Management Improvement Study; Section 6086 of H.R. 6, the SUPPORT Act

Dear Administrator Verma:

On behalf of the Indiana Society of Anesthesiologists (ISA) and the American Society of Anesthesiologists (ASA), we are writing to provide feedback on the Dr. Todd Graham Pain Management Improvement Study, Section 6086 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The ISA is a state component society of the 54,000 member American Society of Anesthesiologists (ASA). As the medical specialty dedicated to patient safety and the care and treatment of pain, physician anesthesiologists are pleased the Centers for Medicare and Medicaid Services (CMS) is making opioid use disorder and pain care a priority.

We understand that CMS is tasked with implementing Section 6086, the Todd Graham Pain Management Improvement Study; accordingly, the purpose of these comments is to provide input on the categories identified by the agency during the August 27 and September 16 listening sessions: barriers to care, Medicare coverage, issues specific to beneficiaries with substance use disorders (SUD), and pain care during the COVID-19 pandemic.

As physicians who are experts in the management of pain, physician anesthesiologists understand the devastation that chronic pain and substance use disorders have on over two million Americans and their families. We applaud the Dr. Todd Graham Pain Management Improvement Act's intent to inform future CMS policies, including innovative solutions to improve access to non-addictive pain therapies for our patients. In our experience, there are significant Medicare coverage issues and barriers for patients seeking acute and chronic pain care that we will elaborate on in these comments.

Barriers to Care

Many patients do not have primary care physicians, and if they do, many primary care physicians are hesitant to treat pain due to concerns over opioid addiction. As awareness over the opioid epidemic has increased nationwide, both primary care and pain medicine specialists alike worry about appropriately prescribing opioids out of fear of doing harm to their patients or facing scrutiny from their communities. Some physicians may avoid doing so because they may be targeted by patients as the physicians who routinely prescribe opioids or targeted by medical or disciplinary boards as outlier prescribers. As a result, some patients may require referral to a pain specialist either because their primary physician fears criticism or is inexperienced at providing pain care or because their insurance mandates it. This creates an additional step for patients, necessitating a prolonged interval of time before patients can have their pain addressed in a comprehensive way.

Once patients are able to establish care with pain medicine specialists, they continue to experience barriers to care through burdensome prior authorization processes. Addressing patients' pain needs requires a multimodal and thorough approach that starts with an initial history and physical examination and additional studies that investigate the source of the pain. This may include imaging, physical and occupational therapy, and support from psychologists and psychiatrists, as well as social workers and case managers, even before we are able to make a diagnosis. In testimony from an ASA member during a September 9, 2019 hearing before the House Committee on Small Business, "Barriers to Care and Burdens on Small Physician Practices," it was emphasized that many of these evidence-based interventions require prior authorization imposed by payers, pharmacy benefit or behavioral management companies, often resulting in delays and denials that are costly to patients, who suffer the consequences with their time and well-being. Thus, we applaud efforts established by the SUPPORT Act to remove prior authorization and other inappropriate administrative burdens that delay or deny care for evidence-based pain treatments, as well as FDA-approved medications used for medication assisted treatment for opioid use disorder.

In addition, our organizations are concerned about the impact of the Medicare overutilization programs. Arbitrary limits or numerical thresholds on opioids for Medicare beneficiaries does not align with comprehensive pain care or the concept that patient care decisions should be made by physicians with their patients. We urge the agency to re-evaluate overutilization programs that are not based on evidence of patient harm or physician over-prescribing.

For some patients, their first experience with pain management is not in the clinic but in the surgical setting. Patients and physicians are both concerned about patient exposure to opioids following surgery, as numerous studies indicate that having a prescription for opioids on discharge is an independent risk factor for chronic opioid use one-year later. For patients, this represents a significant risk factor for chronic opioid abuse in the post-surgical setting. The perioperative surgical home (PSH) and the surgical setting are therefore ideal arenas for preventing initial opioid use, and later misuse, addiction, and overdose. Working together, physician anesthesiologists and surgeons can tailor a patient's plan of care to address pain with a multi-modal pain approach involving Enhanced Recovery After Surgery (ERAS) protocols and alternative pain relief techniques including non-opioid analgesics and nerve blocks. For example, before, during and after surgery, regional anesthesia such as nerve blocks and epidurals can be used to deliver local anesthetics to numb specific areas of the body. These opioid-sparing techniques can prevent a patient from relying on opioids after surgery to manage the acute pain. Unfortunately, these techniques are not always widely offered or covered and often, physician payment is not adequate. Therefore, our organizations urge CMS to consider the importance of alternative approaches to multidisciplinary pain management, and address payment and authorization policies that will facilitate and encourage widespread implementation of these best practices.

Lack of Coverage

Patients and pain physicians also face the issue of limits to coverage when considering non-opioid therapies as part of the treatment plan. In the clinic setting, payers such as Medicare either impose restrictive coverage policies or do not always cover effective non-opioid therapies, that although supported by evidence-based studies, can be more expensive than opioids. An example is spinal cord stimulator therapy (SCS). For patients for whom other forms of therapy and analgesia have failed to treat their chronic and debilitating back pain, SCS is an evidence-based therapy that can improve physical and psychological function and decrease the need for opioids. However, as a physician anesthesiologist testified at the same September 2019 hearing, SCSs are frequently denied by insurers on the basis that the treatment is not "medically efficacious." While patients and physicians await lengthy appeals of the insurance company's decision, such coverage policies involuntarily force physicians to treat pain with opioids until alternative evidence-based therapies can be approved. In fact, many of the prior authorizations for SCS are ultimately approved, further demonstrating the unnecessary delays in care and administrative burdens that are incurred.

In the surgical setting, access to non-opioid analgesia such as nerve blocks and epidurals can be another coverage hurdle. Currently, Medicare will cover post-operative pain blocks when performed *in conjunction*

with anesthesia care when the block does not provide anesthesia for the underlying diagnostic or therapeutic procedure. For example, an epidural for post-op pain is covered when the underlying surgical procedure is done performed general anesthesia. Peripheral blocks are similarly covered if the underlying procedure is performed under general or neuraxial anesthesia. However, Medicare also requires that the surgeon request that the physician anesthesiologist provide this postoperative pain care. This arrangement does not consider the full complement of physicians providing care to the patient and can impede appropriate access to pain care when payers cover peripheral nerve blocks or neuraxial techniques only under a general anesthetic. If payer limitations prohibit physician anesthesiologists from offering a multi-modal approach to pain care for patients, they will never likely have this discussion with the patient and family. We know that patients want to know more about alternatives to opioids when preparing for surgery, and CMS should allow physician anesthesiologists the opportunity to be a resource for these discussions without the restrictions imposed by issues of coverage.

It is therefore imperative that Medicare beneficiaries receive educational resources regarding opioids and pain management, both in the pain clinic and in the surgical setting, and to support physicians by covering alternative, non-opioid treatments. Additionally, we strongly support the provision under the Todd Graham Pain Management, Treatment, and Recovery provision that requires CMS to review payments under Medicare for opioid and non-opioid pain management procedures to ensure that there are no payment incentives for using opioids instead of non-opioid alternatives.

COVID-19 Impact on Care

Finally, the unprecedented COVID-19 public health emergency has magnified the chronic pain issues our patients face, and the challenge our physicians have in caring for them holistically. Because of the mandate for social distancing, many patients were unable to see their physicians during the nationwide stay-at-home orders. The pandemic therefore greatly hindered patients' progress in the continuum of their therapeutic plan, everything from visits with psychologists or psychiatrists, to participating in physical therapy, to obtaining the necessary imaging for diagnosis in a timely manner. As a result, healthcare has had to quickly evolve to incorporate telemedicine as a means to improve access to care for thousands of patients. Being able to access their pain physician via video visits or computer screens is a widely needed expansion of healthcare access for all patients. In addition to improving patient access to their physicians via telehealth during the pandemic, our organizations applaud policies that exempt substance-use disorder telehealth services from specified Medicare requirements such as geographic restrictions. Ensuring that patients can access their prescriptions during this pandemic is paramount. Therefore, our organizations also support the policies that have given providers the ability to transmit electronic prescriptions for controlled substances covered under Medicare.

As clinicians dedicated to treating pain, we thank you for your time and consideration of our input. We are encouraged by the promise of the SUPPORT Act, and the Dr. Todd Graham Pain Management Study in affording our communities a future with improved pain care and treatment for addiction. If you have any questions or if we can be of further assistance, please call 202-289-2222 or email: Ashley Walton, Senior Congressional and Political Affairs Manager at a.walton@asahq.org.

Sincerely,

Nicholas Datzman, MD
President
Indiana Society of Anesthesiologists

Beverly Philip, MD, FACA, FASA
President
American Society of Anesthesiologists