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CMCS Informational Bulletin

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SUBJECT: Medicaid Strategies for Non-Opioid Pharmacologic and Non-Pharmacologic Chronic Pain Management

The Center for Medicaid and CHIP Services (CMCS) has issued several Informational Bulletins (Bulletin) outlining state approaches and effective practices for addressing the opioid overdose epidemic within Medicaid. In partnership with the Centers for Disease Control and Prevention (CDC), the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration (SAMHSA), CMCS issued a Bulletin in 2014 to provide states with information, examples of state-based initiatives, and useful resources related to medication-assisted treatment.[1] A 2016 Bulletin describes a broad array of strategies and options in Medicaid for managing prescription opioids and preventing opioid-related harms,[2] and a 2017 Bulletin highlights flexibilities that states may have to facilitate timely access to naloxone for Medicaid beneficiaries.[3]

The purpose of this Bulletin is to expand on earlier guidance by providing information to states seeking to promote non-opioid options for chronic pain management. This Bulletin supports the goal of reducing the use of opioids in pain management included in the President's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand[4] and is

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[1] CMCS, Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, National Institute on Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, Informational Bulletin: Medication Assisted Treatment for Substance Use Disorders, July 11, 2014 [Accessed February 11, 2019 at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-11-2014.pdf].
[2] CMCS Informational Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction, January 28, 2016 [Accessed February 11, 2019 at https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf].
[3] CMCS Informational Bulletin: State Flexibility to Facilitate Timely Access to Drug Therapy by Expanding the Scope of Pharmacy Practice Using Collaborative Practice Agreements, Standing Orders or Other Predetermined Protocols. January 17, 2017 [Accessed February 11, 2019 at https://www.medicaid.gov/federal-policy-guidance/downloads/cib011717.pdf].
[4] President Donald J. Trump's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand, March 19,

consistent with the U.S. Department of Health and Human Service (HHS) 5-Point Strategy to Combat the Opioid Crisis.[5] This Bulletin also meets the requirements of Section 1010 of the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271), which requires CMS to issue guidance, or update existing guidance documents, to states on mandatory and optional items and services, for non-opioid treatment and management of pain that may be provided in the state Medicaid program.

Specifically, this Bulletin describes Medicaid authorities that states may use for coverage of non-opioid pharmacologic and non-pharmacologic pain management therapies, highlights some preliminary strategies used by several states, and includes useful resources to help states consider appropriate pain relief approaches within the context of the national opioid crisis. While the focus of this Bulletin is on non-opioid chronic pain management, states may consider the strategies outlined here for the treatment of acute pain as well.

Background

The consequences of the opioid overdose epidemic have been tragic. In 2017, 47,600 people in America died of an opioid overdose.[6] Nonfatal opioid overdoses presented to emergency departments increased nearly 30 percent from July 2016 through September 2017, with some areas increasing by as much as 70 percent.[7]

Overdose death rates involving all forms of opioids (prescription and illicit) have steadily risen since 1999,[8] but the relative proportion of deaths from prescription and other forms of opioids has shifted. While overdose deaths associated with prescription opioid pain medications have remained relatively stable in recent years, deaths from synthetic opioids such as illicitly-made fentanyl account for an increasing share of deaths.[9] The rate of drug overdose deaths involving synthetic opioids other than methadone increased on average eight percent per year from 1999 through 2013 and by 71 percent from 2013 through 2017.[10]

2018 [Accessed February 11, 2019 at https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand/].

[5] U.S. Department of Health and Human Services, 5-Point Strategy to Combat the Opioid Crisis [Accessed February 11, 2019 at https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/index.html]].

[6] Hedegaard H., Miniño A.M., Warner M. Drug overdose deaths in the United States, 1999–2017. NCHS Data Brief, no 329. Hyattsville, MD: National Center for Health Statistics. 2018 [Accessed November 29, 2018 at https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf].

[7] Vivolo-Kantor, A.M., Seth, P., Gladden, R.M., et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses—United States, July 2016–September 2017. *Morbidity and Mortality Weekly Report*, March 9, 2018, No. 9 [Accessed November 5, 2018 at https://www.cdc.gov/mmwr/volumes/67/wr/mm6709e1.htm].

[8] Jones, C., Einstein, E., Compton, W. , Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States, *Journal of the American Medical Association.* May 1, 2018 Vol. 319, No. 17, p. 1819 [Accessed February 11, 2019 at https://jamanetwork.com/journals/jama/article-abstract/2679931?redirect=true].

[9] Rudd, R.A., Aleshire, N., Zibbell, J.E., Gladden, R.M., Increases in Drug and Opioid Overdose Deaths—United States, 2000-2014. *Morbidity and Mortality Weekly Report,* January 1, 2016. Vol. 64, Nos. 50&51, pp. 1378-1382 [Accessed February 11, 2019 at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm].

[10] Hedegaard H., Miniño A.M., Warner M. Drug overdose deaths in the United States, 1999–2017. NCHS Data Brief, no 329. Hyattsville, MD: National Center for Health Statistic, November 2018 [Accessed November 29,

The leveling off of fatalities from prescription opioids has coincided with declines in opioid prescriptions; after peaking in 2012, the total opioid prescribing rate has declined for commercial insurers, Medicare and Medicaid.[11,12] In 2017, the prescribing rate fell to the lowest it had been in more than 10 years to nearly 59 prescriptions per 100 persons, down from more than 81 prescriptions per 100 persons at the 2012 peak in opioid prescriptions. Still, prescribing rates continue to remain very high in certain areas across the country;[13] and the per capita opioid use in the United States continues to vastly surpass those of other countries.[14]

Overprescribing of opioids has played a role in the epidemic. Overall, an estimated 21–29 percent of people prescribed opioids for chronic pain misuse them,[15,16] and 8–12 percent develop an opioid use disorder.[17] Moreover, prescribing patterns for opioid naïve patients can influence the likelihood of long-term use. A recent study suggested that the chances of long-term opioid use begin to increase after just three days of use and rise rapidly thereafter.[18]

At the same time, chronic pain can severely impact a person's quality of life and people who

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2018 at https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf].

[11] Centers for Disease Control and Prevention. Annual Surveillance Report of Drug-Related Risks and Outcomes — United States, 2017. Surveillance Special Report 1. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. August 31, 2017 [Accessed February 11, 2019 at https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf].

[12] Ketcham, M., Sexton, G., Sparkman, S., Thorpe, L. CARA/Opioids. Medicare Advantage & Prescription Drug Plan: Spring Conference & Webcast, May 9, 2018 [Accessed February 11, 2019 at https://www.cms.gov/Outreach-and-Education/Training/CTEO/Event_Archives.html].

[13] Centers for Disease Control and Prevention. U.S. Opioid Prescribing Rates Map. [Accessed February 11, 2019 at https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html].

[14] United Nations International Narcotics Control Board. Narcotic Drugs: Report 2016 [Accessed February 11, 2019 at https://www.incb.org/incb/en/narcotic-drugs/Technical_Reports/2016/narcotic-drugs-technical-report-2016.html].

[15] Vowles K.E, McEntee M.L, Julnes P.S., Frohe T., Ney J.P., van der Goes D.N. Rates of Opioid Misuse, Abuse, and Addiction in Chronic Pain: A Systematic Review and Data Synthesis. *Pain*. April 2015, 156(4):569-576 [Accessed February 11, 2019 at https://journals.lww.com/pain/Abstract/2015/04000/Rates_of_opioid_misuse,_abuse,_and_addiction_in.3.aspx].

[16] Chou, R., Turner, J, Devine, E., et. al. The Effectiveness And Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review For A National Institutes Of Health Pathways To Prevention Workshop, *Annals of Internal Medicine* 2015, Feb 17:162(4) 276-86 [Accessed February 11, 2019 at http://annals.org/aim/fullarticle/2089370/effectiveness-risks-long-term-opioid-therapy-chronic-pain-systematic-review].

[17] Muhuri P.K., Gfroerer J.C., Davies M.C. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. *CBHSQ Data Rev*. August 2013 [Accessed February 11, 2019 at https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm].

[18] Shah A., Hayes C.J., Martin B.C. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. *Morbidity and Mortality Weekly Report* 2017; 66:265–269 [Accessed February 11, 2019 at http://dx.doi.org/10.15585/mmwr.mm6610a1].

experience chronic pain need effective and safe pain management.[19] Federal efforts to address the issue include the formation of the Pain Management Best Practices Inter-Agency Task Force, authorized by the Comprehensive Addiction and Recovery Act of 2016,[20] and the National Pain Strategy, developed by the Interagency Pain Research Coordinating Committee.[21] Recognizing the need for clinical guidance, in 2016, CDC issued its evidence-based CDC Guideline for Prescribing Opioids for Chronic Pain,[22] intended for primary care physicians treating adult patients with chronic pain, for the roughly 20 percent of adults in the United States who live with chronic pain.[23]

CDC Guideline for Prescribing Opioids for Chronic Pain

CDC found that while there is well documented evidence of the potential harm of opioids, there is insufficient evidence to demonstrate sustained pain relief or improvements to quality of life or functioning with the use of opioids to treat chronic pain. Thus, CDC recommends that providers consider non-pharmacologic therapy and non-opioid pharmacologic therapy as the first-line treatment for chronic pain.[24] Exceptions to this recommendation include pain associated with active cancer treatment, palliative care, end-of-life care, or clinical circumstances in which the expected benefits of opioids for pain and function outweigh the risks.[25]

Based on a review of the evidence, CDC suggests that multi-modal therapies and multidisciplinary rehabilitation are more effective at reducing long term pain than care as usual or physical treatment alone.[26] The CDC guideline encourages providers to continue to use their clinical judgment and base their treatment on what they know about their patients, including the use of opioids if they are determined to be the best course based on an

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[19] Institute of Medicine. Committee on Advancing Pain Research, Care, and Education; Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: The National Academies Press; 2011 [Accessed February 11, 2019 at https://www.uspainfoundation.org/wp-content/uploads/2016/01/IOM-Full-Report.pdf].
[20] Additional information is available at https://www.hhs.gov/ash/advisory-committees/pain/index.html.
[21] Interagency Pain Research Coordinating Committee. National Pain Strategy: A Comprehensive Population Health Level Strategy for Pain [Accessed February 11, 2019 at https://iprcc.nih.gov/sites/default/files/HHSNational_Pain_Strategy_508C.pdf].
[22] Dowell, D., Haegerich, T.M., Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States 2016, *Morbidity and Mortality Weekly Report* March 18, 2016: 65) [Accessed February 11, 2019 at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm].
[23] Dahlhamer, J, Lucas, J., Zelaya, C., et. al. Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults — United States, 2016, *Morbidity and Mortality Weekly Report* September 14, 2018:67 [Accessed November 26, 2018 at https://www.cdc.gov/mmwr/volumes/67/wr/mm6736a2.htm?s_cid=mm6736a2_w].
[24] Dowell, D., Haegerich, T.M., Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States 2016, *Morbidity and Mortality Weekly Report* March 18, 2016: 65)1 [Accessed February 11, 2019 at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm].
[25] Dowell, D., Haegerich, T.M., Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States 2016, *Morbidity and Mortality Weekly Report* March 18, 2016: 65)1 [Accessed February 11, 2019 at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm].
[26] Dowell, D., Haegerich, T.M., Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States 2016, *Morbidity and Mortality Weekly Report* March 18, 2016: 65)1 [Accessed February 11, 2019 at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm].

individualized benefit/risk analysis. Whatever the treatment selected, CDC stresses the importance of discussing the potential benefits and harms of all treatment options with patients and establishing treatment goals and expectations.[27]

The CDC guideline defines chronic pain as "pain continuing or expected to continue for greater than three months or past the time of normal tissue healing." However, the guideline also urges caution in prescribing opioids for acute pain, noting that long-term opioid use often begins with treatment of acute pain; when opioids are prescribed for non-traumatic, non-surgical acute pain, clinicians should prescribe the lowest effective dose for the shortest duration possible— usually three days or less is sufficient and more than seven days will rarely be needed.[28]

The guideline also notes that there are other effective treatments for chronic pain. Non-pharmacologic therapies pose minimal risks, and many of these treatments—such as exercise therapy, physical therapy, and cognitive behavioral therapy (CBT)—have been shown to effectively treat chronic pain associated with some conditions.[29] For example, exercise therapy can be effective in treating lower back pain, osteoarthritis, and fibromyalgia.[30] The guideline notes that non-opioid pharmacologic therapy, such as acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs), can improve pain with lower risks relative to opioids for most patients. In addition, the guideline notes that selected antidepressants or selected anticonvulsants can relieve neuropathic pain.

Since the 2016 CDC guideline was published, the Agency for Healthcare Research and Quality (AHRQ) developed a systematic review of the evidence base for multiple non-pharmacologic treatments for chronic pain. For example, the AHRQ review found that exercise therapy demonstrates benefits for a range of conditions associated with chronic pain, including lower back pain, neck pain, fibromyalgia, hip osteoarthritis and knee osteoarthritis. Additionally, the AHRQ review found that acupuncture treatment was associated with improvements in pain and functioning for at least one month for patients with chronic low back pain, chronic neck pain, and fibromyalgia.[31]

Medicaid Approaches for Non-Opioid Chronic Pain Management

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[27] Additional information on assessing the harms and benefits of pain treatment is available at https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf.

[28] Dowell, D., Haegerich, T.M., Chou, R. CDC Guideline for Prescribing Opioids for Chronic Pain-United States 2016, *Morbidity and Mortality Weekly Report* March 18, 2016: 65)1 [Accessed February 11, 2019 at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm].

[29] For a review of the evidence base for CBT, see Ehde D.M., Dillworth, T.M. and Turner, J.A. Cognitive-Behavioral Therapy for Individuals with Chronic Pain: Efficacy, Innovations, and Directions for Research. *American Psychologist,* 69(2); 153–166.

[30] Additional information on non-opioid treatments for chronic pain are available at https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf.

[31] Skelly A.C., Chou R., Dettori J.R., et al. Noninvasive Non-pharmacological Treatment for Chronic Pain: A Systematic Review. Comparative Effectiveness Review No. 209. Agency for Healthcare Research and Quality; June 2018 [Accessed February 11, 2019 at https://effectivehealthcare.ahrq.gov/topics/nonpharma-treatment-pain/research-2018].

According to a survey jointly conducted by the Kaiser Family Foundation and the National Association of Medicaid Directors, an increasing number of states are implementing the CDC opioid prescribing guideline. In that survey, 34 states reported they had already implemented CDC's guideline or planned to implement the guideline in 2018 in their fee-for-service (FFS) programs (compared to 21 states in the previous year's survey). Of 39 states with Managed Care Organization (MCO) contracts, 18 states required MCOs to use the CDC opioid prescribing guideline or plan to add the requirement in 2018.[32] In addition, several state Medicaid agencies have implemented their own opioid prescribing guidelines, and some states have implemented legislation to allow Medicaid recipients to access non-opioid pharmacologic and non-pharmacologic pain treatment therapies, such as acupuncture.[33] In a State Medicaid Director letter, CMS recently announced a new "opportunity to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees residing in residential treatment facilities." One of the expectations established by CMS for states seeking approval for this FFP is that those states implement opioid prescribing guidelines along with other interventions to prevent opioid abuse.[34]

Preliminary data suggests that implementing opioid prescribing guidelines, such as those recommended by CDC, can decrease the quantity of opioids prescribed and dispensed, particularly when the prescribing guidelines are combined with strategies to better monitor, manage, and appropriately prescribe opioids. One integrated payor and provider health system utilized a multi-faceted strategy to improve opioid prescribing patterns to reduce opioid prescriptions in a 580,000 member health plan. This approach included use of electronic health records to track prescriptions, patient and provider education, and the use of non-pharmacologic treatment as the first line for chronic pain management. Results of these efforts led to a reduction in opioid prescriptions by half since the program was initiated in 2014.[35] Virginia's Medicaid program began implementing the CDC guideline through strategies such as increasing access to non-opioid pain relievers, requiring prior authorizations for prescription opioids, introducing quantity limits and educating providers and patients regarding opioid prescriptions. As a result, since the project launch on July 1, 2016, Virginia saw a 59 percent decrease in opioid pills dispensed and a 51 percent decrease in related spending in its fee-for-service program.[36]

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[32] Gifford, K., Ellis, E., Edwards, B.C., Lashbrook, A., Hinton, E., Antonisse, L., Valentine, A., Rudowitz, R. Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. *The Henry J. Kaiser Family Foundation and the National Association of Medicaid Directors* October 2017 [Accessed February 11, 2019 at https://www.kff.org/medicaid/report/medicaid-moving-ahead-in-uncertain-times-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2017-and-2018/].

[33] Arizona Department of Health Services. 50 State Review on Opioid Related Policy, August 28, 2017 [Accessed February 11, 2019 at https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/50-state-review-printer-friendly.pdf].

[34] CMS State Medicaid Director Letter: Strategies to Address the Opioid Epidemic. November 1, 2017. [Accessed August 8, 2018 at https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf].

[35] Kravitz, J., Geisinger: Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients. Testimony before the Health Subcommittee on the House Energy and Commerce Committee, April 12, 2018 [Accessed February 11, 2019 at https://docs.house.gov/meetings/IF/IF14/20180411/108092/HHRG-115-IF14-Wstate-KravitzJ-20180411.pdf].

[36] Francioni-Proffitt, D., "Virginia Medicaid's Strategies for Implementing Evidence-Based Prescribing

Several states have designed and implemented targeted initiatives to promote the provision of non-opioid pain management therapies for specific conditions. In most cases, the benefits of these efforts are yet to be established through rigorous, independent evaluations, though preliminary results show some promise. Below are examples of what some states are doing to expand treatment options for the treatment of chronic pain.

Beginning in July 2016, Vermont conducted a short-term state-funded pilot program to provide acupuncture as an adjunct therapy for the treatment of chronic pain among its Medicaid population. Patients with chronic pain were treated by Vermont-licensed acupuncturists.[37]

In July 2016, the Oregon Health Plan, Oregon's Medicaid program, launched an initiative to treat uncomplicated back and neck pain among the estimated 50,000 Oregon beneficiaries who were experiencing this type of pain (30,000 of whom were receiving opioids for their pain). Through this initiative, the state modified its Prioritized List (the mechanism Oregon uses to determine what services are covered under its Oregon Health Plan Medicaid 1115 Demonstration Project) to add coverage for non-opioid treatment for pain, including acupuncture, chiropractic services, osteopathic manipulation, cognitive behavioral therapy, and physical therapy as potential alternatives, when appropriate, to surgeries, opioids, and epidural steroid injections. Additionally, the Oregon Health Authority convened a Stakeholder Task Force to develop statewide opioid prescribing guidelines. On November 18, 2016, the Task Force approved adoption of Oregon-specific prescribing guidelines, based on the CDC Guideline for Prescribing Opioids for Chronic Pain.[38]

Partnership HealthPlan for California ("Partnership") provides coverage to California Medicaid beneficiaries in 14 California counties. In January 2014, the plan officially launched the Managing Pain Safely (MPS) program geared toward reducing opioid prescriptions. Originally funded through the California Health Care Foundation, a significant decline in opioid prescriptions allowed Partnership to continue to invest in the MPS program through an intensive prescriber education campaign focusing on education about opioids and other options for managing pain. Provider education was coupled with technical assistance and prescriber support, including a toolkit with clinical resources. The plan also initiated several formulary changes (e.g., daily dose limitations, removing drugs with high street value from the formulary), and new benefits for chronic pain management (i.e., acupuncture and chiropractic care). As a result of these efforts, the program cut the

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Guidelines" CMS State Opioid Workshop, September 24, 2018.

[37] Gobeille, A., Gustafson, C., Medicaid Acupuncture Pilot Project Outcomes Report: Report to the House Committees on Health Care and on Human Services: Senate Committee on Health and Welfare Pursuant to Act 173 of 2016, Sec. 15a. September 29, 2017 [Accessed February 11, 2019 at https://legislature.vermont.gov/assets/Legislative-Reports/DVHA-Acupuncture-Pilot-Outcomes-Report-FINAL.pdf].

[38] Bui, L. Smits, A. State Experience: Oregon. Medicaid Innovation Accelerator Program Presentation [ND] [Accessed February 11, 2019 at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/06102016-iap-sud-tlo14.pdf].

total opioids prescribed by half within 21 months of launching its MPS program.[39]

Non-Pharmacologic Therapy Coverage Options

States and other payors have multiple pathways to provide non-pharmacologic chronic pain management options available to Medicaid providers and beneficiaries. Below, we highlight a range of options for states considering ways to promote non-pharmacologic treatment approaches through their Medicaid programs.

State Plan Authorities

Federal Medicaid law requires states to provide certain "mandatory" benefits under section 1905(a) of the Social Security Act (the Act) and allows states the choice of covering other "optional" benefits for adults. Section 1905(r) of the Act defines the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as any medically necessary section 1905(a) service ("state plan service") for children under 21 that corrects or ameliorates any physical or behavioral health condition. State plan services for children under 21 include any service classified as "mandatory" or "optional," regardless of services covered for adults in that state.

States have considerable flexibility in determining what non-pharmacologic services are available in the state plan under optional benefits. For example, a state may elect to provide coverage for acupuncture, massage therapy, chiropractic care, cognitive behavioral therapy, physical therapy or other Medicaid-coverable services through an array of Medicaid coverage authorities. States wishing to add coverage in optional benefit categories described below would need to submit a state plan amendment for CMS approval.

Some relevant mandatory state plan benefit categories, as specified in section 1905(a) of the Act, are described below.

Mandatory 1905(a) Benefits

- *Inpatient Hospital Services.* The inpatient hospital service mandatory benefit is defined in section 1905(a)(1) of the Act and in regulations at 42 CFR §440.10 that provides coverage authority for inpatient hospital services (other than services in an institution for mental diseases). 42 CFR §440.2 defines inpatient as a "patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who receives room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours." Inpatient hospital services, as defined in 42 CFR §440.10, are those services that are ordinarily furnished in a hospital for the care and treatment of inpatients; are furnished under the direction of a physician or dentist and

[39] California Health Care Foundation, Issue Brief: Case Studies: Three California Health Plans Take Action Against Opioid Overuse. June 2016 [Accessed February 11, 2019 at https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaseStudiesHealthPlansOpioid.pdf].

are furnished in an institution that is maintained primarily for the care and treatment of patients with disorders other than mental diseases; is licensed or formally approved as a hospital by an officially designed authority for State standard-setting, meets the requirements for participation in Medicare as a hospital, and has a utilization review plan in effect unless a waiver has been granted.

- *Outpatient Hospital Services.* The outpatient hospital services mandatory benefit is defined at section 1905(a)(2)(A) of the Act and in regulations at 42 CFR §440.20(a) that provides coverage authority for outpatient hospital services. "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients; are furnished by or under the direction of a physician or dentist; and are furnished by an institution that is licensed or formally approved as a hospital by the state and meets the requirements for participating in Medicare as a hospital.
- *Federally Qualified Health Center Services (FQHC).* FQHC services are defined in section 1905(a)(2)(C), section 1905(l)(2), and section 1861(aa)(3) of the Act. This mandatory benefit includes services provided by certain core providers including physicians, nurse practitioners and physician assistants (subject to any state law prohibition on furnishing primary health care), nurse midwives, clinical psychologists, clinical social workers and visiting nurses in areas with a shortage of home health agencies. FQHC services also include other ambulatory care services otherwise included in the Medicaid state plan. Although FQHC services are a mandatory benefit and a state must cover services furnished by core providers, the state has flexibility in determining the other ambulatory care services covered under this benefit to the extent that the services are already covered in another benefit of the state plan.
- *Rural Health Clinic Services (RHC).* The RHC services are defined in section 1905(a)(2) (B), section 1905(l)(1) and section 1861(aa) of the Act and in regulations at 42 CFR §440.20(b) and (c). RHC services are provided by a rural health clinic certified in accordance with 42 CFR Part 491 and include services provided by certain core providers including physicians, nurse practitioners and physician assistants (subject to any state law prohibition on furnishing primary health care), nurse midwives, clinical psychologists, clinical social workers and visiting nurses in areas with a shortage of home health agencies. The state has flexibility in determining the other ambulatory care services covered under this benefit to the extent that the services are already covered in another benefit of the state plan.
- *Physicians' Services.* The physician services mandatory benefit defined in section 1905(a)(5) of the Act and in regulations at 42 CFR §440.50. Physicians' services are furnished within the scope of practice of medicine or osteopathy as defined by State law whether furnished by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy. Physicians' services can be furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere.
- *Nurse Practitioner Services.* The nurse practitioner services mandatory benefit is defined in section 1905(a)(21) of the Act and in regulations at 42 CFR §440.166.

Nurse practitioner services mean services that are furnished by a registered professional nurse who meets a State's advanced education and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses. The requirements for Certified Pediatric and Family nurse practitioners are also described in 42 CFR §440.166.

Optional 1905 (a) Benefits

- *Rehabilitative Services.* Rehabilitative services are an optional benefit as specified in section 1905(a)(13) of the Act. Medicaid regulations at 42 CFR §440.130(d) broadly define rehabilitative services as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level" except as otherwise provided in the regulations. Examples of services that states could cover under the rehabilitative services benefit include biofeedback, cognitive behavioral therapy, occupational therapy, and physical therapy.

- *Physical and Occupational Therapy Services.* States have several options for providing coverage for physical therapy and occupational therapy. Both are optional Medicaid state plan benefits as specified in section 1905(a)(11) of the Act. Both or either can be covered as a therapy benefit as specified under section 1905(a)(11); as a rehabilitative services benefit, as described above and defined in Section 1905(a)(13); or through the home health benefit specified in section 1905(a)(7) of the Act. Regardless of the mechanism for coverage, the practitioners of physical therapy or occupational therapy must meet the qualifications set forth in 42 CFR § 440.110.

- *Other Licensed Practitioner Services (OLP).* Section 1905(a)(6) of the Act provides states flexibility in covering services provided by licensed practitioners as defined by state law. As set forth in 42 C.F.R. § 440.60(a), other licensed practitioner services are "any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses an acupuncturist, for example, then their services could be covered under the OLP benefit. Similarly, chiropractor services could be covered if, as required by 42 C.F.R. § 440.60(b), they are provided by a chiropractor who is licensed by the state and meets standard specified in 42 C.F.R. § 405.232(b) and if chiropractors' services consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the state to perform.

- *Preventive Services.* Section 1905(a)(13) of the Act authorizes preventive services which are defined in 42 C.F.R. § 440.130(c) as "services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to:
    (1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency."

Preventive services must "involve direct patient care and be for the purpose of diagnosing, treating, or preventing (or minimizing the adverse effects of) illness, injury, or other impairments to an individual's physical or mental health."[40] An example of a service that can be covered under this benefit is physical activity counseling, provided the counseling is not logically an inherent part of an otherwise paid-for service such as physicians' services or physical therapy.

Regardless of the specific authority chosen, states must meet certain requirements in their state plan benefits. A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. Medicaid beneficiaries must also be permitted to choose a health care provider from any qualified provider who undertakes to provide the services, and services provided under the state plan must be available statewide to all eligible individuals. However, states may request waivers as described below to allow exceptions to these requirements. For example, a state could request an 1115 demonstration for a waiver of statewideness to allow a certain service (e.g., acupuncture) in a limited geographic area within the state.

Other authorities available to states are described below.

Section 1945 Health Home Benefit

Through the Medicaid Health Home optional state plan benefit, states can establish Health Homes to coordinate care for people with Medicaid who have chronic conditions as set forth in Section 1945 of the Act. Since individuals with chronic conditions may experience chronic pain, the Medicaid Health Home benefit provides states with another strategy to help address chronic pain management among those individuals. Specifically, health home providers integrate and coordinate all primary, acute, behavioral health and long term services and supports to treat the whole-person to promote wellness. The health home works with beneficiaries to educate them about their condition(s) and to support the individual in developing the knowledge and activities that support lifestyle changes, focusing on the goals of maintaining and protecting wellness. A few states with approved health home state plan amendments specifically target musculoskeletal conditions to include back and neck pain and other chronic pain syndromes, which may be a useful strategy to enhance non-pharmacologic chronic pain management options.[41]

Home and Community Based Services 1915(c) Waivers

States have the option to apply for home and community-based services waivers (HCBS

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[40] State Medicaid Manual, Section 4385(b).

[41] Additional information on the Health Home benefit, including descriptions of how states are utilizing this option is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/index.html.

Waivers) to enable beneficiaries who would otherwise need an institutional level of care to receive long-term care services and supports in their home or community, rather than in an institutional setting. HCBS waivers allows states to waive certain Medicaid requirements (statewideness, comparability of services, and/or income and resource rules applicable in the community) enabling them to target populations by age or diagnosis. Some states utilize this authority to provide non-opioid treatments for pain management in specific populations. For example, Colorado's Persons with a Spinal Cord Injury 1915(c) waiver allows individuals with spinal cord injuries in the Denver metropolitan area to receive acupuncture, massage therapy, and chiropractic services, which are not otherwise covered under Colorado's Medicaid state plan.

1915(i) State Plan Amendment

Like the Section 1915(c) waiver, the 1915(i) State Plan Amendment (SPA) allows states to provide HCBS not already available under the State plan targeted to individuals who meet state defined needs-based criteria. The 1915(i) also enables states to establish additional needs-based criteria for specific services, establish a new eligibility group for people to receive HCBS for a limited period of time, and define the services included in the benefit, as set forth in 42 C.F.R. § 441.700. States could use the 1915(i) SPA to offer specific pain management services that are not already available under the State plan to specific target populations by age, disability, diagnosis, and/or Medicaid eligibility group.

Section 1115 Demonstrations

States may also utilize Section 1115 demonstration authority to test non-opioid pain management strategies. Since Section 1115 demonstrations are intended to give states the flexibility to pilot new approaches that are likely to assist in promoting the objectives of the Medicaid program, states have a great deal of flexibility to design their demonstrations accordingly subject to CMS approval. States could, for example, elect to pilot a specific treatment option for a subset of the Medicaid population (e.g., beneficiaries with a specific diagnosis) or in a limited geographic area. Some states (e.g., Rhode Island) have used 1115 authority to build a multi-modal, multi-disciplinary program specifically targeting chronic pain management.

Managed Care Strategies

States may provide non-pharmacologic treatment options in either a fee-for-service or managed care delivery system. When states use a risk-based managed care delivery system, a managed care plan may voluntarily choose to provide additional pain management benefits that are not covered under the state plan but the cost and utilization of such additional benefits may not be used in developing capitation rates for the managed care plan. A managed care plan may also provide alternative pain management services in lieu of pain management services covered under the state plan so long as the state and the managed care plan meet-the requirements for in lieu of services outlined in 42 CFR 438.3(e)(2). Services provided in lieu of services covered under the state plan may be taken into account when developing rates for the managed care plan if the regulation requirements are met, including

the requirement that the state determine that the alternative is a medically appropriate and cost effective substitute for the covered service.

Payment Strategies

States may also design payment methodologies for individual services, or may consider creating a bundled rate for pain management in which the state pays an all-inclusive rate for a range of pain management services associated with a specific condition. Bundled payments can be constructed to support a multidisciplinary, multi-modality approach to pain management, including such elements as cognitive behavioral therapy, physical therapy, patient education, acupuncture, etc. To assist states with bundled payment methodologies, CMS has issued guidance to states for designing and developing bundled payment methodologies under state plan authority. This document can be accessed through the following link: https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf.

Non-Opioid Pharmacologic Therapy Options

As detailed in the January 28, 2016 CMCS Informational Bulletin, *Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction*[42] and the CMS Quality Improvement Organization Campaign for Meds Management, which can be accessed at the following link: https://qioprogram.org/campaign-meds-management-resource-page-3, there are a number of effective Medicaid pharmacy benefit management strategies to discourage overuse of opioids and to drive providers toward non-opioid pharmacologic therapy to treat chronic pain, when clinically appropriate, including:

- Provider education and training of appropriate use of opioids and effective non-opioid analgesic alternatives;
- Patient education on pain management;
- Prescribing guidelines for pain management;
- Prior authorization for long-acting opioid prescriptions;
- Prescription drug monitoring programs;
- Patient medication reconciliation reviews and comprehensive medication management; and
- Provider-patient medication management agreements and lock-in programs.

In addition, states may wish to consider pharmacy benefit management strategies such as prioritizing non-opioid analgesics for non-cancer chronic pain.

Conclusion

Providers and beneficiaries need access to effective therapy for chronic pain. A

[42] CMCS Informational Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction, January 28, 2016 [Accessed February 11, 2019 at https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf].

multidisciplinary approach to chronic pain management that incorporates non-opioid pharmacologic and non-pharmacologic therapies, well-communicated treatment goals and expectations, and a careful consideration of the individual and the benefits and risks of a range of available treatment options is the most appropriate approach for most patients and has the potential to lead to more appropriate prescribing of opioids. States may use any combination of the strategies noted in this Bulletin to enhance Medicaid treatment options for chronic pain. CMS welcomes the opportunity to discuss these options with states. Please direct questions about this Bulletin to Kirsten Jensen, Director of the Division of Benefits and Coverage, at kirsten.jensen@cms.hhs.gov.