Transcript from AACIPM Fall Symposium

Equity in Access to Comprehensive Integrative Pain Management for People with Pain - September 24, 2020

44 minute transcript - accompanying video can be found here.

Moderator: Cindy Steinberg, National Director of Policy and Advocacy, US Pain Foundation

- Kirk Williamson, MPH, Health Policy Analyst, National Governors Association
- Nicole Hemmenway, CEO, US Pain Foundation
- David Elton, DC, Chief Strategy Officer, United Health Ventures
- Matt Salo, Executive Director, National Association of Medicaid Directors

Interactive Discussion, Q&A

Cindy Steinberg, Moderator (00:01):

We're now going to have an interactive discussion with the panelists. I'm going to get us started with a few questions for them to answer first, but really, we want to encourage everybody in the audience to participate by submitting questions in the Q&A. We're going to be monitoring those questions. Amy, I'll be turning to her to give me some of the questions from the Q&A after the panelists answer some of the questions I have to them. So please, please participate by hitting that Q&A button and give us your questions.

Cindy Steinberg, Moderator (00:37):

My first question is going to be a round robin to each of the panelists. I think we can start with Matt, since he's right up here in front. My first question is, from the work that each of you have spoken about, what do you think would be your number one approach to increasing access to complementary care for pain management? I'm talking about chiropractic, acupuncture, massage, exercise programs like yoga and tai chi for underserved individuals living in underserved communities on Medicaid. Matt?

Matt Salo, Nat'l Association Medicaid Directors (01:18):

There's enormous interest in exploring all of those alternatives. I think there was probably a couple of presenters who talked about stressing the fact that we're not talking about getting rid of opiates as a blanket issue but rather are there ways that we can either transition people are off them safely or just avoid having that be the only solution that people with pain management get as a first course. There's an enormous amount of interest in looking at chiropractics and yoga and all sorts of other things.

Matt Salo, Nat'l Association Medicaid Directors (01:53):

But what is going to be really meaningful for my members, for the Medicaid directors, is where is the data to back it up that this works. We hear anecdotally, and that's great. Where there's smoke, there may be fire, but there's going to have to be more than just the smoke of anecdotally this works for so-and-so, because, again, Medicaid is a battleship. It is a 70-million-person, $600-billion-a-year program, and turning that battleship around takes time, but it also means you have to be very, very clear about what you're doing, because big changes like that, Medicaid now pays for chiropractics or Medicaid now pays for swimming lessons or whatever, has massive repercussions throughout the healthcare system. You really want to make sure that

you're taking a data-driven approach, that what we're doing clearly and demonstratively makes sense.

Matt Salo, Nat'l Association Medicaid Directors (03:00):

I think the second part of that question is what we do about it right now. Per David's point, and I think Kirk mentioned this too, so much of Medicaid is delivered via some kind of managed care plan. There are multiple managed care entities in any given state. What I think would be really, really useful is to empower the plans, who are much closer to the patient, you have those direct relationships with providers of all stripes, to be able to say, "Okay, well, United, they're going to have a big demo. They're going to have a big pilot and they're going to do something. We're going to study it. We're going to see did that work, did that make sense." If they did it in Kentucky and it works Kentucky, then maybe United does it in every state they're in. If it starts to work like that, then all of the other plans will say, "Oh my god, that's great. We want to do that too." That's, to me, how we really get the ball rolling.

Cindy Steinberg, Moderator (04:08):

That's great, Matt. Thanks a lot. I'm just going to dig a little bit deeper with you and say, okay, let's say in a particular state you had and were shown the data or your managed care plan really believed in the data and wanted to implement this program. What would have to happen from a Medicaid director's standpoint to get it going?

Matt Salo, Nat'l Association Medicaid Directors (04:35):

States have different approaches to managed care. Some take a more laissez faire approach of "We've got a goal. Our goal is improved health. We don't care how you get there. You go forth and innovate. Be the laboratories of democracy. Go figure this out and come back to us. If you can show us that you have achieved this goal of improved health, however we define that, that's all we need." A lot of states, either as they're doing the contracting process or an RFP process with the plans, will either make that explicit or implicit in their relationship or in the discussions with those plans.

Matt Salo, Nat'l Association Medicaid Directors (05:20):

Otherwise, yeah, it's trying to find the bandwidth to put together a control group and a demonstration and a pilot. State government doesn't have the bandwidth right now to be taking that on. That's why we really do need the plans to be able to be our force multiplier, to be able to say, "You've got the bandwidth. You test this in this area or this population or with this particular alternative to pain and show us. When you can show us" ... It's not just Missouri, the show me state. It shows us that the data is there to back up a decision that is going to shift reimbursement and coverage policy in a big way.

Cindy Steinberg, Moderator (06:16):

Great. That's interesting, and it's interesting to see how the plans and having the plan sold on it has an effect on the Medicaid population. I think we'll attack that when it's David's turn to speak. I'm going to ask Kirk that same question. Again, from the work that you've done, what would be your number one approach to increasing access to complementary care? Then, if you were told to implement it in a particular state, how would you do it?

Kirk Williamson, National Governors Association (06:54):

I would have to agree wholeheartedly with what Matt just said. It really comes down to the data. I won't belabor that point.

Interactive Discussion, Q&A

Kirk Williamson, National Governors Association (07:03):

I think, from my role at NGA, I work a lot with governors' health policy advisors. I think if I was asked by the governor to ... I'm just trying to be in their shoes ... to say, "Okay, I want large scale pain management delivery reform. I've heard about Medicaid being one avenue. How do I go about doing this?" I think the approach would be to use the governor's office as the bully pulpit or as the vision center to also convene and work with the Medicaid director to understand what benefits do we offer, our chronic pain population, what's the size of that, are people going to their primary care physicians for low back pain, is it neck pain, what are our health systems doing, and working hand in hand with our Medicaid managed care plans. They are great at care management. They're great at care coordination. That is what they sell themselves on. I think we should hold their feet to the fire a bit and say, "All right, we have all this evidence. We're wanting to be a willing partner. So, let's try, as Matt said, to do some sort of demonstration."

Kirk Williamson, National Governors Association (08:15):

I think there are the realities, though, that they face today of are we going to have to cut provider rates. When you do that, you also make it challenging for access to those providers or those services that are provided.

Kirk Williamson, National Governors Association (08:28):

So, I think it comes down to convening stakeholders, listening to your pain management community. What barriers are they facing? They may have tried chiropractic services, and that's the only non-opioid benefit in a Medicaid plan. If you have an overwhelming majority of your pain population saying, "I need more access. I need transportation. I need whatever," it's going to take a lot of creative thinking on behalf of the state to say, "How do we provide this to our members in a way that makes fiscal sense as well and that would be clinically appropriate?"

Kirk Williamson, National Governors Association (09:06):

I think it will take time. I think that there are those lessons learned. I think the expert round tables we held was really instrumental in understanding how states were going about this, but I think more conversations over connecting states together to say, "How do we move the needle? How do we do this in a resource-constrained environment going forward?" because the conversation we're having today and the answer we're getting today is very different than the answer I probably would've given back in 2018 or even in 2019 or even in January. That would be my answer.

Cindy Steinberg, Moderator (09:47):

Thanks very much, Kirk. Next, I think I'm going to go to David and have David answer that question.

David Elton, United Health Group (09:54):

Thanks, Cindy. Back to the data point, we've convinced ourselves through years of study, actuarial, healthcare economics, clinical, that these therapies are very beneficial, both in terms of quality, cost, health, and wellbeing. In the commercial space, these therapies are covered. They're available through networks, but they're not used.

David Elton, United Health Group (10:17):

Then to transition this to your question then, which the context really was underserved individuals living in underserved communities and Medicaid, I reviewed the presentation I gave with our

disparities leader last week, and his immediate, first reaction was to the point of taking action and what can we do. Rather than adding another thing to these already-stressed individuals to have to pack into their life, we need to focus on removing stressors. That will free up time. That will give people the ability to even access these therapies if they are covered.

David Elton, United Health Group (10:54):

That raises housing, food, transportation, education. Many might be single parents. We've got public safety issues. We've got fundamentals of public health. What's the individual's support system, social network, mental health? If we start to address all of those, then we can begin to take on the conversation of "Oh, and for your pain, let's go to a chiro." We really can't lead with that until we have the conversation on the first elements, because this population we're talking about has a number of stressors, and just transportation's classic. If the local chiro is 10 miles away and you don't have transportation, how do you get there? So, we need to address those.

David Elton, United Health Group (11:35):

I think once those are being addressed and productively, we're engaging on those broader topics, then we get to the discussion of people accessing the therapies that we're talking about. The strategy I would encourage, and I think it came up around demonstration, is some 24-month demonstration pilot. I would advocate for sourcing local, volunteer, non-prescribing providers aligned with the race, culture, ethnicity of the population being served to take down the reimbursement barrier. There's a lot of well-intended, strong clinicians that would be on board with this. So, source local, volunteer clinical resources.

David Elton, United Health Group (12:24):

The issue of literacy and numeracy is really important. If we were to make an investment, it's developing communication tools for the population we're targeting that help convey why these therapies may be helpful and put all of this into context.

David Elton, United Health Group (12:42):

Make access no cost. We in the commercial space last year rolled out benefit plan designs to eliminate patient cost sharing for chiro and PT for back pain just to take down that barrier, more important in the Medicaid space.

David Elton, United Health Group (12:57):

And then do the CBA over two years. What are the anticipated costs to add these therapies and study intently the benefits? In total, health and wellbeing are where the benefits are going to emerge. You need two years because this takes time to build momentum around use and medical physicians, comfort in referring for. How do we build collaboration on a local zip code to make this real for patients? So, a two-year demonstration pilot sourcing local volunteer clinical talent and communicating with population served in a way they understand after the other social determinant issues are addressed, because we just can't add one more thing into people's lives.

David Elton, United Health Group (13:44):

Long-winded answer, Cindy.

Cindy Steinberg, Moderator (13:47):

No, no. It's a great answer. I think some of that we'll have Kirk address in a later question that I'm going to ask on follow-up. The only thing that I will say about the social determinants is, when we're talking about pain as severe as what Nicole presented, and most of the people who are our members, the thousands of members that we have, are people disabled by pain. So, while the social determinants are critical, pain would rise to the top of that if you can't even function. For example, when I run support groups, I have people that take the Ride, which, in Massachusetts, is free transportation from underserved communities. They come to the support group so they can learn how best to take care of their pain in order to take care of the other parts, like their children and some work if they can. Pain can be so severe that it really almost outweighs some of the social determinants, such that we need to support that person to attack the others, if you know what I mean.

David Elton, United Health Group (15:05):

For sure. I'm with you, and I agree. That gets to the issue of how do we bring services out to where people are as opposed to forcing them to go to a bricks and mortar, which could be challenging.

David Elton, United Health Group (15:15):

In this space what's fascinating is the virtual tele in that ... I think Matt Taylor's going to do some work coming up. There's some really compelling stuff around yoga therapy and virtual [inaudible 00:15:25] therapy to bring services in, assuming people have access to high-speed internet. But some of these therapies are manual. Acupuncture, pretty hard to do virtually. Chiro, hard to do virtually. Virtual could be a path, but we need to solve for the manual nature of some of these interventions and making it convenient.

David Elton, United Health Group (15:44):

But I'm totally with you. If you're in chronic, disabling pain, that's at the top of your list. Then it becomes an access issue. I'm with you.

Cindy Steinberg, Moderator (15:55):

Great. Thank you.

Cindy Steinberg, Moderator (15:56):

Next, Nicole, finally getting to you to answer this question from the patient-organization perspective.

Nicole Hemmenway, US Pain Foundation (16:06):

Yes. Thank you so much. I really just have to say to Matt and Kirk and David, you raised some great points and added some interesting context to this.

Nicole Hemmenway, US Pain Foundation (16:17):

Of course, as Cindy mentioned just a minute ago in her response, we are coming from a slightly different perspective, because we are representing patients that are completely underserved right now. They reach out to us every single day saying that they're unable to access the care that they need. They can't see providers that they want. They're helpless and they're desperate,

and they don't know where to turn. They're very, very frustrated with the system as a whole, which I understand. I know that they're not blaming anyone. It just is the nature of the beast.

Nicole Hemmenway, US Pain Foundation (16:53):

So, what we are trying to do, as an organization, is really trying to empower them and educate them along their way. We have a volunteer program that has over 2,000 we call them ambassadors and advocates. They're individuals living with chronic, disabling pain, and they are looking for any way that they can either increase awareness in their local communities that they can advocate for better options to come.

Nicole Hemmenway, US Pain Foundation (17:22):

I definitely think, to Kirk's point and to the report, which, if you have not read the NGA report, I highly recommend everyone taking a read ... It really is great and fascinating. I think how it talks about the different models that explain Medicaid in different states is really interesting from our perspective, because if we maybe delve deeper into looking at a couple of states that are seeing some successes, maybe we can advocate better or at least educate those within our community about the options that are already out there that, A, they might not know about, and then, B, if they aren't in necessarily one of those states that we are looking at, we can help them with tools on how to advocate, whether it is reaching out on the federal side or if it's just reaching out locally to their state governors, sharing their experiences and stories to hopefully move that needle and allow them to have the access that they need. So yes.

Cindy Steinberg, Moderator (18:30):

Thanks, Nicole. Thanks, everyone.

Cindy Steinberg, Moderator (18:32):

I do have some other questions, but I'm thinking that, given the time, I'm wondering what the audience questions are. Amy, have there been any particular questions that stand out that we can take at the top?

Amy Goldstein, Alliance to Advance CIPM (18:47):

Yes. Thanks, Cindy. And thanks to all of you. This is just fascinating, and the chat is strong in people appreciating all of this information.

Amy Goldstein, Alliance to Advance CIPM (18:58):

There's a number of questions. Let me start with one that came related to massage. This question is from folks at the American Massage Therapy Association. When asked which providers pain patients would like to see but cannot because of barriers, massage therapy is at the top of the list. Likewise, massage is covered by Medicare Advantage but not traditional Medicare. How can we improve states' awareness and utilization of massage therapy as a non-opioid pain treatment for Medicaid patients?

Cindy Steinberg, Moderator (19:38):

Okay. I'm going to go to Kirk first to answer that one.

Kirk Williamson, National Governors Association (19:43):

Oh boy. We do review the evidence for massage therapy in the report. It is helpful for certain conditions, but I would note it's not a silver bullet, just like opioids are not a silver bullet. A lot of

what we talked about or discussed at the round table was the need to reorient how we think about pain and shifting from alleviating pain in the near term to restoring functionality and empowering people to go out to work, to live their lives, to take a walk with their grandkids.

Kirk Williamson, National Governors Association (20:24):

To the coverage decision, Medicare Advantage, like MCOs, they have a little bit more broader flexibility than what is provided through maybe Medicare part A or part B, but I think that those decisions need to be tied to mental health parity. We need to recognize that it's going to take a shift in someone's mind to how they think about pain, how they experience their activities of daily living, and massage is one tool, but it also needs to be paired with psychotherapy services and really working with the patient to understand the drivers of their pain. Hopefully it's one tool in the toolbox that plans are looking at, that federal government's looking at, states are looking at, but I would say it's probably not a silver bullet, but it is one tool in the toolbox.

Cindy Steinberg, Moderator (21:14):

Thanks, Kirk. David, I'm wondering if we could follow up with you. Do you have a different perspective on that question or something to add? Of patients in the survey we found, most want massage, but we also know that's almost never covered. What would you do to change that from a payer perspective?

David Elton, United Health Group (21:41):

Again, I'll offer you my opinion, as opposed to the formal UHD position. Massage is something we're looking at. Employers and their members are wanting this massage benefit for good reasons that we've talked about today.

David Elton, United Health Group (21:55):

And then we distinguish between the soft-tissue-based manual therapies that PTs, chiros, other providers provide today and is covered today. Then there's a line into, quote, massage benefit. When we talk about coverage, it's not only covering the service, but it's all the infrastructure that goes with it. What providers are qualified to deliver this service? What's their training? Is there licensure and malpractice infrastructure to build a network and vet providers so when consumers go, they know they're going to a licensed provider with malpractice insurance in a setting that meets minimum ADA standards?

David Elton, United Health Group (22:34):

So, coverage is actually really a complex topic. Very few would disagree with the notion that massage therapy is beneficial for people. It's how you move that to a covered benefit and bring in all the infrastructure that goes with it that needs to be solved for. I'm not as well versed in the whole licensing infrastructure for massage therapy in all 50 states across the country and how uniform are the standards and how might you vet that. Are massage therapists populated in CAQH so there's a source of provider data?

David Elton, United Health Group (23:07):

This is a number of elements, Cindy, that go with the issue of coverage that, in my mind, still need to be solved for, but the modality itself, super beneficial.

Cindy Steinberg, Moderator (23:19):

Okay, great. Thanks, David.

Interactive Discussion, Q&A

Matt Salo, Nat'l Association Medicaid Directors (23:22):

If I could jump in there -

Cindy Steinberg, Moderator (23:23):

Absolutely.

Matt Salo, Nat'l Association Medicaid Directors (23:23):

... and just make some wrapping-around comments. We often say, "Elections have consequences." Coverage decisions have consequences too. When Medicaid or Medicare or any big payer comes along and says, "We are now covering X," that creates significant ripple effects, some of which are very good. You get more access to X. People who are doing X are going to get paid more. But it also does tend to create ... If all you're doing is focused on a service or a modality, it creates people trying to maximize that. This is just basic. I'm not blaming anybody. This is economics. This is capitalism at work. When you create a revenue stream for something, you're going to drive a lot of people who try to focus on that one thing.

Matt Salo, Nat'l Association Medicaid Directors (24:31):

One analogy is, as we've struggled in the past to think through how are we treating autism, and then CMS came along and said, "Every Medicaid agency must cover autism, this defined applied behavioral therapy services," and left it out there: "This is a coverage decision." What we saw was costs just absolutely exploding with very little connection to those costs and those additional treatments actually creating better health, actually fixing something. Rather it was just like "I'm going to follow the money."

Matt Salo, Nat'l Association Medicaid Directors (25:16):

That's why I just say you've got to be careful about just saying, "We're covering X. Mission accomplished. Let's go home." Rather, and I think a number of other people have really hit on this, it's how are we thinking more holistically about the individuals? Because massage therapy may be good for me and not you, and equestrian therapy may be good for you but not me. I think the key is to really empower somebody to say, "We're going to figure out what it is that's going to help Cindy get back on her feet physically and emotionally." That may be a little of this, a little of that. It's a social determinant health issue.

Matt Salo, Nat'l Association Medicaid Directors (26:02):

That's why I think it's important to say Medicare doesn't do this. Medicare Advantage does. That's the analogy here in Medicaid too. Medicaid may not do this, but plans, MCOs, are going to have the flexibility to say, "We're closer to you as the patient. Let's try to figure out what it is that you need and craft a personalized plan of care that will hopefully be data driven but will be flexible enough to be focused on an outcome," as opposed to, "We're covering X service and our job here is done."

Cindy Steinberg, Moderator (26:43):

Matt, that was a great answer to remind us about the holistic approach, because we do want to go back to that. Certainly, like you're saying, one modality might help somebody but not somebody else, so that managed care approach I think is really we're pointing in that direction. And it's a good point you also made about the economics of doing this and how that changes the availability. Thanks very much for that.

Interactive Discussion, Q&A

Cindy Steinberg, Moderator (27:12):

Nicole, did you have anything to add?

Amy Goldstein, Alliance to Advance CIPM (27:13):

Cindy?

Cindy Steinberg, Moderator (27:14):

Yes, go ahead.

Amy Goldstein, Alliance to Advance CIPM (27:15):

Apologies for interrupting you. We won't be able to do this very often, but Janet Kahn has something she'd like to mention around this. I think it's pertinent to this discussion. She is a massage therapist working at the comprehensive pain program in Vermont that is a partnership with Blue Cross Blue Shield and the University of Vermont Medical Center. Vermont Medicaid was in the conversations to potentially be covering this program.

Amy Goldstein, Alliance to Advance CIPM (27:45):

I am going to hope this works. I'm going to click answer live and see if that allows Janet to be able to just quickly give some comments. Janet, are you available now? Let's see. Maggie, can you help me find Janet and make her available, Janet Kahn, if I didn't do that correctly?

Janet Kahn, PhD, LMT (28:13):

Okay. Am I audible now?

Amy Goldstein, Alliance to Advance CIPM (28:15):

Yes, we can hear you.

Janet Kahn, PhD, LMT (28:16):

Great. This is obviously going back to the issue of massage therapy. What I wanted to say is two things. One is it's clear from my personal conversations, and also I've seen one survey, but I can't locate it right now with my computer, that one of the concerns about massage therapy by both payers and potential referrers, PCPs who might be referring, is the relatively short duration of the basic training which is the requirement in most states for licensure. I want to say to the American Massage Therapy Association, which I know is a partner in this conference, that I think the AMTA and the national certification board should take some responsibility for creating what is now being left to private entities to create, and that is some specific training, both certification in pain management and in clinically based massage, so that people really become prepared to operate in the context of a clinical team. It's really that that I wanted to say.

Cindy Steinberg, Moderator (29:37):

Great. Thanks very much. That was great that we could go to Janet. Thank you, Amy.

Cindy Steinberg, Moderator (29:44):

Some of this will be really interesting to approach in the afternoon panel with Sherry Lane, because we all know that, for chronic low back pain, there is going to be Medicare coverage for acupuncture. So it's going to be interesting to see both the economics of that, the accessibility of that, and we do know that people who are severely disabled by pain, which is

largely our population, do have access to Medicare. It will be interesting to see what changing that one modality has.

Cindy Steinberg, Moderator (30:25):

Amy, are there any other questions that pop up? I definitely have some other questions I wanted to ask, but I wanted to see if there are ones that you think would be interesting for most of our audience.

Amy Goldstein, Alliance to Advance CIPM (30:43):

A general question around the level of evidence and research, stating that the claim that we're always looking for more data has been said for a long time. That often contributes to a lack of access. There is so much evidence available now as we're seeing large payers include these therapies in their care. I think people are wondering what's really the deal there with research and data and what advice around helping researchers who intentionally want to find the right research to get there.

Cindy Steinberg, Moderator (31:33):

That's interesting because it's very much in line with the question I was going to ask that I think is even more specifically at that. It's for David. David, eliminating work that you and your colleagues at United Healthcare have done, you seem convinced that coverage for comprehensive pain care with a focus on non-invasive complementary care is really the best approach for patients and payers, yet we hear most payers are reluctant to move towards covering these treatments, largely because of this evidence issue. What would you say to the CEOs of payers and the directors of Medicaid programs to convince them that this is the way to go like United Healthcare is convinced?

David Elton, United Health Group (32:18):

Well, how much time do we have left? This is a big one.

Cindy Steinberg, Moderator (32:23):

About 10 minutes, but I want to get some more questions in.

David Elton, United Health Group (32:33):

Again, I can share just what my experience is. For the typically covered therapies, PT, chiro, acu, mental health, most commercial insurers are covering these therapies. Naturally, coverage comes with some limitations. Chiro's typically 20 to 24 visits. PT's 60, acu 10 to 15 visits. They're selective UM. Look, there's real fraud, waste, and abuse that happens in these therapies. As a fiduciary protecting sponsors, whether they be government agencies or employers, there's a need for UM in this space. There is some unbelievable activity that happens out there, so UM is needed.

David Elton, United Health Group (33:20):

From a payer perspective, we've convinced ourselves. I've been trying to pay attention to questions, a lot of questions on data and is there an abundance of data. Yeah, there really is. We've convinced ourselves through years of heavy analytic work that these therapies spin off a number of cost, quality, health, and wellbeing benefits that more than offset the cost of the services themselves. That data is settled science in our view. In fact, we've been told, "Stand

down on spinning up more analytics on this." We already have a very clear point of view on the value of these therapies.

David Elton, United Health Group (33:55):

Some of the other ones we've been talking about, yoga therapy, massage. We've been intensely interested in studying these, and we have some work underway to understand the value of these therapies, which then informs coverage.

David Elton, United Health Group (34:07):

Other entities: VA, man, they're doing some outstanding work in this space. We're going to hear from Medicare later on some innovative work Medicare is doing to expand coverage in this space. I think payers are there, that there's values in these therapies and they should be covered.

David Elton, United Health Group (34:20):

I'm a little bit random here, but what would I say to the purchasers? At this point, and setting aside the random, poorly executed, RCT, randomized trial, which are still happening and really frankly just introduces static into the environment that's not helpful, I really think there's near universal agreement on the benefits of these non-pharma therapies.

David Elton, United Health Group (34:46):

I think it was Matt earlier that just raised the dynamic that budgets are type. Reducing cost is the focus, and there's a lot of competing priorities. You add an autism benefit that dramatically increases the budget for a state and you want to go to them and talk about covering massage therapy now, wow, that's a tough conversation to have. The economics are really what drives the attention, but my sale to a CEO or an employer would be grounded in all the data that we have that demonstrates really the unquestioned benefit of these therapies, and it frankly is pretty black and white. And then you need to get over the hump. If I'm going to add this benefit, which translated in their mind is do a new line item with added cost on an already tight budget, you need to have patience, because the return for these therapies is not going to show up next quarter or next budget year. It's going to be two years plus to be able to prove a return on the investment that a CEO or a local government is making.

David Elton, United Health Group (36:02):

So, I don't have an easy answer. It's not an easy conversation to have. The data's clear. The benefits are clear. Budgets are tight. It takes patience to get a return on the investment you're making in these therapies. You have to have an innovative leader who's willing to take a two-year run at it.

Cindy Steinberg, Moderator (36:16):

One thing I would add to that is just the interesting nature of putting this group together, because I would say, with the slide that Nicole presented where patients in long-term severe pain, and most of the people answering that had spent 10 years looking for help, most want these complementary therapies, as we've seen, and what we've seen in David's data is that most of them are offered surgery or injections right off the bat, which are covered. Those are the most expensive treatments possible, and I know from the perspective of knowing hundreds of people living in chronic pain that isn't what they want first. There's such a cost-effective argument in that. When you look at David's data showing that surgery, injections, and medications are the things most offered yet Nicole's data of people with most experience living

with pain want complementary care, to me, that just makes a cost-effective argument right there, but we'd have to combine our work.

David Elton, United Health Group (37:39):

Hey, Cindy, one more just quick comment.

Cindy Steinberg, Moderator (37:41):

Yes.

David Elton, United Health Group (37:42):

[crosstalk 00:37:42] there's a number of researchers on here, and I've been pretty transparent with Amy that I think, and to your point exactly, the research in this space needs to open the aperture and not get so focused on pain control but look at total health and wellbeing, blood sugar control, pronamic markers of inflammation, and the ability of people in chronic pain just to be able to move more spins off these health and wellbeing benefits from BMI control, better blood sugar control, better control of inflammation, better mental health and wellbeing. That downstream, over one, three, five years, has health and wellbeing benefits that need to be quantified to justify the expense of adding this as a covered service. If you're just going to do it to look at offsetting reduction in opiate prescribing, there's just not enough money there to demonstrate the CBA. You need to look at the impact on diabetes and cardiovascular disease and other condition categories, which I think is real, and that's the space that we're pretty focused on.

Cindy Steinberg, Moderator (38:46):

What do you think about my argument about the surgery issue? Because I can't even tell you how many failed back surgeries we see in the pain space, yet those have got to be way more costly than covering massage.

David Elton, United Health Group (39:01):

Yeah. I don't know what the average episode cost for surgery is, $40,000. Average visit to a massage therapist is going to be, what, $50, $60, $70? I'd say it's under reimbursed, but that's where the market is. You can buy a lot of massage therapy for a $40,000 surgical procedure. When you look at the cost experience pre- and post-surgery in the one-year run up to and the one-year follow, in any case, the surgery's not that helpful, to your point, in the spine space. You can buy a lot of massage for that and keep people functional and have better blood sugar control and keep people more functional. I'm with you.

Cindy Steinberg, Moderator (39:42):

Yeah. Good point. I guess a lot of physicians, particularly surgeon groups, would not be with us, but that's what we're up against with something like that.

Cindy Steinberg, Moderator (39:51):

We still have a few more minutes left, and I had a question I'm just dying to ask Kirk. Unless, Amy, there's something that you think really comes to the top, I wanted to end with this question to Kirk, because it helps us make the rubber hit the road.

Amy Goldstein, Alliance to Advance CIPM (40:09):

You bet. I'm going to give that to you, Cindy. I just want to quickly say, though, no time for a question here, but with this last piece of discussion I think it highlights also the need for inter-professional education related to all these therapies, because, as Kirk said, it isn't a silver bullet of any one or another. This is a comprehensive approach, and all these things matter, and they matter when you have healthcare providers that understand how to work together. I just want to throw that in because I think that's imperative for us to stay connected with and how we can help on that end too. So please, go ahead, Cindy.

Cindy Steinberg, Moderator (40:49):

Great. Kirk, I was intrigued in your report about all these innovative strategies that specific states have used for expanding access to non-opioid pain management, everything from incremental expansion to Medicaid-managed-care partnerships to the health homes that you talked about to the waivers. Could you give an example of a particular state that has successfully used an innovative approach that you think is most easy to replicate in other states?

Kirk Williamson, National Governors Association (41:22):

Sure. With the caveat that none of this is very easy to do, I was most impressed probably from Rhode Island. They had an 1115 demonstration where they partnered with the MCOs to provide complementary approaches. Massage therapy was one. Acupuncture was another, chiropractic services to qualifying beneficiaries. In their analyses, NCOs examined those patients that were showing up in emergency departments four or greater times in a 12-month period and targeted those individuals to offer those services. At the end of the demonstration period, Rhode Island decided not to renew the 1115 demonstration waiver, but they did decide to continue the partnership with NCOs. They both cited reduce in emergency department visits, which we all know is highly costly. This generated a return on investment.

Kirk Williamson, National Governors Association (42:22):

I think it goes to show that health plans, and particularly Medicaid managed care plans, are very integral in this work. They provide coordinated care.

Kirk Williamson, National Governors Association (42:34):

I think we also need to remember the pain community, it's not monolithic. Individuals, they may come with trauma. They may have PTSD. That won't be solved by adding massage therapy as a benefit. We have to take a whole-person approach. I think by offering the services with the most or the most robust evidence and providing a nurse care manager to coordinate that care and to make that patient feel like the system is working for them, I think that is where you're going to find success.

Cindy Steinberg, Moderator (43:14):

Great. Thanks a lot for that example. You know I'll be following up with you and getting the Rhode Island contacts at the end of this.

Kirk Williamson, National Governors Association (43:22):

Happy to, yeah.

Interactive Discussion, Q&A

Amy Goldstein, Alliance to Advance CIPM (43:24):

Thank you, Cindy. Thank you so much. You did a fantastic job moderating this session, really. Hats off to you. And thank you.

Cindy Steinberg, Moderator (43:33):

Hats off to the speakers. The speakers were fantastic. Thanks all of you, and Amy, for putting together this set of speakers. I think it was just brilliant, so thanks.

Amy Goldstein, Alliance to Advance CIPM (43:43):

Absolutely. This is exciting to put together. When all get in the same room, it really does just illuminate different things. It really triggers a lot of different opinions and thoughts. We appreciate everyone seeing this through our chat feature and Q&A.

Amy Goldstein, Alliance to Advance CIPM (44:02):

We now have a brief break. We will start again at 1:15. Please log in just a few minutes early. Matt Taylor is going to grace us with a few minutes of breathing to center us for this long and productive day we're having together. So, we'll see you in a few minutes. Thanks, all.