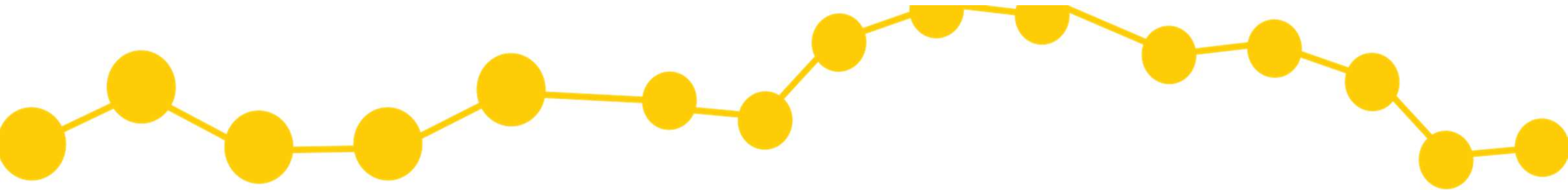


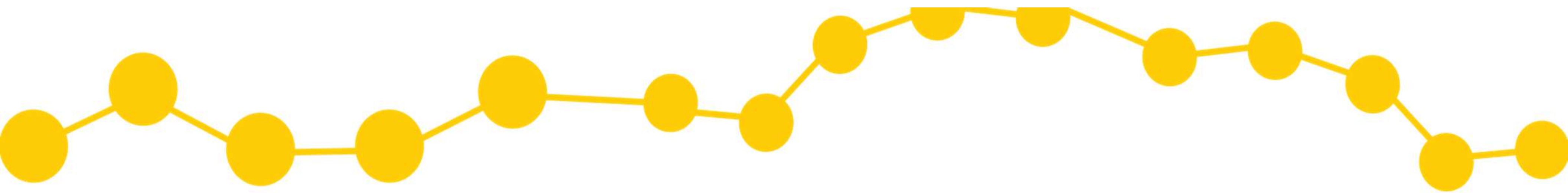
Advocacy: Local, State & National Policy Changes

The Imperative for Integrative Practitioners to Engage in Policy & Advocacy

January 16, 2023 | 10:15 AM-11:15 AM

Andrew Weil Alumni & Associates Conference

Tucson, Arizona



Thank You

THE UNIVERSITY OF ARIZONA
Andrew Weil Center
for Integrative Medicine

https://painmanagementalliance.org/Advocacy-Engagement/

Batting Cleanup

Connecting the dots so that you can translate your passion into action

Amy Goldstein, MSW

***Director*, AACIPM**
***Founder*, Healthcare Collaboratives, LLC**

Most recently Director, Advocacy & Alliance Development, Academy of Integrative Pain Management (AIPM) before it closed in 2019 after 30 years.

Founded Healthcare Collaboratives, LLC in 2019 to continue mission-driven work.

In the healthcare field 25 years, advocating, building alliances and changing systems every step of the way. Promoting person centered care for people living with kidney failure, cancer, chronic pain, rare diseases, substance use disorder, mental health issues, multiple sclerosis

Alliance to Advance Comprehensive Integrative Pain Management

Website: painmanagementalliance.org

Social Media: @AACIPM

Agenda

1. Practice Gap / Learning Objectives
2. Background, Alliance to Advance Comprehensive Integrative Pain Management
3. Why is Advocacy Important?
4. Access Challenges
5. Low Back Pain Example
6. Advocacy – Fostering Collaboration
7. State Policy
8. Federal Policy
9. Advocacy Ideas for When You Go Home
10. Q&A

Practice Gap Being Addressed

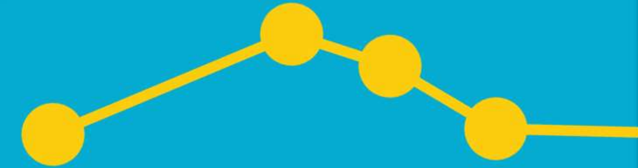
- The use of integrative care has been increasingly recommended by policymakers at local, state, and national levels, but often reimbursement for this type of care remains elusive.
- Most pain-related clinical guidance points to first-line use of non-pharmacological and team-based therapies, yet extensive challenges make attaining this care difficult and make addressing this gap highly complex.
- Advocating for improved policies is a key lever for change, but this is not effectively taught or understood despite the ethical obligations to engage in these efforts.

Learning Objectives

After this session, participants will be able to:

- Understand that policies at the local, state, federal, and health system levels affect access to integrative care.
- Identify the gaps that exist between guideline-concordant care, and service delivery and payment.
- Advocate for policies that will improve access to person-centered, integrative care.

AACIPM



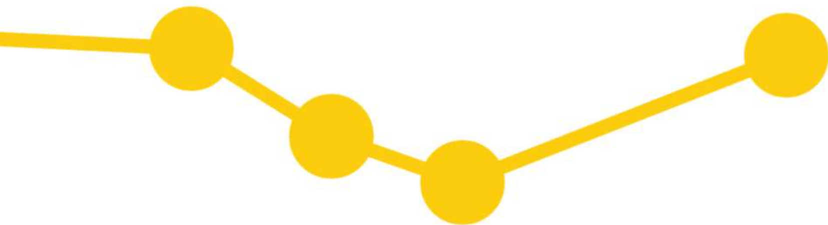
The Alliance to Advance Comprehensive Integrative Pain Management is a multi-stakeholder collaborative.

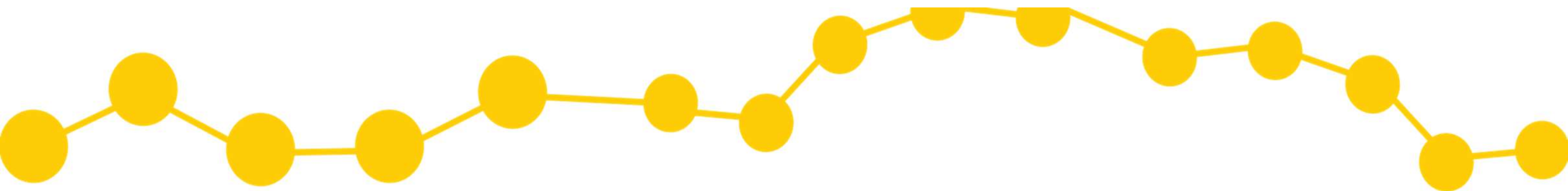
AACIPM is not an organization. It is a nimble, grant-funded initiative born from past advocacy efforts of the American Academy of Pain Management, later called the Academy of Integrative Pain Management.

Stakeholders:
People with Pain | Payers | Purchasers | Healthcare Providers | Academia | Government Agencies | Advocates | More

Outputs:
Strategic Digital Communication | Policy Advocacy | Education & Awareness | Coordinated Responses

AACIPM CONNECTS THE DOTS TO ADVANCE EQUITABLE, WHOLE PERSON, MULTI-MODAL PAIN CARE.





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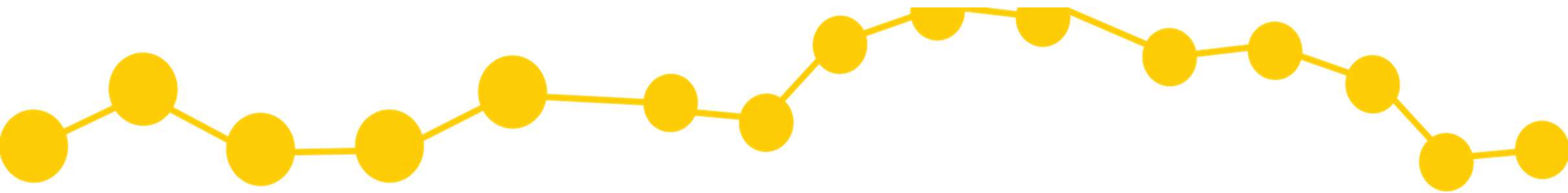
Primary sponsor for the AACIPM Initiative is:

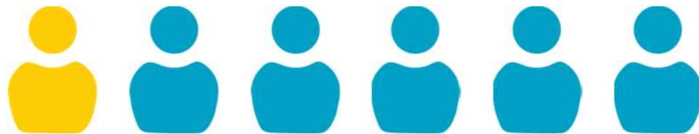


Thank You

Special thanks to the fiscal sponsor for this project:

Why do we need AACIPM?

Chronic pain is the #1 cause of disability globally.



1 in 6 Americans lives in pain every day.

Billion in Expenses & Lost Productivity

Multimodal Care is the Gold Standard but **Not Accessible** for Many, Especially Underserved Persons

CIPM TOOLBOX

IMPORTANT FACTORS

Trauma-Informed Care
Education
Risk Assessment
Stigma

SOCIAL FACTORS

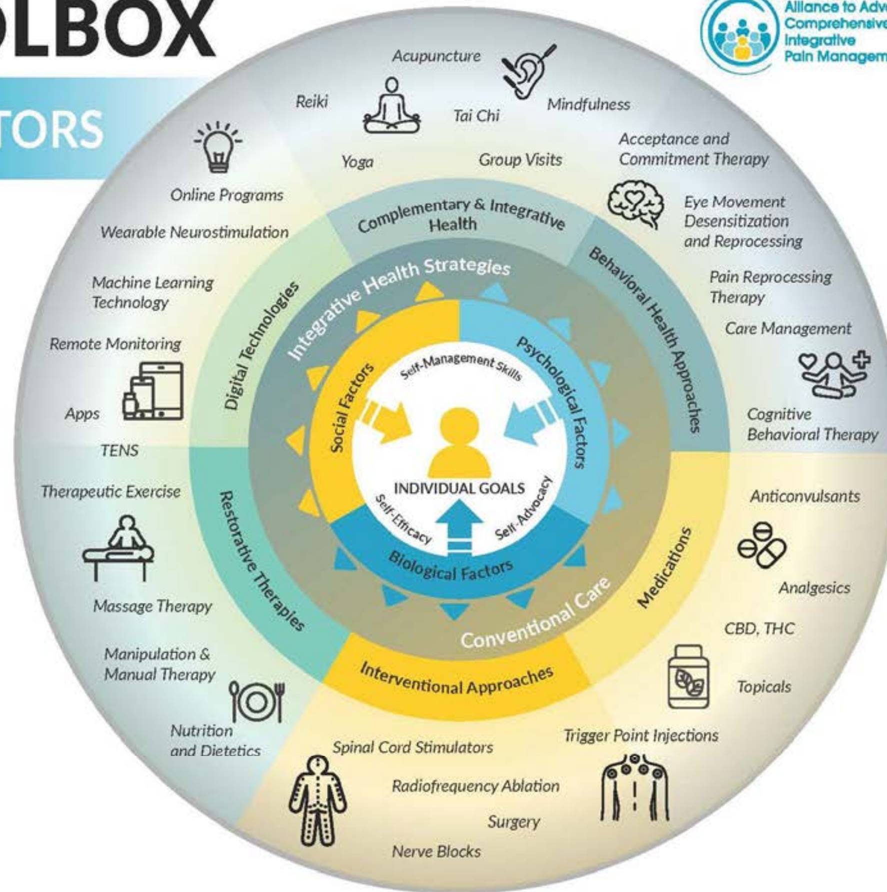
Environmental
Stigma
Cultural
Racism
Discrimination
Housing
Transportation
Food Security

PSYCHOLOGICAL FACTORS

Mood
Stress
Coping
Trauma
Isolation

BIOLOGICAL FACTORS

Age
Injury/Past Injury
Illness/Diagnosis
Neurologic
Genetic
Hormones
Nutrition
Metabolic Health



AACIPM offers this visual tool to illustrate and increase awareness of the various therapies that may be a part of whole person, multidisciplinary, multi-modal, evidence-informed, integrative pain management. This does not represent an exhaustive list of interventions, and not all interventions will be covered, covered without limits and/or without patient out-of-pocket cost." Most services must be provided by a licensed or credentialed health care provider or community-based service provider.

https://painmanagementalliance.org/what-is-cipm/

The Relevance of Pain Policy in Integrative Health and Medicine

The information we will discuss about integrative pain management and pain policy is also relevant to supporting integrative health and medicine in general.

Kudos to You!

You already have a deep commitment to patient care & changing the paradigm.

You may not have signed up for an advocacy role, but...

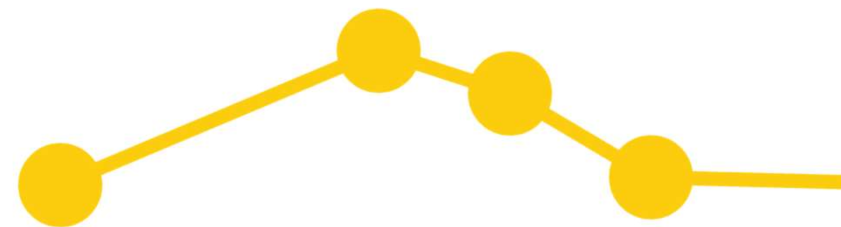
Your ability to do this work—and to meaningfully affect patient access—hinges on your engagement in advocacy.

Why is Advocacy Important?

- **Ethical obligation.** We must advocate for all members of society.
- **Unique Expertise.** Your trusted perspective can contribute to the formation of healthcare policy.
- **Lack of Existing Education.** Policies and policy formation related to integrative care are not effectively taught in professional schools.
- **Access is Essential.** We must address the lack of availability for treatment in our communities and beyond.
- **Equity as Cornerstone.** Understanding disparities, inequities, social determinants of health.

Why is Advocacy Important?

- Patient
- Local
- State
- Federal
- Global



Healthcare Providers as Patient Advocates

Many of you are already doing this daily

- Insurance appeals
- Learning about patient's values and preferences
- Listening/addressing SDOH with health care team to help connect patients/families with needed resources (e.g., transportation, legal)
- Discussing self-management (e.g., concept not clear to many but they likely are doing some)
- Engaging in shared decision-making (e.g., balancing your knowledge, patient preferences, current evidence, risk/benefits)

Common Concerns & Misperceptions

“If only…

…more non-pharmacological therapies were covered.”

…doctors, nurses, pharmacists, dentists, etc. were taught about integrative, whole person care in schools.”

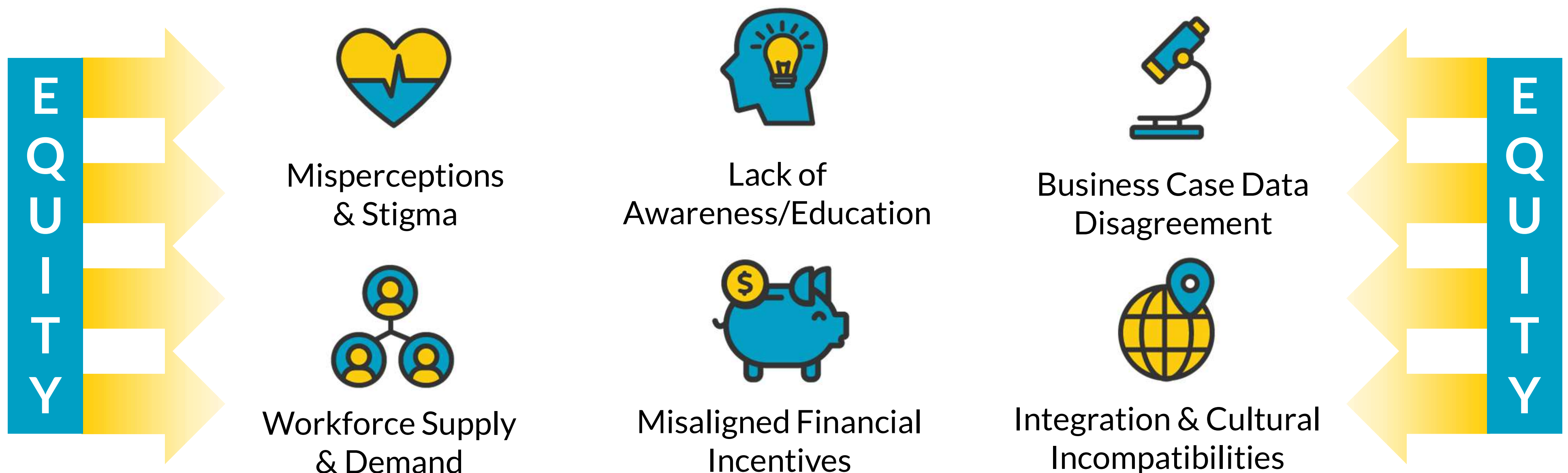
…my patients engaged more around self-management.”

…integrative therapies were conveniently available.”

For every complex problem, there is an answer that is clear, simple, and wrong.
-H.L. Mencken

CHALLENGES

Why is evidence-based, guideline-concordant, multimodal care **inaccessible** for many people, especially those who are underserved?



Misperceptions and Stigma

- Individuals with pain often face both hidden and obvious stigma from family, friends, coworkers, and the health care system.
  - Intersection of pain, SUD, mental health challenges, ACEs
- Ex. Racial and ethnic stereotyping by physicians can affect the way pain is assessed and managed. Pain assessment is subjective, and the way it's assessed can interfere with how it is treated.
- Debunk stereotypes, myths and stigmas:
  - *"Blacks' skin is thicker than whites'"* (NPAS study found 40 percent of 1st and 2nd -year medical students surveyed believe this)
  - *"MAT is substituting one drug for another"*
  - *"Anyone can change if they try hard enough"*
  - *"catastrophizing"; "crazy"; "drug seeker"; "doctor shopper"*

Lack of Education and Awareness

Understanding is key to cultural transformation.

Healthcare Professionals

Barriers

- Pain is complex and integrative care requires a solid understanding of all options. Most med schools have a median of 9 hours of formalized pain management education.
- Problematic constructs related to chronic pain often start in training and are perpetuated into practice (increasing negative opinions of pts w pain leading to decline in empathy)
- Core competencies in interprofessional and pain care generally do not inform undergraduate/graduate curricula, even in pain medicine.

Facilitators

- Early clinician education (e.g., scalable medical education curricula)
- Collaboration

Lack of Education and Awareness

Understanding is key to cultural transformation.

People with Pain & Members of the Public

Patient Education Obstacles

- Poor understanding of pain
- Confusion from misperceptions and focus on pharm therapies
- Skepticism about efficacy and availability of nonpharm therapies
- Lack of nationwide self-management programs and related support

Facilitators

- Need a national awareness campaign to counter misperceptions and stigma
- Momentum with policy changes to include nonpharm in Medicaid, Medicare, etc.
- Collaboration among stakeholders

Resources: National Pain Strategy; HHS Best Practices Pain Management Task Force Report

Dr. Robert Bonakdar's slides/resources https://painmanagementalliance.org/acimh-congress/

Business Case Data Disagreement

- Wide Variations in Clinical Practice
- Perception of Scalability and Sustainability
- Need for pragmatic trials, comparative effectiveness studies, healthcare utilization data, and cost analyses, in addition to randomized controlled trials.
- Addressing Regulatory Constraints (e.g., expanding telehealth, licensed providers oversee unlicensed)
- Address Access for Underserved (e.g, medical group visits, medical/legal partnerships, innovative partnerships, nutrition)

Examples: How AACIPM is Addressing These Challenges

Focus on Employers/Self-insured groups to change benefit designs

AACIPM partners with payors, purchaser/business coalitions, providers, researchers, and patients to create business cases and a repository of practical tools to aid in implementing change.

National Alliance, AACIPM partner to help employers address pain management for employees

More than half of covered lives are through employer-sponsored health plans.

Mar 2020: Focus Group with AACIPM and Midwest Business Group on Health

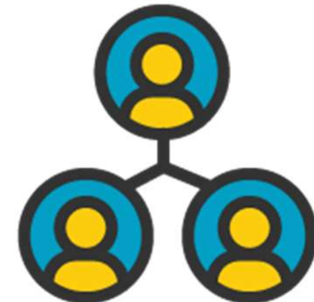
Pictured (left to right): David Elton, United Health Ventures; Alyssa Wostrel, AACIPM; Leah Hole Marshall, Washington Health Benefit Exchange; Amy Goldstein, AACIPM; Daniel Blaney-Koen, American Medical Association; Christine Goertz, Duke University; Lance Luria, Mercy Care Management; Kavitha Reddy, Veterans Health Administration

Not Pictured: Robert Bonakdar, Scripps Pain Management Center

Workforce Supply and Demand

The Problem:

- Overall provider shortage; unmet needs
- Extreme shortage of BIPOC providers (e.g., zipcode data)
- Lack of training and interprofessional knowledge re: team-based care
- Substantial geographic variation



Need: Innovative Partnerships to Improve Access to Guideline-Concordant Care:

- Employees:
  - Onsite health clinics (convenient access; reduce travel burden; employee retention)
- Underserved / Rural Access:
  - AHEC, AHEC Scholars program
  - Ex. People's Community Clinic relationship with local acupuncture school

– Equity Question: Are there different care experiences for individuals with spinal disorder based on socioeconomic disadvantage and primarily non-white population?

- **Data Tools**: HRSA Health Workforce https://bhw.hrsa.gov/data-research/access-data-tools

Health care providers (HCP) per 1000 population

2. The **lowest availability** of chiropractors (DC) was in zip codes with high deprivation and a primarily non-White population.

3. The **highest availability** of DCs was in middle income primarily non-Hispanic White (NHW) zip codes

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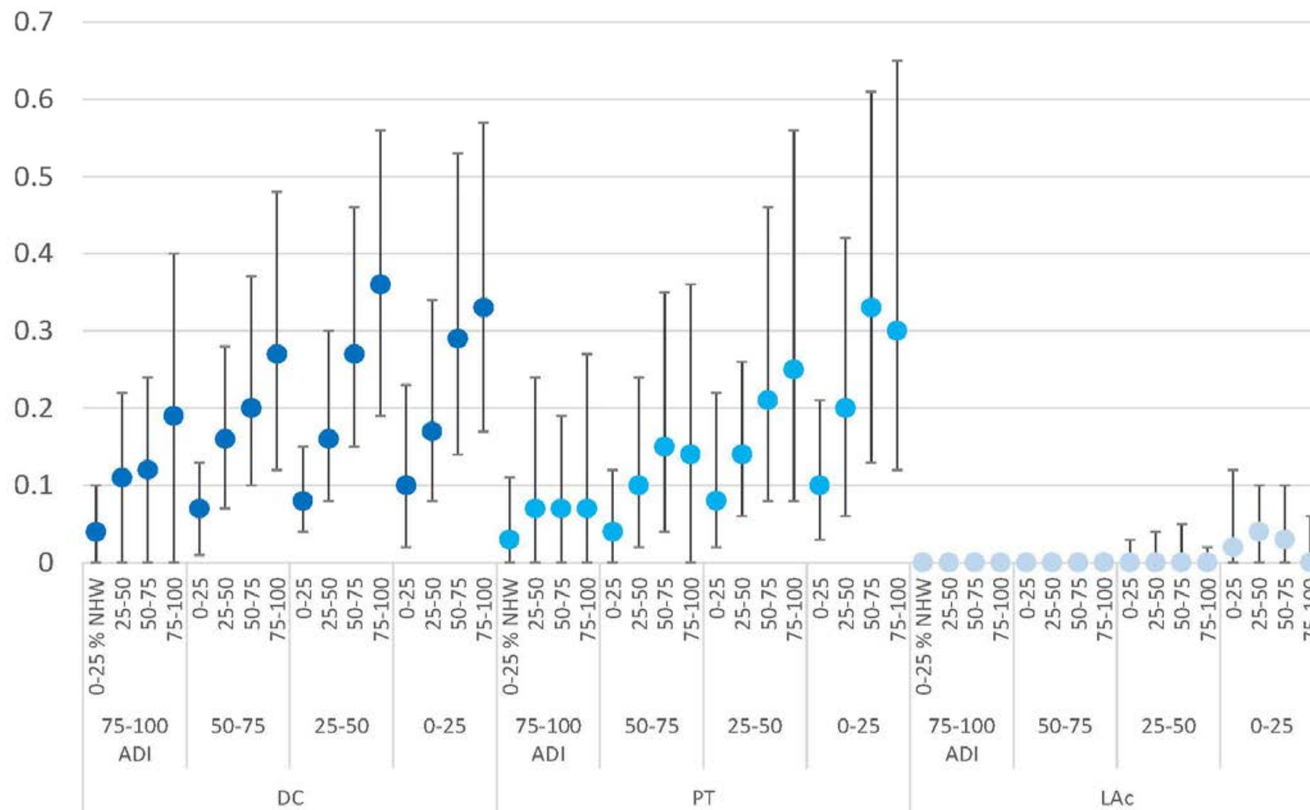
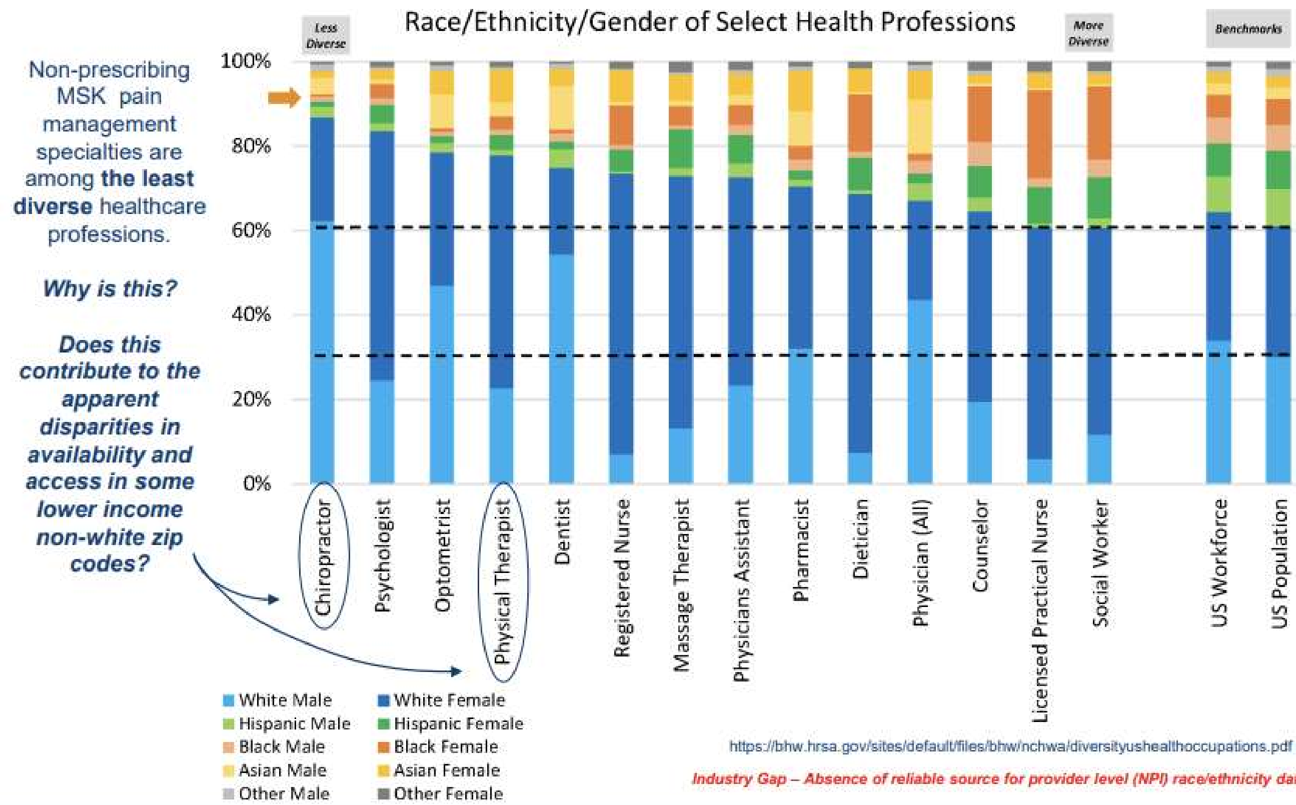
Optum ADI and Race/Ethnicity Data on Availability of DC, PT, LAc



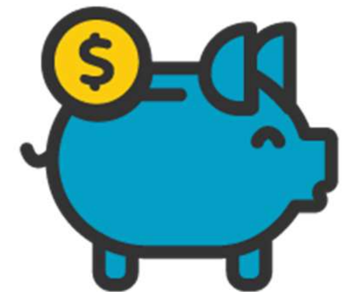


https://painmanagementalliance.org/wp/wp-content/uploads/2020/09/Equity-in-Access-Symposium-Data-about-Access-to-Pain-Therapies-Based-on-Zip-Code-9-24-20.pdf

Misaligned Financial Incentives

Achieving value-based care requires creative adjustment to current payment structures.

- Provider/Payer partnerships and other non-traditional partnerships are integral to increasing access to a variety of evidence-based therapies in all geographic locations.
- Flexible Payment Models
  - Fee-for-service can make access to a multimodal approach quite difficult, while bundled payment models may be difficult to sustain.
  - Subsidizing unreimbursed services with reimbursed ones (e.g. linked visits)
  - Adopting alternative payment models, such as bundled and capitated payments (e.g., UVMC and BC/BS of Vermont)
  - Reducing, eliminating PA requirements and co-pays for some integrative services (e.g., zero co-pays for PT, chiro)



Over time, as we learned more about one another's areas of expertise, we have adopted a common language that reinforces the value of a multimodal, interdisciplinary approach.

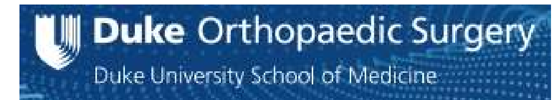
Real time collaboration leveraged synchronously among multiple disciplines is the key to interdisciplinary optimization of patient care and outcomes.

Excellent Examples from a Growing Many

Dr. Diane Flynn, a physician in Madigan's Interdisciplinary Pain Management Center at Joint Base Lewis-McChord, Wash., discusses available pain management treatments with her patient. Photo credit: Ryan Graham, Madigan Army Medical Center.

Providing individualized pain care during COVID in West Virginia (WVU)

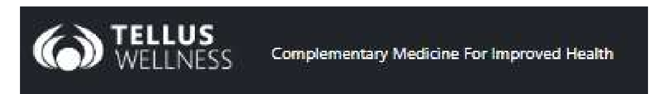
Putting the "multi" in multimodal care (Inner Atlas)



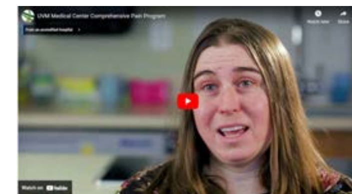
A PAIN MANAGEMENT DELIVERY SYSTEM THAT FOCUSES ON FUNCTION

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

Ex. In 2020 NGA Report, Expanding Access to Non-Opioid Pain Mgmt (Swedish Hospital)



HEALTH



Integration and Cultural Incompatibilities

Integration of conventional clinical care and complementary and integrative health is complicated.

- Example - Oregon Medicaid Back and Neck Pain Policy (PCORI study)
  - 2 guidelines; primarily focus on expanding NPT services and ability for such to best support sought improvements in patients' pain-related functioning
  - “trying to model and understand one or more complex adaptive systems and, as such, the inter-relationships and how and when sensibilities/needs/priorities of the various constituency groups align or mis-align is where most of the opportunities and challenges lie.”
- Example - Tellus Wellness innovative narrow network
  - Network of chiropractors, acupuncturists, nutritionists, massage therapists, health coaches, and naturopathic physicians.

- Differences in provider approaches; cultural barriers (e.g., not in same health system or EHR, variance in education/clinical experience)

How AACIPM is Addressing These Challenges

AACIPM is focused on connecting the dots.

Example: Low Back Pain

Problem:

- ✓ Leading MSK condition
- ✓ Leading cost driver
- ✓ Everyone is vulnerable

Climate:

- ✓ American College of Physicians Guidelines on Low Back Pain (2017) recommends non-Rx options
- ✓ Patients want these options

"…patients should treat acute or subacute low back pain with non-drug therapies such as superficial heat, massage, acupuncture, or spinal manipulation."

The American College of Physicians is the largest medical specialty organization in the United States.

Guidelines agree on use of integrative therapies – people also want it

Why is it not happening?

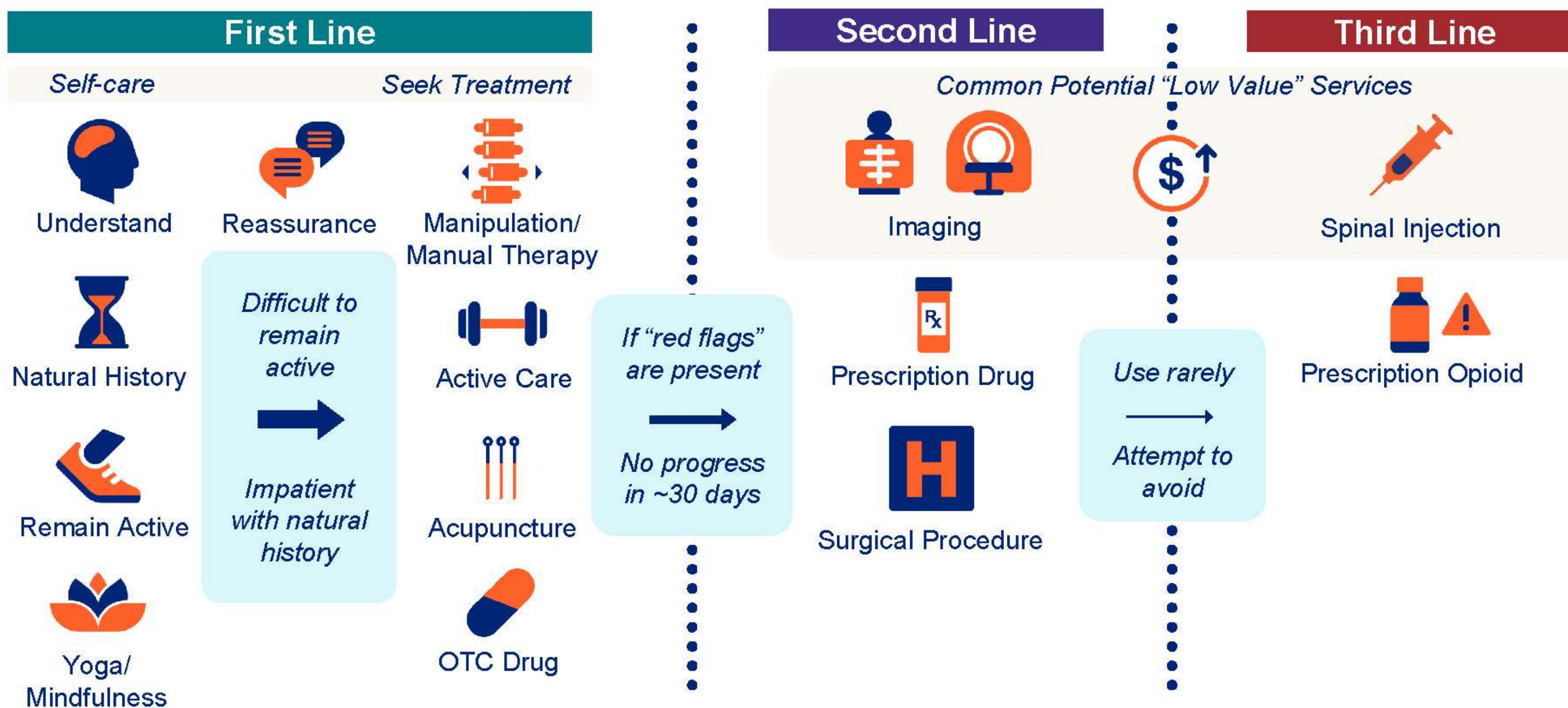
Example: Low Back Pain

American College of Physician Guidelines
http://annals.org/aim/fullarticle/2603228/noninvasive-treatments-acute-subacute-chronic-low-back-pain-clinical-practice

THE LANCET

Lancet Low Back Pain series
https://www.thelancet.com/series/low-back-pain

Clinical Practice Guidelines For Low Back Pain



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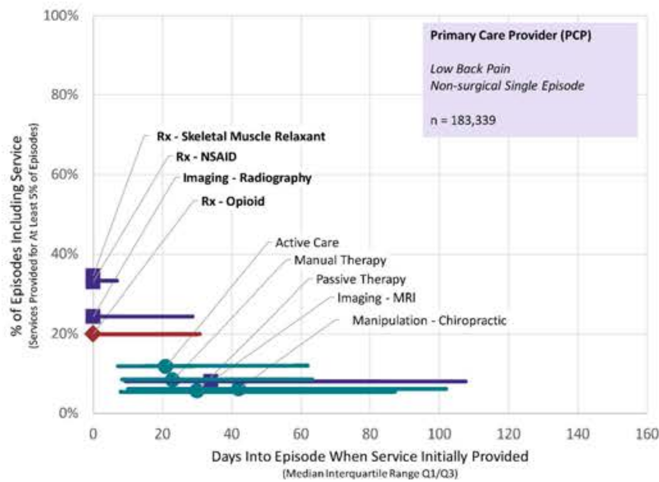
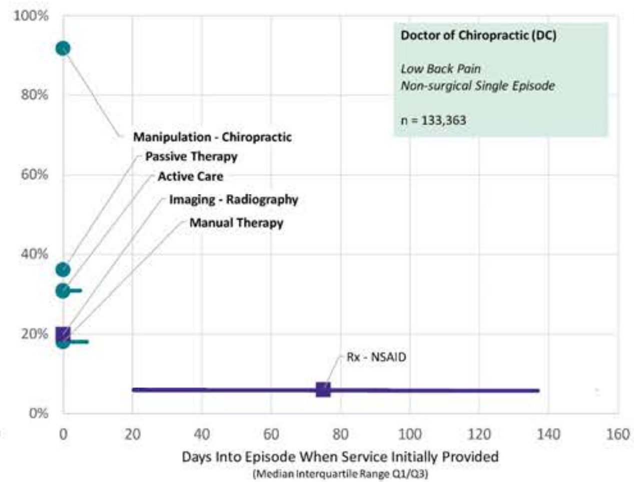
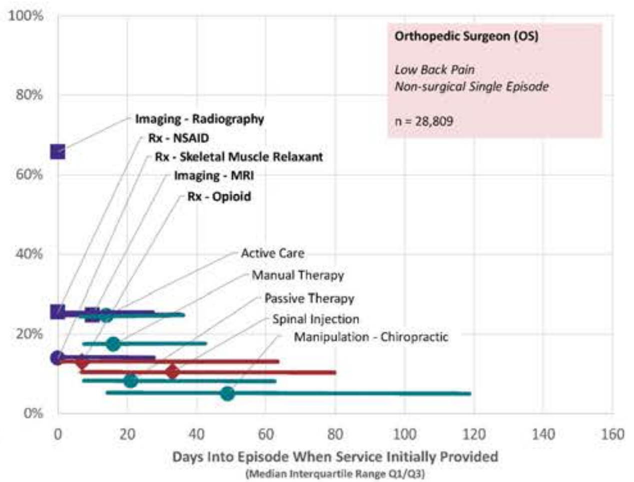
Example: Low Back Pain

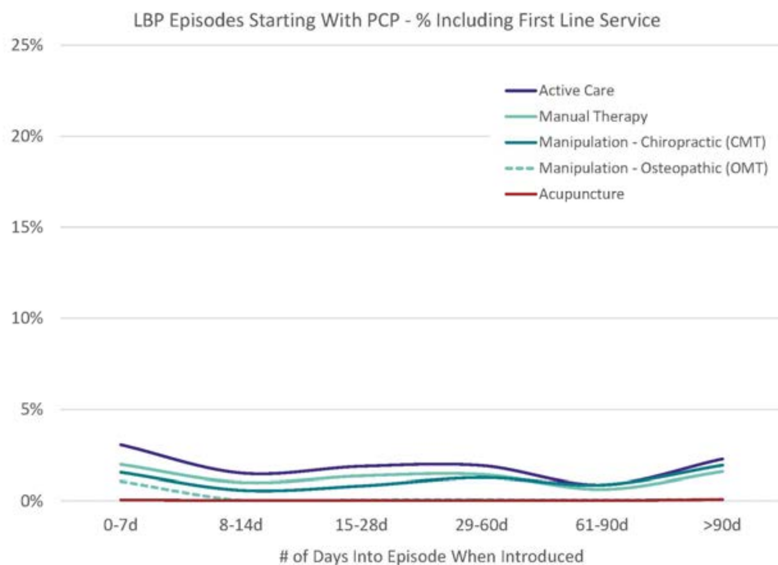


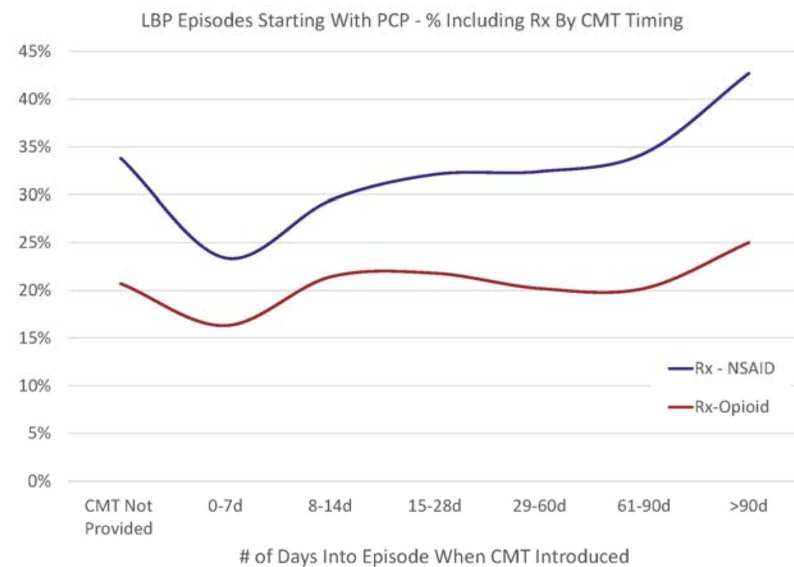




DCs have LBP total episode of care attributes that are **best aligned with high quality clinical practice guidelines**

Example: Low Back Pain

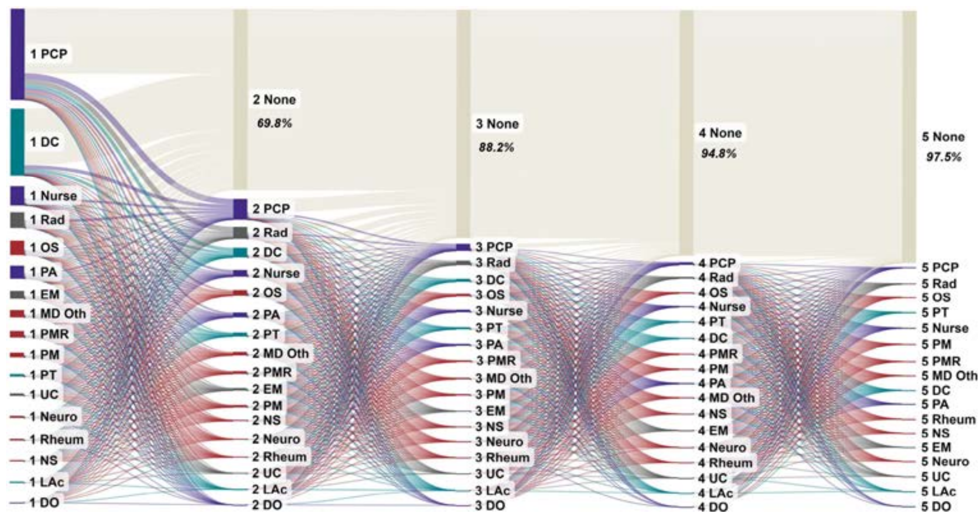




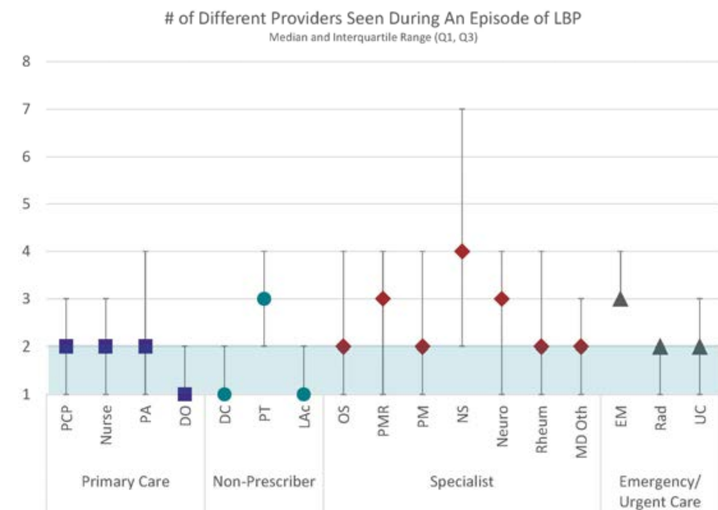
<5% of LBP episodes starting with a PCP **include a first-line service in the first 14 days**

For LBP episodes starting with a PCP, **Rx avoidance benefits of CMT are only present if provided in the first 7 days of an episode**

Example: Low Back Pain



The management of LBP is fragmented, with individuals having **to navigate many types of different health care providers either directly or by referral**



Individuals with LBP initially contacting a DO, DC or LAc **go on to see the lowest number of different providers**

Example: Low Back Pain

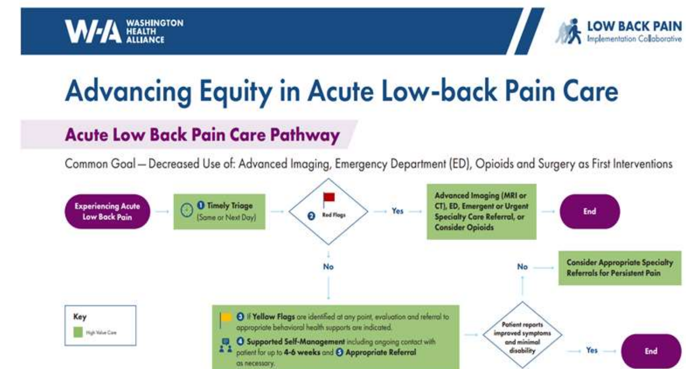
In Summary: UHG series of papers, a commercially insured population with continuous coverage, ages 18+, very large network, low/no out of pocket costs

- Geographic Variation
- PCP referral for non-Rx services is very low; provided late after Rx, imaging, interventional procedures
- Spine management is very fragmented; order of who a patients sees first or last matters
- Efficiency with chiro manipulation, active care, manual therapy, acupuncture dose/response; (1-3 visits article)
- Some health systems require an MD referral for PT which can create unnecessary barriers to care

Example: Low Back Pain

Implications for Action:

- Push back on payer policies; take good notes; record your experiences
- Assess barriers in your own system by asking more questions (e.g., direct access)
- Be an advocate for early access to chiropractic, PT and acupuncture for LBP
- Learn where the gaps exist in your local community
- Write/Speak! E.g., Op-eds, LTE, share views
- Consider promoting care pathway for LBP, don't need to reinvent the wheel (e.g., Duke, WA Health Alliance, Intermountain Healthcare, UHG paper)
- Promote collaboration; team-based care



Advocacy Efforts

Because…it's about what is best for your patient.

Integrative pain care requires having many options to create an individualized plan.

This means other team members can deliver aspects of guideline-concordant care plan.

A leading challenge shared by multidisciplinary providers is not knowing what other providers actually do and when/how to refer to other disciplines.

How do you build relationships with other members and bring them with you?

How can you build connections to best identify care delivery gaps in need of your advocacy efforts?

Advocacy – Fostering Collaboration

Ideas to Consider:

- Ask a pharmacist, nurse, PA, chiropractor, PT, OT, physician, dentist, massage therapist, yoga therapist, health coach, social worker, etc. out to lunch
- Schedule a meeting with an administrator to get to know them
- Invite a team member to consult on a patient, to visit you during clinic, or you visit them to learn more
- Inquire about committees, boards, SIGs, advocacy efforts, & join when you can
- Be a liaison to connect leaders, organizations with shared interests and goals

You have a great deal of power to make changes with your current health system and in your local area. It can start with very small steps.

What difference do you want to make?

State Advocacy

Why State Healthcare Policy is Important

State issues vs. federal issues

- Scope of practice for various professions
- Standards for the practice of medicine, nursing, pharmacy, etc.
- Requirements for CE (e.g., pain management, substance abuse)
- Requirements for insurance coverage
- Medicaid coverage

Climate:

- Dominated by restricting access to opioids and high cost/low value services
- Encouraging non-pharmacological options yet biases are still common
- Battles among providers / scope of practice / turf issues
- Guideline-concordant care is not practically accessible for many

Policies:

– Insurer
– Purchaser/Employers
– Health System
– Legislative
– Regulatory
– Guidelines

Examples State-Level Advocacy for Coverage of Integrative Therapies

- **Massachusetts**, Medicaid coverage for acupuncture
  - MassHealth covers 20 visits
- **New Hampshire**, requirements for insurance coverage, HB 303, public hearing 1/18/23. Sponsor is physician just elected as state rep.
  - Collaboration with NH Med. Society, NH Chiropractic Assn, and NH Acupuncture Assn.
  - provide broader, multimodal coverage for pain management services
  - includes behavioral health interventions, manual treatments, movement therapies and other treatments by licensed practitioners
  - At least 20 visits (number in MA policy)
- **Colorado**, requirements for insurance coverage, HB-1085, 2020 – acu, chiro, OT, PT, see AMA's actuarial report
  - Provide 12 visits for acupuncture, PT, OT, chiropractic

State Advocacy Example, CO

requirements for insurance coverage

AACIPM collaborated with stakeholders in support of CO House Bill 20-1085.

"When patients are able to receive the types of care proposed in HB 20-1085, physical therapy, occupational therapy, chiropractic and acupuncture, they improve faster and the costs associated with their care go down," said Amy Goldstein, Director, AACIPM during the public meeting. Furthermore, "in a review of Colorado insurance claims from 2018, Oliver Wyman found that 13% of patients treated for pain incurred over $2,500 per person in pain-related claims that year, and that these individuals had roughly eight times the healthcare costs of all remaining insured members."

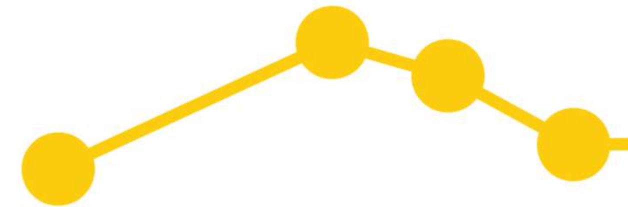
DOI Request for Information - Costs and Benefits of Certain Substance Use Disorder Coverage Provisions

The Division of Insurance (Division) is issuing a Request for Information (RFI) on the costs and benefits associated with the following substance use disorder (SUD) health coverage provisions:

- A minimum of six physical therapy visits, six occupational therapy visits, six acupuncture visits, and six chiropractic visits (with cost sharing that is no greater than that charged for a non-preventive services primary care visit) as non pharmacological alternatives to opioid treatment;
- Not require prior authorization for nonpharmacological treatments as an alternative to opioids;
- Provide coverage for at least one atypical opioid (defined as a nonopioid analgesic with far lower fatality rates than pure opioid agonists) for the treatment of acute or chronic pain at the lower cost tier, without step therapy or prior authorization for that atypical opioid; and
- Not require step therapy for the prescription and use of any additional atypical opioid medications for the treatment of acute or chronic pain.

https://painmanagementalliance.org/2020/10/31/co-public-meeting-with-insurance-commissioner-held-on-10-21-20/

ENGAGING IN LEGISLATIVE PROCESS



1 Bill is drafted and introduced.

2 Bill goes to committee (hearings/markup).

Committee votes to report bill.

Bill goes to floor for final vote.

Passed bill goes to conference (if needed).

President/Governor signs the bill and law is printed.

Most engagement opportunities will be here

Veto Power

3 Law is implemented.

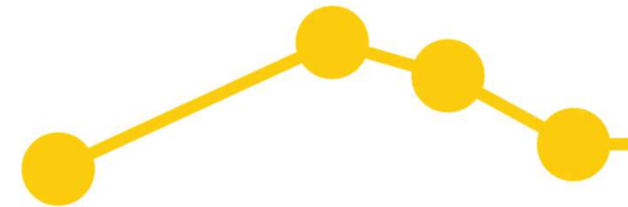
(This is where regulatory process takes over.)

Implementation is often overlooked and key to making change

Regulations

- An agency's authority to regulate is established by a combination of executive authority and authorizing legislation.
- Health care regulations are developed and implemented by all levels of government (federal, state and local), most often by Departments of Health, Insurance Regulators, and other agencies specialized in healthcare and payment.
- The primary reason for health care regulation is to ensure that the care being provided by health care practitioners and health care facilities is safe and effective for everyone who accesses the health care system.

ENGAGING IN REGULATORY PROCESS



Advocacy efforts are well spent to impact legislation before bill passes - once passed, regulations can only do so much.

Most engagement opportunities will be here.

The implementation phase is often overlooked but vital to make change.

Ex. Acupuncture/Payer Policy

This is about acupuncture as an example to illustrate the complexities of state and federal advocacy

Achieving a coverage determination isn't simple or straightforward:

- State Level -
  - Acupuncture coverage is inconsistent
  - Medicaid determinations
    - 13+ states
    - MassHealth covers 20 visits, 2022
  - State Acupuncture Pilot in VT, 2017, legislative report, overview
    - Led to formation of BC/BS partnership with UVMC, Comprehensive Pain Program

- Federal Level -
    - Medicare determination – Jan. 2020
    - Opportunities and challenges
    - Social Security Act

Excellent Resource: Hospital Handbook Project
https://www.thehospitalhandbook.com/

National Academies of Medicine as a Catalyst for Whole Health

- 2009 - ***Summit on Integrative Medicine and the Health of the Public*** in Washington, DC. Dr. Donald Berwick's inspiring keynote address with patient-centered focus of "what matters to you".
- 2011 –***Relieving Pain in America*** a report that estimated 100 million people live with chronic pain, costing approximately $640 billion annually in medical expenses and lost productivity, yet the disease remains widely undertreated.
- 2016 - After long-time stakeholder engagement, including at a coordinated federal level, the ***National Pain Strategy, A Comprehensive Population Health-Level Strategy for Pain,*** was released.
- 2018 – Workshop, the ***Role of Nonpharmacological Approaches to Pain Management***, held when leaders agreed that there is enough evidence, data to act on NOW.
- 2020 - NAM ***Action Collaborative on Countering the US Opioid Epidemic***
- 2021 – Workshop, ***Financing that Rewards Better Health and Well-Being Workshop***

Federal Advocacy

- Federal legislation and regulations control many aspects of care nationwide (e.g., Soc. Sec. Act determines definition of a "qualified health provider" for Medicare payments)
- Federal guidelines and task force reports carry substantial weight in affecting state policies, health system policies, and courts.
- Changes to federal policy can help to close the gaps between guideline-concordant, evidence-based integrative care and current payment structures.
- In addition to Congress, a number of federal agencies affect healthcare policy, including: CMS, CDC, NIH, AHRQ, FDA, IHS, SAMHSA, HRSA

Advocating for Integrative Health Care at the Federal Level

Promoting Integrative Care Requires New & Sustained Advocacy Efforts

We must address the disconnect between recommended first-line treatments and treatments that are accessible and affordable.

For example:

- State legislatures, licensing boards, and the CDC have increasingly stated that the use of non-opioid therapies are preferred as a first step in the treatment of pain.
- However, CMS and private insurers have been slow to provide coverage for such therapies.
- Further, CMS coverage is further limited by the Social Security Act's definition of a "qualified health provider."

Advocating for Integrative Health Care at the Federal Level
A Success Story – Physician Fee Schedule 2023

The Advocacy Process

- **Pre-2021 –** Institute of Medicine's 2011 *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*; IPRCC' 2016 *National Pain Strategy*; HHS' 2019 *Pain Management Best Practices Inter-Agency Task Force Report: Gaps, Inconsistencies; and Recommendations.*
- **2021** – CMS comment solicitation re: coding and payment for chronic pain management.
  - Coalition was rallied and a writing workgroup was established.
  - Group sign-on letter with 5 recommendations was submitted on behalf of 26 individuals and 8 organizations.
  - CMS delayed rulemaking, promising to "carefully consider this feedback for future rulemaking."
- **2022** – CMS proposed Physician Fee Schedule for CY2023.
  - Proposed rule addressed much that AACIPM commented upon in 2021.
  - Coalition was rallied, a writing workgroup was established, and a new set of specific recommendations were submitted.
  - CMS adopted the new Chronic Pain Management codes, addressing nearly all of AACIPM's recommendations.

Advocating for Integrative Health Care at the Federal Level

A Success Story – Physician Fee Schedule 2023

- CMS implemented new codes for Integrative Pain Management Services, changing payment structures to support team-based care. Effective Jan. 1, 2023.
- The codes (HCPCS G3002 and G3003) pertain to chronic pain lasting longer than three months, and may be billed by a physician or other qualified health practitioner, and cover a variety of services which advance integrative care, including, in part:
  - ***ongoing communication and care coordination between relevant practitioners*** furnishing care (e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care), and
  - ***facilitation and coordination*** of any necessary behavioral health treatment.

New codes came after years of sustained advocacy.

https://painmanagementalliance.org/2022/11/30/cms-creates-new-pain-management-codes-heeding-advice-of-aacipm/

CMS.gov
Centers for Medicare & Medicaid Services

Advocating for Integrative Health Care at the Federal Level
A Success Story

Advocating Beyond Adoption: The Implementation Phase

Advocacy work is vital even after a policy is adopted.

To ensure patients and providers benefit from the new codes:

- Providers must be educated as to the existence and utility of the new codes.
- The codes must be properly utilized to provide CMS with follow-up data.
- The follow-up data must be utilized to improve the payment rates related to the codes, as well as to hone the covered services within the code.

Advocacy Had a Vital Impact

Without collective advocacy efforts, the well-intentioned CMS codes would have been riddled with unintentional negative consequences.

How Can You Help?

Promote awareness & implementation to ensure patients and providers benefit from the new codes:

- Providers must be educated as to the existence and utility of the new codes.
- The codes must be properly utilized to provide CMS with follow-up data.

While the CMS example may sound complex, it was simply the ***input we received from different healthcare providers about their unique experiences*** with patient care (e.g., billing, access) that made a difference. AACIPM combined multi-stakeholder perspectives into one cohesive letter.

Capture Your Experiences. Collect Your Own Data.
Share Your Stories. Promote Implementation. Get Involved!

Integrative Health Care at the Federal Level
Taxonomy Code - Another Recent Advocacy Win

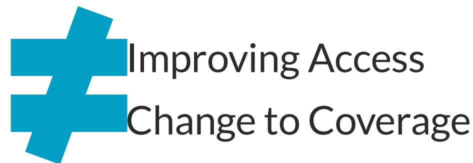
Starting in 2022, integrative allopathic and osteopathic physicians gained access to a taxonomy code for Integrative Medicine (IM): 202D00000X. Credentialing and insurance reimbursement for IM services should now be easier with this code.

- The American Board of Integrative Medicine (ABOIM) successfully applied for an Integrative Medicine (IM) Taxonomy Code from the National Uniform Claim Committee (NUCC) for allopathic and osteopathic integrative physicians.
- The code, designating a health care provider's classification and specialization, is required when applying for a National Provider Identifier and to become a Medicare provider.
- It is important that providers select the correct code that is applicable to the scope of work being delivered, as many insurers require the use of taxonomy codes to issue billing credentials, process health insurance claims, and determine network adequacy.

Source: https://www.aihm.org/integrative-medicine-secures-a-win/

Integrative Health Care at the Federal Level
Taxonomy Code - Another Recent Advocacy Win

In terms of a win, what is the game?



"Integrative Medicine" physician will be able to bill certain integrative care codes, and IM will be identifiable for research/policymakers

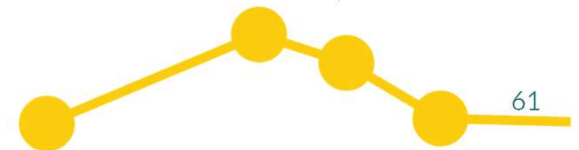
Questions to Ponder:

- What should physicians be able to do without additional certification? (e.g., Nutrition? Botanical medicine? Mindfulness? Acupuncture?)
- What should the certification allow physicians to do?
- Are there physicians doing it today that shouldn't be?
- How would you talk about physician colleagues without the certification?
- How might this improve access to quality care for all people?
- Consider subsets of other providers that may experience limitations after "wins"

Ideas to Consider for Advocacy

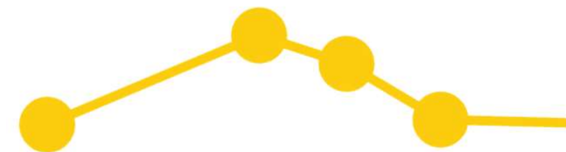
There are many ways to share your expertise to impact policy decisions:

- Network to grow your circles; Contribute your expertise and passion for integrative medicine
- Connect with your US Senators / Representatives & State Legislators
  - Look up their committee, caucus assignments
  - Schedule an in-district meeting/phonecall to share your area of expertise and passion
- Sign up for Coalition Work in an area of interest
- Read Federal Policy Highlights at AACIPM (https://painmanagementalliance.org/federal-action/)
- Write / Speak about integrative care! (e.g., presentation, Op-ed, letter to the editor, blog)



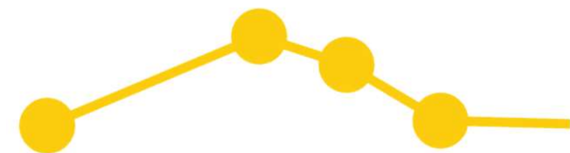
Ideas to Consider for Advocacy

- Read relevant bills in your state and track their progress
- Read insurer policies in your state and start talking about it
- Participate in Task Forces, Advisory Committees
- Attend a Committee Hearing of a pertinent bill, or read others' testimony
- Set up a meeting with team members to talk about gaps in care
- Visit AHEC website and learn about area office, Scholars program and more https://www.nationalahec.org/
- Read participation in the rulemaking process (HHS)



Ideas to Consider for Advocacy

- Think about running for office, or support candidates that matter
- Visit websites or contact your national or state associations and see what policy advocacy issues they are working on (e.g., medical, nursing, pharmacy, dentistry, etc.)
- Explore other relevant organizations and become a member, sign up for their newsletters/updates (e.g., Alliance to Advance Comprehensive Integrative Pain Management, Whole Health in the States, Integrative Health Policy Consortium, CMS, AHRQ)
- Read about some progress at the VA/DOD in terms of coverage and integration of evidence-based integrative therapies.
  - VA Whole Health
  - Advanced by passage of CARA, Veterans connected to Whole Health increased by 193%
  - Connecting the Dots: NAM, CARA and Whole Health
  - Spotlight on VA's Pilot Site in St. Louis - Dr. Kavitha Reddy
  - CMS Approves New HCPCS Codes for Spiritual Health (VA)
  - Improving Transition from Military Service Member to Veteran through Quality Comprehensive Well-Being Experiences



RESOURCES

https://painmanagementalliance.org/Advocacy-Engagement/

This link includes the slides along with other resources related to this topic.

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THANK YOU

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- **Hashtags:** #aacipm #cipm
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