**Preliminary Report of the *Special Commission to Examine the Feasibility of Establishing a Pain Management Access Program***

Commonwealth of Massachusetts



November 2016

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**Executive Summary**

The *Special Commission to Examine the Feasibility of Establishing a Pain Management Access Program* is a 21-member commission co-chaired by Marylou Sudders, Secretary of the Executive Office of Health and Human Services and Michael F. Collins, MD, Chancellor of the University of Massachusetts Medical School.

This commission was created by Chapter 52 of the Acts of 2016, also known as the Act Relative to Substance Use Treatment, Education and Prevention, signed into law by Governor Baker in March 2016. The commission met three times between July and October 2016.

Advances in medicine and, in some instances, surgery or integrative approaches have improved the outcomes for many diseases. As a result more people are now living with chronic conditions often with continued pain and a diminished quality of life. Providers need more help and support in identifying, providing and managing the treatment of chronic pain for their patients.

The Special Commission believes that there is merit in developing a pilot program designed to facilitate access to the expertise of pain specialists in the Commonwealth, a Massachusetts Access Program for Pain (MAPP), based on the well-established Massachusetts Child Psychiatry Access Project (MCPAP) model. Further, the Special Commission recommends the Commonwealth does not establish a pain management specialty certification through the Board of Registration at this time.

The Special Commission will continue to meet to advance the Recommendations herein as well as will continue to deliberate on the additional changes of the Special Commission. This is the Commission’s preliminary report of its recommendations. The Special Commission will file a final report providing a full report on the commission's charges on or before November 1, 2017.

**Special Commission Charges**

*The Commission is charged with:*

* 1. Review the development of a referral process to make pain management specialists accessible to primary care providers, including a process similar to the Massachusetts child psychiatry access project (MCPAP);
  2. Review the establishment of a pain management specialty certification through the board of registration in medicine to refer a primary care provider through MCPAP;
  3. Review ways to incorporate a full spectrum of pain management methods into provider care practices including non-opioid evidence-based alternative treatments;
  4. Review the current coverage of pain management through commercial and public insurers; and
  5. Review ways to ensure a full spectrum of pain management interventions are covered through commercial and public insurance health plans.

*Report #1*: The Special Commission shall file an initial report of its recommendations and drafts of proposed legislation or regulations on or before November 1, 2016.

*Report #2*: The Special Commission shall file a final report providing a full report on the commission's charges on or before November 1, 2017.

**Special Commission Membership**

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| --- | --- | --- | --- |
| **Seat** | **Member Name** | **Role** | **Appointed By** |
| Secretary of HHS \* | Secretary Marylou Sudders | Co-Chair | Ex Officio |
| University of Massachusetts Medical School Chancellor \* | Chancellor Michael F. Collins | Co-Chair | Ex Officio |
| Assistant Director of Medicaid \* | Director of MassHealth Office of Behavioral Health Kevin Wicker | Member | Ex Officio |
| Group Insurance Commission (GIC) Commissioner \* | Program Manager Heidi Sulman | Member | Ex Officio |
| Division of Insurance (DOI) Commissioner \* | Research Analyst Niels Puetthoff | Member | Ex Officio |
| Health Policy Commission Executive Director \* | Executive Director David Seltz | Member | Ex Officio |
| Center for Health Information and Analysis (CHIA) Executive Director \* | Executive Director Ray Campbell | Member | Ex Officio |
| Department of Public Health (DPH) Commissioner \* | Commissioner Monica Bharel, MD, MPH | Member | Ex Officio |
| Board of Registration in Medicine (BORIM) Chair \* | Candace Sloane, MD | Member | Ex Officio |
| Board of Registration in Nursing (BORN) Chair \* | Executive Director Lorena Silva, MSN-L, MBA, DNP, RN | Member | Ex Officio |
| Massachusetts Association of Health Plans (MAHP) Representative | Debra Poskanzer, MD | Member | MAHP |
| Massachusetts Medical Society (MMS) Representative | Dennis Dimitri, MD | Member | MMS |
| Massachusetts Hospital Association (MHA) Representative | Joji Suzuki, MD | Member | MHA |
| Massachusetts Pain Initiative (MPI) Representative | Robert Cohen, MD | Member | MPI |
| Massachusetts Chiropractic Society (MCS) Representative | Dan Fanselow D.C | Member | MCS |
| Oncologist | Tom Lynch, MD | Member | Governor |
| Physician | Paul Mendis MD | Member | Governor |
| Advanced Practice Registered Nurse (APRN) | Alysa Veidis, MSN, RN, FNP-BC | Member | Governor |
| Health Economist | Rosa Rodriguez-Monguio, PhD, MS | Member | Governor |
| Physician specializing in Pain Management | Scott Sigman, MD | Member | Governor |
| Physician | Julian Robinson, MD | Member | Governor |

**\*** Designee

**Special Commission Meeting Schedule**

The Special Commission met three times between July and October 2016. All meetings were open to the public with notices posted in advance at www.malegislature.gov and minutes and meeting materials posted after meetings at http://www.mass.gov/eohhs/gov/commissions-and-initiatives/opioid-addiction/pain-mgmt-commission.

In the Commission’s three meetings, commission members heard from multiple organizations and stakeholders regarding addressing the Commission’s charges.

* In the first meeting held on August 16, 2016, the Commission reviewed two presentations. The Special Commission heard from Marcy Ravech, MSW, Director of the Massachusetts Child Psychiatry Access Project (MCPAP), on the background and history of the original MCPAP model, “*Pediatric Psychiatric Consultation Program*.” The Commission also heard from Massachusetts Medical Society (MMS) former President Dr. Dennis Dimitri and current Legislative and Regulatory Affairs Counsel Brendan Abel presented on MMS’ “*Proposal for a Pain Consultation Program for Primary Care Providers (MAP for Pain or MAPP)*.”
* In the second meeting held on September 19, 2016, the Commission reviewed four presentations. First, the Commission heard from Massachusetts Health Quality Partners (MHQP) President and CEO Barbra Rabson, MPH, on MHQP’s proposal “*Engaging Patients to Co-Design a More Effective Approach to Pain Assessment*.” Second, the Commission heard from Chief of Orthopedics at Lowell General Hospital Dr. Scott Sigman, on his presentation, “*The Societal Impact of Opioid Overreliance Use After Surgery and the Importance of Non-Opioid Options*.” Thirdly, the Commission heard from Dr. Daniel Carr, Professor and Director of the Pain Research, Education & Policy “PREP” Program at the Tufts University School of Medicine on “*Key Points of Managing Pain*.” Lastly, the Commission heard from Niels Puetthoff, a Division of Insurance (DOI) Health Care Access Bureau Research Analyst on DOI’s Pain Management Coverage Questionnaire for Health Carriers.
* In the third meeting held on October 20, 2016, the Commission heard from two panels: 1) Primary Care Provider Panel including: Dr. Robert Saper, MD, MPH, Director, Program for Integrative Medicine and Health Disparities, Boston Medical Center Family Medicine Center and Dr. Larissa Lucas, MD, FACP, HMDC, Medical Director of Quality, Care Dimensions and Dr. Paula Gardiner, Assistant Director for the Program for Integrative Medicine and Health Care Disparities at Boston Medical Center; as well as, 2) Chronic Pain Patient Panel, including Cindy Steinberg, National Director of Policy and Advocacy at the U.S. Pain Foundation and Chair of the Policy Council of the Massachusetts Pain Initiative among other patient speakers. Lastly, the Special Commission reviewed their recommendations, status on additional commission charges and next steps found herein.

**Overview of Current Pain Management Environment Nationally**

In the 1980s and early 1990s, numerous governmental (e.g., US Department of Health and Human Services) and nongovernmental (e.g., World Health Organization) bodies began to recognize pain control as an integral part of patient-centered care. In 1995, amidst these worldwide concerns of providers in managing pain, the American Pain Society presented the idea of evaluating pain as a vital sign, hoping that in elevating pain management to that level, it would become properly evaluated and managed. This hope was affirmed when, in 1999, the Veterans Health Administration (VHA) began a new initiative which measured and documented patients’ self-reporting of pain in their electronic medical records. This initiative, called “Pain as the 5th Vital Sign,” required the use of a 1-10 Numeric Rating Scale (NRS) for all clinical encounters. Separately, when the Joint Commission on Accreditation of Health Care Organizations (JCAHO) recommended pain assessments be conducted for all patients, pain measurement spread across the country very quickly. For example, pain management scores are now included as a quality measure in Hospital Consumer Assessment of Healthcare Providers (HCAHPS) reports.

In response to these recommendations to include pain scores as a quality measure, bolstered by ample data documenting the frequent under treatment of acute, chronic, and cancer-related pain, and the detrimental human and physiological consequences thereof, providers began prescribing more pain medications to minimize pain and improve their pain treatment scores. Since 1999, the amount of prescription opioids sold in the United States nearly quadrupled, yet there has not been a similar change in the amount of pain that Americans report (patient-reported pain is regarded as not well assessed). However, diversion, misuse, and deaths from prescription opioids—drugs such as oxycodone, hydrocodone, and methadone—have also quadrupled in that same timespan. Across the board, evidence shows that overdoses from abused and diverted prescription opioid pain relievers have contributed to the 15-year increase in opioid overdose deaths.

According to a *National Institute of Health* “Fact Sheet” on Pain Management (October 2010), pain affects more Americans than diabetes, heart disease and cancer combined. Pain is cited as the most common reason Americans access the health care system, is a leading cause of disability and it is a major contributor to health care costs. Further, the diversity of pain conditions requires a diversity of research and treatment approaches. In 2010, the National Institutes of Health (NIH) contracted with the Institute of Medicine (IOM, now known as the National of Medicine) to undertake a study and make recommendations “to increase the recognition of pain as a significant public health problem in the United States.”

Published in 2011, the IOM’s report, *Relieving Pain in America,* called for a cultural transformation in pain prevention, care, education, and research and recommended development of “a comprehensive population health-level strategy” to address these issues. The IOM report produced a number of findings which guided the development of the *National Pain Strategy*, published by the U.S. Department of Health and Human Services in March 2016. Several *National Pain Strategy* recommendations directly addressed the need for adequate resources to support evidence-based and appropriate pain management at the primary care physician and front-line provider levels, including:

* Significant improvements are needed to ensure that pain assessment techniques and practices are high-quality, evidence-based and comprehensive
* People with chronic pain require treatment approaches that take into account individual differences in susceptibility for pain and response to treatment, as well as improved access to treatments that take into account their preferences and are in accord with best evidence on safety and effectiveness
* Treatments that are ineffective, whose risks exceed their benefits, or that may cause harm for certain subgroups need to be identified and their use curtailed or discontinued
* When opioids are initiated carefully using existing guidance and resources (e.g., screening instruments to assess likely risk of misuse, or urine drug testing) and appropriately monitored thereafter, they can be safe and effective
* Much of the responsibility for front-line pain care rests with primary care clinicians who are not sufficiently trained in pain assessment and comprehensive evidence-based treatment approaches
* Greater collaboration is needed between primary care clinicians and pain specialists in different clinical disciplines and settings, including multi-specialty pain clinics

**Overview of Current Pain Management Environment in The Commonwealth**

In the last few years, Massachusetts has seen a dramatic increase in deaths due to opioid use. In 2015, there were over 1,500 estimated unintentional fatal opioid overdoses, compared to 911 in 2013 and 603 in 2012. This amounts to a rate of 22.6 deaths per 100,000 residents. The epidemic affects individuals and families across the Commonwealth, of all ages, races and socioeconomic backgrounds. With the opioid epidemic killing over four Massachusetts residents a day, it became essential that all areas of the health care system are involved in combating this public health crisis. One fundamental area to help address this epidemic is appropriately reducing the number of unnecessarily prescribed opioids flowing through the system. Within a new culture of patient-centered concerns for treating pain effectively, primary care physicians and other providers are now called to treat and manage patients with complex pain needs without the necessary background, training, and experience.

In June of 2015, the Governor’s Opioid Working Group published 65 recommendations which including both findings and recommendations regarding the need to provide practitioners training on appropriate prescribing practices through education, training and practice support. The Working Group specifically pointed to working with boards of registration to enforce continuing education requirements related to effective pain management, as well as, enhanced provider training to identify patients at-risk for substance use disorders (SUDs), the addictive nature of the drugs themselves, and patient counseling on the proper use, expected benefits and expected side effects of opioids. Among other recommendations, the Working Group also called for an increase and improvement in the educational offerings about safe prescribing practices.

One significant accomplishment coming out of the Governor’s Opioid Working Group recommendations was the collaboration the Governor was able to forge among the deans of the Commonwealth’s four medical schools, dental schools and the Massachusetts Medical Society to develop and release a pioneering set of medical education core competencies for the appropriate management of pain, and the prevention and management of prescription drug misuse. This action alone ensured over 3,000 enrolled medical students, 1,800 undergraduate dental students and 550 advanced graduate dental students will be better prepared to safely and appropriately prescribe prescription drugs and have the training to help prevent, identify, and treat substance use disorders. A similar set of required competencies was developed for schools of dentistry. Additionally, the Administration developed partnerships with the state’s Advanced Practice Nursing (APRN) programs and professional organizations, physician assistant programs, to expand the reach and use of the pioneering core competencies for the prevention and management of prescription drug misuse. These core competencies will now reach approximately 2,000 enrolled APRN students, 900 enrolled physician assistant students, and the 50 community health centers representing the organizational membership of the Massachusetts League of Community Health Centers.

At the same time, the Drug Formulary Commission (DFC) was reactivated within the Department of Public Health, and charged with evaluating abuse-deterrent formulations of existing opioids for possible inclusion within a state drug formulary. The DFC also prepared a listing of non-opioid drugs for which published evidence and FDA approvals support their efficacy for pain.

As medicine has improved the outcomes for many diseases, such as cancer, diabetes, arthritis and HIV, more people are living with chronic conditions often with continued pain and a diminished quality of life. The same is true for returning veterans who often have chronic pain from war injury (e.g., limb amputation), sometimes in concert with behavioral issues such as post-traumatic stress disorder. Providers need more training and support in identifying and managing the appropriate treatment of chronic pain in individual patients. Prescribing guidelines adopted by the Massachusetts Board of Registration in Medicine: August 2015apply to patients who receive opioids for a more than 90-day period. This includes transferred patients with opioid treatment histories and existing patients who reach a 90-day period of treatment. Without additional resources and training made available to providers, to properly manage pain many Massachusetts providers are faced with a precarious challenge many are not prepared to meet.

**Background of the Massachusetts Child Psychiatry Access Project (MCPAP)**

The initial focus of the Special Commission was to review the *Massachusetts Child Psychiatry Access Project (MCPAP)* to consider the need for the development of a pain management program which would provide consulting, training and pain specialist referrals to improve the ability of providers in addressing pain needs, as well as increase the number of pain management expertise accessible to providers.

The Special Commission reviewed the development, ongoing operations, and “lessons learned” since MCPAP was established in 2004, as well as MCPAP for Moms. MCPAP is funded through the Massachusetts Department of Mental Health and managed by the Massachusetts Behavioral Health Partnership (MBHP). The program provides timely phone access to psychiatrists who provide clinical guidance to primary care providers treating children with mental health problems. Available 9am-5pm, Monday through Friday, these teams are available for consultation by telephone within thirty minutes for participating PCPs. The current annual MCPAP budget is $3.6 million dollars, funded through the Commonwealth’s state budget.[[1]](#footnote-1)

The MCPAP model has served as a national model, NNCPAP, (National Network of Child Psychiatry Access Programs) for other states facing shortages of child psychiatrists with over thirty states having replicated a MCPAP-type program.

The MCPAP program is made up of six regional centers:

1. Baystate Medical Center, Springfield
2. UMass Medical Center, Worcester
3. North Shore Medical Center, Salem
4. Massachusetts General Hospital, Boston
5. Tufts Medical Center/Boston Children’s Hospital, Boston
6. McLean Hospital-Southeast, Middleborough

In 2014, the MCPAP for Moms component was added to promote screening and treatment for prenatal and postpartum depression. Also available 9am-5pm, Monday through Friday, the MCPAP for Moms program has three core components: 1) training and toolkits for providers; 2) real time psychiatric consultation and care coordination; and, 3) links to community based resources. This model has extended PCPs’ capacities to care for and treat patients for perinatal and postpartum depression and, when needed, helped patients find referrals for care within their communities. The current annual budget for MCPAP for Moms is $500,000, funded through the Massachusetts state budget.

MCPAP for Moms has three regional centers:

1. UMass Medical Center, Worcester
2. Baystate Medical Center, Springfield
3. Brigham and Women’s Hospital, Boston

***Commission Recommendation 1#: EOHHS to develop a Massachusetts Access Program for Pain Pilot Program Design***

*The Special Commission believes that there is merit to developing a pilot program to facilitate access to the expertise of pain specialists in the Commonwealth, a Massachusetts Access Program for Pain (MAPP) based on the well-established MCPAP model*. Therefore, the Commission recommends that the next step is that EOHHS develop a potential Massachusetts Access Program for Pain program design and operational framework – including revenue and expense modeling. It is the belief of the Commission that establishing an expert peer-to-peer consultation and referral program for physicians including training on the evaluation and management of acute and chronic pain could improve access to appropriate pain management care and services across the Commonwealth of Massachusetts.

*Objectives of the MAPP program could include:*

* Provide practitioners with expert clinical guidance to review treatment plans
* Create a culture of greater empowerment and confidence for practitioners who want to be able to safely and appropriately treat patients impacted by chronic pain
* Facilitate consultations to strengthen the clinical skills in treating chronic pain
* Guide providers to appropriate resources and referrals to enhance the care of patients
* Educate practitioners on the use of clinically appropriate and evidence-based alternative medical and behavioral therapies to treat pain
* Increase the adoption of evidence-based practices in the treatment of acute and chronic pain
* Develop regional team of pain specialists to gather and develop referral and treatment relationships with community-based resources
* For patients receiving opioid therapy, the importance of a well-monitored program, consistent with accepted guidelines (e.g. BORIM requirements) and “best practices” will be emphasized while providing expert clinical guidance to practitioners
* Team training and peer-mentoring for pain medicine experts
* Develop educational and communication rubrics for best practice for pain specialists to provide support to non-specialist providers
* Evaluation system to evaluate quality/efficacy of consultation and referrals and the program in general

*Key Components of the MAPP program could include:*

* Payer blind
* Serve the entire Commonwealth
* Build upon the existing infrastructure and systems of the MCPAP model
* Serve providers practicing in the state who need a timely consult with a pain specialist for adult patients (over 18 years old) with pain not related to cancer and pain for patients who are not otherwise enrolled in a hospice program
* Encourage the use of clinically appropriate and evidence-based alternative therapies and integrative treatments, as appropriate based on the needs of patients with acute or chronic pain
* Improve awareness about established and credible certification and accreditation programs for practitioners and specialists looking for additional training and competency
* Develop practitioner communications and outreach plan to ensure program awareness

***Commission Recommendation #2: a Pain Management Certification through the Board of Registration in Medicine is not Warranted***

*The Special Commission recommends the Commonwealth does not establish a pain management specialty certification through the Board of Registration*. The Board of Registration in Medicine (BORIM) respectfully suggests that they are not the best entity to establish such a certification. BORIM's mission is to protect the public by licensing only qualified physicians who have demonstrated competence, good moral character and who have met the requirements for licensure and has never certified that a physician is a specialist in any field of medicine. The Accreditation Council for Graduate Medical Education (ACGME), and the American Board of Medical Specialties (ABMS) and the American Board of Pain Medicine (ABPM) exist for the very purpose of ensuring that physicians receive adequate training in their specialties and provide an opportunity to be certified in a specialty. Providers in need of additional training and education for pain management should consider these existing accreditation and certification programs.

***Commission Update: Additional Commission Charges***

Over the first three meetings the Special Commission reviewed and discussed its additional charges:

1. *Review ways to incorporate a full spectrum of pain management methods into provider care practices including non-opioid evidence-based alternative treatments*

Throughout the three meetings, the Commission heard from prominent leaders on the topic of non-opioid, evidence-based alternative treatments, such as Chief of Orthopedics at Lowell General Hospital, Dr. Scott Sigman, who reviewed the importance of non-opioid treatment options and his approach utilized within his practice. Massachusetts Health Quality Partners (MHQP) President and CEO Barbra Rabson, MPH, discussed the role of the patient in designing a more effective approach to pain management. Dr. Daniel Carr reviewed the extensive, published, evidence for nonopioid therapies (both pharmacological and nonpharmacological) in the management of acute, chronic and cancer-related pain. During these and other presentations, particular attention was made to how the Commission could encourage “best practices” of non-opioid, evidence-based alternative treatments in the development of the Massachusetts Access Program for Pain pilot program as well as support commercial and public insurers providing a full spectrum of pain management interventions to their members.

1. *Review the current coverage of pain management through commercial and public insurers*
2. *Review ways to ensure a full spectrum of pain management interventions are covered through commercial and public insurance health plans*

The Commission also worked closely with the Massachusetts Division of Insurance (DOI) to collect coverage information on pain management techniques and services covered by all Accredited Managed Care Health Carriers. The DOI requested detailed covered benefit information across a number of common pain management techniques (acupuncture, chiropractic, physical therapy, massage therapy, non-prescription pain relief, etc.) as well as other pain management services covered by each health carrier. Information requested included the pain management benefits covered by each health plan, applicable quantitative or non-quantitative limits and the number of network providers available to provide noted services. Over 16 unique Accredited Managed Care Health Carriers, as well as, all MassHealth carriers are participating in this information-gathering exercise.

***Next Steps for the Special Commission***

The pain management techniques and services currently included in the benefit designs of public and commercial carriers in the Commonwealth of Massachusetts vary widely. It is clear a more comprehensive cataloguing of all covered pain management techniques and services covered by public and private health carriers is needed. This cataloging exercise should include a deeper analysis of all non-opioid and non-pharmacological clinically appropriate and evidence-based alternative therapies and integrative treatments offered by health plans. Over the coming months, the Special Commission will continue to work closely with DOI to develop a more complete summary of the coverage of pain management techniques – including non-opioid and non-pharmacological evidence-based alternative treatments – in order for the Commission to review ways (i.e., develop a list of “best practices” or suggested pain management interventions) to ensure a full spectrum of pain management interventions are covered through commercial and public insurance plans.

To augment the DOI survey of Accredited Managed Care Health Carriers, the Center for Health Information and Analysis (CHIA) has been working to connect multiple data sets received by commercial and public carriers to improve the analysis of claims across pharmaceutical, medical, and demographic data sets. This linking of data sets across pharmaceutical, medical, and demographic data sources will allow policy makers to more narrowly focus on distinct pain management utilization rates (or under-utilization) within specific patient cohorts, drug classifications, provider specialties, and procedures.

These new data sets will allow the Special Commission to conduct analyses to support the design and development of the Massachusetts Access Program for Pain. For example, helping more narrowly identify the number of pain management specialists needed to meet the needs of the providers who need the consulting, training, and pain management expert referrals. This new data will also allow for the establishment of a baseline from which to evaluate the pilot program’s overall effectiveness. Additionally, the data will be helpful as the Commission continues to review its additional charges.

Lastly, CHIA is also looking into where they are able to correct “blind spots” in the numerous data sets collected from all the carriers required to submit data on a regular basis.  For example, carriers have devised various interpretations of 42 Code of Federal Regulations which is leading to inconsistent data provided to CHIA by carriers. The Special Commission will continue to work with the CHIA to assist these data areas which require special attention as they relate to the additional charges of the Commission.

The Special Commission will continue to collect and evaluate “best practices” for non-opioid, and non-pharmacological, evidence-based alternative treatments to include in the development of the Massachusetts Access Program for Pain (particularly the training, education and consulting support) as well as to review ways to ensure a full spectrum of pain management interventions are covered through commercial and public insurance plans. The Special Commission will continue to meet to advance the Recommendations herein as well as continue to deliberate on the additional changes under the Commissions purview. The Special Commission will file a final report providing a full report on the commission's charges on or before November 1, 2017.

***Appendix: Special Commission Enabling Legislation***

Chapter 52 AN ACT RELATIVE TO SUBSTANCE USE, TREATMENT, EDUCATION AND PREVENTION; *SECTION 59*

*(a) There shall be a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management for patients in need of comprehensive pain management resources.*

*(b) The commission shall review: (i) the development of a referral process to make pain management specialists accessible to primary care providers, including a process similar to the Massachusetts child psychiatry access project; (ii) the establishment of a pain management specialty certification through the board of registration in medicine to refer a primary care provider through the referral system described in clause (i); (iii) ways to incorporate a full spectrum of pain management methods into provider care practices including, but not limited to, acupuncture, exercise and other non-pharmaceutical interventions; (iv) the current coverage of pain management through commercial and public insurers; and (v) ways to ensure a full spectrum of pain management interventions are covered through commercial and public insurance health plans.*

*(c) The special commission shall consist of the following members or their designees: the secretary of health and human services, who shall serve as co-chair; the chancellor of the University of Massachusetts medical school, who shall serve as co-chair; the assistant director of Medicaid; the commissioner of the group insurance commission; the commissioner of insurance; the executive director of the health policy commission; the executive director of the center for health information and analysis; the commissioner of public health; the chair of the board of registration in medicine; the chair of the board of registration in nursing; 1 representative of the Massachusetts Association of Health Plans, Inc.; 1 representative of the Massachusetts Medical Society; 1 representative of the Massachusetts Hospital Association, Inc.; 1 representative of the Massachusetts Pain Initiative; a representative of the Massachusetts Chiropractic Society, Inc.; and 6 members who shall be appointed by the governor, 1 of whom shall be an oncologist, 1 of whom shall be a physician, 1 of whom shall be an advanced practice nurse, 1 of whom shall be a health economist, 1 of whom shall be a physician specializing in pain management and 1 of whom shall be a professor of medicine.*

*(d) The special commission shall file an initial report of its recommendations and drafts of proposed legislation or regulations, if any, on clauses (i) and (ii) of subsection (b) with the clerks of the house of representatives and the senate, the chairs of the joint committee on health care financing, the chairs of the joint committee on mental health and substance abuse, the chairs of the joint committee on public health and the chairs of the house and senate committees on ways and means on or before November 1, 2016. The special commission shall file a final report providing a full report regarding said subsection (b) on or before November 1, 2017.*

1. The state budget permits the Department of Mental Health to impose an assessment not to exceed $3.6 million on surcharge payors, as defined in section 64 of chapter 118E of the General Laws, for services provided on behalf of commercially insured clients. [↑](#footnote-ref-1)