



CONFERENCE REPORT



Georgetown University Conference Center
Washington, D.C.
September 27-29, 2010



H O S T S

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The Institute for Integrative Health
Palmer College of Chiropractic

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**The Affordable Care Act and Beyond:
A stakeholder conference
on integrated healthcare reform**

Conference Report

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June 29, 2011

Dear Friends and Colleagues,

On March 30, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act. This was a long sought, much debated, and historic achievement. It will provide healthcare coverage for more than 32 million people, who otherwise would not have it, and will prohibit some of the most egregious insurance practices, such as denying coverage to people with “pre-existing” conditions. To those of us in the integrative medicine and complementary and alternative healthcare communities, **the Act is significant because it includes provisions that, if implemented appropriately, will give Americans access to healthcare approaches of their choice**; will allow us to move away from the current disease-oriented healthcare delivery model toward a more prevention- and health promotion-oriented model; and will provide more support for this model.

The Act includes provisions that have long been on the agendas of the Integrated Healthcare Policy Consortium, The Institute for Integrative Health, and Palmer College of Chiropractic, as well as many complementary and alternative healthcare professional associations and educational institutions. To celebrate the Act and to organize for rulemaking, we co-hosted an invitational conference in September 2010 at Georgetown Medical School. We brought together healthcare educators, clinicians, and advocates from the conventional, integrative, and complementary and alternative healthcare spectrum for a combination of educational sessions and roll-up-your-sleeves strategizing. Attendees formed six workgroups to develop action agendas that will be pursued throughout 2015. This report summarizes specific outcomes and directives from the conference, as well as actions we have undertaken toward implementing these directives.

We departed from the meeting inspired by the informed, interdisciplinary, and collegial discussions among our colleagues, as well as by the challenges that lie ahead to make inclusive, patient-centered, prevention-oriented, integrative health care available to all. Please join us in this work by participating in an IPHC Federal Policy Committee workgroup. Contact IHPC Chair, Len Wisneski, MD, FACP, at lwisneski@ihpc.org (phone 303.816.7094).

Sincerely,



Janet Kahn



Susan Berman



Christine Goertz



INTEGRATED
HEALTHCARE POLICY
CONSORTIUM




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BACKGROUND AND MISSION OF CONFERENCE HOSTS

The hosting organizations of this conference have histories of bringing together diverse stakeholders to consider major issues of integrated health policy.

Integrated Healthcare Policy Consortium

The mission of the [IHPC](#) is to facilitate policy development



leading to a health-oriented, integrated, system of care that ensures all people have access to the full range of safe and regulated conventional, complementary, and alternative healthcare professionals and therapies. IHPC also supports activities that facilitate access to the building blocks of health, including clean air, clean water, and a healthy food supply.

The idea of IHPC arose during conversations with federal legislators who made it clear that progress toward integrated healthcare policy was hindered by lack of an organization able to articulate the common agenda of somewhat disparate professional and consumer communities. In 2001, the [National Policy Dialogue on Integrated Healthcare: Finding Common Ground](#) conference established that there was a **common agenda and sufficient collaborative will** to warrant such an organization. The agenda was clarified, and shortly thereafter, those who had initiated the meeting founded the Integrated Healthcare Policy Consortium.

In 2005, IHPC recognized that supporting integrative health care in a changing health workforce required that health professions educational institutions incorporate integrative tenets and build collaborative, cross-disciplinary relationships. The [National Education Dialogue to Advance Integrated Health Care: Creating Common Ground](#) meeting included representatives from conventional academic health centers, holistic nursing and public health professions, as well as the five CAM fields with federally recognized accreditation (chiropractic, acupuncture and Oriental medicine, massage therapy, naturopathic medicine, and certified professional midwifery). The [Academic Consortium for Complementary and Alternative Health Care \(ACCAHC\)](#) was formed in 2004 under the auspices of IHPC's Education Task Force as a joint effort of the national educational institutions of the fully federally accredited complementary and alternative healthcare (CAM) disciplines. ACCAHC became independent of IHPC in 2008.

IHPC facilitates inter-professional collaboration among many healthcare professions, including **Conventional Health Providers, Holistic Nursing, Public Health**, and federally recognized **Chiropractic, Acupuncture and Oriental Medicine, Massage Therapy, Naturopathic Medicine, and Certified Professional Midwifery**.

The Institute for Integrative Health

The [Institute for Integrative Health](#) seeks to catalyze new ideas in healthcare. It



is committed to advancing science with expanded research methods, linking experts across disciplines to generate new ideas, mentoring the leaders of today and tomorrow, exploring new models of health, and discovering fresh ways to engage the public in its pursuit of health.

To address these objectives, TIIH has convened a number of critical conferences for the field of integrative health care. These include [Applying Principles from Complex Systems to Studying the Efficacy of CAM Therapies](#) (Washington, DC, October 2007) and the [Stakeholder Symposium on the Evidentiary Framework for Complementary and Integrative Medicine](#) (Baltimore, MD, November 2009). Both conferences engaged a broad range of stakeholders, and each explored how emerging research strategies can be applied to CAM and integrated health care, recognizing that the flexible and individualized practices in this field are not fully captured by the typical double-blind placebo-controlled clinical trial.

TIIH's conferences involving many stakeholders in integrative health care have shown that the flexible and individualized practices in this field are not fully captured by the typical double-blind placebo-controlled clinical trial.

Palmer College of Chiropractic

[Palmer College of Chiropractic](#), established in 1897, has campuses in



Davenport, Iowa; San Jose, California; and Port Orange, Florida. The mission of Palmer College of Chiropractic is to educate and prepare students to become Doctors of Chiropractic qualified to serve as direct access primary healthcare providers and clinicians, competent in wellness promotion, health assessment, diagnosis, and the chiropractic management of the patient's health care needs. Palmer is committed to advancing the understanding of chiropractic through research; to providing services to the field of chiropractic, such as continuing education; and to serving humanity through patient care and community education.

The [Palmer Center for Chiropractic Research](#) (PCCR) is the largest institutional chiropractic research effort in the world, promoting excellence and leadership in scientific research. The PCCR houses a dedicated research clinic, a clinical biomechanics laboratory, neuroscience laboratories, and the Office of Data Management and Biostatistics. PCCR funding has been supplemented by grants from the National Institutes of Health, National Center for Complementary and Alternative Medicine (NCCAM), the Department of Defense (DoD) and the Health Resources and Services Administration (HRSA).

With programs in clinical and translational science, experimental biomechanics, neurosciences, research education, and health services and policy research, the Palmer Center for Chiropractic Research is positioned to facilitate integrative efforts in comparative effectiveness research and patient-centered outcomes research.

EXECUTIVE SUMMARY

The Purpose: Why this conference?

Passage of [PL111-148](#), also known as the [Patient Protection and Affordable Care Act of 2010](#) (or the Affordable Care Act, or ACA) was an historic accomplishment. In addition to its efforts at healthcare cost containment and coverage provided to more than 30 million previously uninsured Americans, the ACA includes a wide range of provisions designed to support Americans' efforts to attain optimal health, and to increase the effectiveness of the nation's healthcare delivery system. Importantly, it does this in large part by redirecting the healthcare system toward a focus on *health* rather than on *disease*. While there has been little media attention to this focus, the ACA includes initiatives designed to increase our understanding of how to promote good health nationwide, as well as efforts to use the knowledge we already have about health promotion to incentivize healthy behaviors at the individual, institutional, and community levels.

The ACA also recognizes the importance of comparative effectiveness research through the creation and funding of the [Patient Centered Outcomes Research Institute](#) and significantly strengthens the healthcare system's emphasis on prevention, public health, and wellness. It implicitly acknowledges that while the US excels in the development and deployment of advanced medical technology, our relative inattention to low-tech approaches to everyday good health is likely a significant reason the [World Health Organization ranks our healthcare system only 37th in the world](#).ⁱ

Proper implementation of the changes embodied in the ACA will require careful regulatory guidance and long-term, system-wide follow-through. To participate meaningfully in this important follow-through effort, the Integrative Healthcare Policy

Consortium (IHPC), The Institute for Integrative Health (TIIH), and Palmer College of Chiropractic co-hosted a stakeholder working conference, *The Affordable Care Act and Beyond* (Georgetown University, September 27-29, 2010). Participants included policy advocates, researchers, social scientists, and a range of both conventional, and complementary and alternative medicine (CAM) professionals, including acupuncturists, chiropractic physicians, homeopathic practitioners, naturopathic physicians, medical physicians, nurses, nurse anesthetists, midwives, and massage therapists.

[The ACA provisions to emphasize prevention, health promotion, and patient engagement strongly reflect the values and practices of CAM and integrative health care.](#)

To help ensure preservation of these important initiatives, we convened stakeholders to distill and to articulate effective concepts and strategies to facilitate the rulemaking process. Many stakeholders across the country are concerned about health promotion and full access to care. We came together to ensure that the [40% of adult Americans \(and children\) who use CAM](#)ⁱⁱ will have increased access to the integrated healthcare approach they have chosen. We wish to assist those engaged in ACA rulemaking, because we know integrated health care can offer valuable insight within terrain that may be unfamiliar to HHS staff.

The Process: Dialogue & collaboration

The "Affordable Care Act and Beyond" conference was convened in the same spirit as previous national dialogues, to foster collaborative planning among integrative healthcare stakeholders.

ⁱ World Health Organization. World Health Organization assesses the world's health systems. [World Health Report](#). 2011. http://www.who.int/whr/2011/media_centre/press_release/en/. Accessed December 4, 2011.

ⁱⁱ Source: National Center for Complementary and Alternative Medicine. The use of complementary and alternative medicine in the United States. http://nccam.nih.gov/news/camstats/2007/camsurvey_fs1.htm, September 14, 2011; accessed November 17, 2011.

Mornings were devoted to plenary presentations by leading experts in government and academia, as well as integrative health practitioners, program administrators, and researchers focusing on aspects of the ACA relevant to integrative care (see the conference agenda, [Appendix A](#)). In the afternoons, [conference attendees](#) participated in one of six workgroups formed to address certain aspects of the ACA. With the information from the plenary presentations as a foundation, the broadly based interdisciplinary workgroups noted many positive policy changes in the ACA and identified provisions where specific regulatory action is needed to resolve ambiguities in statutory language regarding integrative healthcare delivery. The workgroups then presented their findings to the full conference.

Key areas addressed by the workgroups include:

- [ACCESS & NONDISCRIMINATION](#)
- [INTEGRATION IN PRACTICE](#)
- [COMPARATIVE EFFECTIVENESS RESEARCH AND THE PATIENT CENTERED OUTCOMES RESEARCH INSTITUTE \(PCORI\)](#)
- [THE HEALTHCARE WORKFORCE](#)
- [PREVENTION AND WELLNESS](#)
- [CURRENT PROCEDURAL TERMINOLOGY® \(CPT\) CODES](#)

The tasks of the workgroups include ensuring that the ACA is fully implemented by working to repeal any efforts to repeal it, in whole or in part; clarifying and advocating the best possible implementation of each provision of importance to integrative health care; and collaborating in these efforts with all stakeholders. **See [Table 1](#) for a summary of workgroup recommendations and [Table 2](#) for a summary update of workgroup initiatives.**

As described throughout this report and in [Figure 1](#), the ACA provides several opportunities to incorporate integrative care throughout the US healthcare system.

Sections of the Affordable Care Act addressed at this conference

- Section 2706
Pediatric Accountable Care Organization demonstration project
- Section 3502
Establishing community health teams to support the patient-centered medical home
- Section 4001
National Prevention, Health Promotion, & Public Health Council
- Section 4206
Demonstration project concerning individualized wellness plan
- Section 5101
National Health Care Workforce Commission
- Section 6301
Patient-centered outcomes research

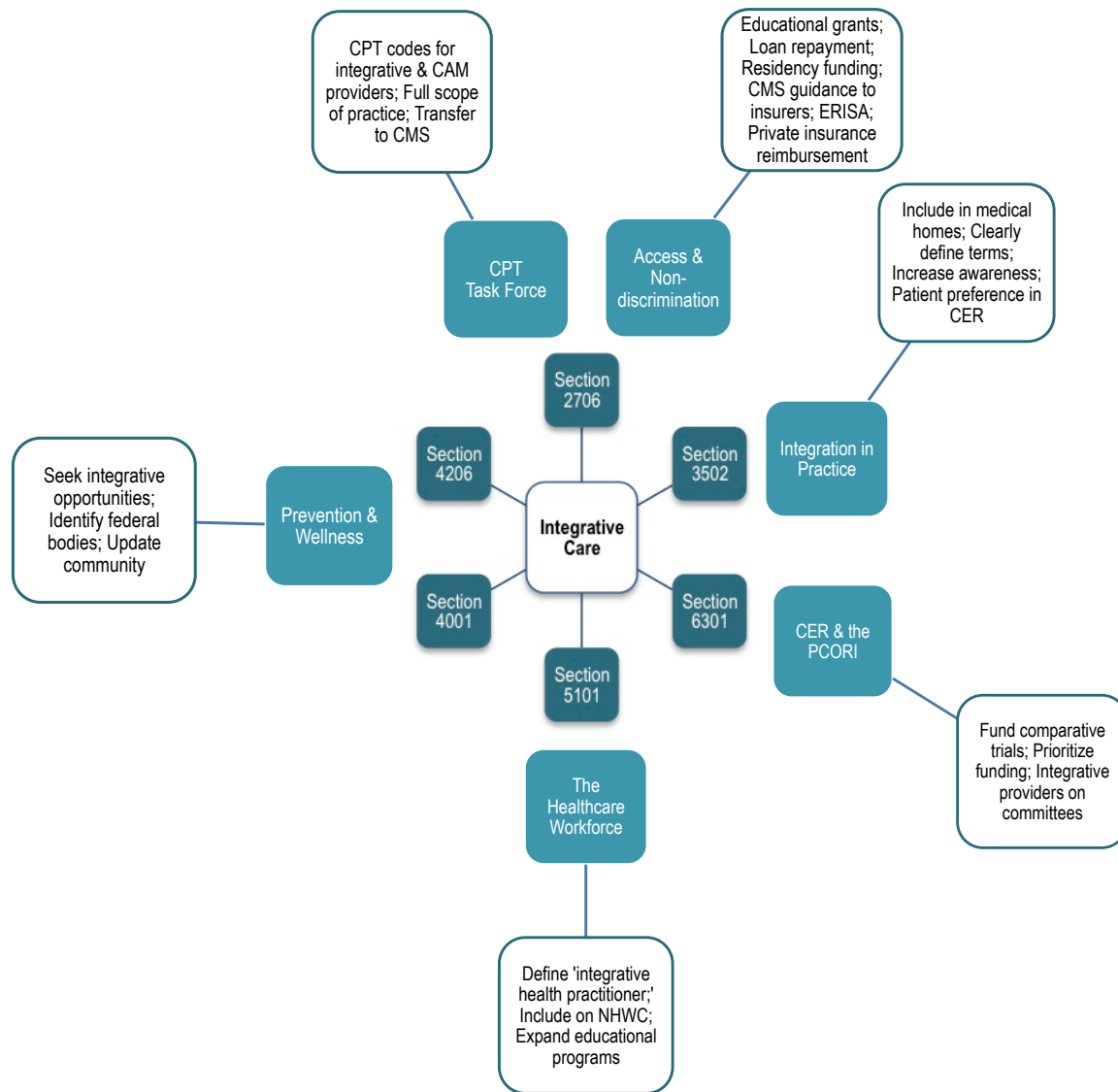


Figure 1 Stakeholder Conference workgroups and relevant sections of the ACA. The workgroups addressed issues pertinent to selected sections of the ACA and formulated recommendations based on their discussions.

RECOMMENDATIONS & ACTION ITEMS IDENTIFIED BY THIS CONFERENCE

Table 1 Workgroup recommendations

Workgroup	Recommendations
Access and Nondiscrimination	<ol style="list-style-type: none"> 1. Regulatory language clarifying the new nondiscrimination policy should list specific examples of insurance company actions that are prohibited under ACA Section 2706, as well as those that are permitted. 2. The Center for Medicare and Medicaid Services (CMS) or the Office of the Secretary of the Department of Health and Human Services (HHS) should issue a bulletin or guidance document to insurers (including Medicare Advantage, ERISA, and state plans) and providers clarifying that practitioners of all licensed CAM provider types must be included on an insurer’s network, such that a member shall be able to access a provider in a period of time comparable to that typical for other readily accessible providers. 3. Because entrenched funding patterns generally preserve a status quo that favors conventional healthcare professionals and therapies, and denies such benefits to CAM professionals and therapies, regulatory language is needed to ensure that a policy of nondiscrimination also is applied to: i) grants to educational institutions; ii) loan repayment programs; and iii) residency funding. 4. The IHPC and its Partners for Health should establish a task force to address specific language for rulemaking, and to determine what other strategies and actions should be taken. Suggested language should be formally submitted to HHS. The task force also should work with state insurance commissioners, insurance exchanges, National Association of State Insurance Commissioners, and other major decision-makers. 5. Issues of loan repayment, eligibility for the National Health Service Corps, Public Health Service, and a variety of federal programs, might be best dealt with via a comprehensive non-discrimination bill for the Public Health Service Act. 6. Request that congressional leaders adopt these recommendations as part of their agenda. 7. Confer with key legislators to determine whether Medicare and Medicaid are best dealt with as part of this law during rulemaking, or by inclusion separately in the Social Security Act.
Integration in Practice: Lessons for implementing the ACA	<ol style="list-style-type: none"> 1. Regulatory language is needed to ensure meaningful inclusion of a broad range of practitioners in medical homes, including licensed CAM providers and integrative healthcare practitioners. This could involve vigorous HHS incentives to form “integrative medical homes” and/or to incorporate a range of CAM/integrative practitioners into all medical homes. 2. Regulatory language is needed to define “integrative healthcare practitioner” in clearly inclusive terms that no reasonable person would interpret as giving permission to exclude or marginalize CAM practitioners. (The term, ‘integrative health practitioner,’ left undefined in the law, is addressed in Section 4 by the workgroup on the Healthcare Workforce.) 3. A patient-centered medical home is one where patients retain the choice of provider and are informed of all available options in an unbiased manner by a coach/navigator/advocate or primary care provider. Individuals in a navigator role must be thoroughly familiar with the full range of options available through the medical home and the community support team. 4. Regulatory language is needed to link comparative effectiveness research with the patient’s preference to ensure that the care being provided links the patient with a group of providers that best serves the patient and protects against inappropriate or unwanted care.

Workgroup	Recommendations
<p>Comparative Effectiveness Research and the Patient Centered Outcomes Research Institute: Setting the research agenda</p>	<ol style="list-style-type: none"> 1. PCORI should fund a series of well-designed, head-to-head pragmatic trials comparing conventional methods with integrative or complementary methods, taking into account patient- and practitioner-driven priorities. 2. PCORI should prioritize funding for studies that include an integrative or complementary care arm, in these areas: i) chronic disease (e.g., chronic pain, cardiovascular disease, arthritis); ii) adjunctive therapy in which integrative approaches are added to conventional care (e.g., cancer); and iii) areas in which conventional therapies lack efficacy. NCCAM / CDC survey data on integrative health care utilization can be used to drive specific decisions, especially for areas in which utilization of integrative care approaches or outpaces conventional care. 3. PCORI should have integrative healthcare representation on every committee, including peer review study sections for proposals submitted. 4. PCORI should seek, as appointees to the Methodology Committee, and other committees, innovators who understand integrative healthcare. The IHPC should submit nominees. 5. IHPC should send a letter to PCORI, signed by all stakeholder organizations, articulating our enthusiasm for their mission and strong recommendation that integrative healthcare be a priority area.
<p>The Healthcare Workforce</p>	<ol style="list-style-type: none"> 1. Regulatory language is needed to define the new provider designation, “integrative health practitioners,” that is included in ACA. 2. Appointments to the National Health Workforce Commission should include members of integrative and complementary health professions. Since this was not the case in the first round of appointments, we recommend that members of such professions be included on working groups, sub-groups, and committees established to further the Commission’s work, and that future appointments more fully reflect the health workforce defined in the ACA. 3. Health professions’ educational institutions should be incentivized to develop (or expand) both didactic and clinical programs in integrative health care, including cross-disciplinary training for both CAM and conventional providers.
<p>Prevention & Wellness: Reorienting American Health Care</p>	<p>These involve proposed actions by the Integrated Healthcare Policy Consortium, rather than the federal government. Many of the recommendations, while worthy, are beyond the capacity of IHPC at its current staffing level; therefore, the group recommended creation of a special task force from the conference, operating under the auspices of IHPC, to move this agenda forward. Recommendations include:</p> <ol style="list-style-type: none"> 1. IHPC should identify an inventory of existing prevention, health promotion, and wellness efforts across the federal government (e.g., Healthy People 2020 Health Objectives for the Nation, Centers for Disease Control and Prevention, Institute of Medicine, National Institutes of Health, etc.) and continually monitor changes and opportunities as they emerge. 2. IHPC should identify federal bodies in the fields of prevention, health promotion, and wellness, nominating potential appointees when appropriate and seeking other forms of participation, as well. 3. IHPC should collaboratively determine areas of opportunity and match community members with the goals shared by member groups and the broader integrative health community. This should include an ongoing search for information and programs on better ways to incentivize healthy behaviors. 4. IHPC should regularly update community members and others about key issues, serving as a mini-clearinghouse. IHPC communication should include: <ol style="list-style-type: none"> a. internal communication to the integrative health community about areas of prevention and wellness, and action steps that can be implemented by local, state, regional, or national integrative health organizations (i.e., communicating to constituent groups who can disseminate timely information to their members). This will require greater use of the IHPC website for posting relevant articles and related information, and timely grant opportunities as well as an IHPC member discussion board to facilitate and help expedite the grant proposal process. This could prove valuable in helping integrative health researchers find collaborators to glean important background information or develop partnerships.

Workgroup	Recommendations
CPT Codes	<ol style="list-style-type: none"> 1. Recognize that CPT codes are needed for all healthcare professionals. <ol style="list-style-type: none"> a. Begin by maximizing the existing codes for CAM and integrated healthcare use. b. Recruit provider groups to interact with/become advisors to HCPAC. (It was noted that acupuncturists have been advised to apply for a seat on the CPT Editorial Panel/HCPAC). c. Have professions identify changes needed in CPT codes and/or descriptions of CPT codes; use HCPAC Committee and CMS for assistance in securing the needed changes. d. Change language on CPT codes from “physicians” to “providers.” e. Approach CPT editorial panel to invite clarification of several issues, including the critical distinction between “shall” and “may.” f. Improve reimbursement for team care codes and explore the impact of inclusion of emerging non-licensed health professions. g. Examine and amend coding to facilitate valid comparative effectiveness research. 2. Prepare for enactment of Section 2706 of the Affordable Care Act (Non-Discrimination) which will take effect in 2014. <ol style="list-style-type: none"> a. Develop provider codes at 3 levels of complexity under Affordable Care Act (ACA) Section 2706 on Non-discrimination (see Access Workgroup). b. Actively engage with HHS to develop regulations that affect CPT code sets pursuant to Section 2706 of the ACA. 3. Collaborate with CMS. <ol style="list-style-type: none"> a. Work to amend Medicare rules to allow full scope of practice for all professions. b. Urge the movement of CPT ownership and management from the AMA to CMS, as the appropriate public/federal entity, thereby rendering the CPT function appropriately as a non-profit activity rather than a for-profit arm of the AMA. This should allow the CPT to become a healthcare information and reimbursement system that is more integrative, multi-disciplinary, and healthcare-focused. c. Approach CMS for contract/grant to modify codes as needed for each CAM/IHC profession. This might include development of new codes for “integrative health practitioner” groups that are not currently included in CPT, but which might become part of medical homes under the ACA.

WORKGROUP REPORTS

Access & Nondiscrimination

Members Gregory Goode; Michael Traub, ND, DHANP, CCH, FABNO; Deborah Senn, JD; Pamela Snider, ND; Richard Miller; Michael McGuffin; Janice Lipsen; Randi Gold, MPP; Caitlin Donovan, DC; Corinne Axelrod, MPH, LAc, Dipl Ac, CMS

Committee's Charge To discuss strategies concerning access-related issues, including: i) rulemaking plans for Section 2706 of the Affordable Care Act (see description below); ii) other aspects of discrimination, including grants to educational institutions, loan reimbursement opportunities, and residency funding; and iii) addressing the disparities across patient demographics regarding access to integrated healthcare.

Background

NONDISCRIMINATION TOWARD PROVIDERS

[Section 2706](#) of the ACA states, “a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law.”ⁱⁱⁱ

- Discrimination against CAM providers has been allowed by private insurers and this has rendered CAM use a privilege for those who can afford to pay for it out of pocket.
- The Congressional Research Service has documented extensive discrimination in all federal healthcare programs, citing the Veterans Administration as the least discriminatory.
- Discrimination can encompass refusal to include entire categories of healthcare professionals for reimbursement by insurance. Naturopathic physicians, for instance, are not included in many programs, even when they are performing services for which they are trained and licensed, and which other professionals (such as conventional and osteopathic physicians, mental health practitioners, or nurse practitioners) are being compensated.
- In other cases, CAM healthcare professionals have been “allowed” into a system, but not allowed to practice to the full extent of their

licensed scope of practice. Chiropractic physicians, for instance, are reimbursed for performing spinal adjustments to Medicare patients, but not if they adjust any other joint, such as the ankle or alignment of bones in the feet.

DISCRIMINATION IN HEALTH PROFESSIONS EDUCATION

Current facts and figures:

- CAM educational institutions typically rely on tuition for the majority of their total budgets. The comparable figure for conventional institutions is significantly less, with much of the difference due to various forms of government support.
- Federal loan repayment programs (e.g., service in the US Public Health Service Corps) currently are not available to CAM practitioners.
- CAM educational institutions have historically been excluded from federal grants for training programs, laboratory capacity-building, and other support, although this is changing somewhat, now.
- The IHPC and CAM professional associations have, for years, sought federal protection against such discrimination, asking for a more level playing field. While the ACA appears to make an important step in this direction, **key terms in the language of the law remain ambiguous and the language of this law leaves critical questions unresolved.** For instance, the phrase “shall not discriminate” must be defined, as well as “health insurance issuer,” to clarify whether Medicaid and Medicare, for example, are included within this legislative mandate.

Summary Section 2706 of the ACA was hailed by conference participants as a major breakthrough. To the extent that it succeeds in leveling the playing field for providers and supports the right of patients to access integrative providers of their choice, integrative health care will become more accessible to more people.

ⁱⁱⁱ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, SEC. 2706 [42 U.S.C. 300gg-5]. NON-DISCRIMINATION IN HEALTH CARE: (a) p 51.

Group members emphasized that nondiscrimination must not be left as a vaguely framed concept and wish to urge the Secretary of Health and Human Services to ensure that the rulemaking process clearly defines a variety of specific examples of insurance company behaviors that are prohibited under Section 2706, along with examples of actions by insurers that comply with the law.

Prohibited behaviors can be drawn from past cases of discrimination. The regulations must be very precise; insurers need to know what latitude they have and where that latitude ends. IHPC is asked to prepare a series of examples for consideration during the rulemaking process. A principal task will be to ensure that the term “insurer or insurance plan” refers to the US government and to the health plans it provides (including Medicaid, Medicare, and Tricare), and to private insurers.

Access and Nondiscrimination: Workgroup recommendations

1. Regulatory language clarifying the new nondiscrimination policy should list specific examples of insurance company actions that are prohibited under Section 2706, as well as those that are permitted.
2. The Center for Medicare and Medicaid Services (CMS) or the Office of the Secretary of the Department of Health and Human Services (HHS) should issue a bulletin or guidance document to insurers (including Medicare Advantage, ERISA, and state plans) and providers clarifying that practitioners of all licensed CAM provider types must be included on an insurer’s network, such that a member shall be able to access a provider in a period of time comparable to that typical for other readily accessible providers.
3. Because entrenched funding patterns generally preserve a status quo that favors conventional healthcare professionals and therapies, and denies such benefits to CAM professionals and therapies, regulatory language is needed to ensure that a policy of nondiscrimination also is applied to i) grants to educational institutions; ii) loan repayment programs; and iii) residency funding.
4. The IHPC and its Partners for Health should establish a task force to address specific language for rulemaking, and to determine what other strategies and actions should be taken. Suggested language should be formally submitted to HHS. The task force also should work with state insurance commissioners, insurance exchanges, National Association of State Insurance Commissioners, and other major decision-makers.
5. Consider providing a comprehensive non-discrimination bill for the Public Health Service Act that addresses issues of loan repayment, eligibility for the National Health Service Corps, Public Health Service, and a variety of federal programs.
6. Request that congressional leaders adopt these recommendations as part of their agenda.
7. Confer with key legislators to determine whether Medicare and Medicaid are best dealt with as part of this law during rulemaking, or by inclusion separately in the Social Security Act.

Integration in Practice: Lessons for implementing the ACA

Members Leonard Wisneski, MD, FACP; John Weeks; William Reddy, LAc, DiplAc; William Updyke, DC; Beverly Pierce, MLS, MA, RN, CHTP; Demi Stathoplos, MSW, MBA; Lori Knutson, RN, BSN, HN-BC; Anne Doherty-Gilman, MPH; Jenn Bahr

Committee's Charge To share their own experiences with integrated service delivery and their awareness of other important sites of integration, identifying key lessons learned from their experience; explore the application of those lessons to the Affordable Care Act (and beyond); and develop strategy for sharing those lessons with those responsible for implementation of the relevant sections of law.

Background High-quality integrative care blends the best of conventional medicine with the best of complementary and alternative medicine, engaging the patient in the decision-making. The ACA mentions integrative care several times and recognizes its potential value in the development of patient-centered medical homes, which occupy a role of increasing importance in the organization of coordinated outpatient care delivery under this law. [Section 3502](#) of the ACA establishes grants for medical homes, requiring that these be supported by community health teams as a means toward enhanced coordination and integration. Recognizing a contemporary healthcare workforce that includes both conventional and CAM providers, the law states that community-based interdisciplinary and inter-professional teams to support the patient-centered medical home may include "licensed complementary and alternative medicine practitioners" and "doctors of chiropractic."^{iv}

Bringing integrated practice into the US healthcare system via the ACA's patient-centered medical homes supported by community health teams could apply the lessons learned by current initiatives to a large-scale system. The question, of course, is how to do this well.

Summary The group focused much of its attention on the patient-centered medical home and its potential to serve as a fulcrum for transformative changes toward integration. It was noted that with [38% of adult Americans](#)

[and 12% of children utilizing CAM every year^v](#), a medical home that fails to fully integrate CAM providers and services is neither patient-centered nor a true 'home.'

CAM practitioners currently play significant roles in progressive clinics that embrace the medical home concept, including onsite integrative clinics at major corporations and at hospitals and HMOs, such as the [Holzer Clinic](#) in Ohio and West Virginia, [Allina Hospitals & Clinics](#) in Minnesota, and [Group Health Cooperative](#) in Washington. During the past decade, the [Veterans Administration](#) has integrated chiropractic and acupuncture into the health services provided to military veterans. Meditation, massage, yoga and other mind-body practices are increasingly utilized in programs for veterans returning from battle or service.

The group also discussed the need for all medical homes to have one or more staff members whose role is to help the patient "navigate through the system" without bias. Depending on the circumstances, this might be a 'health coach,' 'health navigator,' or 'health advocate' with specialized training, an 'integrative care manager,' or a primary care practitioner. Individuals in this role must be thoroughly familiar with the full range of options available through the medical home and the community support team. A patient-centered home is one in which patients retain the choice of provider and are informed of all available options in an unbiased manner by a coach/navigator/primary care provider. Moreover, every practitioner in every medical home should demonstrate lifestyle educational competency (training in basic nutritional, physical activity, and stress management needs), as well as team competency training. Comprehensive health and risk-factor assessment tools should be employed with all patients to establish baseline prevention and treatment needs.

Finally, the group focused on the importance of public education about health and health care, as a path toward broader self-knowledge and self-care

^{iv} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, SEC. 3502 [42 U.S.C. 256a-1]. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME, para. 4, p. 435.

^v National Center for Complementary and Alternative Medicine. [The use of complementary and alternative medicine in the United States](#). Published September 14, 2011, http://nccam.nih.gov/news/camstats/2007/camsurvey_fs1.htm. Accessed December 10, 2011.

skills. Without this understanding, *individual* choice is not *informed* choice. Integrative practice must be “health creating” practice, in which acute symptom treatment is used as a springboard to a broader,

sustained focus on self-care, prevention, and health promotion. This is a path toward improved health and reduced costs. In the medical home setting, patients should be asked about their interest in receiving comprehensive preventive care (whether or not they present with symptoms). If they are interested, they should be provided with this care.

Integration in Practice: Workgroup recommendations

1. Regulatory language is needed to ensure meaningful inclusion of a broad range of practitioners in medical homes, including licensed CAM providers and integrative healthcare practitioners. This could involve vigorous HHS incentives to form “integrative medical homes” and/or to incorporate a range of CAM/integrative practitioners into all medical homes.
2. Regulatory language is needed to define “integrative healthcare practitioner” in clearly inclusive terms that no reasonable person would interpret as giving permission to exclude or marginalize CAM practitioners. (The term, “integrative healthcare practitioner,” left undefined in the law, is addressed in Section 4 by the workgroup on the Healthcare Workforce.)
3. A patient-centered medical home is one where patients retain the choice of provider and are informed of all available options in an unbiased manner by a coach/navigator/advocate or primary care provider. Individuals in a navigator role must be thoroughly familiar with the full range of options available through the medical home and the community support team.
4. Regulatory language is needed to link comparative effectiveness research with the patient’s preference to ensure that the care being provided links the patient with a group of providers that best serves the patient and protects against inappropriate or unwanted care.

Comparative Effectiveness Research and the Patient Centered Outcomes Research Institute: Setting the research agenda

Members William Meeker, DC, MPH; Wayne Jonas, MD; Michele Maiers, DC, MPH; Brian Berman, MD; Ian Coulter, PhD; William Duncan, PhD; Michael Cronin, ND; Todd Hoover, MD, DHT; Rory Zahourek, PhD, PMHCNS-BC, AHN-BC

Committee's Charge To advise the assembled body on the suggested relationship to the [Patient Centered Outcomes Research Institute](#) (PCORI) and other bodies with related responsibilities; and to address the research agenda itself, including the most important areas of study: methodological issues in comparative effectiveness research, definition of effectiveness, and commentary on the Institute of Medicine's comparative effectiveness research agenda.

Background Comparative effectiveness research (CER) is critical to the development of effective, integrative health care. Patients, providers, policymakers and insurers need the kind of evidence that allows them to make decisions regarding care. This requires evidence that allows [comparisons across potential treatment options](#), examining outcomes such as functional effectiveness, cost-effectiveness, side effects, and risk. In this arena, distinctions between methods considered conventional, complementary, alternative, or integrative should disappear.

The only distinction that matters in CER is whether a particular approach is effective or ineffective in achieving desired health outcomes and avoiding adverse side effects.

Established under [Section 6301](#) of the ACA, the [Patient Centered Outcomes Research Institute](#) (PCORI) will be the federal government's main body determining the agenda and overseeing funding of patient centered outcomes research (PCOR). PCOR itself is not defined in the ACA, but the law plans for PCORI to oversee, but not be limited to, the funding and conduct of comparative effectiveness research. The ACA includes dedicated funding for PCORI, generated through Medicare. (The PCORI Board of Governors had just been appointed as this conference commenced. Among them is Christine Goertz, DC, PhD, of Palmer College of Chiropractic, a co-host of the conference.)

Summary The group discussed i) research design, ii) research agenda priorities for integrative care, and iii) support for research training and infrastructure in CAM and integrative healthcare educational institutions. The workgroup compiled a list of potential nominees for the PCORI Methodology Committee, which will exert strong influence over the types of studies PCORI will fund.

The group emphasized the need to fund well-designed, head-to-head, pragmatic trials in which conventional methods are compared with integrative or complementary methods. These trials should take into account patient- and practitioner-driven priorities that were components of the original tri-partite concept of evidence-based practice. There also is a strong need for economic simulation modeling studies and for cost-effectiveness studies, which should consider resource use and total risk.

In addition, the group proposed that PCORI's actions also should reflect patient-driven input and therefore recommended creation of a Patient Advisory Panel.

Discussion of the PCORI research agenda regarding integrative care highlighted the need for PCORI funding priorities to be informed by the existing research agendas of the Institute of Medicine and the National Center for Complementary and Alternative Medicine (NCCAM). It was noted that PCORI could utilize survey data from NCCAM to determine areas where CAM utilization is the highest, although NCCAM already does this. It was also noted that public use patterns do not always correspond to the greatest public health needs and that these needs should be identified. The group identified three primary areas for which a CAM or integrative arm should be included in PCORI-funded studies: i) chronic disease (e.g., chronic pain, cardiovascular disease); ii) adjunctive therapy where integrative approaches are added to conventional care (e.g., cancer); and iii) areas where conventional therapies have fallen short, beyond the well-known inadequacies of care for chronic illness and pain.

1. PCORI should fund a series of well-designed, head-to-head pragmatic trials in which conventional methods are compared with integrative or complementary methods, taking into account patient- and practitioner-driven priorities.
2. PCORI should prioritize funding for studies that include an integrative or complementary care arm, in these areas: i) chronic disease (e.g., chronic pain, cardiovascular disease, arthritis); ii) adjunctive therapy in which integrative approaches are added to conventional care (e.g., cancer); and iii) areas in which conventional therapies lack efficacy. [NCCAM / CDC survey data](#) on integrative health care utilization can be used to drive specific decisions, especially for areas in which utilization of integrative care approaches outpaces conventional care.
3. PCORI should have integrative healthcare representation on every committee, including peer review study sections for proposals submitted.
4. PCORI should seek, as appointees to the Methodology Committee, and other committees, innovators who understand integrative healthcare. The IHPC should submit nominees.
5. IHPC should send a letter to PCORI, signed by all stakeholder organizations, articulating our enthusiasm for their mission and strong recommendation that integrative healthcare be a priority area.

The Healthcare Workforce

Members David O'Bryon, JD, LLD; Sherman Cohn, JD, LLM; Nancy Gahles, DC, CCH; Adi Haramati, PhD; Karen Howard; Elizabeth Goldblatt, PhD, MPA/HA

Committee's Charge To discuss the "new" healthcare workforce including: definitions of categories never seen before (e.g., integrative healthcare practitioner), which need to be defined for rulemaking; the implications of the new definition for educational institutions; and how the integrative and CAM healthcare community can collaborate with the [National Healthcare Workforce Commission](#).

Background The Affordable Care Act provides a framework for ongoing reconsideration of the US healthcare workforce and its capacity to address the country's healthcare needs. Two important elements within [Section 5101](#) of the law address this issue: creation of the National Healthcare Workforce Commission, and expansion of who is included in the law's definition of the healthcare workforce.

Ensuring that the nation has an appropriate healthcare workforce is not a simple task. The challenges facing the current US healthcare workforce have resulted from many factors. Laws

have been enacted with the usual mix of public good and special interests involved; professional priorities and assumptions have been expressed through curricula of each profession's educational institutions with all the conscious consideration and encrusted habits that academia may entail; reimbursement patterns of federal and state programs and private insurers have provided conscious and unconscious incentives; cultural tendencies influence geographic variation in both need and capacity, and have also undoubtedly led to the increased number and uneven distribution of CAM providers of various types.

The National Healthcare Workforce Commission (NHCWFC) is charged with:

- evaluating current educational institutions' ability to provide for the needed workforce
- identifying barriers to optimal coordination between diverse levels of government
- recommending solutions to those barriers
- encouraging innovations to address the changing needs of the population (e.g., healthspan, environment, and age) and changing opportunities within developing knowledge and technology

- communicating and coordinating with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education
- serving as a resource for Congress and for the President, as well as for States and localities

This is a significant task for a commission whose appropriations were not built into the law.

In Section 5101, the ACA defines the American healthcare workforce as specifically including integrative health practitioners, licensed complementary and alternative medicine providers, and doctors of chiropractic. While doctors of chiropractic have been included in some federal legislation before, and licensed complementary and alternative medicine providers are relatively easy to identify (although they vary state by state), the category named [‘integrative health practitioners’](#) is new and, being undefined by the law, remains subject to interpretation.

Despite the law’s recognition of integrative health practitioners, licensed complementary and alternative medicine providers, and doctors of chiropractic as part of the healthcare workforce, no representatives from any of these groups or experts in integrated healthcare, were included in the initial round of appointments to the National Healthcare Workforce Commission.

A key impediment to mainstreaming integrative care is that most health professionals (and the institutions in which they work) largely function within their own individual silos. Many healthcare professionals lack sufficient awareness of both the training and licensed scope of practice of other health professionals, or of the full range of conventional and CAM options available for the conditions they commonly treat. This is true for both CAM professionals and conventional professionals. Cross-disciplinary, inter-professional education, now in its infancy, must be broadly taught, along with the skills of working in teams. Both are critical to developing a truly integrated healthcare system. When all health professionals become familiar with the scope of practice and the evidence base of all other health professions, practitioners will be able to provide patients with comprehensive informed consent opportunities, including awareness of the methods generally classified as integrative or complementary care.

Summary The workgroup discussed the variety of topics encompassed within a workforce discussion, and specified three priorities to address: i) definition of terms, both workforce and integrated/integrative; ii) recommendations for educating the workforce in an age of integrated healthcare; and iii) the National Healthcare Workforce Commission.

Because “integrative health practitioner” is not defined in the ACA regulatory language, defining the term clearly is required. As noted earlier, integrative care blends the best of conventional medicine with the best of complementary and alternative medicine. Thus, the definition of “integrative health practitioner” should explicitly include a health and wellness paradigm, and should specifically include CAM providers and practices. It should not express a bias toward conventional providers and practices.

The group drafted the following definition that was read to conference attendees. Given time constraints, the definition could not be evaluated for approval.

Integrative Health Care Practitioner

“Integrative Health Care Practitioner,” acting within the scope of that provider’s license, certification, or registration under applicable state law, promotes individual health and increases individual capacity to engage in activities of daily living through lifestyle change, including strategies relating to diet, exercise, smoking cessation, and stress reduction; and provides patient-centered care that:

- addresses personal health needs;
- uses a multidimensional approach to encourage patients to improve their own wellness through lifestyle changes that will facilitate the inherent ability of the human body to maintain and restore optimal health;
- uses outcomes-based research and evidence-informed practice in working in partnership with the patient;
- addresses the underlying causal factors associated with chronic disease;
- utilizes clearly defined standards to determine when the implementation of health and wellness promotion activities will be useful for each patient, based on the diet, exercise habits, individual health history, and family health history of the patient;

- refers to and collaborates with appropriate practitioners in other healthcare disciplines.

Policy Statement to Aid Credentialing In a separate effort, initiated prior to this conference but completed afterward, the Integrated Healthcare Policy Consortium (IHPC) prepared guidelines for hospitals, clinics, government entities, or others seeking to safely credential integrative healthcare practitioners. In particular, IHPC sought to provide clarity for credentialing those who are unlicensed but hold national certification. IHPC undertook this effort in response to two critical factors: i) some professions are unlicensed by their choice, but others are not allowed licensure by their state, because the state feels there is no endangerment to the public without licensure; and ii) there is wide variation in the requirements for, and thus the meaning of, national certification. IHPC offers the following framework for duly recognizing those professions that have established high standards for their national certification and to distinguish them from those that have not. The IHPC recommendation, "The National Healthcare Workforce in an Era of Integration," ([Appendix C](#)) states:

“Seeking a balance between strongly held values of patient access to healthcare therapies and professionals

of their choice AND proper recourse if inappropriate or unethical care should occur, the Integrated Healthcare Policy Consortium (IHPC) supports inclusion in the National Healthcare Workforce of:

- all licensed conventional, complementary and alternative healthcare providers
- all state certified healthcare providers
- all nationally certified healthcare providers when the certification agency is accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence (ICE)
- For healthcare professions that do not yet have state licensure/certification/registration or national certification, IHPC strongly encourages them to pursue state licensure/ certification/registration and/or national certification.“

Healthcare workforce development is directly dependent on the quality and focus of healthcare education, both in core training programs and in continuing and in-service educational settings. The group discussed the need for all health care professionals to be trained in conventional, complementary and integrative concepts and approaches, beginning at the pre-professional level and continuing throughout the career.

The Healthcare Workforce: Workgroup recommendations

1. Regulatory language is needed to define the new provider designation, “integrative health practitioners,” that is included in ACA.
2. Appointments to the National Health Workforce Commission should include members of integrative and complementary health professions. Since this was not the case in the first round of appointments, we recommend that members of such professions be included on working groups, sub-groups, and committees established to further the Commission’s work, and that future appointments more fully reflect the health workforce defined in the ACA.
3. Health professions’ educational institutions should be incentivized to develop (or expand) both didactic and clinical programs in integrative health care, including cross-disciplinary training for both CAM and conventional providers.

Prevention & Wellness: Reorienting American health care

Members Brian Thiel, MBA, MSBA, MS; Lucrezia Mangione, CMT; Matthew Fritts, MPH; Duffy MacKay, ND; Jean Robinson; Mary Jo Kreitzer, PhD, RN, FAAN; Daniel Redwood, DC; Sue Berman; Anne Doherty-Gilman, MPH; Lori Byrd, MS; Donna Feeley, MPH, RN, NCTMB

Committee's Charge To explore aspects of the law that address prevention, health promotion, and wellness, including: how these new entities and declarations interface with existing efforts; opportunities in rulemaking to strengthen this new focus; and our community's historic, present, and future place in prevention and wellness efforts.

Background Among the potentially far-reaching aspects of the ACA is its emphasis on prevention and wellness. Our current healthcare system is predominately focused on the response to and treatment of disease, rather than on disease prevention and health promotion. Current prevention efforts in the US concentrate more heavily on secondary prevention, such as early disease detection (for example, blood pressure monitoring, mammography, colonoscopy, skin cancer screening, diagnostic laboratory testing). Primary prevention, on the other hand, focuses on behavioral elements that create and maintain optimal health and wellness (for example, healthy eating, regular exercise, preventing injuries, and managing stress) with the goal of preventing injury and illness from occurring. It is well understood that in order for detection to be effective, it must be followed by behavior change.

Detection itself, whether of early disease or of genetic or other propensities, does not constitute prevention. Only when the resulting information is used to prompt behavior change can it truly be called "prevention."

There is keen interest by the medical research establishment in probing genetic contributors to disease vulnerabilities, despite the fact that [behavior accounts for far more of a person's risk for developing the most common and costly diseases \(heart disease, for example\) than does heredity.](#)^{vi} Perhaps the most fundamental health question our

society faces in the future is whether we can educate and coach enough people into changing behaviors harmful to health and replacing these with health-affirming choices. The ACA recognizes that without greater nationwide implementation of evidence-based and lifestyle-based prevention and health promotion, this will not happen. How, then, can we incentivize such changes?

There has been a long-term national movement to create a paradigm shift toward prevention, beginning in 1979 with [Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention](#) and the corresponding [Health Objectives for the Nation](#). This strategy has been active for the last three decades. The successes of these initiatives over the years have helped shape the public health prevention emphasis incorporated into the new Patient Protection and Affordable Care Act. The need for a shift in focus has been driven in part by the difficulty in ameliorating chronic diseases and their skyrocketing healthcare costs. The fact that [our current health system costs more per capita than any other industrialized country,](#)^{vii} yet yields a [sub-par ranking in the cumulative population health status](#)^{viii} has motivated the need to escalate change.

[Section 4001](#) of the ACA called for establishment of the [National Prevention, Health Promotion and Public Health Council](#), chaired by the US Surgeon General. It also called for designation of an [Advisory Group on Prevention, Health Promotion, and Integrative and Public Health](#), that will report to the Council and to the Surgeon General. The Council, composed of federal cabinet members across the spectrum of federal government agencies, is tasked to provide coordination and leadership at the interagency federal level and among all executive departments and agencies on prevention, wellness, and health promotion practices, the public health system, and integrative health care. The Advisory Group will be composed of 25 members, including "licensed integrative health practitioners" and will serve to advise the Council.

[Section 4206](#) of the ACA establishes a pilot program to test the impact of providing at-risk

vi Whitlock EP, Orleans CT, Pender N, and Allan J. Evaluating primary care behavioral counseling: an evidence-based approach. US Preventive Services Task Force.. <http://www.uspreventiveservicestaskforce.org/3rduspstf/behavior/behsum1.htm#table3>. Accessed December 1, 2011.

vii World Health Organization. Spending on Health: A global overview. Fact sheet no. 319, March 2007. <http://www.who.int/mediacentre/factsheets/fs319/en/>; accessed December 13, 2011.

viii World Health Organization. World health statistics, 2011. Geneva: 2011. http://www.who.int/gho/publications/world_health_statistics/en/index.html. Accessed December 6, 2011.

populations who utilize community health centers with individualized wellness plans designed to reduce risk factors for preventable conditions, as identified by a comprehensive risk-factor assessment. The components of the wellness plan include nutrition counseling, a physical activity plan, alcohol and smoking cessation counseling and services, stress management, dietary supplements that have health claims approved by the Secretary of Health and Human Services, and compliance assistance provided by a community health center employee.

In efforts to implement a new direction in health care, ACA stipulated the development of a [National Prevention Strategy](#) by the Council to lay the foundation for making prevention and wellness a priority for the national health agenda. The strategy is to propose evidence-based models, policies, and innovative approaches to promote transformative models of disease prevention, health promotion, integrative health, and public health on individual and community levels across the United States. Although great strides have been made over the years with *Healthy People*, the ACA breaks new historic ground by: i) placing it in the forefront of the nation's efforts to improve health, and ii) recognizing a potential role for integrative health care in our nation's healthcare system. How prevention is further defined, incorporated, and implemented within our system will substantially influence the nation's future health status.

Summary Members of this group included individuals and organizations with backgrounds in integrative and public health academics, workplace wellness programs, health coaching training, health education training, knowledge of and experience with other current and past federal prevention efforts, and dietary supplement industry expertise. The workgroup began by recognizing the historical significance of the ACA, especially for inclusion of integrative health as a landmark component. The discussion involved several prevention-related topics from an historical perspective, specific community needs, and the extensive implications of the current legislation. Discussions included the importance of identifying cost channels as key determinants of federal actions, the potential for action through executive branch regulation to spur development of cross-disciplinary teamwork, and how to influence public opinion as well as that of decisions makers. There was also extensive discussion about the need to incorporate a primary prevention, complementary, and integrative health focus into existing public health efforts, nurse-managed health centers, community health centers,

and community health teams for medical homes. In the discussion process, the work group emphasized the concept of 'one health' which was used to include the health of people, communities, and the environment, as inextricably inter-related.

The workgroup considered several post-conference organizational needs to support an agenda regarding ACA, such as:

- [how the diverse integrative health community can collaborate to advance a common message.](#) It was recommended that a focus be placed first on key implementers within various federal agencies, and then on organizing communities.
- [messages from the integrative health community to regulators.](#) Members emphasized the need and value of healthcare providers working in teams and engaging patients to allow care to be patient-directed. They also acknowledged the importance of addressing health disparities regarding access and vulnerability, and the critical issue of cost effectiveness.
- [the need and importance of having a centralized location to monitor](#) the Federal Register, emergent issues, and grant opportunities as they relate to the new law.
- [the need for well-established communication functions,](#) and internal and external channels for communication throughout the integrated health care community, and for federal agencies responsible for relevant rulemaking and implementation.
- [the importance of message content](#) and the need to distinguish the integrated community's particular meaning of commonly used terms. An example given was the consensus understanding of the importance of a 'healthy diet,' and the CAM/integrated health understanding of the importance of 'whole foods nutrition.' It was recommended that the use of commonly used terms from current public health, health promotion, and disease prevention terminology be incorporated for relevance and consistency to definition and meaning.
- [the gap between people's knowledge about healthy choices and their actual behavior.](#) There was discussion about the extent to which lack of behavior change indicated a failure of the messaging or difficulty in changing behavior and habits. Mainstreaming the role of 'health coaches' to facilitate behavioral change was seen as a potentially important element for further development.

These involve proposed actions by the [Integrated Healthcare Policy Consortium](#), rather than by the federal government. Many of the recommendations, while worthy, are beyond the capacity of IHPC at its current staffing level. This was recognized and the group recommended creation of a special task force from the conference, operating under the auspices of IHPC, to advance this agenda. The group recommended that the IHPC should:

1. Identify an inventory of existing prevention, health promotion, and wellness efforts across the federal government (e.g., *Healthy People 2020 Health Objectives for the Nation*, Centers for Disease Control and Prevention, Institute of Medicine, National Institutes of Health, etc.) and continually monitor changes and opportunities as they emerge.
2. Identify federal bodies in the fields of prevention, health promotion, and wellness, nominating potential appointees when appropriate and seeking other forms of participation, as well.
3. Collaboratively determine areas of opportunity and match community members with the goals shared by member groups and the broader integrative health community. This should include an ongoing search for information and programs on better ways to incentivize healthy behaviors.

4. Update community members and others regularly about key issues, serving as a mini-clearinghouse. IHPC communication should include:
 - a. internal communication to the integrative health community about areas of prevention and wellness, and action steps that can be implemented by local, state, regional, or national integrative health organizations (i.e., communicating to constituent groups who can disseminate timely information to their members). This will require greater use of the IHPC website for posting relevant articles and related information, and timely grant opportunities as well as an IHPC member discussion board to facilitate and help expedite the grant proposal process. This could prove valuable in helping integrative health researchers find collaborators to glean important background information or develop partnerships.
 - b. external communication to key government leaders who may be influential in implementing prevention, wellness, and integrative care components of healthcare legislation and regulation.

CPT® Task Force

Members Debra Baas, JD; Beth Clay; Alan Dumoff, JD; Anthony Hamm, DC; Janet Kahn, PhD, LMT; Bruce Milliman, ND; and David Riley, MD

Committee's Charge Explore issues related to the creation, management, ownership, and usage of [Current Procedural Terminology](#) (CPT® codes^{ix}). Although CPT codes are not addressed in the ACA, the conference organizing committee believed this issue required the attention of a workgroup. While no limits were placed on the boundaries of the group's deliberations, the group was encouraged to discuss:

- how CPT codes currently serve (or don't serve) the various CAM and integrative healthcare professions;
- the potential value of alternative approaches to reporting and reimbursement (e.g., [Alternative Link](#), methods used by other governments that have greater degrees of integration, etc.);
- action strategies, including using the current committee structure to add codes needed.

Background on CPT Codes Current Procedural Terminology Codes (CPT Codes) are the numeric system used in the US by all healthcare providers to identify and/or seek reimbursement for

^{ix} CPT is a registered trademark of The American Medical Association.

procedures performed or services rendered in treating a patient. Use of the CPT system is a requirement for payment via public (e.g., Medicaid/Medicare) and private insurers in the US.

The CPT system is managed by the American Medical Association (AMA) through an agreement established in 1983 with the Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA). HCFA was later replaced by the Center for Medicare and Medicaid Services (CMS). Prior to 1983, competing coding systems existed, but in order to streamline Medicaid/Medicare payments with a single coding system, HHS authorized the AMA to manage the development and continual updating of a coding system that would be required by everyone billing Medicaid or Medicare for outpatient services. Not long afterward, private insurance companies also adopted CPT codes as a requirement for reimbursement.

The AMA was granted the copyright for this system and derives a substantial portion of its annual budget from this source. In a [2001 letter to Tommy Thompson \(then Secretary of HHS\), Senator Trent Lott](#) estimated the AMA's annual revenue from CPT-related sales and leasing agreements at \$71 million.^x That figure, for which Lott cites *The Wall Street Journal* as his source, is substantially more than the AMA's annual revenue from membership dues or any other source. In addition to Senator Lott, complementary and alternative medicine (CAM) providers, as well as many nurses and other "conventional" healthcare professionals, have been troubled by the AMA's ownership of and income from CPT Codes. Of particular concern has been the AMA's ongoing effort to limit the scope of practice of non-MD healthcare professionals, with some questioning the appropriateness, and even the legality, of a membership organization of one profession receiving required payments from other professionals for what should be a public function (a reimbursement code system), as well as controlling the specifics of that system, thus having a strong influence on the procedures for which healthcare professionals can receive (or not receive) insurance reimbursement.

[Senator Lott's letter](#) focused on legal and practical implications of the AMA's "statutory monopoly" with different, but related, questions. The potential practical and legal problems he cited include:

- "...the AMA has been able to impose on the entire nation the AMA's obviously self-interested policy against consumers comparison shopping for medical care based on price by suing web sites and others to prohibit them from posting comparisons ...using the CPT codes."
- Noting that comparison shopping and proper billing to prevent fraud and honest error are critical to containing escalating health care costs, Lott notes that, "The AMA's proprietary interest in the CPT has also reportedly hampered efforts to educate doctors about proper practices in billing Medicaid, Medicare, and insurance companies."
- Lott found it "...noteworthy that the Ninth U.S. Circuit Court of Appeals held in 1997 that the AMA's exclusivity agreement with HCFA for using CPT 'gave the AMA a substantial and unfair advantage over its competitors' and 'constituted a misuse of the copyright by the AMA.'"
- Lott raises the possibility that "the AMA's conditions and high prices for a licensee's use of the CPT code constituted violations of anti-trust law as well."

Lott then noted that, after the court ruling cited above, HCFA and the AMA eliminated the exclusivity clause in their agreement, thus deterring such lawsuits. However, by that time, the AMA/CPT hegemony had been established. Other codes which existed prior to the 1983 agreement were no longer in use, and the effort required to develop and garner serious attention for any other system would be daunting.

BACKGROUND ON ABC CODES While some advantages of a single, universally accepted coding system are obvious, the concerns cited above about the CPT code set also have been voiced by nurses, physicians, and various CAM healthcare professionals. In 1996, Alternative Link (later renamed, [ABC Coding Solutions](#)) was founded to provide a more comprehensive coding system that would apply to the broadened range of healthcare approaches Americans were then using. Their system, ABC Codes, includes more than 4,500 descriptions of healthcare services, remedies, and supply items; is HIPAA compliant; and can be used in tandem with CPT codes for a variety of non-MD healthcare professionals.

ABC codes have not been widely adopted in the US, although in January 2003, HHS approved a

^x Association of American Physicians and Surgeons. Senate Update, July 2001. <http://www.aapsonline.org/medicare/lottcptletter.htm>. Accessed December 15, 2011.

two-year pilot study for the [“...use of Advanced Billing Concepts \(ABC codes\) for Alternative Medicine, Nursing and other Integrative Health Care.”](#)^{xi} ABC Coding reported that the demonstration project showed that ABC codes could be readily and successfully used for Medicaid billing, and that [“...Alaska Medicaid, the largest beta test site, reported a 50% cost benefit by using ABC codes to file claims based on behavioral health care services delivered by 500 paraprofessionals to 4,000 underserved people in bush communities of the state from 2004-2007.”](#)^{xii}

The IHPC Coding Task Force was established in 2003 to evaluate the existing CPT code set and the proposed ABC code set, and their comparative use and usefulness by complementary and integrative health professions. During this time, IHPC undertook a thorough evaluation of the strengths and weaknesses in both systems. IHPC and the Coding Task Force facilitated meetings to increase access to participation in coding decisions and health insurance reimbursement for complementary and alternative medicine (CAM) professionals.

On January 29, 2003, members of the IHPC Coding Task Force submitted testimony to the [National Committee on Vital Health Statistics \(NCVHS\)](#).

Testimony from IHPC was given by Alan Dumoff, JD; Bruce Milliman, ND; and Konrad Kail, ND, PA, expressing profession-wide support for the existing CPT code set. The group’s testimony also supported the ABC Code Set Demonstration Project, which had been proposed at that time, as a means to evaluate the ABC system.

The Task Force report and testimony delivered by Dr. Milliman and Dr. Kail highlighted the following concerns about perceived weaknesses in the ABC code set, and potential problems with nationwide adoption of the ABC codes:

- the ABC code set is large, compared with the CPT code set
- utilizing the ABC code set would require increased physician time and training
- currently, the ABC code set is not widely used
- the ABC code set may not be reimbursed, or may be inequitably reimbursed, by public and private payers.

Testimony included a proposal that the CPT Editorial Panel include a wider array of non-MD (CAM and integrative) healthcare providers in its

advisory panel, in order to address some of the concerns raised by the non-MD healthcare community, and to ensure broad representation and participation from all healthcare providers regarding code formation, modifications, and deletions.

Alan Dumoff’s testimony addressed gaps in current CPT medical code sets. Dumoff identified several problems with CPT coding that had implications for accuracy in reporting and subsequent research, costs of health care, and equity across professions: “...Many procedures simply have no code, including oriental medicine techniques such as cupping, chiropractic therapies such as closed joint adjustments, bodywork therapies such as zero balancing, or energetic therapies such as therapeutic touch. Integrative medical physicians also face numerous gaps in codes, such as allergen immunotherapies aimed at alleviating sensitivities mediated by non-IgE reactions. Coding difficulties faced by CAM practitioners, nurses and integrative physicians are often more difficult than simple gaps, however, and arise from uncertainty as to whether a service can be fairly represented by a code written with a biomedical procedure in mind.... Decisions about levels of E/M visits, bundling of procedures, and coding categories affect the tracking of utilization and outcome data and reimbursement decisions.... The determination that an E/M component is bundled into chiropractic manipulation effectively bars chiropractors from correctly representing a range of services within their training and scope of practice... ”^{xiii}

Following the NCVHS testimony, IHPC arranged subsequent discussions at a two-day meeting in Washington, DC, with representatives from AMA/CPT, Alternative Link (ABC Coding Solutions), and CAM profession representatives, to facilitate the CAM professions’ participation in CPT’s [Health Care Professions Advisory Committee \(HCPAC\)](#), which advises on the creation and definition of codes. Representation on the CPT HCPAC was considered to be an essential step by the licensed CAM professions. As a result of this meeting, two CAM representatives were added to the HCPAC — one from the [American Association of Naturopathic Physicians](#) and one from the [American Massage Therapy Association](#). This now offers an avenue to address gaps in CPT coding and to achieve beneficial interdisciplinary contact.

xi Downing R. ABC codes: key to integrative success? [Integrative Nursing Newsletter](#), March/April, 2003.

xii Giannini JM. A rational proposal to fix healthcare. ABC Coding Solutions. <http://www.abccodes.com/ali/press/FixHealthcare-08.10.27.asp>. Accessed November 19, 2011.

xiii Department of Health and Human Services, National Committee on Vital and Health Statistics, January 29-30, 2003. <http://www.ncvhs.hhs.gov/030129mn.htm>. Accessed December 12, 2011.

IN OCTOBER, 2005, A LETTER FROM THE AMERICAN NURSES ASSOCIATION to HHS petitioning for recognition of ABC codes as a designated standard code set for healthcare services reporting, including HIPAA transactions, noted that ["...sole reliance on the ICD-9 CM, HCPCS II, and CPT coding systems will continue to force incorrect or omitted documentation of health services... This practice often results in inaccurately reported and represented diagnoses, procedures or interventions, and total costs of healthcare services..."](#)^{xiv} Nurses and other professions also have argued that CPT codes are inadequate for identifying best practices or for conducting useful comparative effectiveness research, including obtaining an accurate reflection of comparative cost effectiveness.

At the 2009 Senate HELP Committee hearing, ["Principles of Integrative Health: A Path to Healthcare Reform,"](#) Brian Berman, MD, testified, ["The existing medical coding does not adequately represent the services delivered by the vast majority of licensed health care practitioners...; therefore, accurate actuarial data cannot be generated to sort out what works from what does not. ABC codes have been successfully piloted in several Medicaid programs and demonstrated real cost savings..."](#)^{xv}

Despite the apparent limitations of CPT codes, and concerns about AMA copyright and income from them, ABC Codes is the only other system to be developed since the 1983 decision, and it has not received much attention from the federal government, despite support from a number of healthcare professions.

Summary Committee members included physicians who were constantly engaged with coding for reimbursement, and other clinicians who avoided CPT engagement through cash-only practice; lawyers familiar with both CPT and ABC codes (one of whom had secured the HIPAA exemption for the ABC Coding demonstration in Alaska and another who trains MDs); and two members of AMA/CPT code-related committees (one on the AMA Relative Value Update Committee of HCPAC and another who is on the AMA CPT Editorial Panel/HCPAC); a person who teaches coding, documentation, and Medicare and risk management, and is a contributing author for the *American Chiropractic Association Coding Solutions Manual*; and a lobbyist whose work has included CPT-related issues.

Initial discussion addressed problems experienced with CPT, untapped potential within the CPT system to obtain new codes, advantages and disadvantages of ABC Coding, potential of SNOMED CT (a comprehensive multilingual health terminology developed for international health information exchange), and the coding/reimbursement practices of other countries. Problems included not only coding gaps or bias, but also reimbursement practices. For instance, Medicare currently reimburses chiropractors only for spinal manipulation but not for other aspects of necessary treatment, such as physical examination, radiological procedures, physiotherapeutic modalities, exercise and rehabilitation, or nutrition counseling.

CPT vs. ABC CODES After determining that many countries use CPT coding and that SNOMED CT was not relevant to the discussion at hand, conversation focused on ABC Codes. While noting that they had conducted successful demonstration projects and that the Dubai Healthcare City has successfully adopted them, the group felt that ABC Codes were not likely to gain much more attention in the US and decided that the limited meeting time should be used to focus on how to work with the CPT system. Specific reservations raised about the ABC codes included concern by some that the "granularity" of the code set added a potentially onerous additional burden of coding and documentation for providers who already have limited time; and that unless universally accepted, payers would likely undervalue services and procedures coded differently from the majority of reimbursed providers. Opposing views to the first concern were that the granularity, while burdensome, produced more complex and potentially more helpful data, and more accurately portrayed the theoretical framework and actual practices of CAM and some conventional professions. Nonetheless, as stated, the conversation focused primarily on issues related to CPT coding.

EVALUATION & MANAGEMENT (E&M) CHARGES/CODES This includes the following areas of inadequate CPT coding for CAM/IHC providers:

Use of 'physician:' in areas where E&M is limited to 'physician' it should be broadened to 'provider' or to some more inclusive term. One workgroup member noted that this change has been continually incorporated into all new codes, and at

xiv American Nurses Association letter to Hon. Michael O. Leavitt, US Dept. of Health and Human Services, October 5, 2005, p. 2. www.leg.state.nv.us/74th/Exhibits/Senate/CL/SCL725C.pdf. Accessed December 11, 2011.

xv *Principles of Integrative Health: A Path to Healthcare Reform: Hearings on S. 111-387, Day 1, Before the Comm. on Health, Education, Labor, and Pensions, 111 Cong., Feb. 23, 2009, p. 105.* <http://www.gpoaccess.gov/congress/senate>

each mandated five-year review of existing codes. It was not applied retrospectively to old codes. E&M is reimbursed according to level of complexity, as are other CPT domains. The elements of E&M are history, physical examination, and complexity/medical decision-making. One problematic aspect of this is the prohibition against diagnosis (assessment) by massage therapists (MT), so CPT coding should be rewritten to accommodate MT assessment procedures. One member of the group noted that the codes are “provider blind,” and that if state licensure and scope authorize any provider to diagnose (assess), then that provider may use the appropriate code specified in CPT.

Use of the term “may” in the following language:

“When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify

for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.”^{xvi}

Switching terminology from “may” to “shall” would ensure that providers be reimbursed for their evaluation and management efforts — aspects of practice that can be more time-consuming for contact-intensive professions, such as acupuncture and Oriental medicine that involve extensive assessment to understand the etiology of symptoms/conditions, and the many CAM/IHC providers whose treatments involve labor-intensive patient education and evaluation of follow-through.

The group concluded its deliberations with an agreement to meet, perhaps monthly, to continue the discussion and to begin action.

**CPT Task Force:
Workgroup recommendations**

1. Recognize that CPT codes are needed for all healthcare professionals.
 - a. Maximize the existing codes for CAM and integrated healthcare use.
 - b. Recruit provider groups to interact with or become advisors to HCPAC. (It was noted that acupuncturists have been advised to apply for a seat on the CPT Editorial Panel/HCPAC.)
 - c. Have professions identify changes needed in CPT codes and/or descriptions of CPT codes; use HCPAC Committee and CMS for assistance to secure needed changes.
 - d. Change language on CPT codes from “physicians” to “providers.”
 - e. Approach CPT editorial panel to invite clarification of several issues, including the critical distinction between “shall” and “may.”
 - f. Improve reimbursement for team care codes and explore the impact of including emerging non-licensed health professions.
 - g. Examine and amend coding to facilitate valid comparative effectiveness research.
2. Prepare for enactment of Section 2706 of the Affordable Care Act (Non-Discrimination) which will take effect in 2014.
 - a. Develop provider codes at 3 levels of complexity under Affordable Care Act (ACA) Section 2706 on Non-discrimination (see Access Workgroup).
 - b. Actively engage with HHS to develop regulations that affect CPT code sets pursuant to Section 2706 of the ACA.
3. Collaborate with CMS.
 - a. Work to amend Medicare rules to allow full scope of practice for all professions.
 - b. Support transfer of CPT ownership and management from the AMA to CMS, as the appropriate public/federal entity, thus rendering the CPT function appropriately as a non-profit activity, rather than a for-profit arm of the AMA. This should allow the CPT to become a healthcare information and reimbursement system that is more integrative, multi-disciplinary, and healthcare-focused.
 - c. Approach CMS for contract/grant to modify codes as needed for each CAM/IHC profession. This might include development of new codes for “integrative health practitioner” groups that are not currently included in CPT, but which might become part of medical homes under the ACA.

^{xvi} American Medical Association. *CPT® 2010 Professional Edition*. Chicago, 2010:10.

POST-CONFERENCE PROGRESS

IT HAS BEEN 18 MONTHS SINCE THE AFFORDABLE CARE ACT WAS SIGNED INTO LAW, and one year since recommendations for action were established by this conference. The ACA is so comprehensive and complex, that full implementation was designed for a four-year process. Only some of the provisions most closely related to integrated health care have been enacted. Other provisions still are in the rulemaking process and some require further time until they are enacted.

Overall Support of the ACA & Integrative Health Care

In this era of virulent partisanship and serious financial strain, there have been several attempts to undermine the ACA. Challenges regarding its constitutionality have reached the Supreme Court, with a decision expected by June 2012. IHPC, like other organizations supportive of the ACA, maintains an active interest in the law's survival and in specific strategies, outlined here, to implement the sections of the law that are most important to our constituencies.

Congressional Briefings

Given the Congressional upheaval of 2010, there are many new legislators and staffers on Capitol Hill who were not involved in crafting the ACA and who may be unfamiliar with some aspects, including those related to integrative health care. The IHPC and its [Partners for Health](#), along with other allies, will present a series of three or more Congressional briefings on integrated health care throughout 2011-12. These educational briefings will address the following topics:

- the definition of integrated health care
- the potential role of integrated care in preventing and treating chronic pain and illness
- the national healthcare workforce as defined in the ACA
- implications of the ACA for medical home models and for other federal planning efforts

- the relationship between patient empowerment and non-discrimination against provider types, as stipulated in Section 2706 of the ACA.

Support of Councils, Groups, Institutes & Commissions

The [National Healthcare Workforce Commission](#) (NHWC) has been stipulated by the ACA to oversee “evaluations of education and training activities to determine whether the demand for healthcare workers is being met;” to identify and address barriers to improved coordination across all levels of government (local through federal); and to encourage “innovations to address population needs, constant changes in technology, and other environmental factors.” The NHWC is to undertake this challenge within the context of a redefined healthcare workforce that includes licensed CAM providers. Those opposed to the ACA have refused to appropriate funds for activities of some bodies created by the ACA, including the NHWC. To date, no funds have been appropriated for NHWC. Although commissioners have been appointed by the Comptroller General, as specified in the law, the commission has not yet met or taken action.

The [National Prevention, Health Promotion and Public Health Council](#) was created to address the enhanced focus on prevention and health promotion stipulated by the ACA. It is a cabinet-level body chaired by the Surgeon General. This council (similar to that proposed by the [Samueli Institute's](#) and IHPC's *Wellness Initiative for the Nation*) is charged with developing and implementing the [National Prevention Strategy](#).^{xvii} This level of commitment to health promotion by so many senior members of the administration is unprecedented and reflects the commitment made in the law to prevention and wellness in the US healthcare system. In an encouraging early move, the Surgeon General immediately strengthened this Council by adding five additional agencies to the 13 agencies stipulated in the law: the Department

xvii National Prevention, Health Promotion, and Public Health Council. [National Prevention Strategy: America's plan for better health and wellness](#). Rockville, MD. 2011. www.healthcare.gov/prevention/nphpphc/strategy/report.pdf. Accessed November 8, 2011.

of Justice, the Department of Defense, the Department of Veterans Affairs, the Department of Housing and Urban Development, and the Office of Management and Budget.

The [Advisory Group on Prevention, Health Promotion, and Integrative and Public Health](#) is a grassroots group whose job is to provide advice to the Council emanating from needs identified at the grassroots level. This group is chaired by Jeffrey Levy, PhD, and reports to the Surgeon General. President Obama has appointed 17 of a possible 25 members to this group. Two members have clear links to, and knowledge of, integrated health care.

Actions to support prevention and health focus of the ACA

Stakeholder groups have pursued the following actions to support and/or expand the prevention and health promotion focus of the law:

- resisting abbreviation of the council and advisory group names: to avoid inadvertently de-emphasizing or neglecting the intended focus of “health promotion” and the implicit inclusivity of “integrated and public health”
- co-signing letters to protect appropriations: although the ACA provided for funds to be appropriated in specific annual amounts into a Prevention and Public Health Fund to be administered by the Secretary of HHS, some have called for a negation of those appropriations. Consequently, several stakeholder groups, including the IHPC, have signed letters initiated by the [Trust for America’s Health](#) to protect this critical resource.
- co-signing letters for suggested actions: in March 2011, IHPC delivered a letter to the Surgeon General (see [Appendix B](#)), addressing the National Prevention, Health Promotion and Public Health Council and IHPC’s five top priorities for the council to address. Suggestions for these priorities were solicited from all stakeholder conference attendees and sponsors, and the letter was co-signed by IHPC, the American Association of Naturopathic Physicians, Bastyr University, the National Association of Certified Professional Midwives, the National Center for Homeopathy, and

Sojourns Community Health Clinic. Council support staff ensured the letter was distributed to members of both the council and the advisory group.

- submitting responses to the draft of the National Prevention Strategy.
- attending meetings of the Advisory Group (Samueli Institute and IHPC have attended)
- collaborating with the Surgeon General and with Dr. Levy, chair of the advisory group, to offer assistance: Wayne Jonas, of the Samueli Institute, presented to the Prevention and Integrative Health Working Group of the Advisory Group about the concept of resiliency and the Samueli Institute’s work in prevention and wellness with the military. Janet Kahn of the IHPC has been appointed as a member of the Prevention and Integrative Health Working Group of the Advisory Group.
- participating in the Patient Centered Outcomes Research Institute (PCORI) ([see p.18](#))

Access and Non-discrimination

While Section 2706 of the ACA (which focuses on non-discrimination), is not planned to go into effect until 2014, there has been ample opportunity to address issues of patient access and discrimination against provider types within other sections of the law. Encouraging broad use of the expanded definition of the ‘healthcare workforce’ (as it appears in Section 5101), is one vehicle for addressing these issues. The following efforts have been undertaken in this regard.

- In October 2010, IHPC and The Institute for Integrative Health presented this discussion to HRSA’s Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas. Supporting information was provided, including an overview of states in which naturopathic physicians, chiropractic physicians, and certified professional midwives are recognized as primary care providers, and journal article, “[Estimating the de-designation of single-county HPSAs in the United States by counting naturopathic physicians as medical doctors.](#)”^{xviii}

xviii Albert DP and Butar FB. Estimating the de-designation of single-county HPSAs in the United States by counting naturopathic physicians as medical doctors. *Applied Geography* 2005;25:271-285.

- The committee's proposed algorithms, published in September 2011, subsequently excluded these three professions. IHPC responded with another letter (see Appendixes [E](#) & [E](#)) which was presented to the committee by David O'Bryon.
- Efforts to include the services of CAM and integrated healthcare professions in the Essential Benefits Package have taken place. IHPC joined the [American Association and Acupuncture and Oriental Medicine](#) (AAAOM) on efforts to have AOM included. In addition, knowing that the National Association of Insurance Commissioners was asked to make recommendations on this issue, as was the Institute of Medicine, members of IHPC's Federal Policy Committee approached the insurance commissioners in their states. In Hawaii, a statewide meeting of the integrative health care/CAM community with the insurance commissioner and legislators is planned to discuss a progressive approach to healthcare policy in that state.
- Several organizations within the chiropractic community are collaborating to address the integration of chiropractors into wellness and prevention efforts, and into primary care. These include the American Chiropractic Association, the International Chiropractors Association, the Association of Chiropractic Colleges, and the Council of Chiropractic State Organizations.

Integration in Practice

A task force is being activated to provide guidance on proposed regulatory language to promote inclusion of CAM providers in medical homes and on community health teams. Since definitions and guidelines for credentialing will be essential in this effort, the [American Association of Naturopathic Physicians](#) has developed a definition for 'integrative healthcare practitioner' and the IHPC has produced guidelines for credentialing (see [Appendix D](#)).

Comparative Effectiveness Research and Patient-Centered Outcomes Research

Christine Goertz, DC, PhD (an organizer of the Stakeholder Conference), was appointed to the PCORI Board of Governors shortly before the conference began. Still to be appointed at that time were members of the PCORI methodology

committee, which the [workgroup on Comparative Effectiveness Research](#) and PCORI saw as a high priority. Several candidates were vetted and both IHPC and the Academic Consortium for Complementary and Alternative Health Care submitted nominations, raising the profile of the integrated healthcare community with this group.

PCORI has, to date, informed the public of its activities and has solicited feedback. The [Consortium of Academic Health Centers for Integrative Medicine](#) (CAHCIM) has been represented at every meeting of the PCORI Board of Governors, to maintain focus on integrative health care and the offer of assistance to PCORI. Many integrated healthcare stakeholders exchanged views and offered assistance at a listening session hosted by PCORI in Seattle, in September 2011.

Many organizations responded to PCORI's request for feedback about the definition of PCOR and their proposal for eight "[Tier One](#)" Pilot Projects. IHPC's Partners for Health suggested the term, 'clinician,' should always be understood to refer to all healthcare providers and practitioners named as members of the National Healthcare Workforce in Section 5101 of the Affordable Care Act." This suggestion and IHPC's feedback were disseminated via [The Integrator Blog](#).

The Healthcare Workforce

The National Healthcare Workforce Commission has been rendered temporarily inactive due to lack of funding. Efforts are being made to encourage all agencies with HHS to adopt the definition of 'healthcare workforce' in Section 5101 of the ACA.

Prevention and Wellness

See discussions regarding the National Prevention, Health Promotion and Public Health Council, the Advisory Group on Prevention, Health Promotion and Integrative and Public Health, and the planned Congressional briefings for activities, to date (pp. [16-17](#)). The shift to prevention as a key responsibility of the healthcare system, and the associated role of CAM and integrated health care will be pursued consistently.

CPT Codes

The word “may” was changed to “shall” in the Evaluation and Management Services Guidelines section of the 2011 CPT® Professional Edition. It now reads: “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time

shall be considered the key or controlling factor to qualify for a particular level of E/M services...” This, along with the language change incorporated into CPT from “physician” to “qualified health care professional” significantly neutralizes biased language and provides more profession-neutral, CPT codes. The change in language from “physician” to “qualified health care professional” is being hotly debated by the AMA CPT Editorial Panel.

Table 2 Summary and update of post-conference activities

Activities to Support ACA & Integrated Health Care	Post-conference Activities
Congressional briefings	<p>IHPC, its Partners for Health, and other allies, will present a series of three or more congressional briefings on integrated health care throughout 2011-12. The briefings will address these topics:</p> <ul style="list-style-type: none"> • the definition of integrated health care • the potential role of integrated care in preventing and treating chronic pain and illness • the national healthcare workforce as defined in the ACA • implications of the ACA for medical home models and for other federal planning efforts • the relationship between patient empowerment and non-discrimination against provider types, as stipulated in Section 2706 of the ACA.
Support of councils, groups, institutes & commissions	<p>National Healthcare Workforce Commission (NHWC) To date, no funds have been appropriated for NHWC. Although commissioners have been appointed by the Comptroller General, as specified in the law, the commission has not yet met or taken action.</p> <hr/> <p>National Prevention, Health Promotion and Public Health Council Two members have clear links to, and knowledge of, integrated health care.</p> <hr/> <p>Advisory Group on Prevention, Health Promotion, and Integrative and Public Health Two members have clear links to, and knowledge of, integrated health care.</p>
Support in maintaining and/or expanding the prevention and health promotion focus of the ACA.	<p>Actions include:</p> <ul style="list-style-type: none"> - Maintaining a focus on “health promotion” and the implicit inclusivity of “integrated and public health” by resisting abbreviation of the council and advisory group names. - Co-signing letters to protect appropriations provided for by the ACA in specific annual amounts into a Prevention and Public Health Fund administered by the Secretary of HHS. Dissenters have called for negation of these appropriations. Stakeholder groups, including the IHPC, have signed letters initiated by the Trust for America’s Health to protect this critical resource. - Co-signing letters for suggested actions. These include: letter to the Surgeon General (see Appendix B), addressing the National Prevention, Health Promotion and Public Health Council and IHPC’s five top priorities for the council to address (March 2011). Suggestions for priorities were solicited from all stakeholder conference attendees and sponsors. The letter was co-signed by IHPC, the American Association of Naturopathic Physicians, Bastyr University, the National Association of Certified Professional Midwives, the National Center for Homeopathy, and Sojourns Community Health Clinic. Council support staff ensured the letter was distributed to members of both the council and the advisory group. - Submitting responses to the draft of the National Prevention Strategy. - Attending meetings of the Advisory Group (Samueli Institute and IHPC have attended). - Collaborating with the Surgeon General and with Dr. Levy, chair of the advisory group, to offer assistance. Wayne Jonas of the Samueli Institute presented to the Prevention and Integrative Health Working Group of the Advisory Group about the concept of resiliency and the Samueli Institute’s work in prevention and wellness with the military. Janet Kahn of the IHPC was appointed to the Prevention and Integrative Health Working Group of the Advisory Group. - Working with the Patient Centered Outcomes Research Institute (PCORI). (See below).

Conference workgroup updates

Non-discrimination & Access to Care

IHPC and The Institute for Integrative Health presented to HRSA's Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas (October 2010). The groups provided supporting information, including an overview of states in which naturopathic physicians, chiropractic physicians, and certified professional midwives are recognized as primary care providers.

The committee's proposed algorithms (pub. September 2011) excluded the 3 professions listed above.

- IHPC sent another letter (see Appendixes F & G) to the committee (presented by D. O'Bryon, JD).
- IHPC joined the American Association and Acupuncture and Oriental Medicine (AAAOM) to support AAAOM's inclusion in the Essential Benefits Package.

The National Association of Insurance Commissioners and the Institute of Medicine were asked to make recommendations on the Essential Benefits Package.

- IHPC's Federal Policy Committee contacted the insurance commissioners in their states.
- A state-wide meeting of integrative health care / CAM community with the Hawaii State Insurance Commissioner and legislators is planned to discuss a progressive approach to healthcare policy in that state.

Progressive Research in Health requested assistance from IHPC regarding ACA implementation and strengthening state-level access to integrated health care and to CAM. IHPC directed PRH to appropriate state-level legislative examples and to experienced personnel at that level.

Integration in Practice

- A task force is being activated to provide guidance on proposed regulatory language to promote inclusion of CAM providers in medical homes and on community health teams.
- The American Association of Naturopathic Physicians developed a definition for 'integrative healthcare practitioner' and the IHPC has produced guidelines for credentialing (see [Healthcare Workforce workgroup](#), p. 6).

Comparative Effectiveness Research & Patient Centered Outcomes Research

- Members of the PCORI methodology committee, are still to be appointed. IHPC and the Academic Consortium for Complementary and Alternative Health Care submitted nominations, increasing the profile of the integrated healthcare community.
- The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) has been represented at every meeting of the PCORI Board of Governors.
- Integrative healthcare stakeholders exchanged views and offered assistance at a PCORI listening session, September 2011, in Seattle.
- In response to PCORI's Tier One Pilot Project request, IHPC's Partners for Health suggested the term 'clinician' should always be understood to refer to all healthcare providers and practitioners named as members of the National Healthcare Workforce in Section 5101 of the Affordable Care Act. This suggestion and IHPC's feedback were shared with other organizations via [The Integrator Blog](#).

The Healthcare Workforce

The National Healthcare Workforce Commission has been rendered temporarily inactive due to lack of funding. Efforts are being made to encourage all agencies with HHS to adopt the definition of 'healthcare workforce' in Section 5101 of the ACA.

Prevention & Wellness

See discussions (p. 19) regarding the National Prevention, Health Promotion and Public Health Council, the Advisory Group on Prevention, Health Promotion and Integrative and Public Health, and the planned Congressional briefings for activities, to date. The shift to prevention as a key responsibility of the healthcare system, and the associated role of CAM and integrated health care will be pursued consistently.

CPT Task Force

The word “may” was changed to “shall” in the Evaluation and Management Services Guidelines section of the [2011 CPT® Professional Edition](#). It now reads: “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services. . .” This, along with the language change incorporated into CPT from “physician” to “qualified health care professional” significantly neutralizes biased language and provides more profession-neutral, CPT codes. The change in language from “physician” to “qualified health care professional” is being hotly debated by the AMA CPT Editorial Panel.

APPENDIX A

Conference Agenda

Monday, September 27th

Welcome & Overview of Meeting Objectives and Agenda

Janet Kahn, PhD, LMT & Christine Goertz, DC, PhD

Introduction of Robert Fisher, Conference Facilitator

Overview of CAM and Integrated Health Care in the Affordable Care Act

Janet Kahn, PhD, LMT, Executive Director, Integrated Healthcare Policy Consortium

Improving Access:

Non-Discrimination Against Provider Types

Jenelle Krishnamoorthy, PhD, Health Policy Director, Senate HELP Committee; & Deborah Senn, JD, The Zielke Law Firm, P.S., former Wash. State Insurance Commissioner

Improving Access: Expanded Definition of the Healthcare Workforce and the National Healthcare Workforce

Gail Hansen, DVM, MPH, Senior Officer, Human Health & Industrial Farming, Pew Charitable Trusts, (formerly Healthcare Legislative Asst. for Sen. Bernie Sanders)

Overview of Prevention, Health Promotion, and Wellness in the Affordable Care Act

Wayne Jonas, MD, President and CEO, Samueli Institute

Medical Homes and Community Health Teams

Mona Shah, Staff Director, Subcommittee on Aging, Committee on Health, Education, Labor and Pensions and Office of Sen. Barbara Mikulski

CPT Codes — How They Are Set and Their Relevance to Integrated Health Care

Bruce Milliman, ND, Nat'l. Rep. for AANP on AMA CPT Editorial Panel/Health Care Professional Advisory Committee; and Anthony Hamm, DC; ACA chair, Coding and Reimbursement Committee; representative to the AMA RUC HCPAC

Lessons for the Rulemaking Process — A Panel of Policy-Setting Experts

Beth Clay, Capitol Strategy Consultants, Inc.; Janice Lipsen, President, Counselors for Management, Inc., Legislative Affairs, AANP; and Richard Miller, Miller Consulting, representing the American Chiropractic Association

Breakout Sessions by Workgroup Topic

ACCESS: strategies to address access-related issues, including:

- ❖ rulemaking plans for Section 2706 of the Affordable Care Act;
- ❖ other aspects of discrimination, such as grants to educational institutions, and loan reimbursement opportunities
- ❖ breaking down the disparity across patient demographics regarding access to integrated healthcare.

THE HEALTHCARE WORKFORCE: the “new” healthcare workforce including:

- ❖ definitions of categories never seen before (e.g. “integrated healthcare practitioner) which need to be defined for rulemaking;
- ❖ the implications of the new definition for educational institutions;
- ❖ how our community should related to the National Healthcare Workforce Commission.

PREVENTION AND WELLNESS: Reorienting American Health Care: exploring aspects of the law that address prevention, health promotion and wellness, including:

- ❖ how these new entities and declarations relate to existing efforts,
- ❖ opportunities in rulemaking to strengthen this new focus, and
- ❖ our community’s historic, present and future place in prevention and wellness efforts.

CPT CODES: STRATEGIES FOR INTEGRATION: exploring any or all of the following:

- ❖ how CPT codes currently serve (or don’t serve) various CAM and integrative medicine professions;
- ❖ the potential value of alternative approaches to reporting and reimbursement (e.g., Alternative Link, methods used by other governments that have greater degrees of integration, etc.);
- ❖ action strategies, including using the current committee structure to add codes needed, etc.

**COMPARATIVE EFFECTIVENESS RESEARCH & PCORI:
SETTING THE RESEARCH AGENDA:** advising the larger group on:

- ❖ suggested relationship to the Patient Centered Outcomes Research Institute and other bodies with related responsibilities;
- ❖ the research agenda itself including most important areas of study, methodological issues in comparative effectiveness research, definition of effectiveness, and commentary on the IOM-generated CER agenda.

INTEGRATION IN PRACTICE: LESSONS FOR IMPLEMENTATION OF THE AFFORDABLE CARE ACT: group members (who have extensive knowledge of integration) will:

- ❖ share their own experiences with integrated service delivery and their awareness of other important sites of integration;
- ❖ identify key lessons learned from their experiences;
- ❖ explore the application of those lessons to the Affordable Care Act (or the beyond);
- ❖ develop strategies for sharing those lessons with those responsible for implementing the relevant sections of law.

Report back

Highlights and Summary from Breakout Sessions

Facilitated Panel Discussion

Summary and Perspective on Day's Accomplishments and Focus for Next Day

[Tuesday, September 28th](#)

Reflections from Yesterday/Plan for the Day NCCAM's 3rd Strategic Plan: Directions for the Future

Josephine Briggs, MD, Director, National Center for Complementary and Alternative Medicine

A Look at a Corporate Integrative Health Clinic and the Affordable Care Act

William Updike, DC, Administrator of integrative clinic for large Fortune 500 Company

Players in Health Reform

Christine Goertz, PhD, DC, Vice Chancellor for Research and Health Policy at Palmer College of Chiropractic

Comparative Effectiveness Research/PCORI

Steve E. Phurrough, MD, MPA, Chief Operating Officer and Senior Clinical Director, Center for Medical Technology Policy; former medical officer in the Center for Outcomes and Effectiveness at the Agency for Healthcare Research & Quality (AHRQ)

Ian Coulter, PhD, Samueli Institute Chair in Policy for Integrative Medicine, and Senior Health Policy Analyst, RAND Corporation; Professor, UCLA School of Dentistry

HR 4568 — A Novel Approach to Reimbursement

William A. Duncan, PhD, President, Capitol Strategy Consultants, Inc.

Breakout Sessions (continuation of groups that met on Monday)

Report back

Highlights and Summary from Breakout Sessions

Facilitated Panel Discussion

Summary and perspective on day's accomplishments and overview of Wednesday

[Wednesday, September 29th](#)

Reflections/Questions from Group at Large Leadership Panel offers Reflections and Day's Tasks Discussion: Conference Follow-Up

- ❖ Conference report plans
- ❖ Collaborative actions identified
 - specific implementation actions
 - legislative briefings
 - goals for engaging in public discourse
- ❖ Ongoing workgroups
- ❖ Funding for ongoing efforts

APPENDIX B

IHPC Top Five Priorities Statement



INTEGRATED
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Top Five Priorities for the National Prevention, Health Promotion, and Public Health Council

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Michael Cronin, NMD

Donna Feeley, MPH, RN, NCTMB

Nancy Gahles, D.C., CCH, RSHom
(NA)

Gregory J. Goode, MA

Mary Lawlor, CPM, LM, MA

Michael Traub, ND

IHPC Partners for Health
American Association of
Acupuncture and Oriental Medicine

American Association of
Naturopathic Physicians

American Massage Therapy
Association

Bastyr University

National Association of Certified
Professional Midwives

National Center for Homeopathy

Palmer Center for Chiropractic
Research

Introduction

The creation under the Patient Protection and Affordable Care Act (PPACA) of the National Prevention, Health Promotion, and Public Health Council acknowledges that one key to reducing health care costs is through efforts to prevent disease onset and progression and to deepen our understanding and commitment to helping people enhance their own health. This will require substantial change in the orientation of a health care system which has been focused on disease treatment, often to the neglect of health promotion. We celebrate the creation of this inter-agency Council as it is an acknowledgement that virtually every aspect of federal domestic policy affects Americans' health, and paying attention to this is where health promotion begins. We also applaud the creation of the grassroots Advisory Group on Prevention, Health Promotion and Integrative and Public Health, which can provide much needed perspective and data to the Council.

As the Council and the Advisory Group begin your work we would like to offer a few suggestions from the field of integrated health care.

1. **First**, we hope that you will **give strong attention to primary prevention** as well as secondary, and bear in mind that **health promotion and disease prevention are about human behavior first and foremost**. In our technology-oriented world it is easy to become captivated by the promise of genomic discovery with its possibility of altering people's inborn propensities, as well as other high tech interventions. It is possible to focus on requirement of colonoscopies or other diagnostic procedures, and forget that information alone is not preventive. It is only when information guides behavior that

preventable disease will be prevented. We urge you to seek the low cost, low tech interventions that are available through both conventional and complementary and alternative health care disciplines. It is well known that changing people's behavior is far more difficult than securing changes in knowledge or stated attitudes. We urge attention to how best to provide and incentivize patient education that works, including development of health coaching criteria to ensure quality and revised reimbursement structures that allow for time spent with patients whether individually or in groups.

2. We also encourage you to adopt systems thinking when considering human health and wellbeing, and this is reflected in a number of suggestions made below. This will put an emphasis on **whole systems of care as most likely to yield positive health outcomes**. By this we mean at least two things:
 - a. If it takes a village to raise a child, it also takes a village – or at least a team, to keep each of us going well. This is reflected in the Affordable Care Act in the proposal for Medical Homes. We encourage you to **promote the use of teams which can provide the kind of continuity of care and attention that allows the dots of a person's health presentation and data to be connected** and potentially harmful patterns to be recognized and corrected.
 - b. We also implore you to **allow all health care providers to practice to the full extent of their scope of practice**. When systems of medicine are implemented piecemeal, such as Medicare's reimbursement of chiropractors for spinal segment adjustment only, one disrupts the optimal practice of medicine and reduces a health care provider to the status of technician. We must have systems of reimbursement that honor the full training and expertise of every direct entry provider. **There are synergies that are destroyed and quality of care and attention that is prohibited when techniques or services are separated from the whole diagnostic and treatment system in which they are embedded**.
3. Recognizing that attending to health promotion and wellness at this unprecedented level requires some reorientation of our assumptions and resources, we recommend that **you begin by gathering information**, perhaps through the Congressional Research Service. We need a **comprehensive review of all federal health care programs (Medicare, DoD, VA, FEHBP, etc.) to identify the existence and scope of any currently existing programs and benefits available specifically for the purpose of wellness, health enhancement and disease prevention. All cost-benefit information should be included in this review**.
4. Over 40% of Americans use some form of complementary and alternative medicine (CAM), including medical systems that have traditionally been oriented toward the establishment and maintenance of optimum health and wellbeing. We encourage the Council and Advisory Group to **conduct hearings to inform**

yourselves fully about the practices and outcomes of both integrative health care (patient-centered multi-disciplinary collaboration) and individual systems including naturopathic medicine, acupuncture and Oriental medicine, Ayurvedic medicine, chiropractic medicine, therapeutic massage, homeopathy and professional midwifery, as they relate to both primary and secondary preventive efforts. **We encourage the inclusion of all regulated health care professionals in medical homes and their community health teams.** (See attached document for regulation criteria.)

5. **In all policy-creation and rulemaking** related to health care in this era the Council should require **attention to issues of equity as they relate both to patients and providers.**
- a. **Patient Equity Issues** revolve around access to both the social and environmental conditions (e.g. walking paths, healthy school lunches, clean air and water) as well as specific healthcare interventions that promote health and wellbeing and mitigate disease onset and progression. Wellbeing should not be available only to those who can afford it and are easy to reach and teach.
 - b. **Provider Equity in Reimbursement** rules is a matter of patient access and is sorely needed. We suggest the following:
 - i. **If a particular service is reimbursed it must be reimbursed for any licensed** (or otherwise qualified – see attachment) **health care professional for whom it is included in their scope of practice.**
 - ii. **It is likely that cost savings and improved care will both be supported by more widespread adoption of team and care-based reimbursement** such as is practiced with hospice reimbursement. We suggest the council examine such de-siloing of reimbursement as medical homes and community health teams are being established.
 - iii. **Explore the use of patient-specific data in decision-making re: reimbursement.** The principle for this is described in a current bill, HR 396. While large clinical trials yield critical information about treatment safety and efficacy writ large, we all know that averages do not apply to all people equivalently. Even when the “overall” results of a treatment are good, there are some people who are tremendously responsive to it and others who are non-responsive or harmed by it and for whom alternative treatments should be covered.

***About IHPC:** The Integrated Healthcare Policy Consortium (IHPC) is a broad coalition whose Partners for Health represent over 300,000 clinicians and healthcare educators committed to public policy that supports a health-oriented, integrated system, ensuring all people access to the full range of safe and regulated conventional, complementary, and alternative healthcare professionals. Integrated Health Care describes a coordinated system in which healthcare professionals are educated about one another's work and collaborate with one another, and with their patients, to achieve optimal well-being for the patient including physical, emotional and spiritual well-being. Visit www.ihpc.info to learn more.*

APPENDIX C
National Healthcare Workforce
Policy Statement

**IHPC Policy Statement
on the National Healthcare
Workforce in the Era of
Integration**

IHPC applauds the inclusion in the Affordable Care Act of an expanded definition of the healthcare workforce that includes, as stated in Section 5101, "...licensed complementary and alternative medicine providers, integrative health practitioners..." (See full definition below.) We recognize that while licensed complementary and alternative medicine providers can be readily identified (and include acupuncturists, chiropractors, massage therapists, naturopathic physicians, and professional midwives), "integrative health practitioners" have yet to be defined.

Seeking a balance between strongly held values of patient access to health care therapies and professionals of their choice AND proper recourse if inappropriate or unethical care should occur, we support:

- 1) Inclusion of all licensed complementary and alternative health care providers.
- 2) Inclusion of all state certified health care providers.
- 3) Inclusion of all nationally certified health care providers, when the certification agency is accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence (ICE).

For healthcare professions that do not yet have either state licensure/certification/registration or national certification, IHPC encourages such professions to obtain state licensure/certification/registration and/or national certification.

From the Affordable Care Act

HEALTH CARE WORKFORCE The term "health care workforce" includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

APPENDIX D

IHPC Credentialing Statement



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IHPC Policy Statement to Aid Credentialing of Integrative Health Practitioners

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This policy statement responds, in part, to a broadened definition of the healthcare workforce that appears in the new Public Law 111-148, the **Patient Protection and Affordable Care Act of 2010, Section 5101** and reads:

*“The term ‘health care workforce’ includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), **licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.**”*

Seeking a balance between strongly held values of patient access to health care therapies and professionals of their choice AND proper recourse if inappropriate or unethical care should occur, IHPC supports inclusion in the National Healthcare Workforce of:

- 1) *All licensed conventional, complementary and alternative healthcare providers.*
- 2) *All state certified healthcare providers.*
- 3) *All nationally certified healthcare providers when the certification agency is accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence (ICE).*

For healthcare professions that do not yet have state licensure/certification/ registration or national certification, IHPC strongly encourages them to pursue such credentialing.

About NCCA: *The National Commission for Certifying Agencies (NCCA) was created in 1987 by ICE to help ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs/organizations that assess professional competence. Certification programs that receive NCCA accreditation demonstrate compliance with the NCCA’s Standards for the Accreditation of Certification Programs, which were the first standards for professional certification programs developed by the industry.*
www.credentialingexcellence.org/ProgramsandEvents/NCCAAccreditation/tabid/82/Default.aspx

APPENDIX E
IHPC First LETTER ON
MEDICALLY UNDERSERVED POPULATIONS
& HEALTH PROFESSIONAL SHORTAGE AREAS



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Bastyr University

National Association of Certified
Professional Midwives

National Center for Homeopathy

Palmer Center for Chiropractic
Research and Health Policy

October 20, 2010

Nicole Patterson
Office of Shortage Designation
Bureau of Health Professions
Health Resources and Services Administration
Room 91-18, Parkland Building
5600 Fishers Lane
Rockville, Maryland 20857

Re: 42 CFR Part 5

Negotiated Rulemaking Committee on Designation of Medically
Underserved Populations and Health Professional Shortage Areas

Dear Committee Members:

Insofar as your meeting on October 13-14, 2010, is to establish a comprehensive methodology and criteria for Designation of Medically Underserved Populations and Health Professional Shortage Areas, in the hope that the process will yield a new rule in accordance with Section 5602 of the Patient Protection and Affordable Care Act of 2010 (PPACA), we, the Integrated Healthcare Policy Consortium (IHPC) (see end of letter for information on IHPC) and its Partners for Health, wish to provide comments for your consideration regarding the make-up of the healthcare workforce. In particular, since you are charged with creating a comprehensive methodology, we would call your attention to other sections of the PPACA which we believe are relevant to your assignment.

As you are likely aware, Section 5101 of the PPACA establishes a National Healthcare Workforce Commission. The purposes of this commission are specified as follows:

“(1) serves as a national resource for Congress, the President, States, and localities;

(2) communicates and coordinates with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security,

and Education on related activities administered by one or more of such Departments;
(3) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers is being met;
(4) identifies barriers to improved coordination at the Federal, State, and local levels and recommends ways to address such barriers; and
(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.”

Section 5101 of the PPACA goes on to define the term healthcare workforce as specifically including “...licensed complementary and alternative medicine providers, integrative health practitioners...” (Please see full definition on p. 4). It names them again in the definition of Health Professionals. While this expanded definition applies specifically to this section of the law and thus to the work of the National Healthcare Workforce Commission, we encourage you, in recognition of the fact that 40% of Americans currently use some form of complementary or alternative healthcare and that these numbers are increasing, to adopt this definition of the healthcare workforce for your work as well. It will certainly bring greater coherence to the Federal Government’s healthcare planning to have the agencies working on these related issues utilizing the same definition when considering how to identify underserved populations and professional shortage areas.

The second section of the PPACA to which we would like to draw your attention is Section 2706 entitled Non-Discrimination in Health Care, which says:

“(a) Providers- A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.”

This non-discrimination clause rightly honors the role of each state to decide which sorts of healthcare providers shall operate within that state and what will be the scope of practice of each. We believe this has implications for your work, as there are important variations across states. For example, the state of Vermont recognizes both naturopathic physicians (NDs) and certified professional midwives (CPMs) as primary care providers. Specifically with regard to NDs Vermont health insurance law states: *“A health insurance plan shall provide coverage for medically necessary health care services covered by the plan when provided by a naturopathic physician licensed in this state for treatment within the scope of practice described in chapter 81 of Title 26. ... Any amounts, limits, standards, and review shall not function to direct treatment in a manner unfairly discriminative against naturopathic care, and collectively shall be no more restrictive than those applicable under the same policy to care or services provided by other primary care physicians”* (CHAPTER 107. HEALTH INSURANCE, SUBCHAPTER 1. GENERALLY § 4088d). The impact of this law is quite significant. *“As a result of this law passed by the Vermont Legislature in 2007, all insurance*

companies that are regulated by the state of Vermont are required to reimburse for the services of a naturopathic physician in the same way and to the same extent that they reimburse for the services of any physician. This includes Blue Cross/Blue Shield of Vermont, CIGNA, MVP, Medicaid, VHAP, Dr. Dynasaur, and others. In practice, this means that patients can choose to see a naturopathic physician and get full insurance coverage. With all of these insurers except CIGNA, naturopathic physicians are also eligible to serve as primary care physicians.” (http://www.vanp.org/insurance_reimbursement.php)

In the state of Washington, the Health Personnel Resource Plan for the 1993-94 Biennium identified naturopathic doctors and direct entry certified professional midwives in its analysis of state shortages of eight primary healthcare professions (www.eric.ed.gov/PDFS/ED366817.pdf). Naturopathic doctors are specified in Washington state law as primary care providers, as they are in a number of states, including California, Montana, New Hampshire, Utah and Vermont. Naturopathic physicians are licensed in 15 states, the District Columbia and U.S. territories. (Please see attached: Fleming and Gutknecht, Naturopathy and the Primary Care Practice. Primary Care, 2010, 37, 119-36.) Non-nurse midwives are licensed in Washington, as in 25 other states. (Please see: Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits, 2007 [www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf]; and Certified Professional Midwives in the United States, 2008 [<http://mana.org/pdfs/CPMIssueBrief.pdf>].)

Naturopathic physicians are also eligible primary care providers in Washington and Oregon's State programs which provide student loan forgiveness for service to urban and rural underserved. These two loan forgiveness programs are the Washington State Health Professional Loan Repayment and Scholarship Program (HPLRSP) through the WA State Department of Health and the Higher Education Coordinating Board authorized in 1994; and the Primary Care Loan Repayment Program administered by the Oregon Office of Rural Health, authorized in March 2010. (HB 3639: *Creates Primary Care Services Program to provide loan repayments to providers of primary care who agree to practice in qualifying practice sites. Establishes Primary Care Services Fund.* <http://www.leg.state.or.us/10ss1/measpdf/hb3600.dir/hb3639.a.pdf>).

In addition, ND's are authorized primary care providers by statute in Washington State's Medical Homes Act. For more information on the statutory requirements related to ND inclusion in medical homes please see the attached document entitled Inclusion of Naturopathic Physicians in the State of Washington Medical Homes Act.

Other states have varying levels of recognition of licensed complementary and alternative medicine providers as contributors in meeting their state needs. This certainly should be brought into calculations that determine whether and to what extent regions of such states have a primary care provider shortage. As an example of this kind of analysis, please see the attached: Albert and Butar, Estimating the De-designation of Single-County HPSAs in the United States by Counting Naturopathic Physicians as Medical Doctors (Applied Geography 25, 2005, 271–285). For a summary of the status of chiropractic physicians please see the

attached document from IHPC entitled IHPC Summary of Chiropractor Status and Scope in the US. We bring this issue to your attention and look forward to seeing your suggestions about methodology and criteria that accommodate such differences across states.

The central focus of the PPACA was, of course, threefold – to increase access to affordable health care, to improve the quality of our healthcare system as indicated by standard morbidity and mortality outcomes, and to contain the cost of health care which is currently on an unsustainable upward trajectory. In seeking to meet these goals, legislators included in the law enhanced focus on disease prevention, not just treatment, in part through the use of integrated care. The Integrated Healthcare Policy Consortium, the Academic Consortium for Complementary and Alternative Health Care (a 501(c)3 charitable organization which began within IHPC), and The Institute for Integrative Health would like to make ourselves available to you as resources on these issues related to integrated healthcare, which we have been studying for many years. We can be reached through IHPC at the contact information on the letterhead.

I thank you for the opportunity to offer these comments, and for your attention to this expanded understanding of the healthcare workforce of the United States.

Sincerely,



Janet R. Kahn, PhD
Executive Director

Attachments:

- Albert, D.P., Butar, F.B. Estimating the de-designation of single-county HPSAs in the United States by counting naturopathic physicians as medical doctors. *Applied Geography*, 2005, 25: 271–285.
- Fleming SA, Gutknecht NC. Naturopathy and the primary care practice. *Primary Care*, 2010, 37(1):119-36
- Inclusion of Naturopathic Physicians in the State of Washington Medical Home Act
- IHPC Summary of Chiropractor Status and Scope in the US

Information on IHPC, ACCAHC, TIIH, and the PPACA Section 5101 Definition of the Healthcare Workforce provided on next page.

Definition of the Health Care Workforce from Section 5101 of PPACA on the National Health Care Workforce Commission:

“Health Care Workforce – The term ‘health care workforce’ includes all health care providers with direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, certified nurse midwives, podiatrists, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), licensed complementary and alternative medicine providers, integrative health practitioners, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.”

Information on the Integrated Healthcare Policy Consortium:

The Integrated Healthcare Policy Consortium (IHPC) is a broad coalition whose Partners for Health represent over 300,000 clinicians, and healthcare educators committed to public policy that supports a health-oriented, integrated system, ensuring all people access to the full range of safe and regulated conventional, complementary, and alternative healthcare professionals. Our Partners for Health are organizations central to the licensed and/or nationally certified professions of acupuncture and Oriental medicine, certified professional midwifery, chiropractic medicine, homeopathy, naturopathic medicine and therapeutic massage.

Information on the Academic Consortium for Complementary and Alternative Health Care:

The Academic Consortium for Complementary and Alternative Health Care (ACCAHC-www.accahc.org) is a 501c3 organization dedicated to bettering patient care through enhancing mutual respect and understanding among all healthcare disciplines. ACCAHC’s core members are the councils of colleges, accrediting agencies and certification/testing organizations associated with the licensed complementary and alternative healthcare field that have a U.S. Department of Education-recognized accrediting agency. ACCAHC’s central focus is on developing resources, programs and projects that will support our institutions, educators, students and clinicians in gaining competencies for optimal practices in integrated environments.

Information on The Institute for Integrative Health:

The Institute for Integrative Health seeks to catalyze new ideas in healthcare. We are committed to advancing science with expanded research methods, linking experts across disciplines to generate new ideas, mentoring the leaders of today and tomorrow, exploring new models of health, and discovering fresh ways to engage the public in its pursuit of health.

Attachment #4: IHPC Summary of Chiropractor Status and Scope in the US

Chiropractors (also referred to as doctors of chiropractic, DCs, or chiropractic physicians) practice in all 50 states and the District of Columbia as primary contact, portal of entry providers, licensed for both diagnosis and treatment and directly accessible by patients without referral from a medical physician. In all jurisdictions, chiropractors are licensed to take a complete health history, perform a physical examination, interpret radiologic and laboratory studies, diagnose, treat, manage and co-manage cases, and refer to other practitioners according to the needs of the patient. Thus, chiropractors are physician-level providers.

Unlike dentistry, podiatry, and optometry, chiropractic practice is limited not by anatomic region but by procedure. With two exceptions among the 50 states the chiropractor's scope of practice excludes surgery and the prescription of pharmaceuticals. The exceptions are Oregon which allows minor surgery but prohibits major surgery, and New Mexico which prohibits prescription of controlled or dangerous drugs only.

Over 90 percent of chiropractic cases involve back pain, neck pain, headaches and other musculoskeletal disorders. Chiropractors are also specifically trained in and practice preventive care, including risk factor analysis and lifestyle-based health promotion.

The Federation of Chiropractic Licensing Boards is the best resource for data on the number of chiropractors (currently ~65,000 in the United States) and the specifics on state licensing laws.

Number of licensed DCs by state:

<http://directory.fclb.org/Statistics/LicensureStatisticsUS/tabid/157/Default.aspx>

Information on state scopes of practice:

<http://directory.fclb.org/US/tabid/100/Default.aspx>

While chiropractic practice laws are wholly consistent across the nation regarding direct access and diagnostic responsibility, and relatively consistent regarding treatment methods, state laws vary in other ways. For example, chiropractors with postgraduate training are permitted to perform acupuncture in approximately half of the states, and are permitted to draw blood for diagnostic purposes in a large majority of states, though the right to refer for such tests is permitted by all states.

Few states have specifically addressed the role of chiropractors as primary care physicians. As medical home laws are developed in the coming years, this may be more fully resolved. An example of a forward-looking approach is that seen in Iowa, where chiropractors are one of three professions (MD, DO and DC) recognized by statute as physicians and where the model medical home law includes chiropractors among those who may serve as the "Primary Case Manager."

APPENDIX F
IHPC Second Letter on
Medically Underserved Populations
& Health Professional Shortage Areas



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Michael Traub, ND

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IHPC Partners for Health
American Academy of Pain
Management

American Association of
Acupuncture and Oriental Medicine

American Association of
Naturopathic Physicians

American Massage Therapy
Association

Bastyr University

International Chiropractic Pediatric
Association

National Association of Certified
Professional Midwives

National Center for Homeopathy

Naturopathic Medical Students
Association

Palmer Center for Chiropractic
Research

Sojourns Community Health Clinic

September 21, 2011

Edward Salsberg, Director, National Center
for Health Care Workforce Analysis
Bureau of Health Professions
Health Resources and Services Administration
Room 9-29, Parklawn Building, 5600 Fishers Lane
Rockville, Maryland 20857

Re:
Negotiated Rulemaking Committee on Designation of Medically
Underserved Populations and Health Professional Shortage Areas

Dear Mr. Salsberg and Members of the Rulemaking Committee:

Beginning with your meeting on October 13-14, 2010, you have engaged the complex and critical task of determining a comprehensive methodology and new criteria for Designation of Medically Underserved Populations and Health Professional Shortage Areas. We at the Integrated Healthcare Policy Consortium appreciate the service you have given this task and support much that you recommend.

We are concerned, however, that no credence seems to have been given to the comments we provided for your consideration at that first October meeting regarding the inclusion of Naturopathic Physicians (NDs), Doctors of Chiropractic (DCs) and Certified Professional Midwives (CPMs) in your calculations of primary care providers. We ask you to reconsider this as we believe it is in keeping with the Affordable Care Act (ACA) and is in the interests of good public health, equity, and recognition of states' powers and responsibilities in determining scope of practice of health professionals they license.

While your committee was mandated in Section 5602 of the Affordable Care Act of 2010, Section 5101 of the same law created a National Healthcare Workforce Commission with responsibilities delineated, and very importantly, identification of those professions officially included in the national healthcare workforce. That

definition specifically includes "...doctors of chiropractic...all licensed complementary and alternative medicine providers", the latter being a category that includes NDs, and CPMs. We have recommended to you, and we continue to wholeheartedly recommend, that you include licensed Naturopathic Physicians, Doctors of Chiropractic and Certified Professional Midwives in your calculations of primary care providers in those states in which they are so recognized. We further provided information, which we have appended here, indicating which states recognize those professions, as well as an article by Albert and Butar on de-designation of HPSAs through inclusion of NDs.

Our focus, and we presume yours as well, is getting adequate care to everyone who needs it. We believe this goal will be aided by recognizing NDs, DCs and CPMs, three often under-utilized resources in this nation, as the primary care providers that they are already, in the workforce.

We live in challenging political times, as you know. The National Healthcare Workforce Commission created by the ACA has been appointed, but received no appropriation to date and has not been able carry out their appointed duties. Thus they are unable to weigh in on the critical question with which you are charged.

We hope you will take seriously our recommendation for inclusion of NDs, DCs and CPMs, re-review the information provided, contact us if anything more is needed, and consider what this expanded primary care workforce can offer our nation. We all know that the incentives for medical students are heavily weighted against primary care, thus the shortage we confront. Let us honor all of those who have chosen this focus and trained in it, by letting them work.

Thank you for the opportunity to offer these comments, and for your attention to an expanded understanding of the healthcare workforce of the United States.

Sincerely,



Michael Traub, ND
Co-Chair IHPC Federal Policy Committee



Janet R. Kahn, PhD, LMT
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Attachments:

- IHPC testimony, dated October 20, 2010, to Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas
- Albert, D.P., Butar, F.B. Estimating the de-designation of single-county HPSAs in the United States by counting naturopathic physicians as medical doctors. *Applied Geography*, 2005, 25: 271–285.

The Integrated Healthcare Policy Consortium:

The Integrated Healthcare Policy Consortium (IHPC) is a broad coalition whose Partners for Health represent over 300,000 clinicians spanning the conventional – complementary/alternative spectrum, as well as healthcare educators and countless integrated healthcare consumers. The IHPC is committed to public policy that supports a health-oriented, integrated system, ensuring all people access to the full range of safe and regulated conventional, complementary, and alternative healthcare professionals.

APPENDIX G

Abbreviations & Acronyms

ACA	Affordable Care Act
ACCAHC	Academic Consortium for Complementary and Alternative Health Care
AMA	American Medical Association
CAM	Complementary and Alternative Medicine
CCH	Certified in Classical Homeopathy
CDC	Centers for Disease Control and Prevention
CER	Comparative Effectiveness Research
CMS	Center for Medicare and Medicaid Services
CPM (or LM)	Certified Professional Midwife (or Licensed Midwife)
CPT® Codes	Current Procedural Terminology codes
HHS	US Department of Health and Human Services
DC	Doctor of Chiropractic
DHt	Diplomate of the American Board of Homeotherapeutics
DO	Doctor of Osteopathy
HCFA	Health Care Financing Administration
HCPAC	Health Care Professions Advisory Committee
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
ICE	Institute for Credentialing Excellence
IHPC	Integrated Healthcare Policy Consortium
JD	Doctor of Laws
LAc	Licensed Acupuncturist
LLM	Master of Laws
LMT	Licensed Massage Therapist
MD	Doctor of Medicine
ND (or NMD)	Doctor of Naturopathic Medicine
NCCA	National Commission for Certifying Agencies
NCCAM	National Center for Complementary and Alternative Medicine
NHWC	National Healthcare Workforce Commission
NP	Nurse Practitioner
PCOR	Patient-Centered Outcomes Research
PCORI	Patient-Centered Outcomes Research Institute
RN	Registered Nurse

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