The Affordable Care Act and Beyond: A Stakeholder Conference on Integrated Health Care Reform

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

Conference Report

Hosted by

The Integrated Healthcare Policy Consortium
The Institute for Integrative Health
Palmer College of Chiropractic
June 29, 2011

Dear Friends and Colleagues,

On March 30, 2010 President Obama signed into law the Patient Protection and Affordable Care Act, now known simply as the Affordable Care Act. This was a long-sought, much debated and, in the end, historic achievement. It will give health care coverage to over 32 million people who would not otherwise have it, and 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 and complementary and alternative health care community, this was an historic moment for other reasons, at least as fundamental. The Affordable Care Act includes within it provisions that, if implemented appropriately, will give Americans access to health care approaches of their choice, make substantial steps away from the current disease-oriented delivery model toward a more prevention and health promotion-oriented system of health care, and give people significantly more support for taking good care of themselves. The law includes provisions that had been on the agenda of the three host organizations and many complementary and alternative healthcare professional associations and educational institutions for years.

To celebrate these accomplishments and organize for rulemaking, our three organizations – the Integrated Healthcare Policy Consortium (IHPC), The Institute for Integrative Health, and Palmer College of Chiropractic – co-hosted an invitational conference in late September 2010. “The Affordable Care Act and Beyond,” held at Georgetown Medical School Conference Center, brought together healthcare educators, clinicians, and advocates from across the conventional, complementary and alternative health care spectrum for a combination of educational sessions and roll-up-your-sleeves strategizing.

This report summarizes what we accomplished in those two and a half days, as well as some of what we have done since. We left the meeting inspired by the high level of discussion and the easy inter-disciplinary collegiality, as well as by the challenge that lies ahead to make inclusive, patient-centered, prevention-oriented integrative health care available to all. Six workgroups met during this meeting developing action agendas which can be pursued at least through 2015. Please, consider this an open invitation to join in this work by joining a work group of IPHC’s Federal Policy Committee.

Sincerely,

Janet Kahn  
Susan Berman  
Christine Goertz  
IHPC  
TIIH  
Palmer College of Chiropractic
Appreciation

The hosts of the conference gratefully acknowledge our gratitude to:

The generous sponsorship of BASTYR UNIVERSITY and Hyland’s.

The exquisite facilitation of Robert Fisher of Fisher Collaborative Services in Alexandria, Virginia.

Dr. Adi Haramati for, once again, seeing to our every need at Georgetown Conference Center.

Lori Byrd of Palmer College of Chiropractic and Beverly Pierce of The Institute for Integrative Health for impeccable professional staffing, ensuring that nothing was forgotten.

All of our fabulous presenters. Your wisdom, your generosity, and your dedicated work in the trenches ensured the value of this conference. Dr. Josephine Briggs, Ms. Beth Clay, Dr. Ian Coulter, Dr. William Duncan, Dr. Anthony Hamm, Dr. Gail Hansen, Dr. Wayne Jonas, Dr. Jenelle Krishnamoorthy, Ms. Janice Lipsen, Mr. Rick Miller, Dr. Bruce Milliman, Hon. Deborah Senn, Ms. Mona Shah, Dr. Steve Phurrough, and Dr. William Updyke.

Breakout session facilitators: Mr. Gregory J. Goode, Dr. William Meeker, David O’Bryon, Esq., Dr. Anthony Hamm, Mr. Brian Thiel, and Dr. Len Wisneski.

Breakout session rapporteurs: Ms. Jenn Bahr, Dr. Nancy Gahles, Dr. Michele Maiers, Ms. Lucrezia Mangione, and Dr. Michael Traub.

Editors: to Drs. Janet Kahn, Daniel Redwood and Michael Traub who each in your own way brought coherence and clarity to the information emanating from this conference.
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F. Letter of September 21, 2011 to HRSA’s Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas .................................................................................................................. 60
Background and Mission of Hosts

The three hosts of The Affordable Care Act and Beyond 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 direct the national healthcare agenda toward a health-oriented, integrated system of care that ensures all people access to the full range of safe and regulated conventional, complementary, and alternative healthcare professionals and therapies, as well as to the building blocks of health, including clean air and water and a healthy food supply.

The idea of IHPC arose in conversation with federal legislators that 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 was held to assess whether there was a common ground agenda and sufficient collaborative will to warrant such an organization [http://ihpc.org/resources/NPDFR.pdf]. There was. The agenda was clarified and shortly thereafter those who had called the meeting founded the Integrated Healthcare Policy Consortium.

Four years later, recognizing that the flourishing of integrative health care in a changing health workforce required that health professions educational institutions incorporate integrative tenets and build collaborative, cross-disciplinary relationships, IHPC hosted the National Education Dialogue to Advance Integrated Health Care: Creating Common Ground (2005). This included representatives from conventional academic health centers, holistic nursing, and public health 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 accredited complementary and alternative healthcare (CAM) disciplines. ACCAHC became independent of IHPC in 2008.
The Institute for Integrative Health

The Institute for Integrative Health (TIIH) seeks to catalyze new ideas in healthcare. They 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.

To move thinking and science forward, TIIH has convened a number of critical conferences for the field of integrative healthcare. These include a conference in October 2007 on “Applying Principles from Complex Systems to Studying the Efficacy of CAM Therapies” in Washington DC, and the November 2009 “Stakeholder Symposium on the Evidentiary Framework for Complementary and Integrative Medicine” in Baltimore. 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.

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 health care 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 service to the field of chiropractic, including continuing education; and to serving humanity through patient care and community education.

The Palmer Center for Chiropractic Health Policy develops and sustains relationships with government, federal agencies, policy makers, agency personnel, and members of both the private and public sectors to monitor and coordinate activities relating to advancing the College and the chiropractic profession. The focus of the Center is to enhance educational and research opportunities and expand horizons for funding new initiatives and research programs in chiropractic.

Monday, September 27th

Welcome & Overview of Meeting Objectives and Agenda
Janet Kahn and Christine Goertz

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, Health Policy Director, Senate HELP Committee
Hon. Deborah Senn, The Zielke Law Firm, P.S., Former Washington State Insurance Commissioner

Improving Access: Expanded Definition of the Healthcare Workforce and the National Healthcare Workforce
Gail Hansen, Senior Officer, Human Health and Industrial Farming, Pew Charitable Trusts, (formerly Healthcare Legislative Assistant for Senator 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, National Representative for AANP on AMA Current Procedural Terminology Editorial Panel/Health Care Professional Advisory Committee
Anthony Hamm, DC, ACA Coding and Reimbursement Committee chair and Representative to the AMA RUC HCPAC.
Lessons for the Rulemaking Process - A Panel of Policy-Setting Experts
Beth Clay, Capitol Strategy Consultants, Inc.; Jan Lipsen, President, Counselors for Management, Inc., Legislative Affairs, American Association of Naturopathic Physicians; Richard Miller, Miller Consulting, representing the American Chiropractic Association

Breakout Sessions by Work Group Topic:
- **Access** – This group will discuss and strategize around a cluster of access-related issues including
  - rulemaking plans for Section 2706 of the Affordable Care Act;
  - other aspects of discrimination that need to be addressed such as discrimination in grants to educational institutions, loan reimbursement opportunities, etc.;
  - breaking down the disparity across patient demographics in terms of access to integrated health care.

- **The Healthcare Workforce** – This group will discuss 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** – This group will explore 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** – This group may choose to explore any and all of the following:
  - how CPT codes currently serve (or don’t serve) the 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** – This group will advise the large 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** – We begin with the assumption that this group may have more knowledge of integration than most of the people responsible for implementing these aspects of the law. Given that, this group will:
  - share their own experience with integrated service delivery and their awareness of other important sites of integration;
  - identify key lessons learned from their experience, and
  - explore the application of those lessons to the Affordable Care Act (or the beyond), and
  - develop strategy for sharing those lessons with those responsible for implementation of 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**
Dr. Josephine Briggs, 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 of Capitol Strategy Consultants, Inc.

**Breakout Sessions (these will be continuation of the groups which began their meeting on Monday afternoon)**

**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 engagement in public discourse
- Ongoing Work Groups
- Funding for ongoing efforts
INTRODUCTION

Prelude to a Conference

Passage of the 2010 Patient Protection and Affordable Care Act (referred to in common parlance as the Affordable Care Act or ACA) was an historic accomplishment. In addition to its efforts at cost containment and the coverage provided to over 30 million previously uninsured Americans, the ACA includes a wide range of provisions designed to support Americans’ efforts to attain optimum health, and to increase the effectiveness of the nation’s health care delivery system. Importantly, it does this primarily by redirecting the American healthcare system toward a focus on health rather than 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 in the American population, 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 law recognizes the importance of comparative effectiveness research through the creation and funding of the Patient Centered Outcomes Research Institute and significantly strengthens the health care system’s emphasis on prevention, public health and wellness. It implicitly acknowledges that while the U.S. 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 that the World Health Organization ranks our health care system only 37th in the world. 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 designed and co-hosted a stakeholder working conference, The Affordable Care Act and Beyond, held at Georgetown University on September 27-29, 2010. Participants included policy advocates, researchers, social scientists, and a broad spectrum 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 for emphasis on prevention, health promotion and patient engagement strongly reflect the values and practice of CAM and integrative health care. Stakeholders from these communities met to ensure our involvement in the rulemaking process for the preservation of these important initiatives. We came together to ensure that the 40% of adult Americans (and their children) who use CAM will have increased access to the  

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2 A list of attendees with their affiliations can be found in Appendix A, page 39 of this report.
integrated healthcare approach they have chosen\textsuperscript{3}. We came together to offer our assistance to those engaged in rulemaking on the ACA because we know that integrated healthcare has much of value to offer in terrain that may be new to many DHHS staff.

**Dialogue and Collaboration**

*The Affordable Care Act and Beyond* was convened in the same spirit as previous national dialogues by the hosts, to foster collaborative planning among integrative health care stakeholders. 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. In the afternoons, conference attendees participated in one of six workgroups that had been formed to address certain aspects of the ACA. With the information from the plenary presentations as a foundation, the broadly based interdisciplinary working groups noted many positive policy changes in the ACA and identified provisions where specific regulatory action is needed to resolve ambiguities in statutory language related to integrative health care delivery.

These working groups presented their findings to the full conference. Issue areas addressed by these working groups were: (1) Nondiscrimination and Access; (2) Integration in Practice; (3) Comparative Effectiveness Research and the Patient Centered Outcomes Research Institute (PCORI); (4) Workforce Development; (5) Current Procedures and Terminology (CPT Codes); and (6) Prevention and Wellness.

The tasks of the working groups include ensuring that the ACA is implemented in full by working to repel any Congressional, AMA or other efforts to repeal it in whole or in part, clarifying and advocating the best possible implementation of each provision of importance to us, and collaborating in these efforts.

WORKING GROUP REPORTS

1. ACCESS AND NONDISCRIMINATION

Members: This group consisted of Gregory Goode, Chief of Staff – Bastyr University; Michael Traub, ND, DHANP, CCH, FABNO; Deborah Senn JD; Pamela Snider ND; Richard Miller; Michael McGuffin; Janice Lipsen; Randi Gold, MPP; Caitlin Donovan, DC; and Corinne Axelrod, MPH, LAc, Dipl Ac, CMS.

Committee’s Charge: To discuss and strategize around a cluster of access-related issues including rulemaking plans for Section 2706 of the Affordable Care Act (see just below for description); other aspects of discrimination including grants to educational institutions, loan reimbursement opportunities, residency funding, etc.; and breaking down the disparity across patient demographics in terms of access to integrated health care.

Background: Regarding nondiscrimination toward providers, Section 2706 of the ACA states that “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.” Discrimination against CAM providers has certainly 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. In addition, the Congressional Research Service has documented extensive discrimination in all federal healthcare programs, citing the Veterans Administration as the least discriminatory. Discrimination can take the form of refusal to include whole categories of health care 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 allopathic and osteopathic physicians or nurse practitioners are being compensated. In other cases, CAM health care 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.

In addition, regarding discrimination in health professions education, CAM educational institutions typically rely on tuition for the vast majority of their total budgets, while the comparable figure for conventional institutions is significantly less in comparison, with much of the difference due to various forms of government support. Federal loan repayment programs (e.g., service in the U.S. Public Health Service Corps) are not currently available to CAM practitioners. Similarly, CAM educational institutions have historically been shut out of federal grants for training programs, laboratory capacity-building and the like, although this is changing somewhat now.
Against this backdrop, 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, some key terms in the language of the law are ambiguous, and the language of this law leaves critical questions unresolved. For instance, the term “shall not discriminate” needs to be defined, as does “health insurance issuer” so that it becomes clear whether Medicaid and Medicare, for example, are included.

**Summary of Group Discussion:** 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 many more people. 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 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 need to 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, as well as to private insurers. Other aspects of discrimination also need to be addressed: (1) grants to educational institutions; (2) loan repayment programs; and (3) residency funding. In each of these areas, entrenched funding patterns generally preserve a status quo that favors the conventional and omits CAM practitioners and institutions. For integrative care to fulfill its potential, integrative and complementary practitioners and their training institutions must also have a level playing field. The review of discrimination in relation to CAM disciplines which was prepared by the Congressional Research Service at the request of Senators Harkin and Sanders and can be used as a starting point for these efforts, although it should also be updated.

**Specific Recommendations:**

1. Regulatory language clarifying the new nondiscrimination policy should specifically list 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 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 the conventional and denies such benefits to CAM professionals and therapies, regulatory language is needed to ensure that a policy of nondiscrimination is also applied to (1) grants to educational institutions; (2) loan repayment programs; and (3) residency funding.

4. The IHPC and its Partners for Health should establish a task force to work on specific language for rulemaking and to determine what other strategy and action steps should be taken. Suggested language should be formally submitted to HHS. The task force should also work on the state level with 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 inclusion separately in the Social Security Act.

2. INTEGRATION IN PRACTICE: LESSONS FOR IMPLEMENTATION OF THE ACA

Members: This group consisted of Leonard Wisneski, MD; John Weeks; Bill Reddy, LAc, DiplAc; William Updyke, DC; Beverly Pierce, MLS, MA, RN, CHTP; Demie Stathoplos, MSW, MBA; Lori Knutson, RN, BSN, HN-BC; Anne Doherty-Gilman, MPH; and 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 health care 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.”

CAM practitioners currently play significant roles in forward-looking 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, the Allina System in Minnesota, and Group Health Cooperative in Washington. Over the past decade, the Veterans Administration has also moved to integrate chiropractic and acupuncture into the mix of health services provided to our nation’s military veterans. Meditation, massage, yoga and other mind-body practices are being utilized increasingly in programs for veterans returning from Iraq and Afghanistan. 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 to a very large-scale system. The question, of course, is how to do this well.

**Summary of Group Discussion:** 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 each year, a medical home that fails to fully integrate CAM providers and services is neither patient-centered nor a true “home.”

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” 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 where the patient retains the choice of provider and is informed of all available options in an unbiased manner by the 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 educating the lay public about health and health care, as a path toward broader self-knowledge and self-care skills. Without this understanding, individual choice is not informed choice. Integrative practice must be a “health creating” practice, in which acute symptom treatment is used as a springboard toward a broader, sustained focus on self-care, prevention and health promotion. This is a path toward improved health and reduced costs. Furthermore, in the medical home setting, patients should be questioned as to their interest in receiving comprehensive preventive care whether or not they present with symptoms, and if they are interested they should be provided with this care.
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 health care 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 Four below by the workgroup on the Healthcare Workforce.

3. 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. A patient centered home is one where the patient retains the choice of provider and is informed of all available options in an unbiased manner by a coach/navigator/primary care provider.

4. Regulatory language is needed to tie 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.

3. COMPARATIVE EFFECTIVENESS RESEARCH AND THE PATIENT CENTERED OUTCOMES RESEARCH INSTITUTE:

SETTING THE RESEARCH AGENDA

Members: This group consisted of 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; and 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 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 including 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 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 PCOR to oversee but not be limited to the funding and conduct of comparative effectiveness research. The ACA included a dedicated funding stream for PCORI, generated through Medicare. Appointees for the PCORI Board of Governors had just been named as the conference commenced. They included Christine Goertz, DC, PhD of Palmer College of Chiropractic, a co-host of the conference.

Summary of Group Discussion: The group discussed (1) research design, (2) research agenda priorities for integrative care and (3) the need for support for research training and infrastructure in CAM and integrative health care educational institutions. The workgroup brainstormed a list of possible nominees for the PCORI Methodology Committee, which will exert strong influence over the types of studies that PCORI will fund.

The group emphasized the need for funding well-designed, head-to-head pragmatic trials in which conventional methods are compared to 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 is also a strong need for cost-effectiveness studies, where consideration should be given to resource use and total risk, as well as economic simulation modeling studies.

Discussion of the PCORI research agenda vis-à-vis 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 apply 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 should be identified. The group identified three primary areas for which a CAM or integrative arm should be included in PCORI-funded studies: (1) chronic disease (e.g., chronic pain, cardiovascular disease); (2) adjunctive therapy where integrative approaches are added to conventional care (e.g., cancer); and (3) areas where conventional therapies have fallen short, beyond the well-known inadequacies of care for chronic illness and pain.

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

Recommendations:
1. PCORI should fund a series of well-designed, head-to-head pragmatic trials in which conventional methods are compared to 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: (1) chronic disease (e.g., chronic pain, cardiovascular disease, arthritis); (2) adjunctive therapy where integrative approaches are added to conventional care (e.g., cancer); and (3) areas where conventional therapies lack efficacy. NCCAM/CDC survey data on integrative health care utilization can be used to drive specific decisions, especially for those areas where integrative care utilization approaches or outpaces allopathic 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 excitement in their mission and strong recommendation that integrative healthcare be a priority area.

4. THE HEALTHCARE WORKFORCE

Members: This group consisted of David O’Bryon JD, LLD; Sherman Cohn, JD, LLM; Nancy Gahles, DC, CCH; Adi Haramati, PhD; Karen Howard; and Elizabeth Goldblatt, PhD, MPA/HA.

Committee’s Charge: To discuss the “new” healthcare workforce including: definitions of categories never seen before (e.g., integrative health care practitioner), which need to be defined for rulemaking; the implications of the new definition for educational institutions; and how our community should relate to the National Healthcare Workforce Commission.

Background: The Affordable Care Act set the stage for ongoing reconsideration of the US healthcare workforce and its appropriateness for meeting the country’s healthcare needs. Two important elements are contained in Section 5101 of the law – the creation of a National Healthcare Workforce Commission, and an expansion of who is included in this law’s definition of the healthcare workforce.

Ensuring that the nation has an appropriate healthcare workforce is not a simple task. The workforce we have now is a result of 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 sorts.
In this context, the work of the National Healthcare Workforce Commission (NHCWFC) includes evaluating how well the current educational institutions can provide for the needed workforce, identifying barriers to optimal coordination between the diverse levels of government (federal, state and local), recommending solutions to those barriers, and encouraging innovations needed to address the changing needs of the population (as we age, as we create a more allergenic environment, as we put on weight, etc.) and the changing opportunities of developing knowledge and technology. The NHCWFC is also expected to communicate and coordinate with the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security and Education. In fulfilling its work this commission is expected to serve as a resource for Congress and President, as well as to States and localities. For a commission whose appropriations were not built into the law, the NHCWFC has a tall order to meet.

In this section of the law, the ACA defined 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 health care workforce, no representatives from any of these groups, nor experts in integrated healthcare, were included in the initial round of appointments to the Commission.

A key impediment to the mainstreaming of integrative care is that most health professionals (and the institutions within which they work) largely function within their own individual silos. Many healthcare professionals go through entire careers with insufficient awareness of both the training and licensed scope of practice of other health professionals, or the full range of conventional and CAM options available for the conditions they commonly treat. This is true of both CAM 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 health care 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 the kind of informed consent opportunities they deserve, including awareness of the methods generally classified as integrative or complementary care.

Summary of Group Discussion: The workgroup began with a wide-ranging conversation about the territory this topic might cover, then honed in to define as priorities for their brief time together, 1) Definition of terms, both
workforce and integrated/integrative; 2) Recommendations for educating the workforce in an age of integrated health care; and 3) the National Healthcare Workforce Commission.

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

The group drafted a definition that was read to the whole conference, but given time, could not be evaluated for approval. It read as follows:

**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:

A. Addresses personal health needs;
B. 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;
C. Uses outcomes based research and evidence informed practice in working in partnership with the patient;
D. Addresses the underlying causal factors associated with chronic disease;
E. 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;
F. Refers to and collaborates with appropriate practitioners in other healthcare disciplines.

In a separate effort initiated prior to this conference, but completed after it, the Integrated Healthcare Policy Consortium (IHPC) prepared guidelines for hospitals, clinics, governmental entities or others seeking to safely credential integrative health care practitioners. In particular the 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. First, IHPC recognized that 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. Second, there is wide variation in the requirements for and thus the meaning of national certification. IHPC offers the following framework for duly honoring those professions who have established high standards for their national certification and distinguish them from those that have not. The IHPC recommendation, entitled "The National Healthcare Workforce in an Era of Integration," states:
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, the Integrated Healthcare Policy Consortium (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 state licensure/certification/registration and/or national certification.

Health workforce development is directly dependent on the quality and focus of health care 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, beginning with the pre-professional level and continuing career-long, in conventional, complementary and integrative concepts and approaches.

Recommendations:

1. Regulatory language is needed to define the new provider designation, “integrative health care practitioner,” 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 including both CAM and conventional providers.

5. PREVENTION AND WELLNESS: REORIENTING AMERICAN HEALTH CARE

Members: This group consisted of 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; and 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 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.

**Background:**
Among the potentially far-reaching aspects of the ACA is its emphasis on prevention and wellness. Our current health care system is predominately focused on the response to and treatment of disease rather than disease prevention and health promotion. Present-day prevention efforts in the U.S. concentrate more heavily on secondary prevention, i.e. early disease detection (e.g., blood pressure monitoring, mammography, colonoscopy, skin cancer screening, diagnostic laboratory testing). Primary prevention efforts, on the other hand focus on behavioral elements that create and maintain optimal health and wellness (e.g., healthy eating, regular exercise, injury prevention and stress management) with the aim to prevent injury and illness in the first place. 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 genetic or other propensities, does not constitute prevention. Only when the 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 likelihood of developing the most common and costly diseases (heart disease for example) than heredity. Perhaps the most fundamental health question our society faces in the coming years 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 far 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 towards 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 Healthy People over the years have helped shape the public health prevention emphasis incorporated within 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 health care costs. The fact that our current health system costs more per capita than any other industrialized country, yet yields a sub-par ranking in the cumulative population health status has motivated the need to escalate change.

Section 4001 of the ACA called for the establishment the *National Prevention, Health Promotion and Public Health Council*, chaired by the U.S. Surgeon General. It also called for the designation of an *Advisory Group on Prevention, Health Promotion, and Integrative and Public Health*, which will report to the Council and the Surgeon General. The Council, comprised 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 comprised 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 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 nutritional counseling, a physical activity plan, alcohol and smoking cessation counseling and services, stress management, dietary supplements that have health claims approved by the Secretary, and compliance assistance provided by a community health center employee.

In efforts to implement a new direction in health care, ACA called for 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 for the promotion of 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: (1) placing it in the forefront of the nation’s efforts to improve health, and (2) recognizing a potential role for integrative health care in our nation’s health care system. How prevention is further defined, incorporated and implemented within our system will have a substantial influence on the nation’s future health status.

Summary of Group Discussion:

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, encyclopedic knowledge of and experience with other current and past federal prevention efforts, dietary supplement industry expertise, and more. The work group began by recognizing the historical significance of the ACA, especially for the inclusion of integrative health as a landmark component. The discussion involved a myriad of prevention-related topics from the historical perspective, to specific community needs, to the far-reaching implications of the current legislation. Discussion themes included the importance of identifying cost channels as key determinants of federal actions, to the potential for action through executive branch regulation to spur development of cross-disciplinary teamwork, to 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 this 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.

In addressing the organizational needs post-conference for moving an agenda forward as it related to ACA, the work group considered:

* How the diverse community of integrative health can come together to advance a common message. It was recommended that a focus be placed first on key implementers within the various federal agencies, and then on organizing communities.
* Messages from the integrative health community to regulators. In this discussion, the need and value of health care providers working in teams and engaging patients for care to be patient directed was emphasized. The importance of addressing health disparities both in terms of access and vulnerability and the critical issue of cost effectiveness was also addressed.
* 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 to the integrated health care community itself, 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 issue of 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” in facilitating behavioral change was seen as a potentially important element in need of further development.

Recommendations:
The group’s recommendations involved 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. This was recognized and the group recommended creation of a special task force from the conference operating under the auspices of IHPC to move this agenda forward. The recommendations are as follows:
1. IHPC should identify an inventory of existing prevention, health promotion and wellness efforts across the federal government (i.e. Healthy People Health Objectives for the Nation 2020, Centers for Disease Control and Prevention, Institute of Medicine, National Institutes of Health, etc.) and then monitor in an ongoing way 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. Communication by IHPC should flow two ways:
   (a) Communicate internally 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) Communicate externally to the key leaders within government who may be influential in implementing prevention, wellness and integrative care components of healthcare legislation and regulation.

6. CPT Task Force

**Members:** This group consisted of Debra Baas, JD; Beth Clay; Alan Dumoff, JD; Tony Hamm, DC; Janet Kahn, PhD, LMT; Bruce Milliman, ND; and David Riley, MD.

**Charge:** The CPT task force was charged with exploring a set of issues related to the creation, management, ownership, and usage of *Current Procedural Terminology*, or CPT codes. Although CPT codes are not addressed in the ACA, the Conference organizing committee felt that this issue deserved the attention of a workgroup. While no limits were placed on the boundaries of the group’s deliberations, they were particularly encouraged to discuss at least:
• 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, etc.

Background on CPT Codes: Current Procedural Terminology Codes, or CPT Codes, are the numeric system used in the United States by all health care providers to identify and/or seek reimbursement for 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 put into place in 1983 with the Department of Health and Human Services (DHHS), 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 that year, to streamline Medicaid/Medicare payments with a single coding system, DHHS 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 after, private insurance companies also adopted CPT codes as requirement for reimbursement.

The AMA was granted copyright over this system and derives a substantial portion of its annual budget from this source. In a 2001 letter to Tommy Thompson (then Secretary of DHHS) Senator Trent Lott estimated the AMA’s annual revenue from CPT related sales and leasing agreements at $71 million. 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” health care 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 named 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 code.”

• 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 notes that following 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 play, and the effort required to develop and garner serious attention for any other system would be daunting.

The Integrated Healthcare Policy Consortium (IHPC) facilitated meetings in 2002-2003 designed to increase the access of complementary and alternative medicine (CAM) professionals to health insurance reimbursement. Attending to the problems in the CPT system became part of this and IHPC hosted a two day meeting in Washington, DC with representatives from AMA/CPT, Alternative Link (an organization which had developed an alternative coding system), 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. 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.

In 2003 Alan Dumoff, an attorney serving on the Steering Committee of IHPC testified before the Department of Health and Human Services, National Committee on Vital Health Statistic, Subcommittee on Standards and Security on the “Gaps in Current CPT Medical Code Sets.” Dumoff’s testimony identified multiple problems with CPT coding – problems with implications for accuracy in reporting and subsequent research, costs of health care, and equity across professions. Specific examples were included. “…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....”

While the presence of CAM providers on the CPT HCPAC offers an avenue for addressing gaps in coding and for some beneficial interdisciplinary contact, it cannot be imagined that the presence of two CAM providers at infrequent meetings would have much effect on Dumoff’s concern about whether a CAM service “can be fairly represented by a code written with a biomedical procedure in mind.”

**Background on ABC Codes:** While some advantages of a single universally accepted coding system are obvious, the concerns Dumoff raised in 2003 have been voiced by nurses, physicians and various CAM healthcare professionals as well.

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 health care approaches that Americans were by 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 what the company claims is more complete and successful billing for a variety of non-MD healthcare professionals. ABC codes have not yet been widely adopted in the US, although in January 2003 DHHS approved a 2-year pilot study for the “…use of Advanced Billing Concepts (ABC codes) for Alternative Medicine, Nursing and other Integrative Health Care.” 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.”

A 2005 letter from the American Nurses Association to DHHS petitioning for recognition of ABC codes as a designated standard code set for healthcare services reporting, including HIPAA transactions, notes 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....” Nurses and other professions have also argued that CPT codes are inadequate to the task of identifying best practices within a profession, and conducting useful comparative effectiveness research including getting accurate reflection of comparative cost effectiveness.

At a hearing on “Principles of Integrative Health: A Path to healthcare Reform,” held by the Senate HELP Committee in February 2009, Brian Berman, MD testified that, “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.”

Despite the apparent limitations of CPT codes, and the concerns about the AMA “ownership” and income from them, ABC Codes is the only other system to be developed since the 1983 decision, and it has not gotten much traction with the federal government despite its support by a number of health care professions.

It is against this backdrop that the CPT Code Committee began its deliberations at the conference.

**Summary of Group Discussion:** Opening introductions of committee members revealed that the group included physicians who were constantly engaged with coding for reimbursement and others that avoided that 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 the other of whom 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; one member 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 was wide-ranging, covering problems experienced with CPT, untapped potential within the CPT system to get new needed codes, pros and cons 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 example, at this time Medicare only reimburses chiropractors for spinal manipulation and not for any other aspect of proper treatment such
as physical examinations, radiological procedures, physiotherapeutic modalities, exercise and rehabilitation, or nutritional counseling.

After determining that many countries in fact 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 traction 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 to the lives of providers who are already strapped for time; and that unless universally accepted, payers would likely undervalue services and procedures coded differently from the majority of reimbursed providers. The counters to the first concern was the view by some 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.

An important arena of inadequate CPT coding for CAM/IHC providers is E&M (evaluation and management) charges/codes. A number of issues came to light. Where E&M is limited to “physician” it should be broadened to “provider” or some more inclusive term. One member of the group noted that this change has been continually incorporated in all new codes, and at 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 exam and complexity/medical decision-making. One problematic aspect of this is the prohibition against diagnoses 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.

Another important issue regarding E/M language in the past was the 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.” (p 10 par# 3 CPT Manual 2010)

The switch 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 a good deal of probing to understand the etiology of symptoms/conditions, and the many CAM/IHC providers whose treatments involve labor intensive patient education and evaluation of their follow-through, etc.

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

Specific Recommendations - The overall agenda and action items identified by the end of the conference were:

1) CPT codes are needed for all health care professionals;
   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 a number of 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. Coding should be examined and amended to facilitate valid comparative effectiveness research.

2) Prepare for enactment of Section 2706 of the Affordable Care Act (Non-Discrimination) that will come into play in 2014.
   a. Develop provider codes at 3 levels of complexity under Affordable Care Act (ACA) Section 2706 on Non-discrimination (see Access Group above).
   b. Actively engage with HHS to develop regulations that affect CPT code sets pursuant to section 2706 of the ACA.

3) Work with CMS
   a. Work to amend Medicare rules so that they 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 health care 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 now included at all in CPT, but which might become part of medical homes under the ACA.
SUMMARY AND PROGRESS TO DATE

It has been 18 months since the Affordable Care Act was signed into law, and a year has passed since the recommendations were made at the 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 healthcare have gone into effect, others are still in the rulemaking process, and some have up to two more years until they will be rolled out.

OVERALL SUPPORT OF THE ACA AND INTEGRATED HEALTH CARE

The law itself has run into a variety of attempts to undermine it in this era of virulent partisanship, as well as serious financial strain. As we write, the court challenges regarding its constitutionality have finally reached the Supreme Court that is expected to reach a decision by June 2012. IHPC, like other organizations involved in and supportive of the ACA, has spent time both fighting for its survival as written and working on specifics of implementation of the sections most important to our constituencies.

CONGRESSIONAL BRIEFINGS

Given the Congressional upheaval of 2010 elections, there are many new legislators and staffers on Capitol Hill who were not involved in crafting the law and may yet be unfamiliar with some of its lesser known aspects, including those related to integrative health care. The IHPC and its Partners for Health, along with other allies, will be presenting a series of at least three Congressional briefings on integrated health care during fall and winter of 2011-12. These will be educational briefings on what integrated health care is and its potential role in both preventive efforts and in treatment of chronic pain and illness; the national healthcare workforce as defined in the ACA and implications of this for medical home models and other Federal planning efforts; the intersection of patient empowerment and non-discrimination against provider types as stipulated in Section 2706 of the ACA.

COUNCILS, GROUPS, INSTITUTES AND COMMISSIONS

National Healthcare Workforce Commission (NHWC) - One strategy for those opposed to the law has been a refusal to appropriate funds for the activities of some of the bodies created by the ACA. One of
the vulnerable bodies that matters to the integrated healthcare community is the National Healthcare Workforce Commission whose charge is to oversee “evaluations of education and training activities to determine whether the demand for health care workers is being met,” to identify and address barriers to improved coordination across 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 do all this in the context of a redefinition of the healthcare workforce that includes licensed CAM providers. To date no funds have been appropriated for the Commission. Thus, while commissioners have been appointed by the Comptroller General as specified in the law, the commission has taken no action; in fact, it has not yet met.

**National Prevention Health Promotion and Public Health Council and the Advisory Group on Prevention, Health Promotion and Integrative** - Two bodies were created to address the strongly enhanced focus on prevention and health promotion stipulated in this law. The National Prevention Health Promotion and Public Health Council is a cabinet-level body chaired by the Surgeon General. This council, quite similar to one proposed in the Wellness Initiative for the Nation authored by the Samueli Institute with collaboration by the IHPC, is charged with developing and implementing a National Prevention Strategy. This level of commitment to health promotion by so many senior members of the administration is unprecedented and speaks of the commitment made in the law to prevention and wellness in the US health care system. In an encouraging early move, the Surgeon General immediately strengthened this Council by adding to the 13 agencies stipulated in the law, another five - the Department 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 ACA also created the grassroots **Advisory Group on Prevention, Health Promotion and Integrative** and Public Health, whose job, as the name indicates, is to provide advice to the Council emanating from needs identified and lessons learned at the grassroots level. This group is chaired by one of its members, Jeffrey Levi, PhD, and reports to the Surgeon General. Appointments to the Advisory Group were made by President Obama who has appointed 17 of a possible 25 members. Two members have clear links to and knowledge of integrated health care.

Stakeholder groups have taken a number of actions to support and/or expand the prevention and health promotion focus of the law. Some of these are as subtle as resisting the tendency to shorten the names of the council and advisory group when speaking of them because the shortening could inadvertently lead to a de-emphasis or neglect on the intended focus of “health promotion” and the
implicit inclusivity of “integrated and public health.” While the law provided for funds to be appropriated in specific amounts annually into a Prevention and Public Health Fund to be administered by the Secretary of DHHS, some have called for a negation of those appropriations. For that reason a number of stakeholder groups including the IHPC have signed to letters initiated by the Trust for America’s Health to protect this critical resource.

In March 2011 a letter was delivered to the Surgeon General, addressing the National Prevention Health Promotion and Public Health Council, outlining IHPC’s five top priorities for the council to address. Suggestions for these priorities were solicited from all Stakeholder Conference attendees and sponsors. The letter, 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, is attached as Appendix D of this report. Council support staff saw to it that it was distributed to members of both the council and the advisory group. In addition, a number of the stakeholder groups submitted feedback on the draft of the National Prevention Strategy, and both the Samueli Institute and IHPC have attended meetings of the Advisory Group.

The Samueli Institute has been in touch with the Surgeon General and with Dr. Levi, chair of the advisory group, to offer assistance to them. Wayne Jonas of the Samueli Institute presented to the Prevention and Integrative Health Working Group of the Advisory Group on the concept of resiliency and work Samueli Institute has been doing with the military on prevention and wellness. Janet Kahn of the IHPC has been appointed as a member of the Prevention and Integrative Health Working Group of the Advisory Group.

Patient Centered Outcomes Research Institute (PCORI) – As stated above, Christine Goertz, DC, PhD, an organizer of the Stakeholder Conference, was appointed to the Board of Governors shortly before the conference began. Still to be appointed at that time were the members of the PCORI methodology committee, which the workgroup on CER and PCORI (see above) saw as a high priority. A number of 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 done a good to job to date of keeping the public informed of their activities and soliciting feedback. The Consortium of Academic Health Centers for Integrative Medicine (CAHCIM) has had a representative present at every meeting of the PCORI board of governors, keeping the concept of
integrative health care and the offer of assistance to PCORI front and center. A listening session held by
PCORI in Seattle in September 2011 was attended by many integrated health care stakeholders who
shared their views and again offers of assistance.

Many organizations responded to PCORI’s call for feedback on their definition of PCOR and their
proposal for eight “Tier One” Pilot Projects. Among the suggestions offered by IHPC’s Partners for
Health was that “the term clinician should always be understood to refer to all health care providers and
practitioners named as members of the National Healthcare Workforce in Section 5101 of the Affordable
Care Act.” That suggestion and all of IHPC’s feedback were shared with other organizations via The
Integrator Blog who may have amplified the message in their own responses.

**ACCESS AND NON-DISCRIMINATION**

While Section 2706 focusing on Non-Discrimination is not planned to go into effect until 2014, there
has been much opportunity to address issues of patient access and discrimination against provider types
in 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. The Institute for Integrative Health and IHPC
collaborated on a presentation of this issue to HRSA’s Negotiated Rulemaking Committee on
Designation of Medically Underserved Populations and Health Professional Shortage Areas at their
October 2010 meeting. Back-up 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 an article by Albert and Butar entitled “Estimating the de-designation of
single-county HPSAs in the United States by counting naturopathic physicians as medical doctors.”

This effort is still in progress as the committee’s proposed algorithms, published in September 2011
excluded those three professions. IHPC then sent another letter that was presented to the committee
by David O’Bryon. Those two letters appear as Appendices E and F of this report.

Efforts to have the services of CAM and integrated healthcare professions included 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 had been asked to make recommendations on this issue, as had
the Institute of Medicine, some members of IHPC’s Federal Policy Committee approached the insurance
commissioners in their states. In Hawaii, a statewide meeting of IHC/CAM community with the
insurance commissioner and legislators is planned to discuss a forward-thinking approach to healthcare
policy in that state.
A number of organizations within the chiropractic community are collaborating on efforts to address the integration of chiropractors into wellness efforts and prevention and in primary care.

Finally, IHPC was contacted by a grassroots state level organization called the Progressive Research in Health affiliated with other citizen action organizations. They requested help understanding how the ACA should be implemented and what they can do at state level to strengthen people’s access to integrated health care and CAM. We directed them to appropriate state level legislative examples and experienced people 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 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. Those both appear above in the section on Healthcare Workforce.

**COMPARATIVE EFFECTIVENESS RESEARCH AND PATIENT CENTERED OUTCOMES RESEARCH**

Efforts on this front have been addressed above in the section on PCORI.

**THE HEALTHCARE WORKFORCE**

As stated above, while the National Healthcare Workforce Commission has been rendered, at least temporarily, inactive for lack of funding, efforts are being made to encourage adoption, by all agencies with DHHS, of the definition of the healthcare workforce that appears in Section 5101 of the ACA. Those efforts, both in Congressional Briefings and in relevant HRSA committees are described above.

**PREVENTION AND WELLNESS**

See above 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. The shift to prevention as a key responsibility of the health care system, and the role of CAM and integrated health care in that will be pursued at every opportunity.
CPT CODES

In early 2011, the word “may” was changed to “shall” in the 2011 CPT Manual for the section identified by the conference task force as needing this, thus it now states that *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 change from “physician” to “provider” make for significant neutralization of biased language that has now become more profession-neutral and thus inclusive.
# APPENDIX A.
## CONFERENCE REGISTRANT LIST

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<tr>
<th>First</th>
<th>Last</th>
<th>Title</th>
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<td>Corinne</td>
<td>Axelrod</td>
<td>Health Policy/Insurance Specialist</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>Jenn</td>
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<td>J.P.</td>
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<td>Josie</td>
<td>Briggs</td>
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<td>Sherman</td>
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<tr>
<td>Ian</td>
<td>Coulter</td>
<td>Medical Sociologist</td>
<td>Samueili Institute Chair in Policy for Integrative Medicine, and Senior Health Policy Analyst, RAND Corporation; Professor, UCLA School of Dentistry</td>
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<td>Michael</td>
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<td>Karen Howard</td>
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<td>Wayne Jonas</td>
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<td>Janet Kahn</td>
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<td>Lori Knutson</td>
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<td>Pamela Snider</td>
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<td>B&amp;D Consulting</td>
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APPENDIX B.

The Affordable Care Act and Beyond: A Stakeholder Conference on Integrated Health Care Reform

Hosted by

INTEGRATED HEALTHCARE POLICY CONSORTIUM

PALMER College of Chiropractic

THE INSTITUTE FOR INTEGRATIVE HEALTH

Sponsored by

Hyland's

AND

BASTYR UNIVERSITY
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.
March 24, 2011

The Honorable Regina M. Benjamin, MD

Surgeon General

5600 Fishers Lane
Room 18-66
Rockville, MD 20857

Dear Surgeon General Benjamin:

As Integrated Healthcare Policy Consortium (IHPC) Partners for Health, we write to encourage strong support for the National Prevention, Health Promotion, and Public Health Council, and its Advisory Group.

As you may be aware, IHPC is a broad coalition of clinicians, patients, healthcare educators and organizations committed to public policy that ensures all Americans access to safe, high quality healthcare, including the full range of qualified 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 wellbeing for the patient. Integrated healthcare, of course, provides for the populations’ full health needs from primary prevention through acute illness and trauma care to palliation and compassionate end of life care. Its hallmarks, however, are a focus on health promotion and patient engagement through strong relational care.

At IHPC we also support Integrated Health Policy, which is an approach to policymaking that puts the health of the nation’s population as a key consideration in all domestic policy initiatives and decisions.

The IHPC membership recognizes the Affordable Care Act as a remarkable achievement and fully supports its complete implementation. We celebrate the provision of health insurance to millions of people previously uninsured, and expansion of the system of Community Health Centers that have been proven to be an efficient and cost-effective model of quality primary care. In addition, we applaud the many provisions in the law which begin to redirect
our healthcare system towards a patient-oriented system of health promotion and disease prevention.

It is clear to the IHPC membership that a vibrant and effective National Prevention Council and Advisory Group can play a significant role in promoting and achieving this last opportunity; and we firmly believe that both the quality and cost-effectiveness of that system will be assured by facilitating collaborative healthcare delivery by an inclusive array of providers. The attachment, **IHPC’s Top Five Priorities for the National Prevention, Health Promotion, and Public Health Council**, outlines five opportunities for the Council and the Advisory Group:

1. Mindfulness of the role of human behavior in achieving health promotion and disease prevention, and inclusion of low cost, low technology interventions available through both conventional and complementary healthcare disciplines;

2. Encouragement of a systems thinking approach that supports community perspective, use of healthcare teams, and support for all providers to practice to the full extent of their scope of practice;

3. Full review of existing federal healthcare programs to assess the extent of the focus on health promotion and wellness as well as their effectiveness and return on investment, with an appreciation for the fact that many health promotion practices reach optimal maturity and effectiveness over a relatively long time and that it is imperative to invest in longitudinal evaluation of health promotion practices to learn how to bend the cost curve and achieve a healthier Nation;

4. Accumulation of knowledge about the practices and outcomes of integrative healthcare and the individual systems, and the inclusion of all regulated healthcare professionals in your vision of prevention and health promotion, as well as in medical homes and community health teams; and

5. Continual pursuit of equity in both patient access and provider inclusion and reimbursement.

IHPC and its Partners for Health remain ready to support the Council and look forward to a very close working relationship with you and the Advisory Group as we all pursue the vision of the Affordable Care Act.

Sincerely,

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

Karen Howard
Executive Director
American Association of Naturopathic Physicians

Daniel K. Church, PhD
President
Bastyr University

Mary Lawlor, CPM, LM
President
National Association of Certified Professional Midwives

Nancy Gahles, DC, CCH, RSHom (NA)
President
National Center for Homeopathy

Cynthia Moore, MS, Lic Ac
Executive Director
Sojourns Community Health Clinic
Top Five Priorities for the National Prevention, Health Promotion, and Public Health Council

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 well-being, 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.
IHPC Policy Statement to Aid Credentialing of Integrative Health Practitioners

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)
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:

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

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

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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:

“(I) 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:

- 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, ACCAH, 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:

“The 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:
Information on state scopes of practice:

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.

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
Executive Director

Attachments:
- IHPC testimony, dated October 20, 2010, to Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas

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.