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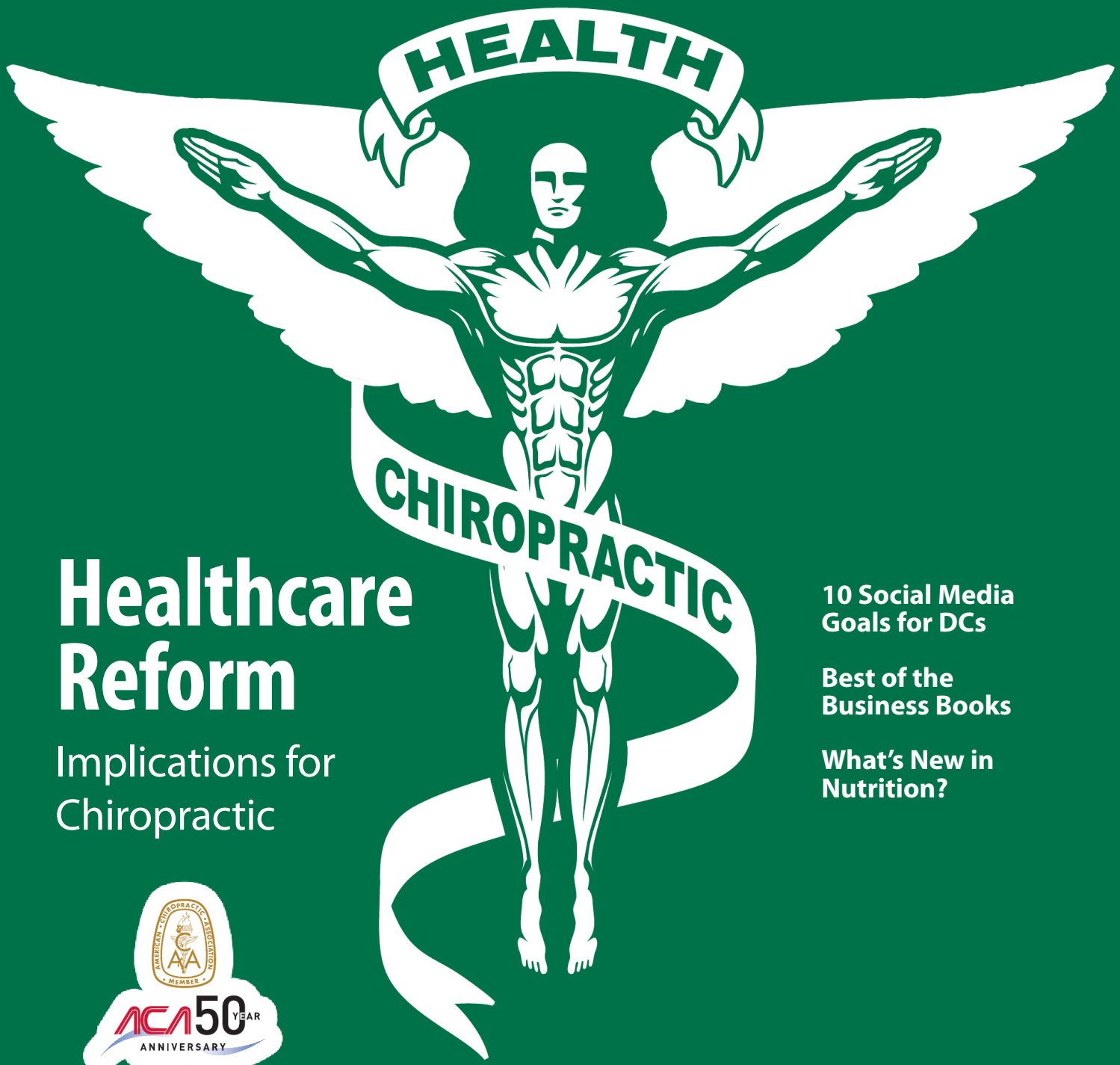

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Healthcare Reform

Implications for Chiropractic

By James J. Lehman, DC

Earlier this year, Daren Anderson, MD, and I discussed healthcare reform, primary care teams and the integration of chiropractic services into the healthcare system as valuable members of the medical team with *ACA News* readers.[1] Since that time, the government of the United States was shut down for 16 days in an attempt to delay healthcare reform and defund the Affordable Care Act.[2] Yet the Health Insurance Marketplace is open with the task of finding quality health coverage for Americans through private companies.[3] Affordable Care Act funding continues as the law of the land.[4]

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What follows is information regarding healthcare reform and suggestions for those chiropractic physicians interested in joining the healthcare delivery systems of the 21st century as valuable members of healthcare teams within coordinated care organizations.

Healthcare Reform

Healthcare reform is not a new concept. In the late 1800s, 11 industrial nations developed social/national insurance. Theodore Roosevelt, the 26th U.S. president, unsuccessfully supported progressive healthcare reform during 1912.

Former Kansas Sen. Bob Dole (R) expressed his concerns regarding our healthcare crises more than 40 years ago. Subsequently, he supported healthcare reform with Sen. Tom Daschle (D), urging "the joint leadership to get together for America's sake."[5]

President Bill Clinton introduced the Health Security plan on Sept. 23, 1993. One year later, healthcare reform died a quiet death.[6]

President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590) and the Health Care Education and Reconciliation Act (H.R. 4872) – together known as the Affordable Care Act (ACA) – on March 23, 2010.

Affordable Care Act

The government promulgates the notion that the ACA will provide Americans with better health security by putting in place comprehensive health insurance reforms that will:

- Expand coverage;
- Hold insurance companies accountable;
- Lower healthcare costs;
- Guarantee more choice; and
- Enhance the quality of care for all Americans.[7]

Despite public perception, it is a fact that the healthcare system in the United States does not deliver the most salubrious care. The United States has a higher rate of medical mistakes, medication errors or lab errors than Canada, Australia, New Zealand, Germany and the United Kingdom.[8] In reality, the American healthcare system has been broken for years.[9] It remains the most expensive healthcare system in the world and spends more per capita on healthcare than all other countries in the world. Healthcare spending per capita in the United States in 2006 ($6,714) was more than twice the median per capita expenditure of the 30 Organisation for Economic Co-operation and Development (OECD) industrialized countries ($2,880),

and 50 percent greater than Norway ($4,520), the second-highest spending country.[10]

By January 2015, the ACA intends to modify the reimbursement model for healthcare by rewarding the delivery of high-quality care and reducing use of the fee-for-service payment approach. Healthcare systems will be required to create innovative delivery systems with a coordinated model that reduces costs while delivering high-quality care across a continuum of care. At this time, two delivery systems, the Patient-Centered Medical Home (PCMH) and the Accountable Care Organization (ACO), are the front-runners in coordinating care.

> *The Agency for Healthcare Research and Quality recognizes that revitalizing the Nation's primary care system is foundational to achieving high-quality, accessible, efficient health care for all Americans. The primary care medical home, also referred to as the patient centered medical home (PCMH), advanced primary care, and the healthcare home, is a promising model for transforming the organization and delivery of primary care.*[11]

> *Coordinated care makes a healthy community. That's why we're letting providers know how they can join together to form Accountable Care Organizations (ACOs) and why we're changing how we reimburse providers – by rewarding them for working together.*[12]

As implementation of the most significant American healthcare law since 1965 moves forward with insurance exchange enrollments, the Kaiser Family Foundation reports that the public trusts that doctors and nurses will be able to provide information about healthcare reform.[13] Yet, many physicians claim to be confused with how ACA's policies will affect them.[14]

Health Insurance Marketplace (Exchanges)

The open enrollment for affordable health insurance began on Oct. 1, 2013 and ends on March 31, 2014. Marketplace coverage starts Jan. 1, 2014. It is estimated that almost 30 million Americans will acquire ACA coverage by 2019. Although individuals with health insurance are not required to apply for marketplace insurance, everyone may investigate through the application process in every state. Enrollment is not required with application. If people are not satisfied with their current coverage, they may enroll.

During the first week of enrollment:

- 28,699 people enrolled in California;
- 17,300 people enrolled in Kentucky;
- More than 40,000 people enrolled in New York;
- More than 9,400 people enrolled in Washington.[15]

Individuals who are without health insurance by Jan. 1, 2014, will be penalized unless an exemption is obtained. The penalties may be assessed monthly or appear on year-end IRS returns. Those Americans covered by Medicare, Medicaid, CHIP, any job-based plan, any self-purchased plan, COBRA, retiree coverage, TRICARE, VA health coverage or other health coverage are not required to purchase Marketplace health insurance during 2014. The Marketplace insurance plans are offered by state, federal or jointly operated exchanges. The State Health Insurance Marketplace website (*healthcare.gov*) offers directions for application.

Benefits of the Affordable Care Act

The Department of Health and Human Services (HHS) considers ten essential health benefits that the ACA requires all new individual and small group insurance companies to cover without annual dollar caps. Every practicing chiropractic physician should consider chiropractic to be essential to the health of patients, but does HHS? Although the government does not specifically mention individual professions or disciplines, it appears that chiropractic would fit in more than one of the categories.

Essential health benefits are:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace. States expanding their Medicaid programs must provide these benefits to people newly eligible for Medicaid.[16]

National Prevention Strategy

The National Prevention Strategy was published in June 2011. It is proclaimed to be "America's Plan for Better Health and Wellness." The strategy has been charged with moving America from a system of sick care to one based on wellness and prevention. Integrated healthcare, defined as a coordinated system that integrates evidence-based CAM providers into healthcare delivery systems and primary care facilities within community health centers, is expected to reduce pain and disability. Research will determine the effectiveness of CAM interventions and identify the best methods to integrate them into clinical environments to prevent disease and disability.[17]

Essential Health Benefits

The most obvious essential benefits of chiropractic services would be ambulatory patient services and chronic disease management. Most specifically, doctors of chiropractic (DCs) should be the providers of choice for the evaluation and management of chronic pain caused by neuromusculoskeletal conditions. Medical training does not properly train primary care providers to evaluate and manage complex pain conditions caused by neuromusculoskeletal disease.[18] It has been my experience at the Community Health Center, Inc. in Connecticut[19] and the Lovelace Medical Center in New Mexico[20] that primary care providers are amenable to referring patients with neuromusculoskeletal pain conditions to chiropractic physicians integrated into the healthcare system.

The Institute of Medicine offers a definition of primary care that mentions addressing a large majority of personal healthcare needs:

Primary care is the provision of integrated, accessible health care services by clinicians *who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.*[21]

Coordinated Care Organizations: The Future

The ACA claims that coordination of care improves health, which justifies rewarding providers that work together in ACOs and PCMHs. Kathleen Sebelius, secretary of the Department of Health and Human Services (HHS), wrote on the Health Affairs blog that our current healthcare system does not incentivize quality or efficiency, but pays providers for the quantity of care, not the quality of care.[22] She also announced that 32 leading healthcare organizations from across the country participate in a new Pioneer ACO initiative made possible by ACA. The Pioneer ACO initiative encourages primary care doctors, specialists, hospitals and other caregivers to provide better, more coordinated care.[23]

The healthcare organizations and providers participating in the Pioneer ACO initiative included five types of organizations:

- ACO professionals in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals (including hospitals employing ACO professionals);
- Federally qualified health centers (FQHC); and
- ACOs.

ACOs

HHS Secretary Kathleen Sebelius established in 2011 a shared savings program that promotes accountability for a patient population while coordinating items and services and encouraging investments in infrastructure and redesigned care processes for high-quality and efficient service delivery.

The ACA authorizes use of ACOs to improve the safety and quality of care and reduce healthcare costs in Medicare. The ACO program – a voluntary program – began on Jan. 1, 2012. This is not a demonstration project or pilot. It creates a new entity, an ACO that can directly contract with Medicare.

An ACO, as defined by the Centers for Medicare and Medicaid Services (CMS), refers to a group of providers and suppliers of services (e.g., hospitals, physicians and others involved in patient care) that will work together to coordinate care for the patients they serve under original Medicare (i.e., those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, while improving quality and lowering costs. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions. Participation in an ACO is purely voluntary.

Although the ACO provisions under ACA are intended for Medicare, state Medicaid programs can enter into an ACO-type contract with a commercial insurer. Several states – Colorado, Maryland, Massachusetts, Minnesota, New Jersey, Oregon, Vermont and Washington – are pilot testing or encouraging the establishment of ACOs.

Requirements for ACO status are that the ACO:

- shall be willing to become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- shall enter into an agreement with the Secretary to participate in the program for not less than a three-year period.
- shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings.

- shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO.
- shall have at least 5,000 such beneficiaries assigned to it.
- shall provide the secretary with such information regarding ACO professionals participating in the ACO as the secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO.
- shall have in place a leadership and management structure that includes clinical and administrative systems.
- shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring and other such enabling technologies.
- shall demonstrate to the secretary that it meets patient-centeredness criteria.
- participant cannot participate in other Medicare shared-savings programs.
- entity is responsible for distributing savings to participating entities.
- must have a process for evaluating the health needs of the population it serves.[24]

Patient Centered Medical Homes

The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchanges and other means to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.[25] Under that definition, would it not be appropriate for DCs to be members of the PCMH primary care team?

The Agency for Healthcare Research and Quality provides information and guidance for anyone with an interest in learning more about primary care and the PCMH.[26, 27]

Community Health Centers

The "Community Health Center," "Federally Qualified Health Center" or "Health Center" model is unique and emphasizes quality,[28] access and cost-effectiveness. Health centers aim to make a difference by raising the standard of chronic care,[29, 30] reducing disparities in healthcare,[31] producing healthier babies[32] and saving dollars[33] without sacrificing quality.[34] This vision is expected once access for all Americans becomes a reality, with a healthcare system in which every person in America has access to comprehensive primary healthcare, regardless of ability to pay, while at the same time the cost of care actually goes down.[35]

"The community health center model has proven effective not only in increasing access to care, but in improving health outcomes for the often higher-risk populations they serve." *Institute of Medicine*[36]

It has been predicted that the number of uninsured Americans will reach 60 million by 2020.[37] I expect that the 1,200-plus health centers (7,000 locations) in the United States will be asked or expected to expand coverage from 18 million to 60 million Americans with the number of community health center primary care sites increasing and serving more than 7,000 communities. DCs should realize that community health centers are a critical part of the health care delivery system, which will provide primary care services and control referrals to specialists.

Primary Care 2025

The Institute for Alternative Futures (IAF), with support from the Kresge Foundation, developed a project to consider the range of forces, challenges and opportunities shaping primary care in the United States and published "Primary Care 2025: A Scenario Exploration." The IAF has performed similar work for the chiropractic profession with its publication of "Chiropractic 2025: Divergent Futures."[38] The four primary care scenarios attempt to clarify the uncertain future of primary care in a time of great flux.[39] These two publications, if read and discussed by DCs, will shine some light on the future of our profession.

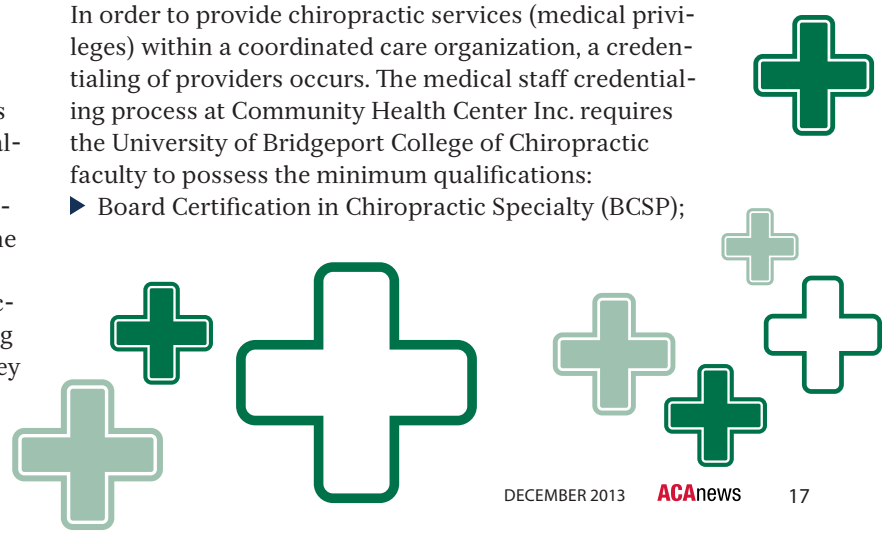
What Does This Mean for DCs?

The passage of the ACA has created an entirely new healthcare system that aims to promote integrated, holistic, patient-centered and evidence-based primary care. In particular, this healthcare reform law highlights the need for wellness and prevention of disease in the National Prevention Strategy. This strategy implies that community health centers, PCMHs and ACOs across the country will be more receptive to the integration of chiropractic into their primary care facilities and health centers to enhance patient access to affordable, safe and effective healthcare services.[40] Thousands of chiropractic physicians could help to fill the void in primary care facilities caused by the shortage of primary care physicians.

Credentialing

In order to provide chiropractic services (medical privileges) within a coordinated care organization, a credentialing of providers occurs. The medical staff credentialing process at Community Health Center Inc. requires the University of Bridgeport College of Chiropractic faculty to possess the minimum qualifications:

- Board Certification in Chiropractic Specialty (BCSP);



- Teaching experience;
- License to practice chiropractic in Connecticut; and
- Professional liability insurance.

Privileges

Based upon the DC's scope of practice, education and training, a list of privileges is granted by the medical review committee. For example, as a board-certified chiropractic orthopedist, I am granted privileges to perform evaluation and management of children and adults of all ages for neuromusculoskeletal conditions, perform soft tissue treatments and manual medicine procedures in a federally qualified health center, which is also a PCMH. I could have requested physical medicine procedures or others that are encompassed in my scope of practice and training.

Coordinated Care Organization Entry

If you are interested in becoming a healthcare provider within a coordinated care organization, then first perform an environmental scan. Ask the medical doctors within your network what they know about ACOs. Most important, find out if the hospitals are forming their own coordinated care organizations. Hospitals frequently purchase medical practices when they initiate the development of their ACOs.[41] If you have not developed a network of healthcare providers that collaborate, it is time you do so. It is essential you earn the trust of MDs, most especially primary care physicians who are willing to accept patient referrals and reciprocate.

Healthcare reform is forcing the healthcare system to coordinate care with the development of collaborative networks.[42] If one of your network doctors is involved with a coordinated care organization, ask if you could become a provider. A hospital might be interested in purchasing your practice due to the shift toward payment for value and population health management.[43]

Your environmental scan should reveal the number of community health centers in your region. Introduce yourself to the facility manager, and discuss healthcare reform. It is important for you to advise management that chiropractic services are reimbursable through ACA. Although the state Medicaid program may not reimburse for chiropractic services, a federally qualified health center (FQHC) could petition for expansion of scope of reimbursement from HRSA. While many DCs may not appreciate the low fees normally paid to individual providers,[44] an FQHC receives a more reasonable reimbursement. This summer, I was advised by a clinic manager of a community health center in New Mexico that her organization receives $139 per visit for Medicaid patients, whereas reimbursement for private practice providers is significantly less.[45] A Rhode Island integrative healthcare pilot study is currently reimbursing chiropractic physicians $55 per 30-minute visit.[46]

While primary care physician incomes average $220,000 per annum,[47] 40 percent earn less than $150,000[48] and primary care-based nurse practitioners earn $86,000.[49] A board-certified chiropractor willing to become a full-time employee of a coordinated care organization should be properly compensated. Based upon experience, quality of care and productivity, it would be reasonable to seek a base salary of $150,000 plus incentives and benefits.

The Rhode Island integrative healthcare pilot discusses the significant costs of care incurred with the chronic-pain patients being treated in the Medicaid population.

> *Also, in Rhode Island, the typical Medicaid patient today costs around $235 per member per month. The expenditures for the costliest chronic pain population, the "Communities of Care" population, are approximately $2,300 per patient per month. This group consists of patients who accessed the emergency room at least four times in a given year and have very high pharma costs. Their rate of increase is about 30 percent, so they're costing Medicaid ten times the typical cost of regular enrollees.*[50]

The Community Health Center Inc. "Chronic Pain" pilot study in Connecticut demonstrated very high degrees of satisfaction, with 98 percent of patients expressing satisfaction with chiropractic treatment. In addition, there was a statistically significant improvement in patients' ratings of their pain following treatment. It appears that integration of chiropractic services into coordinated care organizations to evaluate and manage chronic pain patients is reasonable.[51]

Conclusions

The integration of chiropractic services into coordinated care organizations as essential health benefits would complement the goal of healthcare reform: to provide affordable healthcare to all Americans. Chiropractic specialists should provide neuromusculoskeletal medicine services in order to reduce the suffering of patients with chronic pain due to musculoskeletal conditions. Chiropractors could provide primary care services within coordinated care organizations. ■

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