American Acupuncture Council®

AFFORDABLE CARE ACT

American Acupuncture Council

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The Affordable Care Act for CAM Providers

The **Patient Protection and Affordable Care Act** (**PPACA**), commonly called **Obamacare** or the **Affordable Care Act** (**ACA**), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the country's healthcare system since the passage of Medicare and Medicaid in 1965. The ACA aims to increase the quality, affordability, and rate of health insurance coverage for Americans, and reduce the costs of health care for individuals and the government. It provides a number of mechanisms—including mandates, subsidies, and insurance exchanges—to increase coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex. Additional reforms aim to reduce costs and improve healthcare outcomes by shifting the system towards quality over quantity through increased competition, regulations, and incentives to streamline the delivery of health care. The Congressional Budget Office projected that the ACA will lower both future deficits and Medicare spending.

How it will affect acupuncturists:
This act, especially in California, may increase availability of acupuncture and will create changes in how we practice, both in how we disperse patient care and how we run our small businesses. It is vital to our profession that our practitioners be informed and involved.

C is for Chiropractic

Emphasizes manual therapy including joint adjustment and manipulation with focus on joint dysfunction. It is mainly used for relief of lower back pain. Many chiropractors also recommend therapeutic and rehabilitative exercises, as well as nutritional, dietary and lifestyle counseling.

A is for Acupuncture

Stimulating specific acupuncture points corrects imbalances in the flow of qi through channels known as meridians. Treatment for a variety of different illnesses, mainly psychosomatic ones, but also used for allergic diseases and muscular skeletal disorders. Also commonly used as an anesthetic. It is becoming more accepted in western medicine as a legitimate medicine.

M is for Massage Therapy

Commonly used by athletic trainers and physical therapists, but is also used for relaxation and pain relief. Has been known to treat anxiety and relieve pain, also reduce depression and reduce blood pressure and heart rate temporarily. It is a very popular way to relieve back pain. Massage therapy is the manipulation of the soft tissues of the body with fixed or movable pressure, holding and/or causing movement of the body.

There are ten "titles" in the law, each dedicated to a different part of our "so called" health care system. This massive governmental program has created another great divide between those in favor and opposed to this government takeover. When one considers an overview of the titles an optimistic hope of improved benefits and cost containment may be felt. However, to anyone who has objectively analyzed the promises verses the reality of previous Federal programs such as funding higher education, medicade, social security, Medicare and the income tax system the realization that these programs have failed to address the basic motivations of human behavior and have been costly attempts to correct problems that were created by previous legislation. And without the government's ability to borrow trillions of dollars to keep the various programs implemented they would have collapsed. As always the devil is in the details.

No one really knows what the process will bring forth. However, as with all previous governmental takeovers the unintended consequences and the actual costs will far exceed any estimates that have been put forward.

Title I is **"Quality Affordable Health Care for All Americans"** and is 374 pages. This deals with health insurance. It is a very complicated section, and it makes a complex and costly health care payment system more complex and costly.

Insurance will change. First, Guaranteed -issue policies without preexisting condition limitations, lifetime benefit limits, or annual benefit limits. Second, everyone is required to have coverage. Third, people who have difficulty affording coverage will get assistance paying for it unless they are under the 133% poverty level. Those people will go on Medicaid unless their state refuses to expand Medicaid.

Title II is **"Role of Public Programs"** deals with, public programs. Medicaid and the Indian Health Services are covered. There will be significant changes in how care is delivered. This provision mandates the development of medical care homes, which basically moves us from a paternalistic model of medicine to a team based approach, and the move to home based care for the chronically ill.

This is also the section of the law the Supreme Court had issue with - expanding Medicaid and withholding funding from states who won't expand Medicaid. It will be interesting to see how this pans out.

Title III deals with health care providers and details changes in Medicare. **"Improving Quality and Efficiency of Health Care"** dedicates 501 pages for changing how health care will be delivered. It moves us from a fee-for-service system toward payments based on quality of delivery. This starts with Medicare. The assumption is what Medicare does is usually followed by private insurance. This is designed to eventually control costs.

Title IV "Prevention of Chronic Disease and Improving Health" is designed to address the problem of chronic illness in our country. 130 pages address this issue. Chronic illness is very costly. The 2 goals are to do a better job of preventing disease and/or treating it very early before expensive complications arise. The current health

care delivery system has failed to address chronic illness effectively. Many organizations currently failing in this area were involved in this section of the law - Mayo Clinic and Kaiser Permanente to name a couple.

Title V is what I call "The Jobs Bill." It is actually the "Health **Care Workforce"** and the legislation in these 256 pages recognizes that we don't have enough health care workers to take care of everyone. It especially addresses the lack of primary care in this country. Although we are all special, most of the problems we have don't need a specialist to take care of them. Since we have rewarded specialty care through the years, the primary care system has been decimated. Countries with strong primary care systems have healthier populations with lower costs.

Title VI is 323 pages. **"Transparency and Program Integrity"** is dedicated to reducing fraud and abuse. Billions and billions adding up to trillions are lost each year in federal programs. We definitely need to do something.

Title VII- "Improving Access to Innovative Therapy" and is 65 pages basically dedicated to improving access to generic drugs. Innovative, indeed. For those who consider an increased use of pharmaceutical drugs a benefit this provision is magnificent.

Title VIII "Community Living Assistance Services and Support." The one part of the law that was blatantly troublesome from the beginning. This institutes a federally run long term care insurance program. These 53 pages will implement another nightmare because it creates a program similar to our current Social Security disability system. This was Ted Kennedy's baby. This part of the bill has been played down because the HHS analysis revealed there would be many problems with implementation. Just like the income tax was originally sold as only going to be 1 to 3% on the very wealthy, just wait for the costs of this part to show up.

Title IX is the 93 page **"Revenue Provisions"** and spells out how we were going to pay for the elephant. This provision enables the IRS to administer collection of huge additional costs on the American taxpayer.

Title X was the most challenging, and it ended the novel like it began - complicated. Remember Title I, "Quality Affordable Health Care for All Americans?" Well, in the same law, we already had to strengthen it. Title X is called **"Strengthening Quality Affordable Health Care for All Americans."** It really is called that. My name for it? "The Bucket List." These 372 pages include a lot of neat pilot programs on changes in health care delivery, and the usual favors for special interests. There are two pages dedicated to gun owner rights and a provision that Nebraska doesn't have to follow the Medicaid rules because that Senator would only vote for the law if his state was exempt. (It doesn't say the information about the Senator but that is what happened.)

BETTER ACCESS TO, BETTER EQUALITY FOR: CAM PROVIDERS

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Health Care Reform Act

2010

Young adults will be able stay on their parents' insurance until their 26th birthday.

Insurers will be barred from imposing exclusions on children with pre-existing conditions. Pools will cover those with pre-existing health conditions until health care coverage exchanges are operational.

Insurers will not be able to rescind policies to avoid paying medical bills when a person becomes ill.

Lifetime limits on benefits and restrictive annual limits will be prohibited.

New plans must provide coverage for preventive services without co-pays. All plans must comply by2018.

A temporary reinsurance program will help offset costs of coverage for companies that provide early retiree health benefits for those ages 55 to 64.

New plans will be required to implement an appeals process for coverage determinations and claims.

Adoption tax credit and assistance exclusion will increase by $1,000. The bill makes the credit refundable and extends it through 2011.

Businesses with fewer than 50 employees will get tax credits covering 35 percent of their health care premiums, increasing to 50 percent by 2014.

2011

Medicare will provide free annual wellness visits and personalized prevention plans. New plans will be required to cover preventive services with no co-pay.

A plan to provide a vehicle for small businesses to offer tax-free benefits will be created. This would ease the small employer's administrative burden of sponsoring a cafeteria plan.

The Medicare payroll tax will increase from 1.45 percent to 2.35 percent for individuals earning more than $200,000 and married filing jointly above $250,000.

2012-2013

Implementation of Essential Health Benefits
States decide the minimal health insurance plan or allowance. All plans must then cover the minimum that these plans offer. If chiropractic or acupuncture is decided in a state as an EHB it will mandate all plans have chiropractic or acupuncture benefits

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Health Care Reform Act

2013

Health plans must implement uniform standards for electronic exchange of health information to reduce paperwork and administrative costs.

Contributions to flexible savings accounts will be limited to $2,500 per year, indexed by the Consumer Price Index in subsequent years.

There will be increases to the income threshold from 7.5 percent to 10 percent of adjusted gross income. Those older than 65 can claim the 7.5 percent deduction through 2016.

A 2.9 percent excise tax on the first sale of medical devices will be established. Excepted are eyeglasses, contact lenses, hearing aids or other items for individual use.

2014

Non-discrimination in health care: No health plan or insurer may discriminate against any health provider acting within the scope of that provider's license or certification under applicable State law. This will ensure that insurance companies cannot unfairly exclude doctors of chiropractic (acupuncture) from practicing under the capacity of their training and licensure on a federal level. Provision is a federal protection applicable to ERISA and other plans established or regulated under the bill. Just as the HIPAA protections now apply across the board, the non-discrimination provision will be applicable to all health benefit plans both insured and self-insured.

Community Health Teams: National Health Care Workforce Commission: DCs named as potential members of Community Health Teams to support the development of "medical homes." These teams support the development of medical homes by increasing access to comprehensive, community based, coordinated care. Community health teams are integrated teams of providers including primary care providers, specialists, other clinicians and licensed integrative health professionals as well as community resources to enhance patient care, wellness and lifestyle improvements. The language in the bill ensures that doctors of chiropractic can be included in these patient-centered and holistic teams.

National Health Care Workforce Commission: DCs are specifically included as part of the National Health Care Workforce Commission defined as "Health Care Professionals," and schools of chiropractic are also included in the health professional training schools definition. The Commission is tasked providing comprehensive information to Congress and the Administration about how to align federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other federal funding. The language in the bill guarantees that the need for doctors of chiropractic will be addressed when considering federal health care workforce programs.

Citizens will be required to have acceptable coverage or pay a penalty of $95 in 2014, $325 in 2015, $695 (or up to 2.5 percent of income) in 2016. Families will pay half the amount for

Health Care Reform Act

children, up to a cap of $2,250 per family. After 2016, penalties are indexed to Consumer Price Index.

Workers who are exempt from individual responsibility for coverage but don't qualify for tax credits can take their employer contribution and join an exchange plan.

Companies with 50 or more employees must offer coverage to employees or pay a $2,000 penalty per employee after their first 30 if at least one of their employees receives a tax credit. Waiting periods before insurance takes effect is limited to 90 days. Employers who offer coverage but whose employees receive tax credits will pay $3,000 for each worker receiving a tax credit.

Insurers can no longer refuse to sell or renew policies because of an individual's health status. Health plans can no longer exclude coverage for pre-existing conditions. Insurers can't charge higher rates because of health status, gender or other factors.

Health plans will be prohibited from imposing annual limits on coverage.

Health insurance exchanges will open in each state to individuals and small employers to comparison shop for standardized health packages.

Credits will be available through exchanges for those whose income is above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage.

Medicaid eligibility will increase to133 percent of poverty for all nonelderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. States will receive increased federal funding to cover these new populations.

2018

Taxing "Cadillac" plans: An excise tax will be imposed on high-cost, employer-provided health plans beyond $27,500 for family coverage and $10,200 for single coverage; it will increase to $30,950 for families and $11,850 for individuals, retirees and employees in high-risk professions.

Source: Public Law 111-148; www.speaker.gov.
American Chiropractic Association

National Chiropractic Council | American Acupuncture Council

HJ Ross and AAC Insurance Information Network

Health Care Reform Act

An official state legal counsel was asked the following three questions about how the provider non-discrimination provision, section 2706, in the health reform law will impact his state's health care reform activities:

1. *If providing an essential health benefit/service is within the scope of a chiropractic physician's (acupuncture) license e.g., primary care treatment of illness/injury, home health care, inpatient rehabilitation, lab tests, X-ray services, imaging/diagnostics (MRI, CT, PET etc.), preventative and wellness services and chronic disease management, smoking cessation, diabetes education, allergy testing, screening pap tests, prostate cancer screening, pediatric services, etc., can an insurer deny payment to a participating chiropractic physician who provided one of these essential health benefits/services based solely on that provider's license or discipline?*

2. *Put another way, would an insurer violate federal law if that insurer refuses to pay for an essential health benefit/service provided by a participating chiropractic physician (acupuncture) when providing that service is within that provider's scope of practice to deliver because he or she is not a medical/osteopathic physician?*

3. *If a particular essential health benefit/service is within the scope of practice of a participating health care provider (e.g., chiropractic physicians, naturopathic physicians, nurse practitioners, acupuncturists, etc.) would an insurer violate [Section 2706 of the PPACA] federal law if an insurer refused payment for that service because the participating provider was not considered a "primary care physician/provider?"*

To which the attorney answered: *"The short answers to your questions are a qualified no, yes and yes."*

This is what we envisioned three years ago. It is incredibly exciting to see a third-party, independent legal expert view the law the way we hoped he would. I am intentionally not mentioning the specific state, so as not to interfere with its ongoing processes.

Additionally, the United States Office of Personnel Management found that multi-state health plans being considered for state insurance exchanges must comply with the provider non-discrimination protection provided by Section 2706 of the Patient Protection and Affordable Care Act (PPACA). This is truly remarkable and ground breaking, as it lays the foundation for 2014 when the exchanges will be implemented.

Given that in some states almost 70 percent of insurance enrollees are covered under ERISA (which will now be Section 2706 compliant), the two opinions above will literally change the access to and coverage of chiropractic for millions of patients.

Where we are now:

The U.S. ranks

1. #1 in obesity
2. #50 in life expectancy
3. 30th of 31 countries in infant mortality
4. We have 26.6/1 M MRI units
5. Perform 91.2/1000 MRI exams
6. 45% more coronary artery bypass grafts, angeoplastics, and stints
7. 4th highest per capita in consumption of Rx

We could change these stats if CAM providers were part of the team.

Why Reform?

-Provider culture - use all tests/procedures to confirm or exclude diagnosis
-Fee-for-service payment
-Medical malpractice and defensive medicine
-Patients consider high technology and more tests to be more thorough and have better health care
-Direct-to-consumer marketing
-Third-party reimbursement; shields patients from true cost of care

Affordable Care Act

What did it create?
-ACA (HR 3590)
-Health Care and Education Reconciliation Act of 2010 (HR 4872)

Great Works and their Words

-Gettysburg Address - 272 words
-Ten Commandments - 313 words
-Declaration of Independence - 1137 words
-US Supreme Court Decision - 193 PAGES
-Affordable Care Act - 900 or 2000 PAGES
Oh, yeah...
-2012 - 70,000 pages of "regulatory guidance"

Health Care Reform:

-Accountability, accessibility, affordability
-Quality of care, reduction in variation of care; efficiency
-Improve health outcomes
-Reimbursement based on quality metrics
-Comparative effectiveness research
-Transparency for all stakeholders

Patient Centered Care:

-Patients become active participants in their own care
-Receive services designed to focus on their individual needs
-Higher level of patient engagement
-Care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions
-Better relationship between physician and patient, more communication, and physician empathy

The Affordable Care Act:

Sec. 10607 - Definition of Provider

HEALTH CARE PROVIDER- the term 'health care provider' means any individual or entity-
(A) Licensed, registered, or certified under Federal or State Laws or regulations to provide health care services;
or
(B) Required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

Sec 2706 - Non-Discrimination in Health Care

(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 licensure 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.
-No health plan or insurer may discriminate against any health provider acting within the scope of that provider's license or certification under applicable state law.
-This insures that insurance companies cannot unfairly exclude chiropractors from practicing under the capacity of their training and licensure on a federal level.
-Provision is a federal protection applicable to ERISA and other plans established or regulated under the bill.

-The non-discrimination provision will be applicable to all health benefit plans, both insured and self-insured, and, over time, to an additional 30 million currently uninsured Americans.

Sec. 3502 - Community Health Teams

-Chiropractors are named as potential members of community health teams, designated to support the development of "medical homes" by increasing access to comprehensive, community-based, coordinated care

-Community health teams are integrated teams of providers as well as community resources created to enhance patient care, wellness and lifestyle improvements.

-Medical Homes will present a patient care approach that coordinated teams of multidisciplinary practitioners.

-The language in the bill ensures that chiropractors can be included in these patient-centered and holistic teams.

Sec. 5101 - National Health Care Workforce Commission

-Chiropractors are specifically included as part of the definition of 'health care professionals', and schools of chiropractic are also included in the definition of health professional training schools.

-The language in the bill guarantees that the need for doctors of chiropractic will be addressed when considering federal health care workforce programs.

Essential Health Benefits

-HHS (health and human services) put forth an approached to defining essential health benefits by establishing a 'typical employer plan' benchmark

-Under the HHS approach states would have the flexibility to select a benchmark plan that reflects the scope of services typically offered by resident employers

-The services and benefits offered by the state's benchmark health insurance plan would in essence outline that state's essential health benefits package.

-Of the recently proposed state benchmark plans, 45 of 50 states cover chiropractic care as an essential benefit.

Quality of Care and Patient Safety

This is the next area of concern in the health care system. In the United States stats show that 143 patients out of every 1000 discharged from the hospital come out with some kind of hospital acquired condition. This accounts for 14.4% of readmissions to the hospital.

The World Health Organization has formed a Technical Advisory Group to create internal classification for Quality of care and Patient Safety. This group has begun looking at the idea of clustering diagnosis. This is a reality in the Oriental Medicine arena. We call them Patterns.

In this classification Western and Eastern medicines are on equal footing. The three areas for Traditional Medicine are:

1. Acupuncture
2. Herbal Medicines
3. Manipulative therapies

We are in the process of building these areas now. Built into these areas are both eastern and western codes for treatments, related patterns, and possible associated harms or adverse events.

In this area of health care Traditional Medicine will take its place along with other modalities and procedures for treatments.

Another area of concern is that of communication. Traditional Medicine practitioners must be able to communicate with other medical providers in order to talk about the necessity for acupuncture treatment. Fees will be reimbursed on a per diagnosis basis and the treatments will go from least invasive to most invasive. Where does Acupuncture fit inn this medical model?

This is the most exciting time to be a provider in this medicine. Insurances are going to be reimbursing for Acupuncture Services and Integrated medicine program.

It is time for this profession to step up and take its rightful place in the ACA.

ACA vocab and definitions:

ACO- Accountable Care organization

CMS- Centers for Medicare & Medicaid Services

IPPS- Inpatient Prospective Payment System

DHHS- U.S. Department of Health and Human Services

CHIP- Children's Health Insurance Program

Dual Eligibles- People that are eligible for Medicare and Medicaid

MLR- Medical Loss Ratio
- insurance companies are required to spend a specified percentage of premium dollars on medical care, meeting an MLR.

FSA- Flexible Spending Arrangements
-the cost of an over-the-counter medicine or drug cannot be reimbursed from FSAs or health reimbursement arrangements unless a prescription is obtained. (Insulin and other health care expenses such as medical devices, eye glasses, contacts and co-pays are not affected)

MSSP- Medicare Shared Savings Program

PHS- Public Health Services

CO-OP: Consumer Operated and Oriented Plans

Small group market- employer that employs 1-100 employees

Large group market- employer that employs over 100 employees

EHR- Electronic Health Records

Digital record that theoretically can be shared across different health care settings

May include a range of data, including:
-Demographics
-Medical history
-Medication and allergies
-Immunization status
-Laboratory test results
-Radiology images
-Vital signs
-Personal statistics (i.e. height and weight)
-Billing information

The medical history should include:
-Symptoms causing the patient to seek treatment
-Family history if relevant
-Past health history (general health, prior illness, injuries, hospitalizations, medications, surgical history)

-Mechanism of trauma
-Quality and character of symptoms/problems
-Onset, duration, intensity, frequency, location and radiation of symptoms
-Aggravating or relieving factors
-Prior interventions, treatments, medications, secondary complaints

The examination should include:

-Head, including the face
-Neck
-Chest, including breasts and axilla
-Abdomen
-Genitalia, groin, buttocks
-Back
-Each extremity

The following organ systems are recognized:

-Eyes
-Ears, nose, mouth and throat
-Cardiovascular
-Respiratory
-Gastrointestinal
-Musculoskeletal
-Skin
-Neurologic
-Psychiatric
-Hematologic/lymphatic/immunologic

Medical Decision Making: (MDM)

MDM is considered the thought process of the physician. MDM refers to the complexity of establishing a diagnosis and selecting a management and treatment option as measured by the following:

-The number of possible diagnoses and/or the number of management options that must be considered.
-The amount and/or complexity of data-medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.
-The risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with that patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Opens records to more people and can lead to privacy issues.

AcuCode™ 2012

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Acupuncture Medical Treatment Guidelines

The following information is excerpted guidelines for acupuncture care from California, Colorado, Massachusetts, and New York workers' compensation. Their inclusion is intended as an aid to assist the acupuncture professional in understanding and articulating the purpose and medical necessity of their services.

(i) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

(ii) "Acupuncture with electrical stimulation" is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

(iii) "Chronic pain for purposes of acupuncture" means pain that persists for at least 30 days beyond the usual course of an acute disease or a reasonable time for an injury to heal or that is associated with a chronic pathological process that causes continuous pain (e.g., reflex sympathetic dystrophy). The very definition of chronic pain describes a delay or outright failure to relieve pain associated with some specific illness or accident. (B) Indications for acupuncture or acupuncture with electrical stimulation include the following presenting complaints.

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Chronic Pain Disorder Medical Treatment Guidelines

Acupuncture: is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

- Time to produce effect: 3 to 6 treatments
- Frequency: 1 to 3 times per week
- Optimum duration: 1 to 2 months
- Maximum duration: 14 treatments

b. **Acupuncture with Electrical Stimulation:** is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

- Time to produce effect: 3 to 6 treatments
- Frequency: 1 to 3 times per week
- Optimum duration: 1 to 2 months
- Maximum duration: 14 treatments

c. Other Acupuncture Modalities: Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise. Refer to sections G.13 and 14. Active Therapy (Therapeutic Exercise) and Passive Therapy sections (Massage and Superficial Heat and

Cold Therapy

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Written by John Weeks
Wednesday, 12 May 2010

Reference Guide: Language & Sections on CAM and Integrative Practice in HR 3590/Healthcare Overhaul

Summary: This article is meant as a reference resource on integrative practice and healthcare policy. Included are locations and exact language in the sections of the Patient Protection and Affordable Healthcare Act (HR 3590) that will shape policy action relative to integrative practices in coming years. Complementary and alternative medicine practitioners and integrative practices are included in these sections (2706, 3502, 4001, 4206, 5101, 6301 and 2301) relative to non-discrimination, workforce planning, community medical homes, wellness, prevention and health promotion, comparative effectiveness research and birthing services. Here are the facts, without interpretation or commentary. (If there are others, let me know.) What they will mean is up to us. The challenge ahead is to bring what one integrative practice lobbyist called "these major steps toward recognition" to life.

Send your comments to johnweeks@theintegratorblog.com
for inclusion in a future *Integrator*.

Purposes

HR 3590: "Major steps toward recognition" of integrative practitioners and integrative practices

This document was created for two purposes. First, it is meant as a guide for anyone who wonders what *exactly* is the language of inclusion relative to integrative practices in the Patient Protection and Affordable Healthcare Act (HR 3590), otherwise know as healthcare overhaul legislation. Second, this compilation is meant as a useful reference document for all who are presently interest in federal policy and integrative practice. I have mostly kept my opinions out of it.

Meaning to the Integrative Practice Community: "Leveling the Playing Field"

A subset of the provisions noted here (2706, 3502, 5101) led one long-time lobbyist for an integrative practice profession to state the meaning this way:

> "You have to put it all together. I don't think you can sway that there is one single provision that levels the playing field. I don't think the bill completely levels the playing field. But these are major steps forward and major steps toward the recognition of the profession. Of course, we have big plans to build on the these provisions. This is a significant start, it really is."

Those seeking commentary on the bill from a smorgasbord of 8 professional associations and natural products stakeholders will find links in the first article in this April 2010 *Integrator* Round-up (ACA, IHPC, AANP, APHA, NPA, MAMA, AAAOM, ANH). A thoughtful and hopeful editorial by Daniel Redwood, DC was recently published as Health Reform, Prevention and Health Promotion: Milestone Moment on a Long Journey.

To Go Directly to the Law

1. Put http://thomas.loc.gov/ into your browser.
2. Look on the right under "Weekly Top 5" and click on on H.R. 3590.
3. Click onto Text of Legislation.
4. Click into the 7th and final version of the bill. This will guide you section by section.

Here's hoping this is useful.

Patient Protection and Affordable Healthcare Act (HR 3590)

Sections Directly Related to CAM and Integrative Practices

Note: The **bold lettering** inside the law is added to call out the specific language.

1. Inclusion of Licensed Practitioners Insurance Coverage

US Senator Tom Harkin: Top advocate, key on this and other provisions

SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

(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.

(b) Individuals- The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply with respect to a group health plan or health insurance issuer offering group or individual health insurance coverage.

Note: A case is made here that this non-discrimination reaches into all self-funded ERISA plans, thus opening tc over 50-million coverage of licensed integrative practitioners for services and procedures otherwise covered when this provision takes effect in 2014.

2. Inclusion of Licensed Complementary and Alternative Medicine Practitioners in Medical Homes

Speaker Nancy Pelosi: Without her, no HR 3590 and none of this inclusion

SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) In General- The Secretary of Health and Human Services (referred to in this section as the `Secretary') shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as `health teams') to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants or contracts shall be used to--

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) Eligible Entities- To be eligible to receive a grant or contract under subsection (a), an entity shall--

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;
(2) submit a plan for achieving long-term financial sustainability within 3 years;
(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;
(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), **doctors of chiropractic, licensed complementary and alternative medicine practitioners**, and physicians' assistants;

Note: The language in (4) is "may include" rather than "shall include," which every legislator and lobbyist knows can mean the difference between night or day. Still, "may" puts one in the conversation.

3. Integrative Health Care and Integrative Practitioners in Prevention Strategies

US Senator Barbara Mikulski: Steady advocate on numerous provisions

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.

(d) Purposes and Duties- The Council shall--

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and **integrative health care** in the United States;
(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and **integrative health care strategy** that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;
(3) provide recommendations to the President and Congress concerning the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and public health goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;
(4) consider and propose evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, **integrative health**, and public health on individual and community levels across the United States;
(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;
(6) submit the reports required under subsection (g); and
(7) carry out other activities determined appropriate by the President.

(f) Advisory Group-

(1) IN GENERAL- The President shall establish an Advisory Group to the Council to be known as the `Advisory Group on Prevention, Health Promotion, and Integrative and Public Health' (hereafter referred to in this section as the `Advisory Group'). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.
(2) COMPOSITION-

(A) IN GENERAL- The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.
(B) REPRESENTATION- In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes **a diverse group of licensed health professionals, including integrative health practitioners who have expertise in**--

(i) worksite health promotion;
(ii) community services, including community health centers;
(iii) preventive medicine;
(iv) health coaching;
(v) public health education;
(vi) geriatrics; and
(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES- The Advisory Group shall develop policy and program recommendations and advise the Council on lifestyle-based chronic disease prevention and management, **integrative health care practices**, and health promotion.

4. Dietary Supplements in Individualized Wellness Plans

Obama: Kept the pressure for the overhaul on Congress for months

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

`(s) Demonstration Program for Individualized Wellness Plans-
`(1) IN GENERAL- The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.
`(2) AGREEMENTS- The Secretary shall enter into agreements with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).
`(3) WELLNESS PLANS-
`(A) IN GENERAL- An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual's identified risk factors:
`(i) Nutritional counseling.
`(ii) A physical activity plan.
`(iii) Alcohol and smoking cessation counseling and services.
`(iv) Stress management.
`(v) **Dietary supplements that have health claims approved by the Secretary.**
`(vi) Compliance assistance provided by a community health center employee.
`(B) RISK FACTORS- Wellness plan risk factors shall include--
`(i) weight;
`(ii) tobacco and alcohol use;
`(iii) exercise rates;
`(iv) nutritional status; and
`(v) blood pressure.
`(C) COMPARISONS- Individualized wellness plans shall make comparisons between the individual involved and a control group of individuals with respect to the risk factors described in subparagraph (B).

(4) AUTHORIZATION OF APPROPRIATIONS- There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.'

Note: This focus on the "individualized wellness plan" may have exceptional applications beyond dietary supplements.

5. Licensed Complementary and Alternative Providers and Integrative Practitioners in Workforce Planning

US Senator Bernie Sanders: Led in placing the workforce language

SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.

(i) Definitions- In this section:

(1) 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.

(2) HEALTH PROFESSIONALS- The term 'health professionals' includes--

(A) dentists, dental hygienists, primary care providers, specialty physicians, nurses, nurse practitioners, physician assistants, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacists, allied health professionals, doctors of chiropractic, community health workers, school nurses, certified nurse midwives, podiatrists, **licensed complementary and alternative medicine providers**, the EMS workforce (including professional and volunteer ambulance personnel and firefighters who perform emergency medical services), and **integrative health practitioners**;

(B) national representatives of health professionals;

(C) representative of schools of medicine, osteopathy, nursing, dentistry, optometry, pharmacy, chiropractic, allied health, educational programs for public health professionals, behavioral and mental health professionals (as so defined), social workers, pharmacists, physical and occupational therapists,m oral health care industry dentistry and dental hygiene and physician assistant; ...

Note: This is the one place where non-licensed integrative practitioners (Yoga therapists, certified homeopaths, etc.) appear to be referenced. Among the educational institutions noted in (C), only chiropractic of the distinctly licensed CAM fields with federally-recognized accrediting agencies is mentioned.

US Senator Kent Conrad Credited with working with Mikulski on CER language

SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.

Part D--Comparative Clinical Effectiveness Research

(d) Duties-[Under (4)

`(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA-

`(A) IDENTIFYING RESEARCH PRIORITIES- The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of clinical outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new evidence to improve patient health, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health conditions, as well as patient needs, outcomes, and preferences, the relevance to patients and clinicians in making informed health decisions, and priorities in the National Strategy for quality care established under section 399H of the Public Health Service Act that are consistent with this section.

`(B) ESTABLISHING RESEARCH PROJECT AGENDA- The Institute shall establish and update a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness of the information produced by research) associated with the different types of research, and such other factors as the Institute determines appropriate.

...

`(4) APPOINTING EXPERT ADVISORY PANELS-

`(A) APPOINTMENT-

`(i) IN GENERAL- The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

`(ii) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS- The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

`(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE- In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

`(B) COMPOSITION- An expert advisory panel appointed under subparagraph (A) shall include representatives of practicing and research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have experience in the

relevant topic, and as appropriate, **experts in integrative health and primary prevention strategies**. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

...

(f) Board of Governors-

`(1) IN GENERAL- The Institute shall have a Board of Governors, which shall consist of the following members:

`(A) The Director of Agency for Healthcare Research and Quality (or the Director's designee).

`(B) The Director of the National Institutes of Health (or the Director's designee).

`(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States as follows:

`(i) 3 members representing patients and health care consumers.

`(ii) 5 members representing physicians and providers, including at least 1 surgeon, nurse, **State-licensed integrative health care practitioner**, and representative of a hospital.

`(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

`(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

`(v) 1 member representing quality improvement or independent health service researchers.

' (vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

7. Certified Professional (Direct-Entry) Midwives Covered in Birth Centers

US Senator Maria Cantwell: Sponsored the midwives' provision

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) In General- Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended--

(1) in subsection (a)--

(A) in paragraph (27), by striking `and' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

`(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and'; and

(2) in subsection (l), by adding at the end the following new paragraph:

`(3)(A) The term `freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

`(B) The term `freestanding birth center' means a health facility--

`(i) that is not a hospital;

`(ii) where childbirth is planned to occur away from the pregnant woman's residence;

`(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in

the plan; and

`(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

`(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. **For purposes of the preceding sentence, the term `birth attendant' means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law** (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.'...

Note: This is a provision hard-won by the MAMA campaign on behalf of Certified Professional Midwives (as distinct from nurse-midwives.

Comment: These are not the only sections of the HR 3590 that may open opportunities for integrative practice or integrative practitioners. There are, for instance, some potentially fascinating, integrated care demonstration projects, and significant supports for community healthcare that may open opportunities. In future issues, I will explore these potentially useful aspects of the law. Other than some additional inclusion of chiropractors or chiropractic schools, the above 7 segments are, to my knowledge, the places where integrative practices are most directly noted. Please let me know if I have missed anything.

Send your comments to johnweeks@theintegratorblog.com
for inclusion in a future *Integrator*.

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