The Naprapath in the Rainforest

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I. Introduction

Naprapathy is one of several forms of Complementary and Alternative Medicine (CAM) that makes up the broad and somewhat murky area referred to as manipulative and body based therapies. There are only two states that license naprapaths: Illinois and New Mexico. With a total of less than 500 licensed specialists, it seems unlikely that this small set of CAM professionals will have a strong impact on American health policy. But if naprapathy is added to the
ranks of other licensed CAM providers in manipulative therapies, particularly chiropractors and massage therapists, the numbers become significant and constitute a more distinct presence.4

While the idea of CAM is hardly novel, it still exists in a netherworld of health care. CAM is paradoxically pervasive, but CAM is still only mildly embraced by the medical establishment, which accepts CAM “therapies” believing that these therapies do no harm and may have some type of placebo effect.5 With the exception of chiropractic, CAM therapies may largely be a compliment to allopathic medicine. However, for individuals with certain medical conditions, CAM is not just a casual pursuit, as the armaments of biomedical healing have not ameliorated their suffering.6 In particular, patients with intractable pain often find themselves at a point where the best of established medicine may be limited in potential and dangerous in prospect.7 It is at the point, where allopathic pathways may not be fruitful, that conservative, drug-free approaches offered by licensed specialists in manipulative therapies (and possibly other areas of CAM) may hold promise for supporting necessary public health efforts.8 Certainly questions of efficacy will likely persist when considering any form of CAM, but in the shadows of the Patient Protection and Affordable Care Act (ACA), the inquiries should expand into questions that probe how certain practices in this arena can be utilized to address public health needs and more broadly support national goals in the areas of cost effectiveness, access, and system redesign.

This essay is not written as a broad-based endorsement of complementary and alternative medicine, but rather presents a more modest case for patient use of state-licensed CAM professionals who specialize in manipulative therapies to be incorporated into health reform ef-

8. See id. In 2011, the Institute of Medicine issued a report, which identified pain as a major American public health issue. See also Committee on Advancing Pain Research, Care, and Education; Institute of Medicine, Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research, Inst. of Med. (2011).
forts. The proposed framework for expanded CAM utilization, offered in this piece, is driven by growing pressures on the healthcare system to identify new and creative ways to respond to existing demands, as well as the host of new challenges triggered by the need for more preventive and wellness services. This article contends that the ACA doesn't merely present challenges to meet expanding public demands, but affords opportunities for innovations that should incorporate the use of licensed CAM specialists particularly in areas that concern pain management, and more specifically, chronic lower back pain.⁹

The article is divided into three sections. The first section provides a background discussion on the ACA, highlighting key elements of the law that hold significance for the integration of CAM services.¹⁰ The other portion of the background discussion explores the public health dimensions of chronic illnesses. This portion suggests that CAM approaches to these massive problems, particularly in reference to pain, should be considered within the framework of ACA innovation. The second section of the article presents three sets of arguments for expanding the orbit of CAM manipulative therapy into the health reform arena, including building coverage through integration with statutory provisions in the ACA - particularly Section 2706, a non-discrimination provision - and reconsidering key elements in the lexicon of CAM legitimacy. The third section looks at pathways for creative uses of CAM, drawing loosely on ideas for organizational innovation detailed in management literature. The piece posits a model for expansion of manipulative therapies within the area of chronic lower back pain, incorporating such services into a Patient Centered Medical Home (PCMH).¹¹ A deliberate, focused use of certain CAM therapies, such as licensed naprapathy, can both spark innovations in delivery and provide a vehicle to more effectively assess the utility of manipulative therapies, beyond the scope of currently available clinical efficacy studies.

II. Background

A. Key Elements

Dramatic changes in the landscape of health care insurance and policy have been ushered in by the passage of the ACA and its companion bill, the Reconciliation Act.¹² Not since the enactment of

Medicare and Medicaid laws in the 1960s has there been such wide-sweeping reform undertaken in health care, one that literally touches on all sectors of the enterprise and will chart government efforts for years to come. Fundamentally, the ACA concerns the expansion of health insurance, and it achieves coverage extensions in public and private programs through a series of reform measures that reflect the interplay between these two sectors characteristic of our health system. Among the more notable private sector provisions, the ACA mandates that individuals obtain insurance, that pre-existing condition exclusions and prohibitions on annual and lifetime coverage limitations be abolished, and that there be minimum benefit packages created. The ACA expands Medicare drug coverage and provides premium supports and tax credits for individuals and small businesses to purchase insurance. In addition, the ACA creates new state-based health insurance purchasing programs, known as health insurance exchanges, and allows for states to expand Medicaid programs to new populations using federal funds.

The ACA could not achieve broad reforms in health insurance and large-scale extensions of coverage without addressing an array of other issues that lie at the core of the health care enterprise, namely cost and efficiency. While the ACA, like most massive pieces of legislation, may not be a seamless web of interconnected measures, a critical number of cost containment and structural reforms must work reasonably well to ensure affordability, and requisite efficiencies must be present in order to sustain health insurance expansions. On the cost side, at the macro level, the reform scheme must reduce government health expenditures, as well as introduce multiple strategies to spark future cost approaches to access and quality; as such, a significant number of measures in the law are directed to reducing expenses and increasing revenues. It is estimated that the reform law will cut $716 billion out of Medicare over a ten year period, and those cuts, combined with new taxes,


15. Other key private sector reforms include discontinuance of rate setting based on health status and gender, limiting premium variations based on age, adopting community rating based on geography, creating disincentives for insurers’ spending more than 20% on administrative costs (80/20 rule), and limiting policy rescissions. See John K. DiMugno, The Future of the Patient Protection and Affordable Care Act, aka “Obamacare”, 24 Cal. Ins. L. & Reg. Rep. 1, 2 (2012).

16. See id.

17. See id.

fees, and enhanced fraud and abuse regulations, create a floor of fiscal viability.¹⁹

On the structural side, the ACA launches an array of initiatives to improve quality and patient safety and to foster innovations in delivery systems such as Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs).²⁰ The renovated delivery systems result in a more coordinated, patient-centric system, which, in turn, link up to prior Administration simplification efforts concerning adoption of electronic health record systems.²¹ While there are multiple developments in the architecture of health care that can be culled out of the ACA and that promote systemic changes, three areas stand out as capstones of system reorientation and highlight the balances between cost and quality that must be struck to insure the viability of the ACA scheme.²² First, the National Strategy for Quality Improvement in Health Care ("National Strategy") is a core element of the ACA that sparks a process for developing a roadmap for healthcare directions that underscores a strong intersection of individual and public health measures captured in this law.²³

Second, in support of the National Strategy noted, the ACA contains an ar-

¹⁹. The question of by how much the ACA should cut Medicare was hotly contested in the 2012 presidential election campaign; See, e.g., Sarah Kliff, Romney's Right: Obamacare Cuts Medicare by $716 Billion: Here's How, WASH. Post, Aug. 14, 2012, available at http://www.washingtonpost.com/blogs/wonkblog/wp/2012/08/14/romneys-right-obamacare-cuts-medicare-by-716-billion-heres-how/. Starting in 2014, a series of new taxes and fees required by the ACA will begin to kick in. See generally Billy Hallowell, Here's a List of Tax Hikes & Fees Coming With Obamacare Next Year, THE BLAZE (Dec. 25, 2012), http://www.theblaze.com/stories/2012/12/25/heres-a-list-of-tax-hikes-fees-coming-with-obamacare-next-year/. At this point the financial realities underpinning the ACA are still evolving. No doubt, the cost issues had to be addressed in order to get the legislation enacted, but the future will be one in which issues of affordability will be constant companions of those entrusted with the oversight and administration of public and private health insurance; See Reed Abelson, Health Insurers Raise Some Rates by Double Digits, N.Y. TIMES, Jan. 5, 2013, available at http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?pagewanted=all&_r=0.

²⁰. For a summary of ACA's key provisions, see Focus on Health Reform, THE HENRY J. KAISER FAMILY FOUND. (Apr. 15, 2011), http://www.kff.org/healthreform/upload/6061.pdf. While the ACA has launched a massive array of health initiatives, it is clearly built off existing programs such as Medicare and Medicaid, as well as a host of regulatory programs at the federal and state levels that affect health insurance, employee benefits and tax laws. One major initiative that must be seen as part of the panoply of established and evolving health reforms is the Hi-Tech Act, which is designed to spark the implementation and development of electronic medical records that are so central to the architecture of health delivery. See 45 C.F.R. § 170 (2010).


²². The three areas noted, the National Strategy for Quality Improvement, prevention and wellness, and health innovations in delivery models and research are all vital elements in health system restructuring, but they have been highlighted here as they are also significant elements in making a case for integrating CAM therapies into the ACA reform efforts.

ray of measures that are directed toward enhancement of preventive and wellness services, and the Act marks a significant and deliberate foray into this traditional area of public health. The efforts undertaken in the ACA concerning prevention and wellness may be cast in a traditional biomedical model, but the efforts are certainly reflective of governmental awareness that broader public health approaches, including information awareness, clinical prevention, and workplace wellness, are critical for health maintenance and potentially play important roles in containing costs of chronic illness.24

Third, the ACA creates two new quality initiatives that are bookends of system redesign: the Center for Medicare and Medicaid Innovation (CMMI) and the Patient Centered Outcomes Research Institute (PCORI).25 CMMI is geared toward supporting cost effective innovations in an array of outpatient and inpatient settings.26 PCORI promotes clinical effectiveness research (CER) projects, tracks the National Strategy, and should generate clinical tools to support the innovations in practice and design that flow from CMMI efforts.27

Another key set of elements in the legislative infrastructure of health reform concerns measures that need to be pursued for the ACA to meet its goals of providing meaningful insurance coverage, particularly human resource development. It is indisputable that expanded access to health insurance must be accompanied by meaningful strategies that provide the necessary compliment of providers to deliver this health care. Clearly, the expansion of health insurance coverage to 29 million Americans necessitates an adequate supply of health providers to deal with this new population of insureds.28 In addition, with growing numbers of aging Americans, the need for more primary care resources had to be confronted in the ACA; although, like most long-standing problems in health care, it is one laden with economic and political complexities, calling for multiple solutions.29 In recognition of the severity of primary care shortages experienced, especially by poor populations, the ACA increases primary care Medicaid rates to Medicare levels.30 More gener-

27. See Mission and Values, supra note 25.
ally, the ACA contains an extensive number of measures focused on expanding the health care workforce. The measures range from development of human resource innovation policies, efforts to increase the numbers of primary care physicians and nurses, initiatives to strengthen the dental workforce, increased support for health education and training, and the creation of new education entities focused on community health and primary care teaching health centers.\(^{31}\)

While much of the workforce focus in the ACA revolves around primary care physician shortages, the legislative effort is far more expansive in addressing human resource capacities across a wide continuum of health providers. The law creates a National Health Care Workforce Commission to become the key actor in this area whose mandate includes policy developments affecting an expansive array of health professionals, including chiropractors and licensed complementary and alternative health practitioners.\(^{32}\) Like cost and system redesign, shoring up healthcare human resources is a matter of fostering policy innovations that enhance access. Without major reforms in the workforce, the promise of healthcare expansion will not be realized.

Equally fundamental to the access question is a guarantee that the scope of coverage (what the ACA actually insures under its auspices) represents a meaningfully comprehensive array of necessary medical services. To insure adequacy of coverage, the ACA mandates that minimum essential benefits be afforded for individuals and small businesses accessing coverage on health insurance marketplaces and that those ‘benefits’ requirements apply to Medicaid as well.\(^{33}\) The Secretary of the U.S. Department of Health and Human Services (DHHS) is charged with developing a regulatory framework for health insurance plans that guarantees comprehensiveness, non-discrimination, comparability to traditional employer plans and categorization based on value.\(^{34}\) All plans offered under the auspices of the ACA must not only meet federal standards to become qualified health plans, but are also required to fulfill dictates of benchmarks

31. For an overview of the array of measures taken in the Affordable Care Act, see generally National Workforce Policy Development, HEALTH REFORM GPS: NAVIGATING IMPLEMENTATION (Oct. 3, 2010), available at http://healthreformgps.org/topics/workforce-and-access/. (Most workforce measures are found in Title V of the ACA).


set by states within which they operate, which could entail inclusion of mandates not contained in the federal law.\textsuperscript{35} While there is room for variability built into the coverage offered by ACA qualified health plans, there are ten coverage areas that must be included, and if all ten are not present, explicit supplemental coverage in other targeted areas must be provided.\textsuperscript{36} It is noteworthy that in the list of ten coverage targets, preventive and wellness services are specifically mandated in the law as noted, underscoring the fundamental nature of public health-oriented services in the ACA scheme.\textsuperscript{37}

\section*{B. Chronic Illness and Pain}

The interrelationship between system redesign, necessary changes in cost containment, revenue generation, human resource innovation and meaningful health insurance coverage go a long way to explain the architecture of the ACA (and subsequent regulatory developments). But the goals of the law are also rooted in federal responses to the most pressing medical needs of current and future patient populations. No area of need is more central to the health reform initiatives of the ACA than addressing the multiple challenges posed by chronic illnesses.

An eclectic array of lifelong and rarely curable conditions and chronic illnesses affect half of all Americans. They are the leading cause of death and disability in the United States, accounting for three-quarters of health spending.\textsuperscript{38} The list of chronic diseases includes arthritis, asthma, chronic respiratory conditions, diabetes, heart disease, HIV infection, hypertension and obesity, among others. These chronic diseases challenge all sectors of the health delivery enterprise and cause particular concerns in light of our aging population and the staggering associated costs.\textsuperscript{39} The ability to address chronic illness across its wide swath is

\textsuperscript{35} States may develop benchmark plans that include coverage mandates that are not specified in the federal law or in the plan accreditation process. See 45 C.F.R. §§ 156.20 and 156.275 (2012). States that choose to add additional coverage mandates after 2011 may incur cost sharing responsibilities to do so. Those states that default and fail to select a benchmark plan will have the largest small market plan in their jurisdiction used as the benchmark. See 45 C.F.R. § 156.100(c) (2012).


\textsuperscript{37} See 45 C.F.R. § 156.110 (2013).


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fundamental to the integrity of any healthcare system reform, and that recognition is clearly manifested throughout the ACA. Many of the broad measures noted earlier in this piece, like innovations in delivery models and reinvention of the health care workforce, are examples of measures that are tightly linked to combating chronic illnesses. Certainly, key ACA health insurance provisions, such as the elimination of pre-existing condition exclusions and removal of coverage limitations, are designed to combat coverage challenges faced by those suffering from ongoing chronic health problems. Although there are a surprising number of specific initiatives in the ACA directed at particular chronic health problems, the law establishes a framework within which to address chronic care broadly, as opposed to creating comprehensive programs to target individual diseases.

Dealing with chronic illness requires setting priorities in this area and targeting specific conditions for action. The problem of targeting is compounded by the reality that many adults suffer from multiple chronic illnesses and combating these diseases requires cohesive approaches to care, which have been difficult to achieve. In a recently published report, the Institute of Medicine (IOM) explored dimensions of chronic illness from a medical, social, and public health perspective with a focus on how our health system can be improved to assist individuals to “live well.” The IOM report was written to expand the role of public health in chronic illness. This expanded role must comport with the framework of the ACA. The IOM did not prioritize diseases but rather chose what it referred to as nine “exemplars”, which are conditions where a multisectoral approach could improve the quality of life, assist functioning, reduce disability, and fit within the policy framework of the Centers for Disease Control to engage in “winnable” battles.

42. The ACA establishes a number of measures that are specific to a given chronic disease, such as diabetes and obesity, but the ACA certainly does not include any disease that falls under the broad rubric of chronic disease. However, this area of healthcare is central to the health reform measures, as the future of health reform will rest in large part on confronting population health challenges that are so extensive in this area.
43. See Living Well with a Chronic Illness, supra note 38, at 69.
45. See Living Well with a Chronic Illness, supra note 38.
46. See id.
47. See id. at 9-10; The IOM targeted chronic conditions with cross-cutting clinical, functional, and social implications, non-duplicative of other illnesses for which public health programs have been devised (i.e. cardiovascular disease, stroke), those models of care important for chronic disease, those affecting various organ
While the nine conditions noted by the IOM have great significance for public health, it is notable that, in the context of this essay, one of the exemplars highlighted for particular focus was chronic pain. Interestingly enough, this is one chronic illness that was specifically noted in the ACA. The law mandates both the Secretary of DHHS and the Director of the National Institutes of Health to direct activities aimed at reducing barriers to pain control and to promote efforts in clinical research in the pain area.

The specific nature of responses to chronic illnesses are still unfolding, but based on individual provisions and the broader programmatic frameworks of reform, it seems reasonable to argue that illnesses such as uncontrollable pain fall clearly within the ambit of federal health policy. In light of key ACA focal points considered herein—economics, system redesign, quality of care and human resource needs—an array of possibilities for innovations in confronting chronic illness should be considered.

In seeking approaches to chronic illness, a related question arises as to how broad and open innovation really is in the ACA context generally. By and large, a review of the ACA, in whole or part, leads to the conclusion that reform is largely cast within the context of the biomedical system that currently exists and that innovation largely flows out of redesigned medical models of delivery. But a more liberal reading of innovation in the wake of the ACA could possibly result in incorporating non-allopathic models into certain aspects of a restructured health system that meet some of the fundamental reform goals noted earlier in this piece. In particular, the area of chronic pain appears to be a fruitful one for allowing the ambit of reform possibilities to include complementary and alternative medicine practitioners.

Addressing chronic pain is a health problem that fits into a historic and present role filled by CAM practitioners, covering a range of practices that use non-drug approaches to treat this area. Relative to one major area of chronic pain—systems, and those variations in clinical manifestations and outcomes that hold promise for public health interventions.

48. See id. at 9.

49. See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 4305 (2010) (codified as amended at 42 U.S.C. § 18001). This section mandates a study on pain that was completed by the IOM and titled “Relieving Pain in America.” It explores the multifaceted elements of pain from a public health perspective. Additionally, this section requires NIH to create an Interagency Taskforce on Pain to promote an agenda for basic and clinical research in this field. This section of the legislation does not develop specific pain control programs, but it certainly is a testament to the awareness of the government for the need to address this pivotal area of chronic illness.

50. Any possibility for innovation must, of course, fit within the legal framework of the ACA and be compatible with relevant federal and state laws.

51. The innovations that run through the ACA are byproducts of system redesign and are ones largely structured from rearranging current parts of the existing system.

lower back pain - there is both a body of research and a number of endorsements from traditional medical organizations that support the use of such therapy as a conservative modality of treatment. A particularly compelling reason for expanding the platform of ACA innovation to the use of CAM therapies in pain management is that there are serious problems with drug dependence and addiction in this area that could be mitigated with non-pharmacological interventions. Additionally, and equally significant, is a growing awareness not only of safety and quality, but also of the appreciation that non-traditional therapies may also provide more cost-effective approaches to pain therapy as compared to the more extensive and riskier interventions like surgery.

III. Building a Case for CAM

The idea of expanding CAM therapy is not a new one. There have been concerted attempts to license and insure a wide array of non-traditional services, and these attempts have, notably, garnered a certain amount of success. The controversies between traditional medicine and CAM may have abated to an extent and equilibrium has been achieved, if not acceptance for use of alternative treatment for some conditions such as chronic pain, as previously noted. The question thus arises, in light


53. In 2007, the American College of Physicians and the American Pain Society included spinal manipulation as one of several treatment options for practitioners to consider when low-back pain does not improve with self-care. See Roger Chou et. al., Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society, ANNALS OF INTERNAL MED. (Oct. 2, 2007), http://annals.org/article.aspx?articleid=736814. See also University of Ottawa Evidence-based Practice Center, Complementary and Alternative Therapies for Back Pain II, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY 1, 89 (2010), http://www.ahrq.gov/research/findings/evidence-based-reports/backcam2-evidence-report.pdf, which found that spinal manipulation was more effective than placebo and as effective as medication in relieving back pain.

54. See Maia Szalavitz, Are Doctors Too Reluctant to Prescribe Opioids?, TIME (Feb. 24, 2010), available at http://www.time.com/time/health/article/0,8599,1964782,00.html. Overutilization and underutilization of opioids can lead to problems in the area of opioids and make non-drug regimens attractive and less costly. See also Jennifer Gunter, Why the American Problem with Opioids and Chronic Pain is Here to Stay, MEDPAGE TODAY (Feb. 22, 2013), http://www.kevinmd.com/blog/2013/02/american-problem-opioids-chronic-pain-stay.html.

55. The University of Pittsburg Medical Center Health Plan issued a well-publicized policy stating that it would require more conservative therapy for three months (including chiropractic) prior to approving lower back surgery for pain, which reflects the intersection of quality and cost considerations in this area; See Treatment of Chronic Low Back Pain, UPMC HEALTH PLAN (Dec. 2011), available at http://www.upmchealthplan.com/pdf/Dec_2011_PPU.pdf. See also Spinal Manipulation Proves Equally Beneficial as Surgery in Sciatica Treatment, MED. NEWS TODAY (May 11, 2011), available at http://www.medicalnewstoday.com/releases/224957.php (discussing conclusions of a study that found spinal manipulations as effective for sciatica patients as surgery).


of the prior discussion on ACA challenges, whether the case can be made for expanding the ambit of health care in ways that allow CAM to be incorporated into the new arenas of health reform. This piece posits three approaches to building the case for a more expanded role for non-traditional medicine: (1) using the ACA directly, (2) considering four related elements that have been raised in CAM acceptance discussions for many years, and (3) constructing a case for conservative expansion of CAM based on a broad and specific reading of the concept of innovation interwoven throughout the ACA.

A. On the Face of the Law

A review of the ACA’s legislative history, text, and resultant regulations does not easily lead to the conclusion that CAM plays a role in health care reform. Rather, there is a noticeable absence in the law, the penumbra of policy debate, and the discussion about the ACA regarding the uses of non-traditional medicine in a transformed health system; the national discussion and the resultant work products have been dominated by a biomedical vision of health care. Nevertheless, there are numerous provisions contained within the ACA that advance the case for greater inclusion of licensed CAM providers both broadly and in the context of specialized programs. In addition, general policy initiatives in the ACA, like PCORI and CMMI, can be seen as a springboard for promoting CAM inclusion.

In particular, three sections of the ACA stand out as foundational platforms on which to mount an argument for a wider use of CAM in the health reform context. The first is Section 3502, which creates funding for the establishment of Community Health Teams to support patient-centered medical homes. The teams will be designed to support comprehensive, coordinated, community-based care and are to be interdisciplinary in nature; moreover, the law specifically allows for use of CAM practitioners and chiropractors as team members. The second is Section 5101 and, as previously

58. Clearly advocates of CAM would disagree, as they have strongly argued that the ACA builds a foundation for a major role of licensed CAM. See Case for Full and Non-Discriminatory Inclusion of DCs in America’s Health System, AM. CHIROPRACTIC ASS’N, http://www.acatoday.org/content_css.cfm?Cld=4445.


61. In its first round of grant awards, PCORI funded a number of grants. For a list of awardees, see Michael J. Schneider, A Comparison of Non-Surgical Treatment Methods for Patients with Lumbar Spinal Stenosis, PATIENT CENTERED OUTCOMES RESEARCH INST. (Dec. 18, 2012), available at http://www.pcori.org/assets/PFA-Awards-Cycle-1-2012.pdf.


noted, it mandates the creation of a healthcare workforce taskforce to be the focal point in human resource development, and it specifically includes licensed CAM providers in its definition. The third, and presumably the most significant provision in the ACA regarding CAM inclusion, is a non-discrimination provision that applies to some CAM providers. Under the non-discrimination provision, insurers offering group or individual health insurance coverage are prohibited from discriminating against any licensed or certified health provider acting within his or her respective scope of practice parameters. The non-discrimination section, Section 2706, is not an “any willing provider” provision that would require inclusion of a CAM practitioner in a given health insurance policy nor does it require uniform payment rates.

The nondiscrimination section of ACA resembles nondiscrimination provisions contained in Medicaid and the Medicare Modernization Act, as well as provisions found in state law. While not a coverage mandate, the nondiscrimination provision has been hailed by CAM provider organizations as a significant foray into non-traditional medicine that will, going forward, force insurers to include CAM in areas where coverage is mandated. It appears that the section is self-executing, and there is also evidence in DHHS rules that the agency intends to enforce the nondiscrimination provision in reference to multi-state health insurance plans to be offered on new health insurance exchange beginning in 2014, but a specific case for provider nondiscrimination here is more remote. In addition to the federal nondiscrimination provision in Section 2706, individual states

64. See H.R. 3590 § 5101(i)(1) (2010).
65. See 42 U.S.C. § 300gg-5(a) (2010). 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.
66. See id. (The Section was added in the Senate version of ACA.)
67. See id. “Any willing provider” is a provision which requires a health plan to contract with any provider who is willing to meet the terms and conditions of the plan and accept its reimbursement rates; See Any Willing Provider, Am. Health Lawyers Ass'n (Aug. 10, 2012), http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Any%20Willing%20Provider.aspx.
70. See Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 78 Fed. Reg.15560 (March 11, 2013).
may create mandates for health insurance exchanges and Medicaid expansions that require parallel nondiscrimination provisions for health plans that meet state standards.\textsuperscript{71} Undoubtedly, nondiscrimination requirements advance the uses of licensed CAM, but do so in a rather indirect manner. In particular, the practical importance of Section 2706 is ambiguous in that it must be viewed in reference to the minimum essential benefit requirements mandated under the ACA.\textsuperscript{72} As such, the services afforded by the licensed CAM provider must fit within the scopes of practice of individual categories that are licensed or certified by a given state. Scope of practice issues can be sorted out, but coverage in this context will not be based simply around value-added assessments or non-discrimination principles; instead, it will be locked in the professionalscuffles between allopathic and alternative practitioners.\textsuperscript{73} The implications of nondiscrimination enforcement have not been lost on organized medicine. The American Medical Association Board of Trustees has gone on record to oppose what they perceive to be the potential for inappropriate expansion of non-physician services and to call for the repeal of Section 2706.\textsuperscript{74}

B. Elements of a Conventional Case

The ACA may advance the case for CAM inclusion within the context of several sections of the law as noted, and at the end of the day, those statutory expansions may be the most realistic vehicle to regularize the use of non-traditional medicine in the context of our evolving delivery system. This is not to suggest, however, that the development of a concerted public policy that directly addresses the presence of CAM and deliberately builds a case for its use, albeit a modest one, should not be pursued, independent of the ACA provisions.\textsuperscript{75} Given the vicissitudes of statutory interpretation and the ambiguities in harmo-

\textsuperscript{71} For example, Hawaii and California both require that acupuncture be a covered service for plans listed on the respective state exchanges. See also CRS Section 10-16-107.7 that creates a provider non-discrimination provision for chiropractors, explains in the Colorado Division of Insurance Bulletin No. B-4.60, May 29, 2013.

\textsuperscript{72} See 42 U.S.C. § 18021 (2010). There are ten broad categories of coverage under the ACA: hospitalization, emergency services, maternity and newborn, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pedi- tric services, including oral and vision care.

\textsuperscript{73} See Maguire v. Thompson, 957 F.2d 374 (7th Cir. 1992), a case which typifies both the many battles fought by CAM providers against allopathic medicine and the disputes that can be found in an array of CAM disciplines.


\textsuperscript{75} This area of CAM is highly politicized and has been a long-standing battleground in the annals of American health care. We have come a long way since the days of Wilk v. Am. Med. Ass’n, 895 F.2d 352 (7th Cir. 1990), but there is still great tension between biomedical and CAM approaches to health care that make expansion in insurance coverage for non-traditional health practitioners a matter that will likely be approached in the shadows of the federal regulatory system and the hallways of state government.
nizing CAM expansions with state scope of practice provisions, a more generic case for non-traditional medicine is still foundational to any consideration of expansion in this area. Constructing a case for a more inclusive use of CAM is hardly a new exercise, as that ground has been plowed many times before. But as the landscape of health care has changed, it is important to reconsider core elements in building a case for CAM in the midst of reform implementations. There are four factors that are timely and salient in the current consideration of regularizing the use of CAM: licensure, reimbursement, clinical effectiveness research and patient satisfaction.

The history of CAM is one deeply rooted in the politics and legalities of licensing, as the struggles for professional recognition of non-allopathic practitioners have been focused on gaining legitimacy and distinction through this very basic regulatory process. Aside from being fundamental to official recognition, the existence of licensed status also allows a group of health providers to offer distinct services that are separate from the practice of medicine, shielding them from the possibility of state sanction currently imposed upon traditional licensees for medical practice. Professional licensing, at its core, is a legal mechanism rooted in state police power and government obligation, and it is used as a mechanism that safeguards the public by setting conditions on education, character and the scope and nature of services provided by licensees. While professional licensure has been widely criticized as being ineffective, it nevertheless is a legal standard that sets the foundations that allow a given enterprise to exist and to create a requisite professional organization. Undoubtedly, state legislatures, empowered with the authority to


77. See id.

78. See, e.g., Authority to Require Medical Liability Insurance, Op. Att'y Gen. Fla. 078-25 (1978). See generally Maguire v. Thompson, 957 F.2d 374 (7th Cir. 1992). Maguire involved a challenge by three naprapaths against their exclusion to practice under the Illinois Medical Practice Act (IMPA). The case presents an interesting chronicle of the struggles of one CAM group, naprapaths, to gain inclusion in the Medical Practice Act scheme. It is noteworthy that the IMPA creates two categories of medical license: first, a traditional license to practice medicine generally, and second, a tier of license to treat human ailments without drug or operative surgery. The fact that a particular group is trained to practice without drugs or surgery does not automatically qualify them for the more limited medical licensure, as Maguire illustrates.


license, are often not rigorous bodies of scientific analyses, but until a more effective litmus test is created, such legal recognition should be viewed as pivotal in establishing the legitimacy of respective CAM providers. In particular, the licensed categories of CAM that are established as independent and distinct from medical doctors present a strong case based on this legal status for a meaningful inclusion in the public health enterprise.

While licensure may add legal legitimacy and a degree of public protection to a given CAM profession, it is seen as a baseline requirement, as evidenced by the proliferation of certification and credentialing processes characteristic of most health professions. Further, although licensure acts as a foundational requirement for public and private health insurance payment, the fact that a given provider is licensed does not lead to a guarantee of payment for a particular service. By law, health insurance plans are required to cover certain mandated services, but it becomes a matter of discretion for the insurer to determine what areas of treatment will be covered based on an analysis of what is reasonable, necessary, and not experimental. Generally, for most traditional medical services, coverage decisions of medical necessity rest on the practices of local physicians, and it is the exceptional service that triggers intensive coverage review and analyses based largely on concerns over volume and cost. CAM presents a difficult challenge for health insurance plans that are focused on offering payment for standard biomedical services. Non-traditional health services may not fit into a rubric of experimentation; they are expenditures that may appear unreasonable and largely unproven when measured against a litmus tests of Huijbregts, Chiropractic Legal Challenges to the Physical Therapy Scope of Practice: Anybody Else Taking the Ethical High Ground?, 12 J. MANUAL & MANIPULATIVE THERAPY 69, 69-80 (2007), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2565606/pdf/jmmt0015-0069.pdf.

81. See Cohen, supra note 76, at 26–29 (providing examples of the various definitions of the practice of medicine in states’ medical licensing statutes).

82. Some licensed CAM providers have their own regulatory boards, which clearly creates greater legitimacy and autonomy, while other groups may be regulated under a state medical board. See, e.g., Doctors of Naprapathy, N.M. MED. BOARD, available at http://www.nmmb.state.nm.us/naprapathy.html.

83. For a detailed description of federal coverage policy for Medicare Part B, in which the array of services covered through this part of Medicare are detailed, see Medicare Benefit Policy Manual: Chapter 15 – Covered Medical and Other Health Services, CTR. FOR MEDICARE & MEDICAID SERVS. (Oct. 26, 2012), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf (discussing coverage of chiropractic services in section 30.5, which is specifically restricted to licensed or legally authorized chiropractors who are covered only for manual manipulation of the spine). See also Barbara L. Atwell, Mainstreaming Complementary and Alternative Medicine in the Face of Uncertainty, 72 UMKC L. REV. 593, 598-600 (2004) (presenting the issue of health insurers’ broad discretion in determining whether a patient’s treatment is necessary, unnecessary or experimental) (hereinafter Atwell).

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allopathic medicine. And yet, over the course of many years, there has been a gradual expansion of insurance coverage for CAM, which is based on a combination of factors, including cost-effectiveness, consumer demand, and employer support for wellness and anti-discrimination laws. Although insurance coverage for CAM is still quite limited at this point, even narrow coverage provides certain de facto validity to such services.86

The best way for CAM to distinguish itself as an area that should engender further inclusion is through demonstration of validity via traditional clinical effectiveness studies.87 The fact that a great deal of conventional health care has not been subjected to rigorous assessment does not diminish the need for non-traditional medicine to make its case through current evidence-based studies, as such pressure is being exerted on all areas of health delivery.88 One of the underlying goals of the ACA is to improve the base of medical knowledge concerning therapeutic interventions, harnessing a long-standing goal of health services research dating back to the early part of the 20th century. In reference to CAM evaluation, the foundational purpose of the National Center for Complementary and Alternative Medicine (NCCAM), which is a medical research agency within the National Institutes of Health, is to sponsor research on the effectiveness of CAM therapies.90 While there have been important studies on various aspects of CAM that have shown positive results for a


86. See Atwell, supra note 83, at 610-12 (noting that while insurance coverage for conventional treatments is more readily available, many states recognize the validity of CAM treatments through educational and licensing requirements).

87. Scientific evidence on complementary medicine includes results from laboratory research (e.g., animal studies) as well as clinical trials (studies with people). It encompasses both “positive” findings (evidence that an approach may work) and “negative” findings (evidence that it probably does not work or that it may be unsafe). Scientific journals publish study results as well as review articles that evaluate the evidence as it accumulates. NCCAM fact sheets on specific health conditions or complementary approaches base information about research findings primarily on the most rigorous review articles, known as systematic reviews and meta-analyses. Authors of such reviews often conclude that more research and/or better-designed studies are needed. See National Center for Complementary and Alternative Medicine, Exploring the Science of Complementary and Alternative Medicine, U.S. Dep’t of Health & Human Servs. 1, 5-6, available at http://www.nccam.nih.gov/sites/nccam.nih.gov/files/about/plans/2011/NCCAM_SP_508.pdf.

88. See id. at 50.


number of therapies, the overwhelming body of clinical effectiveness research has not been dramatically conclusive.91 There is also considerable controversy surrounding clinical studies that claim the impact of a given therapy is psychological and that a placebo effect is a legitimate, positive outcome of a health intervention.92 It has been suggested by one commentator that the evaluative mechanism for CAM therapies be based on a concept of reasonableness framed within a universe of professional opinion that extends to licensed health professionals more broadly.93 Undoubtedly, it would be helpful to introduce more liberal and innovative approaches to the assessment of health care services, but such changes must be acceptable to traditional medicine and fit within the current concepts of health services research. CAM practices will continue to face the challenges of demonstrating efficacy in the world of conventional science and must, in addition to forging new approaches to quality assessment, seize on positive findings that fit within current biomedical evaluation formats.

Questions of deciphering clinical efficacy are not static and clearly relate to broader trends across health services research generally. We have entered a period of dramatic change in the practice of medicine as traditional health care providers are grappling with deciphering the appropriate treatments in the face of intersecting cost and quality pressures.94 Long standing concerns over quality and appropriateness in traditional medicine have spawned a change in clinical effectiveness research that not only supports traditional scientific approaches, but has led to an increasing awareness that questions of deciphering appropriate medical care need to be assessed from a patient-oriented perspective.95 The ACA, as previously noted, created the PCORI to support and promote clinical effectiveness studies that help fill the void in providing clinical data on medical procedures that are oriented toward supporting the interests of individuals and families. PCORI represents the most current iteration of a

91. For an interesting view of CAM from an international perspective, which points out the need for more research and coordination of CAM generally, see The Roadmap for European CAM Research: An Explanation of the CAMbrella Project and its Key Findings, CAMbrella 1, 45-51 (Dec. 2012), http://www.cambrella.eu/aduploads/cambrellaroadmap.pdf.


93. See Atwell, supra note 83, at 623-29 (suggesting a paradigm shift in the insurance reimbursement standard from medical necessity to reasonable necessity).


movement toward patient-centeredness in clinical efficacy evaluations and fits into the broader context of framing considerations of appropriateness into inquiries directed to patient engagement. There has been a focus on consumerism in health delivery for some time, but the newer emphasis on patients' concerns involves active engagement in treatment that may result in better outcomes, hopefully at lower costs. A patient-centered outcomes emphasis is a favorable arena for CAM therapies that promote health in areas such as mood disorder and chronic pain, where subjective determinations are necessary markers. In addition, patient satisfaction in CAM therapy can be further validated by cost data that demonstrates that more conservative complementary approaches to illness may hold considerable promise for reducing expenditures.

IV. Innovation

The case for a more inclusive use of CAM can be made specifically on the basis of the ACA's nondiscrimination provision, as well as on the four broader elements noted: licensure, reimbursement, clinical effectiveness research and patient-centeredness. A more generic case for use of CAM can be built upon the need for an enhanced complement of health professionals to address the macro issues of health reform. In particular, the

96. PCORI is directed toward data generation that can be used by patients. It is not directed toward CAM, per se, but clearly will consider licensed CAM therapies, as indicated by its grant program. See, e.g., A Comparison of Non-Surgical Treatment Methods for Patients with Lumbar Spinal Stenosis, PATIENT-CENTERED OUTCOMES RES. INST., available at http://www.pcori.org/cycle1/a-comparison-of-non-surgical-treatment-methods-for-patients-with-lumbar-spinal-stenosis/ (implementing a manual therapy as one of three comparative therapies in the study); see also Evaluation of a Patient-Centered Risk Stratification Method for Improving Primary Care for Back Pain, PATIENT-CENTERED OUTCOMES RES. INST., available at http://www.pcori.org/cycle1/evaluation-of-a-patient-centered-risk-stratification-method-for-improving-primary-care-for-back-pain/.

97. Karen Caffarini, Patient-centered Care Found to Reduce Medical Costs, AM. MED. NEWS (July 18, 2011) http://www.amednews.com/article/20110718/business/307189961/7 (referring to a UC Davis study that found when physicians have more personalized discussions with patients, it may help to reduce health care costs). Consumerism in health care has a long and diverse history. There have been a number of measures developed to assess the nature of patient experiences with the health system, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), that provide helpful measurements but are more oriented to the treatment process than the clinical outcomes. See About CAHPS, AGENCY FOR HEALTHCARE RES. AND QUALITY, http://cahps.ahrq.gov/about.htm (last visited Mar. 23, 2013). In addition, there is a movement to provide greater consumer choice in selecting alternative medicine practitioners, which is directed toward overcoming barriers in licensing and related scope-of-practice restrictions. Such laws essentially allow unlicensed CAM practitioners to function without licenses so as not to deny consumers a right to utilize such services. See, e.g., N. M. Unlicensed Healthcare Practice Act, N.M. STAT. ANN. §§ 61-35-1 to 61-35-8 (2009).


99. See Thompson & Nichter, supra note 85, at 3-4 ("Individuals with chronic disease are more likely to use CAM than those without chronic disease, and there is some evidence that it may also be cost-effective to cover CAM therapies or offer 'integrated' CAM and biomedical care for chronic disease management."). CAM is often not an "either-or" prospect, as such services are often a complement to traditional therapy. If such approaches can forestall or circumvent more costly therapies, whether drug therapy or surgical intervention, they may prove economically viable.
use of CAM can address the need for healthcare professionals to meet what is arguably the ACA’s biggest cost and quality challenge: problems of chronic illness and chronic pain. Undoubtedly, the ACA lays out many pathways to meet immediate and long-term issues in chronic illness, but as the issues presented are large and diverse, solutions need to be broad and inclusive while utilizing credible resources that are available and cost-effective.

The stock and trade of the ACA and the regulatory and policy issues that surround it are frequently characterized by the concept of innovation. The ACA includes multiple initiatives to reform the delivery system, address quality and safety issues, and improve regulatory oversight and program integrity represented by a myriad of provisions that individually and collectively constitute considerable innovation in health policy. While many signature elements can be used to characterize the ACA’s vision of health care delivery, the sum total of its many parts move health care from a siloed and disjointed enterprise into one that is more coordinated and integrated. The operational formats of health care in the post-ACA era are evolving, and in some cases are ill-defined, but the policy makers’ goals of transformation and innovation aspire toward a more cost-effective and cohesive delivery system composed of models that rearrange the existing system and utilize current medical standards and technology supports. The new models of care that will emerge from the ACA may constitute a creative restructuring of pieces of the biomedical care system. Ultimately, innovation is constricted by traditional views of healthcare that rely on powerful mechanisms of control and uniformity. This, at best, presents grudging opportunities for changes that deviate from allopathic frameworks of medical care.

A. The Naprapath in the Rainforest

Although transformation and innovation are goals of the health care system, the need exists for a wider tolerance for creative approaches to health problems than ones that emerge from ACA developments. It would be wise for health care policy makers to draw lessons from innovations in other industries that allow for greater flexibility, experimentation, and, in particular, a more inclusive use of non-traditional licensed health providers. In 2012, Victor W. Hwang and Greg Horowitt presented a compelling analysis of factors that make corporations innova-
tive in their book *The Rainforest: The Secret to Building the Next Silicon Valley* (hereinafter *The Rainforest*). The authors of *The Rainforest* argue that successful change and innovation occurs in organizations that often bring together unlikely groups of professionals to address common problems, and such unlikely combinations foster innovations. Unconventional structures that are forged around cross-disciplinary perspectives, according to Hwang and Horowitt, result in fluid structures that are oriented toward outcomes as opposed to processes. Under *The Rainforest* view, transformation comes from environments that are fluid and freer to select diverse processes to achieve outcomes. Hwang and Horowitt characterize organizations that lack innovation as being entities that are focused on controlling complex systems with very technical measures of productivity designed to spawn efficiency and produce more optimal outputs. Transformation within the ACA context does not appear to be moving toward the model envisioned in *The Rainforest*, but is, instead, heavily weighted toward reinventing healthcare to have it fit into newer, and hopefully more efficient, structures of delivery that share common goals of coordination, quality, and efficiency. While the rhetoric of innovation in the ACA arena is deep, the outputs of CMS mandates are highly detailed and very prescriptive, placing the boundaries of creativity within traditional and cautious administrative constructs.

**B. The Parameters of a Model for Modest Innovation**

It is unrealistic to expect health care policy makers to adopt an approach to innovation that would parallel the open-ended nature of corporate innovation seen in Silicon Valley, particularly in the context of such a regulated industry as healthcare. Nonetheless, as innovation and transformation are central goals of health reform, the ACA must be implemented as a law that not only allows, but also fosters real creative changes and ideas like those discussed in *The Rainforest*. Such ideas should not be summarily dismissed. To date, the sum total of regulation in the most innovative sections of the ACA, like Accountable Care Organizations (ACOs) and Value-Based Purchasing (VBP), do not bode well for the creation of a system that embraces changes unbridled by extreme technicality and not supported by the acquiescence of the hierarchy of health services research. As noted, licensed CAM


103. See id.

104. See id.

105. See id.
providers may find an enhanced role under the ACA. However, it is one driven by statutory inclusion that lies outside the realm of deliberate innovation. Moreover, the limited statutory expansions of CAM appear to be largely devoid of regulatory visions of systemic transformation. In light of the public health pressures noted in this piece, broader system restructuring could be sparked by creative, albeit non-conventional, reform measures that draw on a wider array of licensed health professionals and are more tolerant of organizations akin to those discussed in *The Rainforest* (ones that focus more on outcomes than process and allow for unconventional couplings of health professionals).

The idea of devising more creative and innovative health systems beyond the conventions of unfolding reforms, or *finding the naprapath in the healthcare rainforest*, is constricted by political realities and rigid oversight. But the level of uncertainty concerning conventional health reforms, bolstered by widespread agreement of the necessity for change, fosters a favorable climate for innovators. It is time for CAM providers to seize the opportunity and make a renewed case for inclusion. Such a case needs to be more than rhetorical, but must be specific and molded around programmatic elements and goals of the ACA. As such, the case for CAM must fit into the broad parameters of cost-effectiveness and the enhancement of efficiency in an area of need and it should be collaborative and patient-centric. It is essential that CAM licensure, however imperfect, be used as the baseline for expansion of services, as lack of such status results in an expansion to any form of CAM, which is too ill-defined and amorphous to be efficiently incorporated into a delivery system.

In addition, CAM licensing procedures at the state level must be subjected to meaningful evaluations to insure that professional oversights are rigorous and timely. Expanding the use of licensed CAM should not be a way to make such practitioners a type of primary care doctor who is placed on a trajectory similar to the path followed by osteopathic physicians. The benefits underlying CAM therapists should be extracted from differences in their approaches to healing and wellness, and inclusion should neither create junior allopathic physicians nor result in scope-of-practice expansions that include prescribing authority. Like other areas of health care, the quality of CAM must be rooted in efficacy and a discernible level of satisfaction for patients. Patient satisfaction does not merely require affording individuals and families with better decision-making tools, but it also involves requiring a genuine level of acceptance and support from patients that undergo

106. It may be naive to imagine that any expansion of CAM will not trigger negative responses from certain or all sectors of organized medicine, but certainly as the inclusion of CAM is considered, strategies to minimize such conflicts, particularly in the scope of the practice area, must be found.

treatment.\textsuperscript{108} Creative uses of CAM must be forged within the realities of reimbursement, recognizing the centrality of payment to any type of health reform. Licensed CAM therapists should be incorporated into collaborative group practices under a bundled payment system that would promote divisions in provider reimbursement that are based on trust and cross-disciplinary assessments of value.\textsuperscript{109}

\textbf{C. A Modest Rainforest}

One pathway that lends itself to innovative uses of CAM can be drawn from the ACA's emphasis on the patient-centered medical homes (PCMH), recognizing that the ACA has paved the way for CAM via the funding of grants for community health teams that include CAM practitioners.\textsuperscript{110} While medical homes can follow various models, at their core they are primary-care, collaborative medical practices that use a team of health professionals to provide patient-centric care that is coordinated overtime and not episodic in nature.\textsuperscript{111} A key concept of the medical home is that the structure deals with patients across the life continuum, and in addition to a focus on acute and end-of-life care, the model is very directed toward prevention, wellness, and chronic-care management.\textsuperscript{112} While physician-led, the PCMH is already characterized by both its utilization of a complement of licensed health professionals and its incorporation of non-licensed personnel (particularly community health workers), as well as its recognized, potential extension into inter-professional collaboration.\textsuperscript{113} The goal of the medical home is to more effectively use primary care physicians, and the use of non-medical personnel becomes a vehicle to shift tasks and

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\item It may seem extreme, but the system should move toward a goal of patient happiness. \textit{See Health-care Happiness: Key to Creating a Patient-Centric Healthcare Organization,} \textsc{Patient-Centered Outcomes Res. Inst.}, available at \url{http://www.pcori.org/assets/PFA-Awards-Cycle-1-2012.pdf}.
\item Clearly, Section 3502 of the ACA, which allows for grant funding to create Community Health Teams in conjunction with the patient-centered medical home, begins to move in the right direction for purposes of integration of CAM therapists with primary care medicine. \textit{See Establishing Community Health Teams to Support the Patient-Centered Medical Home,} \textsc{Nev. Dept. of Health & Human Servs.}, available at \url{http://dhhs.nv.gov/HealthCare/Docs/NVPolicyPapers/Section_3502_PCMH_Community_Health_Teams.pdf}.
\item \textit{See} 42 U.S.C. 256a-1 § 3502 (2010); \textit{see also} Jill Bernstein, Deborah Chollet, Deborah Peikes, & G. Gregory Peterson, \textit{Medical Homes: Will They Improve Primary Care?}, \textsc{6 Mathematica Pol'y Research, Inc. 1, 4} (June 2010), available at \url{http://www.mathematica-mpr.com/publications/PDFs/HealthReformHealthcareIB6.pdf}.
\item \textit{See generally} A New Model of Care Delivery: Patient-Centered Medical Homes Enhance Primary Care Practice, \textsc{NCQA}, available at \url{http://www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf}.
\item \textit{See} Gregory Burke, \textit{The Patient-Centered Medical Home: Taking a Model to Scale in New York State,} \textsc{United Hospital Fund} (2011), available at \url{http://www.acponline.org/advocacy/state_health_policy/reports/taking_a_model_to_scale.pdf}.
\item \textit{See} Defining the Medical Home, A Patient-Centered Philosophy that Drives Primary Care Excellence, \textsc{Patient-Centered Primary Care Collaborative}, \url{http://www.pcppc.net/about/medical-home} (last visited Mar. 30 2013). In regards to community health workers, see generally Kelly Volkman & Tina Castaneras, \textit{Clinical Community Health Workers, Linchpin of the Medical Home}, 34 \textit{J. of Ambulatory Care Mgmt.} 221 (July 2011), available at \url{http://www.ncbi.nlm.nih.gov/pubmed/21673521}. \textit{See also} 42 U.S.C. 256a-1 § 3502 (2010) (stating that grants are made available for inter-professional teams to deal with chronic illness).
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reduce inefficiencies in the deployment of primary care physicians. While PCMH models are a growing presence around the country, these models are still evolving and are conceptually fluid enough to meet patient needs in prevention and chronic care through use of creative complements of licensed personnel outside of traditional physician extenders. To an extent, CAM integrative practices developed in the last twenty years, have paved the way for PCMHs that include non-traditional providers, and are often located at major medical centers. What is distinct about CAM providers being incorporated into PCMHs, beyond prior integrated practices, is that such incorporation can be more central and focused on addressing targeted chronic illnesses in which CAM therapy is the primary treatment modality as opposed to being a complementary or alternative set of services.

The question then arises as to how CAM can be integrated meaningfully into a PCMH model. To be meaningful, the construction of an applied model for CAM should be targeted to a core area of need and should fit within a particular priority of the ACA. Undoubtedly, multiple problems could serve as a springboard on which to bring CAM together with allopathic medicine, but whatever area is chosen, beyond meeting broad public needs, it must be defined, safe, and able to meet some litmus test for quality, and it must represent a cost-effective alternative. Cycling back to the prior discussion, a major area of challenge in chronic disease is confronted in the area of pain management, and even more specifically, chronic lower back pain. Chronic lower back pain presents a costly and difficult problem that would be an ideal focal point for integrating licensed CAM specialists in manipulative therapy into more mainstream use, and it already enjoys a certain level of acceptability in allopathic circles. For example, a naprapath who specializes in connective tissue disorders, a form of manipulative medicine, could provide drug-free therapy for lower back pain in conjunction with a physician-directed provider team, not as a complement of care, but rather as the first-line care giver.

Naprapathy, and other licensed manipulative therapists, offer alternatives for back pain at much lower costs than medical intervention while enjoying strong patient support. For reimbursement purposes, the use of bundled payment in a non-traditional medicine area can move licensed CAM away from the

115. There are different groups that claim to represent integrative practices that blend traditional medicine with CAM. The most traditional organization in the integrative practice area is the Consortium of Academic Health Centers for Integrative Medicine, which is composed of programs at large medical centers. See CONSORTIUM OF ACADEMIC HEALTH CTRS. FOR INTEGRATIVE MED., http://www.imconsortium.org/about/home.html (last visited Mar. 26, 2013).
116. See generally Living Well with Chronic Illness, supra note 38.
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world of strict and awkward billing codes and place the burden of reimbursement equity on individual PCMHs. No doubt any inclusion of CAM, for pain or any other chronic illness, will come with a reasonable call for a demonstration of efficacy and quality effectiveness. Clinical efficacy studies for CAM have been slow to demonstrate broad utility, but an integrated PCMH model for back pain would provide an applied setting that would foster cross-disciplinary evaluations. Formal quality measurement programs could be developed by each PCMH, targeting an area such as lower back pain and developing individual approaches to assessment based on the models used in the Medicare Quality Assurance Improvement Program (QAPI) that are more self-directed. 

Expanding the ambit of PCMHs into CAM integration in the area of chronic back pain is a small and incremental step, but innovation outside of convention must be approached cautiously. Undoubtedly, non-traditional medicine advocates may wish to see a more expansive approach to legitimizing the use of CAM therapies in the ACA context, one that goes beyond a narrowly-tailored plan for inclusion in the area of chronic back pain; conceptually, further innovations in CAM as they relate to chronic illnesses are likely. Others may scoff at the idea of using licensed manipulative medicine therapists under the umbrella of physician control as the type of innovation that supports the analogy to corporate innovations presented in The Rainforest. Although the model proposed herein is not a dazzling innovation, it is practical one. If licensed CAM therapists are to join the mainstream of health, even in a time of great need, their cases for advocating such developments are best structured within the context of conventional medical models. The PCMH is not a brand new model, but it is one that affords a logical and, hopefully, workable juncture for coalescing licensed therapists around back pain issues, which is an ideal target area for innovation and has proven to be a persistently illusive problem area. To a large degree, the use of chronic back pain as a test case for CAM serves to both formalize and restructure the realities of patient treatment patterns, and it could serve as a springboard for greater integration in practice and perhaps even in professional education. Back pain is not an end point for integration, but rather a tangible beginning in which the experiences of an unlikely combination of providers can serve as an incubator for further collaboration and innovation. Even greater progress in inclusion can be

118. See Atwell, supra note 83, at 623-4. It is also possible to capitate integrated health care services (rates based on diagnosis), but that requires a more definitive policy on reimbursement where rates are calculated prospectively and could be cast narrowly, not allowing adequate flexibility for non-physician services. A bundled payment forces the provider group to determine reimbursement for team members based on an assessment that is more localized and determinative of a value analysis that is distinct to the group in question and unlike traditional capitation does not shift financial risk.

119. See A New Model of Care Delivery, supra note 111.

120. See, e.g., Atwell, supra note 83, at 630.

121. See Hwang & Horowitz, supra note 101; see also Canning, supra note 102.
served in the future by crafting educational opportunities that bring together students from diverse health professional disciplines to focus on common problem areas such as back pain. Clearly in the maze of health care (i.e. the “rainforest”), patients are already seeking out alternative therapists (i.e. the naprapaths of the world) to obtain relief in the face of frustration with conventional therapeutic options, and as such, broader CAM therapy inclusion is a meaningful response to broader public health needs.

V. Conclusion

The viability of the ACA rests on our facing multiple challenges, including cost containment, provisions of comprehensive insurance that promote prevention and wellness, and the dramatic and persistent shortages in primary care. In the hierarchy of public health, no area is more challenging than the macro and micro issues faced in chronic illnesses. Most apparent in this period of healthcare transformation is the notion that multiple changes must occur, and that in order for systemic reinvention to be feasible, a high level of innovation and creativity needs to be adopted in the health delivery sector. The ACA lays out many pathways for innovation, but those pathways may not be enough to address the long list of public health problems. Innovations that lie outside the boundaries of reshaping the traditional delivery system may be necessary, and resultant models should not ignore the contributions of licensed health professionals across disciplines. It is counterproductive to support open-ended innovation, but within the frameworks of ACA changes, in particular patient-centered medical homes, experiments in interdisciplinary practice should be pursued, in particular, those targeting chronic illness. Pain (specifically, chronic lower back pain) is a costly and persistent issue, and it provides a compelling area for incorporating licensed CAM providers in manipulative therapy, serving as a cautious first step out of the biomedical box. Finding the “naprath in the rainforest” of health care developments is a small step, but it is in such steps that real health care transformation will occur.