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ACA CHIROPRACTORS Hands down better™

November 20, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: Center for Medicare and Medicaid Innovation: Request for Information on Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma:

We are pleased to respond to the request for information regarding the Center for Medicare and Medicaid Innovation (CMMI) New Direction. We appreciate your continued leading role in safeguarding the health of America's future by providing coverage to over 130 million Americans and look forward to our continued collaboration to improve health care access and quality.

The American Chiropractic Association (ACA) is the largest organization in the United States (US) representing doctors of chiropractic. ACA is leading the chiropractic profession in the most constructive and far-reaching ways – by working hand in hand with other health care professionals, by supporting meaningful research, and by using that research to inform chiropractic practice. ACA members pledge to adhere to the highest standards of ethics and patient care, contributing to the health and well-being of the estimated 35 million individuals across the US who seek chiropractic care each year.

The Palmer Center for Chiropractic Research (PCCR) is the most highly-funded chiropractic research center in the US Within the past 10 years, the PCCR has been awarded grants from the National Institutes of Health, National Center for Complementary and Integrative Health, the US Health Resources and Services Administration and the Department of Defense, in addition to private foundation grants. Since 2000, these grants have totaled more than $40 million.

The Spine Institute for Quality™ (Spine IQ™) is a private, not-for-profit organization with the mission to define quality, demonstrate value and build trust in conservative spine care delivery by leveraging multi-disciplinary models, measures, education and research using clinical data registries. The goal of Spine IQ is to use their CMS-approved Spine IQ Conservative Spine Care QCDR, powered by Premier, to support the increased utilization of evidence-based conservative spine care through practitioner benchmarking and education, research, and patient education. Integral to this effort is integration of conservative spine care with allopathic treatment and the use of data to develop evidence-based multi-disciplinary clinical spine care pathways.

<u>Guiding Principles</u>

CMMI outlines new guiding principles for new model designs that promote competition in the marketplace based on quality; outcomes and cost; provider choice and incentives with a focus on voluntary models; patient-centered care; benefit design and price transparency; transparency model design and evaluation; and small-scale testing. We share CMS' goal of fostering "an affordable, accessible healthcare system that puts patients first" and strongly support the new direction and guiding principles. **We encourage CMMI to continue to serve as a leader in testing value-based care models, incorporating the lessons learned into new models.** CMMI's agile processes have afforded the opportunity to test more models, develop rapid cycle evaluations and refine models, develop cross-continuum and multi-payer approaches, and provide data directly to providers. **We request that CMMI continue to develop and test multi-payer models as part of the Health Care Plan Learning Action Network (HCP-LAN) to provide for greater innovation and data collection.**

We support the transparent model design and evaluation, and small-scale testing - we recommend CMMI provide either opportunities for funding or directed assistance to smaller associations or groups. There are several organizations with innovative model concepts that do not have the financial or staff infrastructure to fully develop models. Similar challenges were identified with the development of clinical quality measures and the assistance CMS provided through grant funding to clinical specialty societies, clinical professional organizations, and independent research organizations to develop quality measures under the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA) serves as a viable model for CMMI.

CMMI Models

Expanded Opportunities for Participation in Advanced APMs

CMS also seeks guidance from the stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

Several challenges that healthcare providers have faced with implementing various alternative payment models (APM) include inadequate data capture and sharing, lack of physician participation, and coordination of quality measures across programs. **We recommend CMMI encourage APM model development to leverage the efforts associations and physicians have invested into MIPS adoption.** For example, the flexibility for APMs to develop quality measures *comparable* to those used in MIPS adds a layer of administrative burden when transitioning from MIPS to APMs. Adding more measures is in opposition of two of CMS' new initiatives: Meaningful Measures and Patients before Paperwork. The investment in developing the infrastructure to utilize the measures in the Quality category of MIPS is lost when moving to an APM that requires clinicians to adopt a new set of measures. Harmonization of measures will allow for more rapid development of APMs - as measure development can be very labor intensive - and increase participation since physicians will be familiar with the measures, and EHR vendors and registries are already capturing the data of the MIPS measures.

Additionally, associations and physicians have devoted significant financial and staff resources to the development and implementation of EHRs and registries. The requirement of registries in APMs, similar to the requirement for participants to use Certified EHR technology, will assist with overcoming these challenges and allow for a pathway for transition from MIPS to APMs. Information from clinical data registries is used to compare the effectiveness of different treatments for the same disease or condition, to evaluate different approaches to care. Since this information is increasingly used to ensure that payment is adjusted based on the quality of care provided and to give patients the information they need to make better choices, utilizing registries with APMs is a logical progression.

We encourage CMMI to necessitate the use of MIPS measures and registries in model development to facilitate the transition from MIPS to APMs.

As a partner with Premier for the Spine IQ Conservative Spine Care Registry, we agree with the data sharing comments submitted by Premier regarding participants in all APMs and Advanced APMs need monthly data on an ongoing basis to be successful in the program. Also, we support Premier's recommendation that CMS provide useful and actionable aggregate regional data and metrics that serve as benchmarks for participants in APMs and help identify opportunities for improvement and inform care intervention strategies.

Since Medicare beneficiaries have the right to seek care from any provider that accepts Medicare, it can be a challenge for providers and suppliers to monitor the services received by their aligned patients. The retrospective administrative claims dataset provided by CMS is valuable, but it represents services that have already been provided and do not make available to APMs a point-of-care opportunity to deliver the right care at the right time while avoiding unnecessary services. The agency should consider testing ways to offer a point-of-service notification system that would allow the accountable organization to know when a beneficiary's eligibility is being checked by a provider and a near real-time opportunity to intervene appropriately to coordinate their care, redirect the patient to an appropriate setting, or engage with healthcare providers who may not be participating within the organization.

Physician Specialty Models

One potential option may be to include specialty physician management of a defined population of beneficiaries with complex or chronic medical conditions, including multiple chronic conditions. This may include the specialist serving as the primary source of care and providing care coordination for medically complex beneficiaries.

There is an urgent need for innovative solutions to the public health dilemma created by the high prevalence of spine-related conditions and the resultant opioid crisis. A recent paper published in The Spine Journal proposes a model that places conservative care at the forefront of the patient experience for those suffering from spine-related conditions. This model calls for the integration of clinicians who are already well-trained in evidence-based spine-care management (such as doctoral level physical therapists and doctors of chiropractic) to serve as "Primary Spine Practitioners" (PSPs) by working within multi-disciplinary healthcare delivery teams to deliver "first-line management, case coordination, and follow-up of patients with spine related disorders". As such, the PSP would either work with an ACO, a PCMH or as part of virtual multi-disciplinary team. The PSP model could potentially impact health care delivery by increasing spine care value and by serving as a substitute for primary care, thus freeing PCPs to concentrate on conditions that are better suited to pharmaceutical management.

We look forward to the opportunity to discuss further development of this model, its impact on health systems, and how to overcome barriers of adoption.

Mental and Behavioral Health Models

CMS is actively exploring potential models focused on behavioral health, including focus areas such as opioids, substance use disorder, dementia, and improving mental healthcare provider participation in Medicare, Medicaid, and CHIP through models that enhance care integration and/or utilize episode payment. CMS is interested in stakeholders' views of the best payment models and state and local interventions to improve care in these areas.

In 2014, the Palmer Center for Chiropractic Research received a grant (R34 AT008427) entitled Collaborative Care for Veterans with Spine Pain and Mental Health Conditions, from the National Center for Complementary and Alternative Medicine at NIH to explore the integration of chiropractic services into the management of US military veterans suffering from a combination of chronic low back pain and mental health co-morbidities. Work in this area is critical given the high correlation between spine pain and conditions such as anxiety and depression. One goal of this project is to develop a consensus-based clinical care pathway designed to assist doctors of chiropractic in recognizing and addressing mental health concerns among veterans as part of a multi-disciplinary team through the use of appropriate referral, co-management, documentation, and communication strategies. Examples of the pathways include treatment frequency and duration for acute, uncomplicated episode; acute complicated episode; and chronic condition. The results of this process are outlined in an article recently accepted Journal of Manipulative and Physiological Therapy and the pathway is currently being pilot-tested by a multi-disciplinary team at the VHA in Iowa City. The results from this work will be exceptionally well aligned with CMS's desire to explore "***potential models focused on behavioral health, including focus areas such as opioids, substance use disorder, dementia, and improving mental healthcare provider participation in Medicare, Medicaid, and CHIP through models that enhance care integration and/or utilize episode payment"***

We look forward to the opportunity to work with CMMI on the implementation of these psychosocial care pathways as a model on behavioral health focused on opioids and improving mental healthcare provider participation through models that enhance care integration and utilize episode payment.

In summary, we believe that the Spine IQ QCDR, the Primary Spine Practitioner Model and the development of multi-disciplinary clinical care pathways designed to better integrate doctors of chiropractic as members of multi-disciplinary spine care team provides a unique opportunity to improve the quality and consistency of spine care delivery, an area that is in desperate need of innovative solutions.

We appreciate the opportunity to submit these comments on the new direction for the Center for Medicare and Medicaid Innovation. If you have any questions regarding our comments or need more information, please contact Angela Kennedy, Senior Vice President of Education and Health Policy at the American Chiropractic Association, akennedy@acatoday.org or 703-812-0242.

Sincerely,

American Chiropractic Association
Palmer Center for Chiropractic Research
Spine Institute for Quality

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