

GETTING PAID IN 2017 AND BEYOND

Medicare's New Payment System and Chiropractic



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Getting Paid 2017 and Beyond

How chiropractic physicians should respond to the new Medicare payment system.

Executive Summary

For years we have heard of how pay for performance and reimbursement based on outcomes will someday arrive. Then in the spring of 2015, the Medicare Access and CHIP Reauthorization Act of 2015ⁱ (MACRA) was signed into law. This bipartisan legislation replaced the flawed Sustainable Growth Rate formula for physician payment in Medicare with a new approach to paying clinicians for the value and quality of care they provide. The legislation largely went unnoticed by providers but passed the U.S. House of Representatives on March 26, 2015 by a vote of 392-34 and the U.S. Senate on April 14, 2015 by a vote of 92-8 with the President signing the bill into law 4 days later. On October 14, 2016, the Department of Health and Human Services (HHS) issued a final rule with comment period to implement key provisions of the MACRA law. The final ruleⁱⁱ implements these changes through the unified framework called the “Quality Payment Program,” which includes two paths: The Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM). As a result, the MACRA law singlehandedly will move health care in the United States into value-based care delivery.

The value-based model hinges on paying providers based on performance of clinical activities and outcome measures determined to improve the quality of patient-centered care. The consistency of these clinical activities carried out by health care providers will be rewarded. The evidence on the effectiveness and outcomes of chiropractic care, in addition to the doctor of chiropractic’s training in primary health services, presents a tremendous opportunity for the chiropractic physician in this value-based system. However, hampering the chiropractic profession as a whole is their slow adoption of electronic health records (EHR) and reporting of quality measures as well as non-reimbursement of chiropractic evaluation/ management and certain treatment procedures under Medicare and other public and private payers – altogether dealing a definite disadvantage to a profession that holds a key to a proven delivery of safe, effective health care to the general population.

The opportunity is waiting for the full enlistment of the doctor of chiropractic’s expertise in care delivery, but barriers exist. Clarity must be prioritized around improved and updated Medicare payment policies including extending coverage of benefits for all

procedures or services approved in the chiropractic physician's state of licensure. Grants and federal contracts must seek ways to specifically prioritize provisions for the doctor of chiropractic within their request for proposal process to counter the lack of funding and prioritization in past federal programs, which unfortunately has unintentionally disadvantaged this provider type. As an example, the current relationship between Best Practices Academy (representing the chiropractic profession) and Telligen have partnered to provide services under a new program within the Quality Payment Program called the Small, Underserved and Rural Support (SURS) under the funding provided within the MACRA law. Best Practices Academy will seek to bring a chiropractic focus for other contractors awarded within the SURS program, pending critical support of these entities and CMS to include chiropractic. In addition, third party payers must adopt policies that expect conservative care prior to advance imaging, narcotics or surgery where appropriate to name a few. And allopathic health systems should begin to reach out to their chiropractic colleagues in their respective communities to begin to dialogue on how to work together as well.

Everyone is clamoring for better outcomes, reduced costs, and improved health of the population. Now is the time for a fresh start – a proverbial “do-over” for the care delivery system. The key to better outcomes of care for the population will hinge upon clinical teamwork and care coordination. The recruitment of frontline clinicians should include leveraging the skill set of the doctor of chiropractic. A streamlined and efficient delivery system with appropriately integrated care pathways based upon care coordination with collaboration, evidenced-based/informed practices, and an engaged patient provides reduced costs for patients and payers of health care.

Introduction

In the United States, chiropractic is the third largest primary healthcare profession, surpassed in numbers only by medical physicians and dentists. All 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands officially recognize chiropractic as a primary healthcare profession distinct from medicine.ⁱⁱⁱ It is the largest, most regulated, and best recognized of the complementary and alternative (CAM) healthcare professions and with the advent of a large body of evidence over the past decade, the profession has become a key leader of a growing field within integrative medicine. Integrative medicine incorporates CAM within conventional and traditional care. The

chiropractic physician's clinical expertise entails a holistic, whole body natural approach to care.

History reflects a rugged start as a profession, the repeated victim of unfair and anticompetitive transgressions against the chiropractic profession are well documented over the years. Competing health care professions and payer systems have influenced federal and state legislation in a negative manner towards chiropractic with their powerful lobbying groups leading the way to contain the impact and public perception of chiropractic care. Countering these actions, individual doctors, state and national associations have mustered effort around their legislative strategy on shoestring budgets with few successes along the way. Although the chiropractic profession has had meager growth the profession continues to outperform its health care peers in many aspects of patient care. With the advent of probably the most transformative change in the history of health care upon us, clarity of a vision is needed now more than ever for the chiropractic profession and all stakeholders if we are to truly achieve the triple aim of better patient outcomes, improved population health and lower costs.^{iv} The new payment system through the MACRA law provides an opportunity for all providers (especially chiropractic physicians) to be objectively judged and valued based on performance in patient care.

How did we get here?

Medicare was enacted in 1965^v out of an expressed interest to create affordable access to the elderly who have fixed incomes and who have a greater need for care. Doctors of chiropractic were included as providers in 1972.^{vi} Although the doctor of chiropractic is defined as a physician under Medicare, it is within a limited scope of diagnosis and services which coverage applies for Medicare beneficiaries. Doctors of chiropractic, once registered as a Medicare provider, may not opt out of being a provider, unlike other physicians. An "opt out" refers to a physician's ability to decide not to bill Medicare at all, thereby allowing the ability to enter into private contracts with the Medicare beneficiaries they treat.^{vii} In addition, unless you meet the low volume threshold (\$30,000 or more in allowed Medicare charges and 100 or more unique Medicare patients annually) or are involved in an advanced APM or have only been practicing for a year; no eligible clinician is allowed to "opt-out" of MACRA.

History also shows that physicians, as a group, have faced many changes in financing and in how they are paid for the care they deliver. These shifts include the 1975 creation

of the Medicare Economic Index that limited annual fee increases, Omnibus Budget Reconciliation Act (OBRA) of 1989 that established the Medicare fee schedule, and the Sustainable Growth Rate (SGR) in 1997 that linked payment to service volume. Each of these legislative actions led to new physician adherence requirements and a fundamental industry shift. Today, MACRA is similarly poised to bring many changes to physicians and the health care industry.^{viii}

This transformation hasn't happened overnight, rather it has been in process in somewhat a piecemeal approach over the past decade. In 2006, Centers for Medicare and Medicaid Services (CMS) launched the Medicare Physician Voluntary Reporting Program as an initial step to introduce quality reporting and advance measurement in physician practices. The program created incentives for voluntary reporting of quality measures and was implemented in 2007 as the Physician Quality Reporting Initiative, which advanced by 2010 into the Physician Quality Reporting System (PQRS). PQRS was further extended and enhanced by legislation such as the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, the Affordable Care Act of 2010 and the American Taxpayer Relief Act of 2012.

From 2007 to 2014, Eligible Providers (EPs) participating in PQRS had the opportunity to earn an incentive payment by satisfactorily reporting data on measures chosen from a designated set of Medicare quality measures or by satisfactorily participating in qualified clinical data registries (QCDR). Beginning in 2015, incentives were replaced with negative payment adjustments for individual EPs and group practices that did not satisfactorily report data on quality measures or satisfactorily participate in QCDRs. By 2016, doctors of chiropractic as solo physicians or as small group practices of 2-9 providers will be included in the value-based modifier (VBM) program. The VBM was designed to relate the quality of care furnished and compare it with the cost of care. Those who do not successfully participate in PQRS in 2016 will receive an automatic 2% VBM deduction, in addition to the 2% PQRS deduction. Solo physicians and small group practices, who report to PQRS in 2016, are either subject to a neutral adjustment or 2% payment penalty. The 2014 PQRS reporting year was the last reporting year that a PQRS incentive was possible. For the reporting years of 2015 and 2016, there is no incentive payment - only a neutral or a negative 2% payment adjustment, depending on your PQRS reporting outcome.

Predicted Impact of MACRA Law

The final rule^{ix} under MACRA currently identifies 4,487 or 9.8% of the 45,763 MIPS chiropractic physicians eligible in the MIPS program. The number of current eligible clinicians is primarily the result from the effect of the low-volume threshold (\$30,000 or less in allowed charges or 100 or fewer unique Medicare patients annually). It is anticipated^x that more clinicians will be determined to be eligible to participate in the program in future years. The final rule reports 87.8% of the chiropractic physicians eligible will experience a neutral or positive payment adjustment, basing this prediction upon 2014 PQRS reporting results. Overall, it is known that 12,725 or 27.8% of a total of 45,834 DC eligible professionals reported PQRS in 2014^{xi}. Of those who participated in PQRS through claims reporting in 2014, 6,804 or 14.8% of the DCs successfully reported PQRS to qualify for an incentive payment. It would appear the low-volume threshold captures doctors of chiropractic who have been successful PQRS reporters in the past. The question becomes, “Will the rest of the profession be ready”?

Initially the proposed rule^{xii} captured 20,572 chiropractic physicians due to the low-volume threshold proposed at that time. It was projected 98.4% of the eligible doctors of chiropractic would receive a downward adjustment. As this MACRA law expands to cover more providers, doctors of chiropractic will find themselves squarely in the cross hairs of needing to make changes quickly, unless they begin to voluntarily participate now. In an effort to help small practices, the MACRA law mandated the allocation of \$100 million in technical assistance (MACRA TA) to be available to MIPS eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas (HPSAs), including IHS, tribal, and urban Indian clinics, through contracts with quality improvement organizations, regional health collaboratives, and others to offer guidance and assistance to MIPS eligible clinicians in practices of 15 or fewer MIPS eligible clinicians.

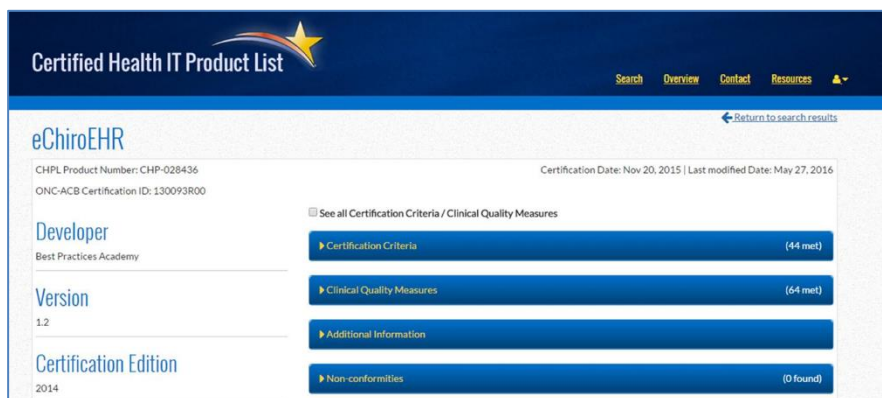
The Disadvantage

The chiropractic physician is at a disadvantage in the MACRA law, as the result of a combination of factors: Medicare only reimbursing for three chiropractic manipulative therapy (CMT) codes (problematic when determining an episode of care and attribution of patients as well as meeting threshold requirements for technical assistance), the DC not being recognized as a priority clinician in the CMS EHR integration and transformation funding through regional extension centers (REC) of the past (i.e. not

being classified as a priority provider in the EHR assistance program resulting in a lower adoption rate of CEHRT), the e-prescribing exclusion sunset in the meaningful use program and was not carried over into the MACRA law (thereby scheduled to eliminate the points allotted for this performance category), and more recently becoming evident is the present lack of acceptance within the Transforming Clinical Practice Initiative (TCPI) networks, which is specifically funded to help clinicians achieve large-scale health transformation with the goal of qualifying participants for an advanced alternative payment model. This is problematic for the doctor of chiropractic as an eligible clinician because, as a result, there has been much less electronic health record adoption and meaningful use/PQRS reporting today among chiropractic physicians as compared to other eligible provider types. Use of EHR technology is the hub of the value-based care delivery model.

The overall effort to “not leave any provider behind” has done just that. The present status of the doctor of chiropractic as an eligible clinician within MIPS presents a unique issue that requires immediate

consideration. As the third largest primary health service provider, the MACRA law is at risk of further disadvantaging this provider type whose primary expertise is accomplished in the success of addressing the number one cost of healthcare in the United States, that of spine related conditions. This provider type has been disadvantaged by being pushed to the “back of the line” of providers in the financial assistance programs and funding of the past. And this needs to stop.



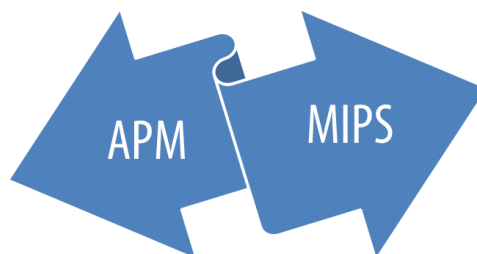
EHR technology capability will define the success eligible clinicians will experience in the new payment system. Clinicians must become more aware of the requirements and be astute purchasers of this impactful investment in their practice. Begin researching CEHRT products here and compare them to Best Practices Academy's eChiroEHR:

<https://chpl.healthit.gov/#/search>

Impact of technology on healthcare

Beginning with the HITECH Act of 2009^{xiii}, we have moved from a people and paper method of care documentation to one of people and information technology. The advancement of the EHR technology is moving from the point-of-sales systems (not built to support shared care) to EHRs being deployed that have potential tangible benefits to patients and healthcare outcomes. The EHR technology provides the capabilities to conduct data analytics using all types of patient data to improve care processes and treatment. This transition from paper to digital has created challenges and the healthcare industry is struggling to come to grip with these systemic changes. At their core, EHRs were architected in a fee-for-service environment to improve clinician workflows and optimize billing. To accomplish that goal, they don't require complete knowledge of patients. However, in a value-based environment, complete knowledge of a patient's health is critical requiring the collection and processing of patient clinical and demographic data.

There is huge potential for data analytics to lead to higher quality care and lower costs, but it requires increased care coordination with collaboration between providers, and the information sharing capabilities between the EHRs they are using is a key to the success of this formula. Effective use of EHRs include being able to continue to process financial transactions of the fee for service model and combining it with clinical data that is key to transforming to a value-based model. The goal is to have an electronic medical record (EMR) system that combines both clinical and transactional data, so healthcare providers will be able to understand patterns to improve care, by analyzing patient profiles to identify segments of the patient population through risk stratification, determining who will benefit most from preventive care and scaling disease profiling to uncover protocols that deliver the best value. The Quality Payment Program goal is to create the incentive for organizations to do just that.



The Dawn of Medicare's Quality Payment Program

Under the Quality Payment Program (QPP), the majority of eligible clinicians will begin reporting in 2017 for Merit-Based Incentive Payment System (MIPS) with the ultimate goal of qualifying and participating in an advanced alternative payment model (APM).

There is sort of a philosophy here of crawling before you walk, with many of the performance measures being similar in both tracks, but with the added contract agreement with CMS through APMs to take “nominal financial risk” (i.e. if you fail to make the performance levels in the contract, you pay money back to CMS). Both tracks are designed to combine quality of care with effective outcomes at a lower cost. CMS along with Congress have been and still are working diligently to reform the payment environment for health care and the ongoing work to determine the final rule is underway, during the publication of this report. Updated information can be accessed at www.CMS.gov.

Within the MACRA law are two different payment options, one is the Merit-based Incentive Payment System (MIPS) and the other is the Alternative Payment Model (APM). These two options are the blueprint of pay for performance by Medicare. If you are not eligible to be a qualified participant in a CMS approved advanced APM, then you will by default be subject to the requirements of the MIPS program. However, you may be exempt from the MIPS program if you meet the “low volume threshold” or if you are in your first year of seeing Medicare beneficiaries.

Merit-based Incentive Payment System (MIPS)

The Merit-based Incentive Payment System (MIPS) combines the existing three quality incentive payment programs; Physician Quality Reporting System (PQRS), Value-Based Modifier (VBM), and Meaningful Use (MU) of Certified Electronic Health Records Technology (CEHRT) into a single quality incentive payment program. As the current three reporting programs sunset, they give rise to the dawn of a new period of reporting.

The former programs are listed below with their current counterparts:

- ✓ The Physician Quality Reporting System (PQRS) which incentivizes professionals to report on quality of care measures is now known simply as **Quality**;
- ✓ The Value-based Modifier (VBM) which adjusts payment based on quality and resource use in a budget-neutral manner is known as **Cost**; and

- ✓ Meaningful use of electronic health records (EHRs) which sets certain requirements to be met in the use of EHR systems has been “rebranded” as **Advancing Care Information (ACI)**.

With these current programs combined, a composite threshold performance score (scale 0-100) is established and aimed at informing providers of the levels of reimbursement based on four key performance measures: Advancing Care Information, Quality, Cost, and Improvement Activities. In addition to the “rebranded” programs, a fourth performance category has been added called Improvement Activities. This new performance category focuses on what you are doing in your practice to improve patient care. Improvement Activities includes 90 improvement activities that have been identified and providers are given an opportunity to select activities that are most appropriate for the services they provide.

Alternative Payment Model (APM)

By March 3, 2016, HHS had already met their 2016 goals to move 30 percent of Medicare payments into alternative payment models. Medicare’s goal is to have 85% of

MPS Performance Categories				
Total of Four Categories = Composite Performance Score				
Payment Period	Advancing Care Information	Quality	Cost	Improvement Activities
2019	25%	60%	0%	15%
2020	25%	50%	10%	15%
2021	25%	30%	30%	15%
* Weighted on a 0-100 point scale				

their payments tied to quality and value in 2018. An Alternative Payment Model is a health care payment and/or delivery model that includes payment arrangements and other design elements as part of a particular approach to care improvement. One can think of this as a plan, which its design is marked by clinical workflows all supported by a financial model that sustains and perpetuates success in achieving the population health goals of the APM. An APM entity is an organization that simply pays the providers involved in the APM and is the contracting entity between the providers and the payer. An accountable care organization could be an example of an APM entity, however to qualify to report under the APM track, the organization must have a “nominal risk” incorporated into their contracts.

There are a number of Medicare requirements to qualify as an APM entity such as 1) Use quality measures comparable to MIPS, 2) Use a certified electronic health record, 3) Bear a defined nominal financial risk for monetary losses under such alternative payment model that are in excess of a nominal amount, or be in a medical home expanded under 1115A(c). Medicare requirements qualify an APM as an Advanced APM allowing higher levels of incentives to be paid, including being exempt from reporting in MIPS. Taking baby steps through successfully participating in performance-based reporting will allow clinicians to develop the internal capability to succeed in an alternative payment system, which is the end-game of value-based care delivery.



For the doctor of chiropractic these rapid changes may initially be perceived as overwhelming. The typical chiropractic practice is a small business with limited staff. Adopting EHR technology comes with significant investment of time and overhead costs. But these changes represent a long awaited opportunity to substantiate the quality of care doctors of chiropractic provide their patients.

Pick Your Pace

On September 8, 2016, Andy Slavitt, Acting Administrator of CMS announced there will be no delay in starting the reporting under MACRA. CMS has however been listening to thousands of physicians and their representative organizations regarding their concerns as to reporting under MACRA and have established four options eligible clinicians may choose for reporting beginning January 2017:

In the transition year CY 2017 of the program, a period^{xiv} is finalized during which clinicians and CMS will build capabilities to report and gain experience with the program. Clinicians can choose their course of participation in this year with four options.

(1) Clinicians can choose to report to MIPS for a full 90-day period or, ideally, the full year, and maximize the MIPS eligible clinician's chances to qualify for a positive adjustment. In addition, MIPS eligible clinicians who are exceptional performers in MIPS, as shown by the practice information that they submit, are eligible for an additional positive adjustment for each year of the first 6 years of the program.

(2) Clinicians can choose to report to MIPS for a period of time less than the full year performance period 2017 but for a full 90-day period at a minimum and report more than one quality measure, more than one improvement activity, or more than the required measures in the advancing care information performance category in order to avoid a negative MIPS payment adjustment and to possibly receive a positive MIPS payment adjustment.

(3) Clinicians can choose to report one measure in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category and avoid a negative MIPS payment adjustment. Alternatively, if MIPS eligible clinicians choose to not report even one measure or activity, they will receive the full negative 4 percent adjustment.

(4) MIPS eligible clinicians can participate in Advanced APMs, and if they receive a sufficient portion of their Medicare payments or see a sufficient portion of their Medicare patients through the Advanced APM, they will qualify for a 5 percent bonus incentive payment in 2019.

In essence and in response to the public comments, CMS has decided to move forward along the final timeline for implementation of the new payment system. However, they are giving a pass against negative payment adjustments if you become involved this first year (2017). This gives the chiropractic physician an opportunity to verify they have an EHR capable of collecting the necessary data and report going forward. This is only a short period of grace and it is critical for doctors to use this time wisely. The transition year provides an opportunity for clinicians to get on the treadmill as it is starting up, choosing not to get involved in 2017 means jumping on a treadmill moving at a fast pace and will make it difficult to avoid the downward payment adjustment in this new reimbursement model.

How is the performance collected?

Clinical data may be reported through a variety of methods, referred to as reporting methodologies. Some of the reporting methodologies are proving to have higher reliability than others. Currently, you can report your performance of your quality measures through claims, directly through a certified EHR, (requiring a Quality Reporting Document Architecture (QRDA) which is a standard for communicating health care

quality measurement information to CMS), qualified registries, qualified clinical data registries (QCDR) and the GPRO web interface. The reporting method that seems to have the best comprehensive reporting capability at this time is the QCDR. To oversimplify a description of a QCDR, it is like a cleaning service that also takes care of cooking and laundry. A QCDR is a CMS-approved entity, such as a specialty society, certification board, or regional health collaborative, which collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. In fact, in the Quality Payment Program, CMS awards bonus points for using a CEHRT and reporting all of the categories. A QCDR will complete the collection and submission of quality measures data on behalf of individual eligible clinicians (EC) and group practices so that they may meet criteria for satisfactorily participating in quality measures.^{xv} The QCDR reporting method currently enjoys a high reporting success rate and a 90% validation process, allowing clinicians to preview their performance on measures selected prior to final submission.

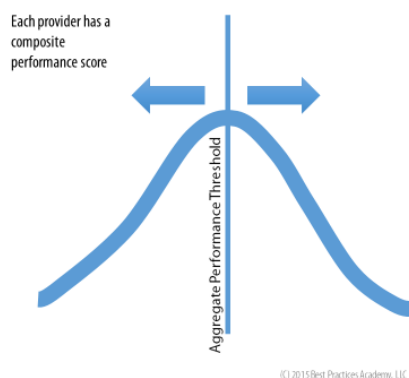
Once measures are submitted, physicians are provided a periodic Quality Resource Use Report (QRUR), which is basically a report card according to the CMS. The QRUR is intended to provide feedback for Medicare enrolled physicians to understand the quality and efficiency of care provided to Medicare beneficiaries and to inform physicians about their performance (as identified by their Taxpayer Identification Number or TIN) on a subset of measures that are currently included in the Value-Based Modifier (VBM).

Performance measurement

Doctors of chiropractic are clinically trained^{xvi} to provide physician-level services to their patients. As an example, rural populations commonly use a chiropractor as a first point of contact with the health system and many times present with non-musculoskeletal complaints^{xvii}. That being said, the doctor of chiropractic can employ neuromusculoskeletal (NMS) and non-NMS systems of care. Chiropractic physicians are capable of performing standardized clinical processes which encompass a complete patient history and review of systems (including all current medications as well as conducting the drug-drug and drug-allergy checks) with identifying and engaging the patient's primary care provider in the development of the patient's care plan.

In addition to these standardized processes, quality measures have now become a part of the patient care visit. Quality measures have a value due to their direct correlation

with producing effective outcomes in patient care. Most doctors of chiropractic are accustomed to using a variety of outcome tools to measure regional pain and disability, but in the value-based model, several other



quality measures are critical in the understanding of what constitutes an effective patient visit. CMS has incorporated flexibility for clinicians in selecting quality measures. The provider goal is to choose measures that are the most meaningful for the services and care provided to the patient. For instance, it is not in the best interest of the doctor of chiropractic to report on immunizations and vaccinations when he/she does not administer those immunizations or vaccinations. The goal is to use individual measures that can provide evidence of informed care and best represent the outcomes associated with that care.

Engaging the patient is a key component in a patient-centered care model. The Gallup-Palmer^{xviii} study revealed nearly half of adults who have been to a chiropractor in the last five years would go more often, but for the expense. It is important for clinicians and their staff to take the time to have cost and value conversations with their patients, supporting them to make better healthcare choices based on their needs and preferences. With the rise in copays and deductibles, the chiropractic practice must develop legal and ethical “cash friendly” systems for their patients and at the same time meet the requirements of the new payment system in a value-based practice model.

Chiropractic Systems of Care

Chiropractic neuromusculoskeletal (NMS) and non-NMS systems of care include the integration of muscles, joints, nerves, exercise instruction, nutrition, stress management and other natural methods in treatment plans and wellbeing care that involve using quality measures to track outcomes. By addressing the patient population health within the chiropractic practice through the employment of preventive care and chronic care

services the doctor of chiropractic can become a valued team player not only in the medical neighborhood but within the patient-centered medical home (PCMH) itself. Utilizing standardized methodologies with evidenced informed decisions will catapult the doctor of chiropractic in the value-based model to new heights. Gone will be the days of silo practitioners working in isolation. The practice silos of the past and present are being replaced by fully integrated providers who are working together, sharing care information for the best outcomes for patients. Doctors of chiropractic have an opportunity to promote care coordination as part of the medical neighborhood, sharing their expertise in a pro-active manner.

The 2016 HealthLeaders Media Value-Based Readiness Survey indicate that 94% of (allopathic-based) health care organization respondents are on a path to value-based care of one form or another, pointing to nearly universal acceptance of the mission to transform healthcare to a value-based model. At the same time however, not all providers are moving at the same pace, and there is variability between organizations in terms of the level of commitment to value-based care activities.^{xix} The doctor of chiropractic needs to join this transformational movement in a commitment to developing value-based care delivery competencies in the area of care coordination with collaboration and encouraging patients to be engaged in their own care process. To begin that process, the doctor of chiropractic should seek practice recognition status from third party accrediting organizations, like their medical counterparts, to achieve parity through achieving the same quality standards as other health care providers delivering primary health services.

Conclusion

The key to better outcomes of care will hinge upon teamwork. Including the chiropractic physician as a frontline clinician can yield positive results. A streamlined and efficient delivery system with appropriately integrated care pathways based upon care coordination with collaboration and evidenced-based/informed practices provides reduced costs for patients and payers of health care.

The opportunity is waiting, but barriers exist.

The doctor of chiropractic has been disadvantaged by being pushed to the “back of the line” of providers in federal and state financial assistance programs and funding of the past. As a result, there is a direct correlation in comparatively poor statistics in PQRS &

MU reporting. The CMS projection of the vast majority of doctors of chiropractic receiving a downward adjustment is a combination of factors including Medicare only reimbursing for three CMT codes, the DC not being recognized as a priority clinician in the CMS EHR integration and transformation funding of the past, and more recently becoming evident is the present lack of acceptance within the TCPI networks due to the factors expressed earlier. Under current Medicare policy, doctors of chiropractic (DC) are reimbursed by Medicare for only services related to the use of chiropractic manipulative therapy (CMT) codes 98940, 98941, & 98942. These codes are currently limited to two clinical quality measures, specifically #131 & #182.

Within the new MACRA Law, the traditional policy by Medicare to limit chiropractic physician coverage for full scope of practice of services is problematic for chiropractic physicians and their Medicare beneficiaries. For instance, chiropractic physicians are paid by other third party payers on evaluation and management (E/M) codes and also perform key activities and outcome measures for their non-Medicare patients. But once someone becomes a Medicare beneficiary (currently growing at a rate of about 10,000 people per day), the doctor of chiropractic no longer is reimbursed for the procedures/codes aligned with these measures; and if they do continue to perform these value-based clinical activities, the DC provider type bears the expense that other provider types are not subject to bear. It is unclear how the chiropractic physician, as an eligible clinician, can be allowed to perform successfully in the new Quality Payment Program while being subjected to this aberrant limitation imposed by legacy Medicare policy. The chiropractic provider type is not on a fair level playing field with other eligible clinicians under the parameters currently in place with CMS for Merit-based Incentive Payment System (MIPS) reporting, creating an anticompetitive environment for the chiropractic physician. The current policy of not covering E/M codes by a doctor of chiropractic creates a disadvantage and discriminates against this provider type from also being invited for participation in any alternative payment model (APM) due to the lack of quality measures to report for the limited scope of covered services.

In addition, the chiropractic provider type is also at a disadvantage for patient attribution. In the final rule, since the doctor of chiropractic will not have enough episodes for the Cost category, it is proposed the Cost points will be redistributed to other categories. CMS has stated, how the cost category will be affected when an eligible clinician does not have any attributed patients will be determined in future rulemaking. This leaves these points up in the air for the chiropractic physician. Will the

chiropractic physician, an eligible clinician, be allowed the opportunity to achieve full points (like other provider types) under the MIPS scoring system, with the Cost category and the eprescribing issue lurking in the Advancing Care Information category of points?

The present status of the doctor of chiropractic as an eligible clinician presents a unique issue that requires immediate consideration, so as not to create unintended consequences that are counterproductive toward meeting the Triple Aim. As the third largest primary health service provider, there is imminent risk of inadvertently disadvantaging the chiropractic provider type whose primary expertise is accomplished in the success of addressing the number one cost of healthcare in the United States, that of spine related conditions.

Where do we begin?

The following recommendations provide a starting point for public and private payers, public policy makers and the chiropractic profession to consider as they embark into this new value-based care delivery environment:

Recommendation #1: Clarity must be prioritized around improved and updated Medicare payment policies including extending to a full scope of practice coverage of benefits for all procedures or services approved in chiropractic physician's state of licensure.

Recommendation #2: Grants and federal contracts must seek ways to specifically prioritize provisions for the doctor of chiropractic within their request for proposal process to counter the unintentional lack of funding and prioritization in past federal programs, which unfortunately has disadvantaged this provider type. Best Practices Academy is leading the way in this area, broadening new relationships to support chiropractic care.

Recommendation #3: Third party payers must adopt policies that expect conservative care (including chiropractic care) be accessed (at a minimum) prior to advance imaging, narcotics or surgery where clinically appropriate within defined care pathways.

Recommendation #4: Allopathic health systems should reach out to their chiropractic colleagues in their respective communities to begin to dialogue on how to work together.

Recommendation #5: The systematic discrimination toward the chiropractic profession in the past requires the doctor of chiropractic and associations to take the “higher road” toward reconciliation. It is critical at this time that the profession actively works together with other providers toward creating a new legacy and become fully part of the value-based healthcare.

Where does the chiropractic physician begin?

Chiropractic physicians must engage the new payment system by implementing the following into their practice and clinical workflows:

Recommendation #1: Adoption of a certified electronic health record technology (CEHRT)

Recommendation #2: Understand the MACRA law and the new payment system (MIPS)

Recommendation #3: Select quality activities and measures that will support your clinical care with patients

Recommendation #4: Determine how you will report your measures to achieve maximum payment

Recommendation #5: Re-engineer your workflows in your practice to accommodate patient-focused, value-based operations and achieve practice recognition through an accredited organization

Quality payment performance will undoubtedly remain a central feature in care delivery for decades. This transformation of health care in the United States has started with this end in mind: placing value on quality. Performance measurement may keep providers accountable, but what about the payer community? This move for everyone (clinicians especially) to be involved in two-sided risk APMs must also keep in check the integrity of the payers of health care within the needs of the ultimate receiver of the care – the patient. Patient-centered care doesn’t begin and end with the provider and the patient but it is truly a team effort aligning the payer with these ideals as well.

Leadership in practice^{xx} truly can be the disruptive innovator for the future of care delivery. And now is the time for public and private payers, public policy makers, patients, and the health care community – including the chiropractic profession - to make it happen.

ⁱ Accessed at <https://www.cbo.gov/publication/50053> on 7-19-2016.

ⁱⁱ Centers for Medicare & Medicaid Services, 42 CFR Parts 414 and 495, [CMS-5517-FC], RIN 0938-AS69 10/14/2016

ⁱⁱⁱ Accessed at http://www.nbce.org/about/about_chiropractic/ on 6-17-2016.

^{iv} Accessed at <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx> on 7-1-2016.

^v Accessed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf> on 9-6-2016

^{vi} Accessed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c05.pdf> on 9-6-2016

^{vii} Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Chiropractors_fact_sheet.pdf on 9-6-2016

^{viii} Accessed at <http://edit.modernhealthcare.com/assets/pdf/CH106774829.PDF> on 9-6-2016

^{ix} Accessed at <https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm> on 7-8-2016.

^x Accessed at <https://www.federalregister.gov/articles/2016/05/09/2016-10032/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm> on 7-8-2016.

^x Executive Summary Department of Health and Human Services Centers for Medicare & Medicaid Services 42 CFR Parts 414 and 495 [CMS-5517-FC] RIN 0938-AS69

^{xi} 2014 Physician Quality Reporting System Reporting Experience and Trends. <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/dataandreports.html>. accessed on 6-27-2016.

^{xii} Centers for Medicare & Medicaid Services, 42 CFR Parts 414 and 495, [CMS-5517-P], RIN 0938-AS69 4/28/2016

^{xiii} Accessed at https://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra_with_index.pdf on 7-19-2016.

^{xiv} Centers for Medicare & Medicaid Services, 42 CFR Parts 414 and 495, [CMS-5517-FC], RIN 0938-AS69 10/14/2016

^{xv} Accessed at <https://www.acponline.org/system/files/documents/practice-resources/business-resources/payment/medicare/pqrs/2016-pqrs-qcdr-made-simple.pdf>. on July 15, 2016

^{xvi} <http://cce-usa.org/>

^{xvii} Smith M, Carber L. Chiropractic health care in health professional shortage areas in the United States. Am J Public Health. December 2002;92(12):2001-9. Accessed allowed from the Palmer Center for Chiropractic Research (PCCR), Davenport, Iowa.

^{xviii} Accessed at <http://www.palmer.edu/uploadedfiles/pages/alumni/gallop-report-palmer-college.pdf> on 7-01-2016.

^{xix} Accessed at <http://www.healthleadersmedia.com/report/intelligence/value-based-readiness-building-momentum-tomorrow%E2%80%99s-healthcare> on July 20, 2016

^{xx} SD Munsterman, DC, FICC. Care Delivery and Chiropractic: An Opportunity Waiting. In process of publication.