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OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research
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Office

H.B. 102
133rd General Assembly

Fiscal Note & Local Impact Statement

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Version: As Introduced

Primary Sponsor: Rep. Lipps

Local Impact Statement Procedure Required: No

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Highlights

- The Medicaid Program could realize an increase in expenditures if the bill results in greater utilization of chiropractic services that are currently covered under Medicaid.
- The Medicaid Program would realize an increase in costs to cover other chiropractic services that fall within a chiropractor's scope of practice, but are not currently covered under Medicaid. Since the federal government limits chiropractic coverage to those currently covered, it is possible that the state would not receive federal reimbursements for these services unless a federal waiver was obtained.
- The Medicaid Program could realize savings due to the substitution of chiropractic services for more expensive treatments, such as surgeries or certain prescription medications.

Detailed Analysis

Bill overview

This bill requires the Medicaid Program to cover services provided by a licensed chiropractor acting within his or her scope of practice, which would expand the chiropractic services covered under the program. Under the bill, at least 20 service visits must be covered per benefit year. The bill also prohibits the Medicaid Program from imposing any prior authorization requirements on chiropractic services and from making coverage of these services contingent upon referral, prescription, etc. from another health professional. Additionally, if a service can be provided by either a licensed chiropractor or a licensed health professional other than a chiropractor, the bill requires Medicaid to pay the chiropractor the same rate it pays the other licensed health professional.

Fiscal impact

Determining the total impact to Medicaid as a result of the bill is difficult due to several factors. The expansion could result in an increased utilization of services for both (1) chiropractic services that are currently Medicaid-reimbursable, and (2) services that a chiropractor is able to perform under his or her scope of practice that are not currently Medicaid-reimbursable, but would be allowed to be performed by a chiropractor under the bill. If this occurs, then Medicaid costs would increase. For those services not currently Medicaid-reimbursable, the Department of Medicaid would need to obtain a federal waiver. The paragraphs below explain the impact for each scenario in more detail. In addition, there could be a decrease in Medicaid expenditures if the provision of these services results in a delay or avoidance in surgery or a reduction in certain prescription drugs, etc.

Increased utilization of services currently performed by a chiropractor

Certain chiropractic services are already covered under Medicaid.¹ However, the scope of those services is limited to manual manipulation of the spine for the correction of a subluxation after a determination has been made via physical examination or diagnostic imaging that the subluxation exists. Payments are permitted for diagnostic imaging to determine the existence of a subluxation. Unless prior authorization is received, coverage is limited to the following: one treatment per day, two images of the entire spine per year, two sessions of any other images per six-month period, 30 visits in an outpatient setting per year for individuals younger than 21, and 15 visits in an outpatient setting for individuals older than 21. Payment is not authorized for any other services, such as treatment for maintenance therapy or treatment where the maximum therapeutic benefit has already been achieved. In 2016, approximately 76,000 Medicaid recipients received chiropractic care at a total cost of \$9.7 million. The average number of visits per recipient was six.

Increasing the number of visits, prohibiting prior authorization, and allowing maintenance therapy may encourage greater use of those chiropractic services currently covered under Medicaid. If this occurs, then costs would increase. The total impact would depend on the number of additional visits or services utilized.

Utilization of other scope of practice services

In addition to an increase in imaging and manipulation procedures, chiropractors could also receive reimbursement for services within a chiropractor's current scope of practice, but currently excluded from Medicaid coverage. This could include laboratory tests, manual manipulation for purposes other than the treatment of a subluxation, evaluation and management services, etc. It is difficult to determine how much the increase in costs would be for these procedures. However, the federal government currently limits coverage for chiropractic services to treatment by means of spinal manipulation. As a result, these other chiropractic services may not be eligible for federal financial participation unless a waiver from the federal government was obtained. Currently, for most services, Ohio receives

¹ Ohio Administrative Code 5160-8-11 outlines coverage for spinal manipulation and related diagnostic imaging services.

approximately 63% from the federal government for reimbursements related to Medicaid expenditures. If a waiver was not obtained, the state would pay for all associated costs. If a waiver was obtained, the total cost associated with this provision would depend on the number of individuals who seek this care through a chiropractor and the types and amounts of services utilized, as well as how many individuals currently use these services, but receive them through another healthcare provider. Some cost shifting could occur if individuals receive the services through a chiropractor instead of another healthcare provider.

Potential savings

Expanding the range of covered chiropractic services may have some benefit via a substitution effect, as recipients seek out chiropractic care instead of potentially more expensive therapies, surgery, or medication.

Reimbursement equal to the amount received by other healthcare providers

In addition to the expansion of services, the bill also requires that Medicaid pay the chiropractor the same rate it pays other licensed health professionals. Currently, Medicaid reimbursement for chiropractic treatment services is limited to Healthcare Common Procedure Coding System (HCPCS)² codes 98940 through 98943. The Medicaid reimbursement for these procedures is the same regardless of whether a chiropractor or other healthcare practitioner renders these services. However, skilled therapy services (HCPCS codes 97110 through 97899) receive 60% of the amount that Medicare pays for these procedures, while HCPCS codes 98940 through 98943 receive approximately 45% of the amount that Medicare pays. The Ohio Department of Medicaid stated that since the skilled therapy services are similar in scope to chiropractic services, there is a possibility that this provision may result in chiropractors being reimbursed at the higher rate.

Administrative costs

Finally, any expansion of Medicaid coverage may result in administrative costs both to modify existing systems and to process newly covered services. At the state level, computer systems must be modified to accept new codes, although no new administrative personnel requirements are expected.

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² HCPCS codes are standardized code sets used by Medicare and other health insurance providers for reporting medical procedures and services claims in a consistent manner. Medicaid's HCPCS fee schedule can be accessed here: http://codes.ohio.gov/pdf/oh/admin/2019/5160-1-60_ph_ff_a_app1_20181210_0910.pdf.