www.lsc.ohio.gov

OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research and Drafting

Legislative Budget Office

H.B. 136
134th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 136's Bill Analysis

Version: As Reported by Senate Health

Primary Sponsor: Rep. Lipps

Local Impact Statement Procedure Required: No

Nelson V. Lindgren, Economist

Highlights

- The bill requires the Medicaid Program to cover evaluation and management (E&M) services provided by a licensed chiropractor. This could result in an increase in spending of about $11.1 million per year. However, it is possible that some cost shifting could occur if a patient chooses to see a chiropractor for E&M services instead of another health care practitioner.
- The provision that requires Medicaid to pay a chiropractor the same amount for services that it pays another licensed health professional that is authorized to provide the service could result in increased costs.
- The bill allows the Medicaid Director to cover other services provided by a chiropractor. Any impact to the Medicaid Program would depend on rules adopted.
- Since the federal government limits chiropractic coverage to those currently covered, it is possible that the state might not receive federal reimbursements for these services unless a federal waiver was obtained.

Detailed Analysis

The bill requires the Medicaid Program to cover evaluation and management (E&M) services provided by a licensed chiropractor. In addition, the Medicaid Director may adopt rules to cover other services provided by a chiropractor under the Medicaid Program. The bill prohibits the Medicaid Program from imposing any prior authorization requirements on covered chiropractic services and from making coverage of these services contingent upon referral, prescription, etc., from another health professional. Additionally, if a service provided by a chiropractor can also be provided by another licensed health professional, the bill requires

Medicaid to pay the chiropractor the same rate it pays the other licensed health professional. The bill applies to both fee-for-service and Medicaid managed care.

Fiscal impact

Currently certain chiropractic services are 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. Allowing E&M services conducted by chiropractors to be covered under Medicaid would result in increased costs. The Ohio Department of Medicaid has previously estimated that 1.33 E&M visits per chiropractic patient at an average cost of $36.50 per year could increase costs by $11.1 million. However, it is possible that some cost shifting could occur if a patient chooses to see a chiropractor for E&M services instead of another health care practitioner. Additionally, it is also possible that if patients are able to go to a chiropractor for E&M services, that utilization of chiropractic services could increase.

The bill also allows the Medicaid Director to cover other services provided by a chiropractor. This could result in impacts to the Medicaid Program. However, any impact would depend on rules adopted. The provision that requires Medicaid to pay a chiropractor the same amount for services that it pays another licensed health professional authorized to provide the service could result in increased costs. The total cost for this is unknown.

The federal government currently limits coverage for chiropractic services to treatment by means of spinal manipulation. As a result, E&M services may not be eligible for federal financial participation unless a waiver from the federal government was obtained. Currently, for most services, Ohio receives approximately 63%[2] from the federal government for reimbursements related to Medicaid expenditures. If a waiver was not obtained, the state would pay for all associated costs.

HB0136SR/lb

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

[2] The federal Families First Coronavirus Response Act (FFCRA), enacted in March 2020, provides for a temporary increase in federal medical assistance percentage (FMAP) of 6.2 percentage points for certain expenditures incurred after January 1, 2020, and throughout the duration of the COVID-19 emergency. During this period, Ohio's FMAP for certain expenditures may be increased by 6.2 percentage points.