Fiscal Note

BILL # SB 1025

TITLE: AHCCCS; chiropractic care; report

SPONSOR: Brophy McGee

STATUS: As Introduced

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Description

The bill would require AHCCCS to cover chiropractic services (up to 20 visits) that are ordered by a primary care physician or primary care practitioner for adults aged 21-64. The bill would also prohibit the Hospital Assessment as a fund source.

Estimated Impact

Based on AHCCCS' actuarial calculations, the JLBC Staff estimates the bill would have a 9-month fiscal impact of $3.9 million General Fund ($19.7 million Total Funds) in FY 2021. The full-year cost of the proposal in FY 2022 would increase to $5.2 million General Fund ($26.2 million Total Funds).

Beyond the first-year costs, the AHCCCS actuarial estimates will depend on actual utilization. Two factors could lower the cost beyond the first-year estimate. The long-run cost of the bill could be lower if AHCCCS enrollees utilize chiropractic services at lower-than-projected rates due to the requirement of a referral from a physician. The cost could also be lower if coverage of chiropractic care reduces the utilization of existing services to address neck and back pain. The magnitude of these impacts is difficult to determine in advance.

Though the bill would preclude the Hospital Assessment from covering chiropractic services, AHCCCS has indicated that it would be unable to limit the portion of capitation rate payments specific to chiropractic services to General Fund dollars without additional administrative resources. If payment from the Hospital Assessment were permitted, the General Fund estimate would decrease to $2.5 million annually.

Analysis

AHCCCS provides acute care, behavioral health services, and long-term care services for Medicaid-eligible adults and children. The acute care program currently covers chiropractic care for enrollees under age 21 through the federally required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, while individuals age 65 and older receive chiropractic coverage through Medicare. The bill would extend coverage of chiropractic services ordered by a physician or primary care practitioner to AHCCCS enrollees aged 21-64. The benefit would be limited to 20 visits unless the primary care practitioner determines additional visits are medically necessary.

The agency estimates that 7.2%, or 59,800, of AHCCCS' non-elderly adult enrollees would utilize chiropractic services with an average of 7.3 office visits per year. These utilization estimates are based on 2016 ADOA employee health plan data. AHCCCS then applied its fee-for-service reimbursement rates to its assumed utilization rates to estimate the fiscal impact.

AHCCCS estimates the bill would cost $5.2 million General Fund ($26.2 million Total Funds) annually. If the Hospital Assessment were permitted as a funding source, the General Fund share would decrease to $2.5 million annually. The Total Fund increase also includes an estimated $19,900 increase in county long-term care costs.

AHCCCS' estimate may overstate the overall cost of the bill for at least two reasons. First, given that the bill would require AHCCCS enrollees to receive a referral from a physician prior to seeking chiropractic care, the utilization of chiropractic services may be lower in AHCCCS than among state employees, who are permitted to see chiropractors without a referral.

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The net impact of the referral requirement on utilization of chiropractic services by AHCCCS enrollees is unknown. On the other hand, state employees have a required copayment for chiropractic care while many AHCCCS adult enrollees have no copayment. Until January 1, 2018 the state employee copayment for chiropractic care was only $15. The state copayment increased to $40 on January 1, 2018, but the impact of the copayment increase was not part of the AHCCCS analysis.

Secondly, coverage of chiropractic care could result in reduced utilization of prescription drugs and other AHCCCS services used to treat neck and back pain, generating offsetting savings. AHCCCS did not attempt to estimate such offsetting savings in its analysis, as the agency believes any associated cost avoidance would materialize in the long run rather than the short run.

An August 2016 review by the National Academy for State Health Policy on the use of non-pharmacological alternatives for pain management in state Medicaid programs concluded that the cost impact of alternative pain management series compared to conventional pain management strategies "has not been adequately studied," and that the available studies have produced mixed findings. As a result, any estimate of net savings in pain management services associated with coverage of chiropractic care would be highly speculative.

Some initial studies of Medicaid pilot programs in other states that offer chiropractic care to select Medicaid enrollees have suggested that chiropractic benefits could be associated with fiscal savings. Rhode Island's Integrated Chronic Pain Program provides case management services by a nurse trained in chronic pain management for Medicaid-eligible chronic pain patients with at least 4 emergency visits over a year and may include referrals to acupuncture, chiropractic, and massage therapy services as appropriate. A September 2017 study found that the program reduced average medical costs for participating members by (36)% compared to non-participating members. The savings were associated with reduced utilization of opioid and other prescriptions, emergency room visits, and inpatients admissions.

A similar pilot program in Florida allowed certain Medicaid-eligible individuals with chronic fatigue, neck or back pain, or fibromyalgia to receive case management services from a holistic nurse case manager, as well as acupuncture, chiropractic services, and massage therapy. A study initially found a (9)% cost reduction for participating enrollees in the first three years of the program, although there were no costs savings in the subsequent three years.

The savings from these programs, however, cannot be readily extrapolated to Arizona. In both Rhode Island and Florida, chiropractic care was offered as part of a specialized comprehensive pain management program including access to other services (e.g. case management, acupuncture, massage, etc.) and was restricted to certain patient populations. In contrast, the bill would not directly create a comprehensive pain management program and would make chiropractic care available to all adults as long as each enrollee receives a referral from a physician.

Other studies of chiropractic care in non-Medicaid populations have determined that increasing access to chiropractic care increases overall health care expenses. A December 2014 analysis conducted by Compass Health Analytics on behalf of the New Hampshire Department of Insurance studied the impact of cost-sharing on utilization of chiropractic care, as well as secondary impacts on utilization of other medical services. The study found that lower chiropractic copayments were associated with reduced utilization of non-chiropractic services, including reductions in the use of opioid-based medications to reduce pain. Overall medical costs still increased, however, because new spending chiropractic care was greater than the reduction in costs for other services.

As the literature review above suggests, the estimated impacts of chiropractic coverage on utilization of other services varies. The net budgetary effects of any utilization changes are therefore uncertain.

Local Government Impact

The bill would generate an estimated $19,900 in costs for counties as a result of chiropractic services rendered to enrollees in the Arizona Long Term Care System (ALTCS).

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