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The Medicare Maze

By James Edwards, DC

As practicing doctors of chiropractic, we are rightfully justified in our anger and frustration regarding the limited reimbursement and authority we face under Medicare. However, a number of key points must be considered regarding any attempt to fairly "evaluate" this matter, and the potential of the chiropractic profession to resolve it favorably. This is serious for all of us, so I would like to provide you with a thoughtful, candid and detailed assessment of the relevant issues at hand.

First, no one should make the mistake of minimizing the severity of the problems faced by the chiropractic profession in attempting to correct the Medicare injustice. The current situation is discriminatory and harmful to our profession. All of us are well-aware of that fact - and most understand that our current status reflects a deliberate attempt by our opponents and detractors to limit our participation in the program, the origins of which reach back to the active days of the AMA's organized boycott against chiropractic.

The question has been - and remains - how do we go about correcting this situation? As a practical matter, we are negatively impacted in two significant ways: First, it is well-recognized that the underlying statute defining our participation in Medicare is substantially flawed to begin with, in that it is written in such as way as to define DCs as "physicians," in a limited manner, in connection with treatment by means of manual manipulation of the spine to correct a subluxation. Second, in addition to the inherent limitations of the underlying statute, the Centers for Medicare and Medicaid Services (CMS) and its predecessor agencies historically have chosen to interpret the statute in the most narrow way possible, not even allowing doctors of chiropractic to order or furnish services "incident to" the provisioning of the chiropractic adjustment.

Essentially, there are two ways to address these dilemmas. Even under the existing limited statute, our situation and reimbursement could be substantially improved via a reinterpretation of CMS's existing regulations regarding chiropractic care, and the replacement of those regulations with a new set of regulations that would allow doctors of

chiropractic to furnish and be reimbursed for "incident to" services, such as evaluation and management, diagnostic imaging and physical therapy. This improvement could be accomplished without any change to the existing statute; however, it would require the support and agreement of the Department of Health and Human Services (HHS) and, as a practical matter, the concurrence of President Bush's Office of Management and Budget (OMB).

The ACA has pursued a regulatory change of this nature for many years, as one strategy for improving our status under Medicare. However, in the past, no HHS secretary or executive branch - Democrat or Republican - has exhibited any willingness to issue new regulations expanding our coverage under Medicare. In fact, our many attempts to persuade the executive branch have always been met with stiff resistance, and have been strongly opposed by a CMS bureaucracy that has remained sometimes hostile, and largely unconvinced, regarding the desirability of expanding access to chiropractic in Medicare.

Despite being "rebuffed" repeatedly on this issue by the executive branch, the ACA has remained persistent in its attempts to win the issuance of more favorable Medicare regulations that would allow for expanded reimbursement. We are continuing to press the executive branch on this issue, and we are hopeful our efforts will result in a "review" of this issue by HHS. Based on meetings and communications with the executive branch, we will probably know by the end of this summer if any regulatory relief in this area is likely.

A word of caution: A major factor expected to impact the outcome of any regulatory revisitation of this issue will be the estimated added cost (or savings) to the Medicare program (as determined by HHS and OMB) of changing the current regulations to allow for greater reimbursement by DCs. If the price tag is judged to be too high, a regulatory change probably won't be made. In this regard, and at no small expense, the ACA commissioned the collection, development and analysis of additional actuarial data that will soon be submitted to HHS in support of our views.

In addition to the regulatory efforts discussed above, the ACA has long sought a broader, more comprehensive fix to our limited coverage under Medicare that could be achieved by the enactment of new legislation explicitly granting chiropractors authority to furnish and be reimbursed for any Medicare-covered service we are licensed to provide under state law. The ACA has a lengthy track record of introducing and attempting to pass such legislation in Congress. The response to these efforts has been "evolutionary" in nature; early legislative attempts resulted in little congressional interest and limited support for the legislative

change desired by us. Again, however, the ACA has remained persistent in its lobbying attempts, and in recent years, each successive Congress has exhibited a growing level of support for legislating along the lines we have advocated.

While we have not yet succeeded in passing the required statutory change, there have been some notable tactical examples of the growing level of support for our position that has been developed. At one time, there was considerable opposition to our efforts in Congress, because of the policy objective (expanded access to chiropractic care) that would be achieved by the legislation we proposed. Over time, a great deal of this opposition has dissipated, and we have succeeded in building a fairly broad-based level of support for the statutory change we want. For example, most DCs do not realize the ACA was successful in winning a crucial vote in the House Ways and Means Committee (the House committee with jurisdiction over Medicare) to grant doctors of chiropractic full "physician" status in the Medicare program. Unfortunately, our provision was later stripped from the committee-approved bill when the Congressional Budget Office (CBO) subsequently produced an unrealistically high cost "score" (calculation) for implementing the proposal. Similarly, the ACA was successful in winning the inclusion of a pilot program authorizing full "physician" status in the Senate Finance Committee (with jurisdiction over Medicare). This provision also was dropped when the CBO produced an unworkably high estimated cost figure for implementation.

Although none of the two above attempts led to the enactment of the legislation that would expand our reimbursement, I cite them because they are important "benchmarks" and concrete examples of the support we have developed, and of the skills of our legislative team. Today, our problem in enacting the legislation we want has less to do with hard-core "opposition" to our policy goals than the practical politics of "money" and federal "budgetary" issues. Essentially, any proposal to expand our reimbursement will be calculated by the CBO (required by law to develop cost estimates for proposed legislation) as "costing" additional federal dollars. In the case of expanded chiropractic care, the CBO can be expected to produce cost estimates projecting added federal costs of hundreds of millions of dollars per year - even reaching into the billions of dollars in "new costs" over a five-year period. Today, the fight is not so much over whether or not expanded access to chiropractic services is a "good thing" (because of our work, many believe it would be) - but whether or not it is "essential," and whether or not it is worth the "cost" to the federal budget as calculated by the CBO.

Allow me to provide you with a specific illustration of all this. We know from our discussions with HHS that it estimates the cost of reimbursing the current chiropractic benefit under

Medicare to be roughly $500 million per year. (The figure used to be less, but has increased, due in part to ACA's separate efforts to increase rates under the RBRVS payment system.) We also know that HHS roughly estimates that an additional $800 million is paid out-of-pocket by Medicare beneficiaries annually for chiropractic services related to the spinal manipulation benefit.

We have already developed hard data that will challenge these assumptions; however, for the purpose of this illustration, assume for the moment that these figures are accurate. If HHS estimates are accepted as true, then before there are any potential savings accrued to the Medicare program by having chiropractic care substitute for theoretically more expensive medical care (the "substitution" effect), there are at least $800 million in new program costs to Medicare (annually) that must be taken into consideration. Over a five-year period (the timeframe often projected by CBO estimates), the new chiropractic benefit would grow to over $4 billion in additional costs.

If the CBO - which traditionally does not "score" or calculate (give credit for) "substitution" offsets when making its estimates - agrees with this estimate, our congressional supporters are facing a situation in which they have to "justify" the expenditure of at least $4 billion in new money (over a five-year period). You and I might feel this is a worthy expenditure, but realistically, faced with estimates in this range, members of Congress will be forced to ask themselves if the expenditure is "essential." Candidly, we have come a long way in our efforts to convince Congress that it would be desirable, for a variety of reasons, including improved outcomes, patient satisfaction and expanded choice of treatment options, for coverage of chiropractic care to be expanded. Whether it is considered "essential" to spend $4 billion for this expansion is quite another matter.

I hope you can appreciate that, as I said earlier, it is important not to minimize the problems we face. The cost-estimate-issue is real and is the most difficult hurdle with which we must deal. I also will state the obvious - the ACA has collected all the valid, credible research studies that support its case, and has made these studies available to its supporters. Again, not wishing to "sugarcoat" matters, they may or may not prove sufficiently convincing, in terms of coming up with a favorable or more realistic cost projection by the HHS, OMB or CBO.

Despite the difficulties discussed above, I am pleased to inform you that the ACA is currently in direct negotiation with Representative Nancy Johnson, chair of the Ways and Means Health Subcommittee, and Senator Chuck Grassley, chair of the Senate Finance Committee,

regarding the inclusion of an acceptable chiropractic provision to be (ideally) part of a larger legislative package of Medicare reform and prescription drug legislation expected to be unveiled later this spring. This issue is not yet settled, but we hope to include a legislative provision that moves us forward, and at least "pilots" the full "physician" status that would allow DCs to furnish all Medicare-covered services consistent with their state scope of practice.

I hope this information is helpful in understanding the current Medicare issues facing the profession. Please do not hesitate to contact me if you would like any of these matters further clarified.

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