KENTUCKY ASSOCIATION
OF HEALTH PLANS

Medicaid Oversight and Advisory Committee

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MEMBERS ARE GETTING HEALTHIER!

Functions of MCO's include:

- Quality of Care oversight
- Utilization management to avoid un-necessary care which can be harmful to a member.
- Avoid institutionalization and limit exposure to health related errors, harm or infections due to setting.
- Ensuring an adequate and credentialed network of providers (and removing providers who pose threats to members)
- Partnering with organizations to address member needs including Social Determinants of Health
- Engaging with professional organizations to address concerns and problem solve.
- Mobilizing resources during emergencies to assist providers to serve members.
- Guiding health care practices with standards of care and innovation.
- Expecting providers to attend to the health care needs of members in equitable settings, languages, and culturally sensitive ways.

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VALUE OF MANAGED CARE

Program

86% of Kentuckians believe it's important to maintain a strong, sustainable Medicaid program

71% of Kentuckians have a favorable view of Medicaid

1.5M Kentuckians are receiving Medicaid benefits (9 in 10 in managed care)

More than ***90%*** of Managed Care dollars are directly invested in healthcare services for MCD enrollees

Managed Care is estimated to have saved Kentucky taxpayers ***$184M in '16*** and ***$194M in '17***

Quality

Kentucky Managed Care continues to raise quality standards since 2016, including:

9% increase in members controlling blood pressure

18% increase in Cervical Cancer screenings

14% increase in Childhood Immunization Status

34% increase in adolescent Well-Care Visits

Outcomes

82% Expecting Moms receive timely prenatal care

97% Children aged 12-24 months receive at least one annual doctors visit

87% Received care as soon as needed, when care was needed right away

49% Reduced hospitalizations of nonelderly adults

40% Reduced Hospital Readmissions

82% Members rated their Health Plan an 8, 9, or 10

1. Kentucky Value of Medicaid – Medicaid Matters for America (modernmedicaid.org)
2. Potential Savings of Medicaid Capitated Care: National and State-by-State Estimates, July 2017
3. https://chfs.ky.gov/agencies/dms/DMSMCOReports/2020TechReport.pdf
4. https://www.healthy-ky.org/res/images/resources/Final_Report_for_Foundation_2_12_2016-SH-1-.pdf
5. 2016-2020 HEDIS/NCQA Quality Reporting

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BEHAVORIAL HEALTH BENEFITS

Benefit Structure

Managed Care Organizations cover all BH services deemed covered benefits by KDMS State Plan

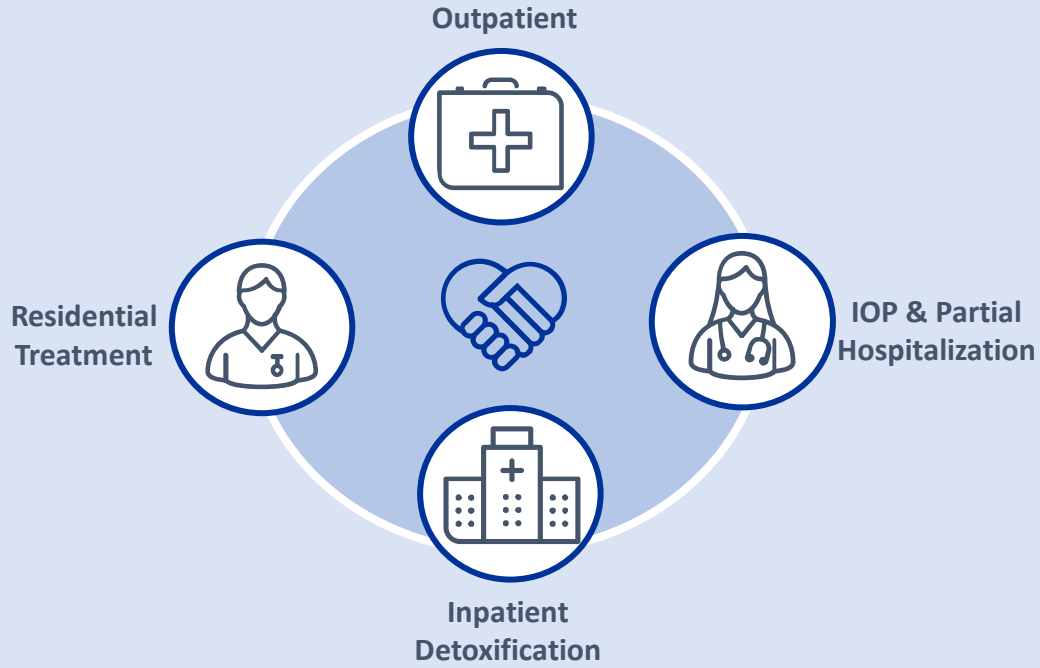
Outpatient, Residential and Inpatient benefits exist for Substance Use Disorder and Mental Health for all age groups of enrollees.

Examples:

- ***Preventative care***
- ***Outpatient services***
- ***Crisis services***
- ***Sub-acute care***
- ***Acute care***

Substance Use Disorder Treatment

All levels of care for SUD treatment are covered benefits for Kentucky Medicaid enrollees



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PRIOR AUTHORIZATION PROGRAM'S PURPOSE

Prior Authorizations are put in place for multiple reasons:

- Member safety and appropriateness of care
- Monitor services that have demonstrated overutilization
- Notification of services to activate care coordination

Mental Health Parity reviews are in place to ensure MCOs and other Insurers are not managing Behavioral Health care in a more restricted manner than Physical Health care

Many Behavioral Health outpatient and preventative services do not require prior authorization, including:

- Individual, group, family therapy; Peer support services; Assessments and screening; MAT office visits

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BEHAVORIAL HEALTH PRIOR AUTHORIZATION IMPACT

Managed Care Impacts of PA Moratorium

Removal of Prior Authorizations for Behavioral Health services ***has adverse impacts*** to Kentuckians

MCOs use many mechanisms to manage care and improve outcomes for members outside of PA activities

Removal of PA activities has many negative impacts to those ancillary functions, including:

- Limits ability to ensure services delivered ***are appropriate and support discharge*** planning
- ***Limits ability to ensure quality*** of services delivered
- Limits ability to monitor for ***Fraud, Waste or Abuse***
- ***Decreases access*** to services for enrollees

Financial Impact of PA Moratorium

Prior Authorization for Behavioral Health services were no longer required effective February, 2020 due to the COVID-19 Pandemic

Since then, MCOs have observed:

- ***Increased costs*** around Behavioral Health services
- Those costs driven by ***increased utilization among enrollees historically receiving services,*** not newly identified Mental Health needs

Main drivers for the increases are related primarily to enrollees with a ***diagnosis of opioid dependence***, including:

- Inpatient/Detox ALOS increases, and
- Residential SUD treatment

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RECOMMENDATIONS

In order to continue with the charge of managing care for Medicaid recipients, improve outcomes and ensure appropriate use of federal Medicaid dollars, Health Plans ***recommend reinstating authorization requirements related to Behavioral Health services.***

Possible strategies may include:

- **Staggering IP before OP** – similar to approach taken with Physical Health
- **Services including inpatient and residential** could be reviewed concurrently vs prior to starting services
- **Select services including substance** use disorder residential should resume PA based on demonstrated misuse or abuse
- **Establish advisory committee** to determine where lack of authorizations and coordination are having most negative impact on member outcomes and program integrity

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Contractual Requirements

- Urban Time & Distance - Thirty (30) miles or thirty (30) minutes from residence
- Rural & Specialists Time & Distance – Fifty (50) miles or fifty (50) Minutes

DMS Oversight - Quarterly MCO Reports

- Provider Service and Network (PSN) – Report 04: Network Adequacy Exceptions Report (Single Case Agreements)
- Provider Service and Network (PSN) – Report 05: Geo-mapping and Access Report
- Provider Service and Network (PSN) – Report 09: Timely Access (Access and Availability Survey)

NCQA Requirements:

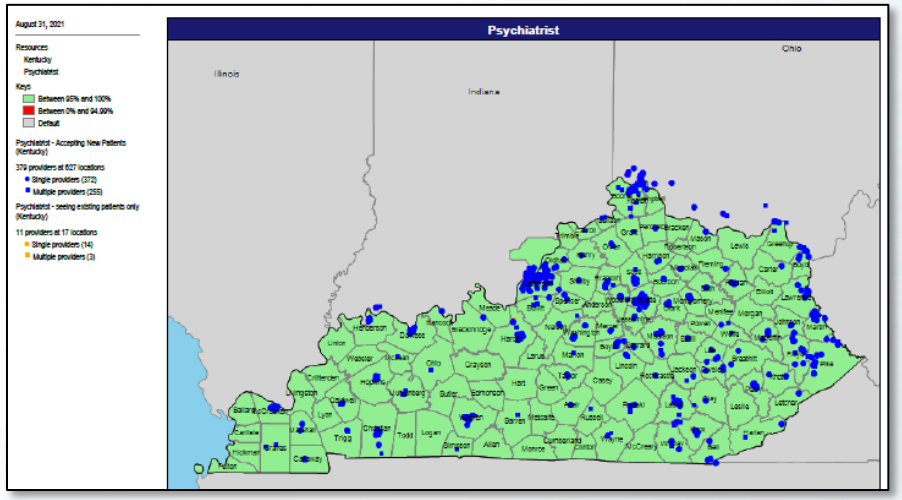
- Network Report 1: Network Availability of Practitioners
- Network Report 2: Appointment Accessibility
- Network Report 3: Assessment of the Provider Network Adequacy

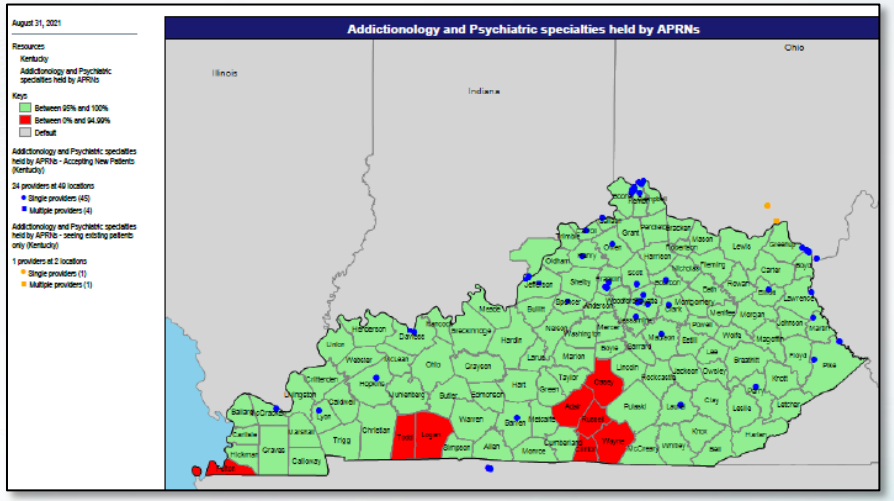
CHAPS Survey – Member Feedback

MCO's engage in Active Recruitment to increase access

TeleHealth and other digital technology is also being used to increase access

Examples pulled from a 47- page report





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TIMELY ACCESS AND AVAILABILITY STANDARDS

Appointment Standards		
Provider type	Appointment type	Contract Standard
PCP	Urgent Care	</= 48 Hours
	Routine Care	</= 30 Days
	Return AH Calls	</= 30 Mins
Pediatrics	Urgent Care	</= 48 Hours
	Sick Care	</= 30 Days
	Return AH Calls	</= 30 Mins
Specialist	Routine Care	</= 30 Days
	Urgent Care	</= 48 Hours
NCQA OBGYN	Next Available Appt	</= 30 Days
	Urgent Care	</= 48 Hours
NCQA Oncology	Next Available Appt	</= 30 Days
	Urgent Care	</= 48 Hours
Behavioral Health	Urgent Care	</= 48 Hours
	Non-Life Threatening Psychiatric Emergency	</= 6 Hours (NCQA) / </= 24 Hours (Contract)
	Inpatient Follow Up	</= 7 Days
	Routine Care	</= 10 Business Days (NCQA) / </= 60 Days (Contract)
	Routine Care Follow Up	</= 30 Days
	Missed Inpatient Appt Follow Up	</= 24 hours (Contract)

KAHP

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