Medicaid Oversight and Advisory Committee
Thursday September 30, 2021

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The Effectiveness and Sufficiency of Substance Use Disorder Treatment and Service Provided or Covered by MCOs.

Good Afternoon, I am Steve Shannon, the Executive Director of KARP, Inc. KARP, Inc. is an association of eleven (11) of the fourteen (14) Community Mental Health Centers (CMHCs). The CMHCs are the behavioral public safety net for serving and supporting individuals in all 120 counties throughout the Commonwealth. The CMHCs provide services and supports to individuals with a mental illness, substance use disorder and/or an intellectual/developmental disability. In a typical year, the CMHCs serve approximately 175,000 or 1 in every 26 Kentuckians: our family members, friends, neighbors, classmates, and co-workers. In addition, CMHCs employ approximately 7,000 individuals across a wide range of job duties and are led by over 300 volunteer, dedicated members of their respective boards of directors. CMHCs make all Kentucky communities better through exceptional services and supports, good jobs and committed community leaders.

I was asked to discuss **"The Effectiveness and Sufficiency of Substance Use Disorder Treatment and Service Provided or Covered by MCOs."** Typically, I discuss the CMHCs but today I will expand my comments to include Behavioral Health Service Organizations (BHSOs) and Alcohol and Other Drug Treatment Entities (AODEs). Clearly, there are two distinct issues to be addressed: one being effectiveness and the other being sufficiency. I want to thank you for this opportunity – as many of you are aware, during the COVID – 19 period, unfortunately, there has been an increase in overdoses. SUD treatment must remain a priority.

The fourteen (14) CMHCs provide SUD services and supports and many have both a CMHC license and an AODE license. For the period SFY 2018 – 2020, the CMHCs served and supported approximately 31,600 individuals annually with a primary SUD diagnosis. SFY 2021, the CMHCs served and supported fewer individuals due to the COVID 19 pandemic. It should be noted the CMHCs report data for all persons served and supported. The data is on the DBHDID website.

Behavioral Health Service Organization

BHSO services are medically necessary services provided by behavioral health specialists through face-to-face interaction with a beneficiary who has a mental and/or substance abuse disorder. It should be noted during the COVID state of emergency, telehealth services are permitted. Services include assessment, service planning, individual outpatient therapy, group outpatient therapy, collateral outpatient therapy and crisis intervention services, family outpatient therapy and other behavioral health services.

BHSO must meet coverage provisions and requirements of 907 KAR 15:020 and 907 KAR 15:022 to provide covered services. Any services performed must fall within the scope of practice for the provider. Listing of a service in an administrative regulation is not a guarantee of payment. Providers must follow KY Medicaid regulations. All services must be medically necessary.

Alcohol and Other Drug Treatment Entity

Alcohol and other drug treatment entity or "AODE" means a nonhospital-based agency owned by an individual or entity that provides one (1) or more of the following services or operates one (1) or more of the following programs:
(a) Outpatient treatment services;
(b) Intensive outpatient services;
(c) Partial hospitalization;
(d) Withdrawal management services, including medication-assisted treatment;
(e) A non-physician owned facility that employs or has an affiliation with a physician or advanced practice registered nurse who provides office-based opiate treatment services to fifty (50) percent or more of the facility's patients;

To determine the sufficiency of the SUD treatment provided by MCOs, the total number of AODEs and BHSOs were counted by county. This information is taken from the CHFS Office of Inspector General list OIG licensed facilities dates September 21, 2021.

Here is some data from the OIG Website, it should be noted this data is licensed providers but does not show how many folks are served, if all MCOs are billable and if they are taking new clients.

AODE Data

There are 588 AODE licensed providers on the OIG licensee spreadsheet. Some of the 588 are CMHCs which also have an AODE license, and some are local Jails and Department of Corrections facilities which currently are not billing Medicaid. Again, all 120 counties are served and supported by one of the fourteen CMHCs.

1. 28 counties do not have an AODE

   a. Crittenden, Livingston, Lyon & Trigg
   b. Bracken, Nicholas & Robertson
   c. Bell & Harlan
   d. Metcalfe & Monroe
2. 30 counties have one (1) AODE
3. 12 counites have two (2) AODEs
4. Nine (9) counties have three (3) AODEs
5. Nine (9) counties have four (3) AODEs
6. 32 counties have five (5) or more AODEs
   a. Floyd has 21
   b. Kenton has 23
   c. Hardin has 28
   d. Fayette has 51
   e. Jefferson has 86

The significance is the is a relatively large number of AODE providers. It should be noted each one of these providers paid $500 to be licensed and an $80 for each additional location. This shows an investment in applying for the AODE license as well as the time and effort to meet licensure requirement.

In conclusion, 92 of 120 KY counties have at least one AODE provider and the vast majority of the 92 counties have both a CMHC and an AODE.

BHSO Data

There are much fewer BHSOs listed on the OIG website. Only 119 BHSOs provide services in 37 of the 120 counties. Again, all 120 counties are served by one of the fourteen CMHCs.

1. Twenty counties have one (1) BHSO
2. 17 counties have more than two (2) BHSOs
   a. Hardin County has seven (7) BHSOs
   b. Kenton Count has nine (9) BHSOs
   c. Fayette County has 19 BHSOs
   d. Jefferson County has 31 BHSOs

Hardin, Kenton, Fayette, and Jefferson counties represent more than half of all licensed BHSOs.

It should be noted some BHSOs may focus on serving and supporting individuals with a mental illness, substance use disorder or co-occurring mental illness and substance use disorder.

Again, 119 organizations opted to get a BHSO license at an initial expense of $750 and $500 each year thereafter.

There are fourteen CMHCs, 588 AODEs and 119 BHSOs on the OIG website. I know the CMHCs are Medicaid providers, and all have contracts with the six (6) MCOs and suspect the majority of AODEs and BHSOs have contracts with some or all the MCOs. Being an AODE or BHSO shows the public that you are licensed and may be

useful for commercial insurance but since AODE and BHSO is a KY license status, commercial insurance may not be as familiar with them. It appears the value is being able to bill Medicaid and the MCOs.

It is safe to conclude there are many Medicaid and MCOs providers in the pool of AODE and BHSO license holders.

The raw numbers speak to sufficiency of the MCO networks but that is not the only criteria which must be evaluated. Sufficiency must include the array of services which are available at each AODE and BHSO and the number of people served and supported by each license holder. For example, are all license entities accepting new individuals, is a full continuum of service options available including Medication Assisted Treatment and residential alternatives. I can answer that question for CMHCs, many provide MAT or partner with a community MAT provider as well as have residential SUD services. I do not know that information about AODEs and BHSOs.

Effectiveness of Treatment

The next issue is the Effectiveness of Treatment – **Treatment Works, People Recover and Get Their Life Back!** Treatment works regardless of the payor!

I think there are two broad issues which negatively impact effective. The first being staffing, and specifically sufficient staff to provide a full array of quality services and supports. I know staffing challenges have been discussed by several committees, but I would be remiss if I did not reiterate staffing challenges in SUD treatment services.

The second broad issue is basic reimbursement rates for services and supports. I believe reimbursement rates need to be adequate to meet the program expectations. Not all rates paid by Medicaid and the MCOs meet this criterion.

The concern is ***"can some managed care business practices negatively impact the effectiveness of treatment?"*** I think the answer is Yes, they can and do.

It should be noted, and appreciation extended to CHFS and DMS for having suspended and continue to suspend prior authorization requirement for behavioral health services and supports during COVID state of emergency. This has allowed individuals to access services and supports.

The primary concern I hear from a wide range of SUD providers pertains to prior authorization requirement and resulting utilization management established within provider organizations. It may not be the intent to impact access to effective care, but the prior authorization process does result in reduced access to some levels of care. These services might be more intensive, therefore more costly, levels of care of individuals with a SUD but they may not be readily available when needed.

Providers learn what services and supports are more readily approved during the prior authorization process. This can result in some providers focusing on the provision of services and supports which can be approved as expeditiously as possible. Ideally, the services and supports meet the needs of the individual as well. But is seems unrealistic to believe that is the case 100% of the time. Again, this is a learned behavior.

Another concern is “does the prior authorization process delay access to services.” Any delay in access may result in the individual opting to not to go to treatment. It may appear counter intuitive but deciding to go to treatment is really a brave decision. The individual is saying I have had enough and need to change. Change is really hard. If the individual’s decision is made but access is delayed only negative things can happen. Reconsideration of the treatment decision often results in not going to treatment. Again, this is not the intent of the prior authorization business practice, but it is an outcome, even if the outcome impacts only 1%, 5% or 10% of Medicaid/MCO members, it is a real issue for that individual and his or her family.

An additional concern relating to effectiveness of treatment is some treatment programs, primarily residential, changed their treatment model as a result of managed care. For example, a ninety to one hundred-eighty-day SUD residential treatment program for adolescents was reduced to 28 days. The completion rate may be the same or even higher with a shorter program but what about the outcome for the individual?

Effectiveness needs to be measured in outcomes and what are the outcomes we all want from SUD treatment? One is Recovery, we want everyone to be Sober, Clean and have a great life. This is a great outcome; however, addiction does not fit that mold the first time someone goes to treatment, intensive supports and repetition are paramount. We need to have mechanisms that get individuals to support each time they are needed.

In closing, we need to recognize the great work of ODCP, KY ASAP, KY Opioid Response Effort, the KY Recovery programs, Substance Abuse Treatment and Prevention Block Grant, Bridge Clinics at ERs, Recovery Housing and Recovery Centers. These are supports which supplement Medicaid but are much needed throughout the Commonwealth.

We need to be ready to act when someone makes that very brave decision to get help – they have had enough and we as a system cannot add to their burden. **Get Help, Treatment Works, Recovery is Real!**