TEAM KENTUCKY®

CABINET FOR HEALTH AND FAMILY SERVICES

Medicaid Oversight and Advisory Committee
Budget Overview for the Department for Medicaid Services
November 10, 2022

Eric Friedlander, Secretary
Lisa Lee, Commissioner

Kentucky Medicaid at a Glance

- Approximately 1,691,695 members
  - 138% of Federal Poverty Level: $18,754
- Over 69,000 enrolled providers
- $15.1 billion in total SFY 2022 expenditures
  (Administrative and Benefits combined)

Medicaid Benefits Budget

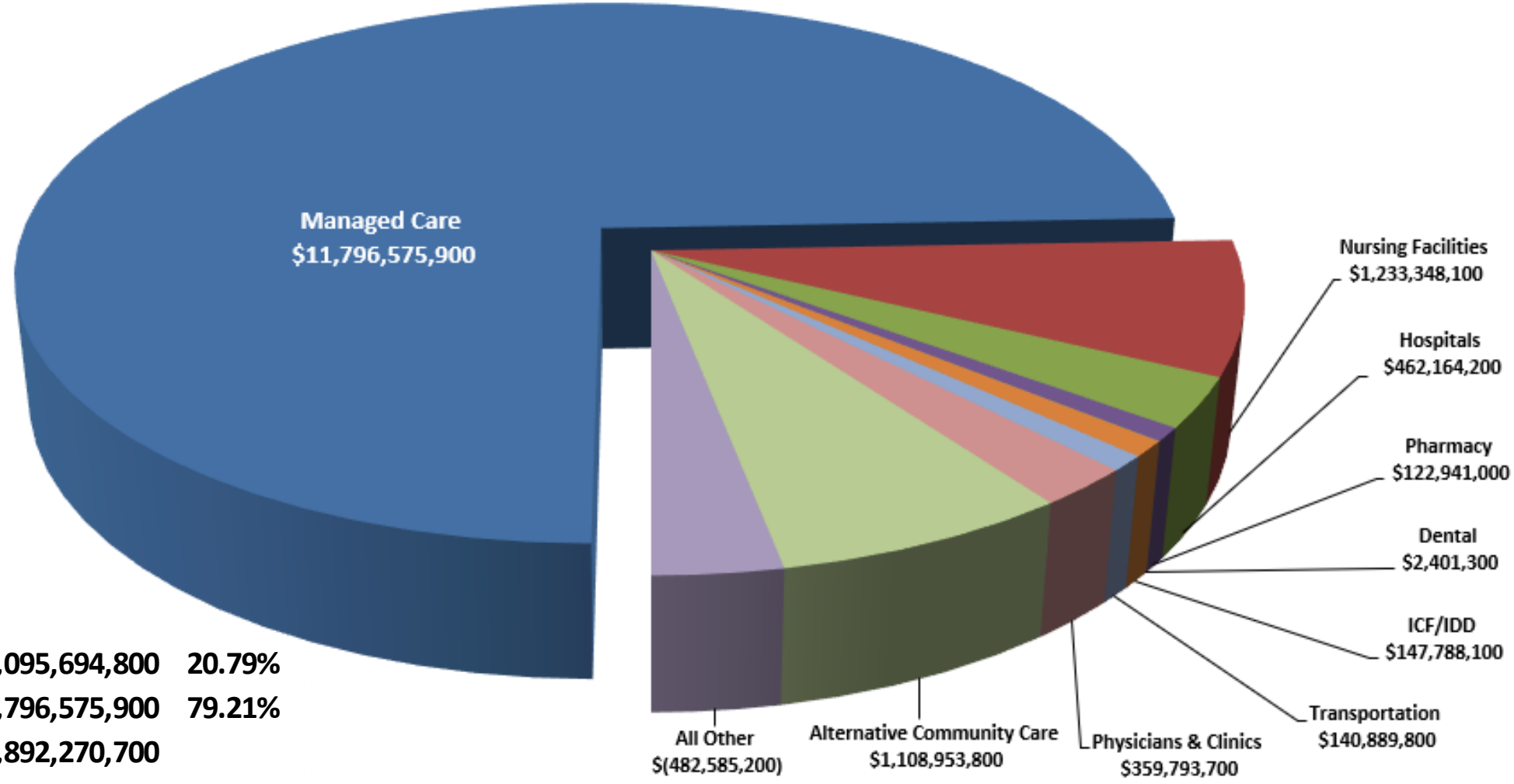
Benefits w/KCHIP (Dept 748)

	SFY 2021 ACTUAL	SFY 2022 ACTUAL	SFY 2023 Budgeted	SFY 2024 Budgeted
General Fund	$2,018,893,700	$1,934,395,200	$1,962,892,300	$2,402,688,700
Restricted Agency Funds	$662,841,900	$599,576,300	$1,586,012,300	$1,383,080,900
Federal Funds	$11,703,230,300	$12,358,299,200	$11,723,695,600	$12,061,242,200
TOTAL	$14,384,965,900	$14,892,270,700	$15,272,600,200	$15,847,011,800

SFY 2023 Expenditures to Date

	Enacted Budget SFY 2023	SFY 2023 Expenditures (through October 2022)	Percent of Enacted Budget
Federal	$11,723,695,600	$4,089,207,900	34.88%
State	$3,548,904,600	$881,556,800	24.84%
Total	$15,272,600,200	$4,970,764,700	32.55%

Medicaid Benefits Budget



Total FFS:	**$3,095,694,800**	**20.79%**
Total MCO:	**$11,796,575,900**	**79.21%**
Grand Total:	**$14,892,270,700**	

Medicaid Benefits Budget

Approximately 22% of MCO payments are related to directed payments

	SFY 2020	SFY 2021	SFY 2022	SFY 2023 (to date)	Total
Hospital Rate Improvement Program (HRIP)	$98,359,800	$781,227,100	$1,145,677,000	$251,258,600	$2,276,522,500
Ambulance Provider Assessment Program (APAP)	$0	$26,248,700	$41,463,500	$14,863,300	$82,575,500
University Directed Payment	$831,091,500	$1,162,908,100	$1,435,465,600	$409,592,500	$3,839,057,700
	$929,451,300	$1,970,383,900	$2,622,606,100	$675,714,400	$6,198,155,700

Medicaid Waiver Expenditures

	SFY 2021	SFY 2022	Increase/Decrease	% change from 2021	SFY 2023 (Thru Sept)
Supports for Community Living Waiver	$ 384,843,900	$ 395,915,100	$ 11,071,200	2.88%	$ 119,924,600
Michelle P Waiver	$ 333,053,200	$ 346,373,800	$ 13,320,600	4.00%	$ 95,879,900
Home & Community Based Waiver	$ 17,229,100	$ 18,976,400	$ 1,747,300	10.14%	$ 7,471,400
Adult Day Care Waiver	$ 202,120,400	$ 265,984,600	$ 63,864,200	31.60%	$ 119,818,500
Brain Injury Waiver	$ 29,211,300	$ 26,760,500	$ (2,450,800)	-8.39%	$ 7,629,800
Brain Injury Long term Care Waiver	$ 27,810,000	$ 31,168,500	$ 3,358,500	12.08%	$ 10,260,900
	$ 994,267,900	$ 1,085,178,900	$ 90,911,000	9.14%	$ 360,985,100

- In aggregate, the six Medicaid Waiver programs experienced a $90.9m (9.14%) increase in total expenditures in SFY 2022 when compared to SFY 2021
  - The decrease in Brain Injury was due to decreased utilization due to COVID in early part of SFY 2022

- The spending plan has been submitted to the Center for Medicare and Medicaid Services (CMS) and the Department for Medicaid Services (DMS) is currently awaiting to receive federal approval to reallocate the increased HCBS FMAP to provide the 10% rate increase across all waivers as detailed in the SFY 2023 budget

Anticipated Future Appropriations

- 2023 legislation that directs Medicaid to increase provider reimbursement or add services

  Additional Federal Fund Appropriations are needed for SFY 2023 due to the 6.2% FMAP for the Public Health Emergency (PHE) being extended past what was assumed in the biennial budget

Public Health Emergency Related Changes

Change	SFY 2020	SFY 2021	SFY 2022	SFY 2023 (to date)	Total	
Nursing Facility $29 Add-on	$0	$54,367,400	$144,325,700	$55,393,100	$254,086,200	Mandatory per State Budget Bill
Nursing Facility $270 Add-on for Covid Positive Patients	$776,400	$16,225,900	$7,641,600	$3,330,300	$27,974,200	Optional
COVID Bed Reserve Increase	$0	$924,400	$1,075,100	$356,200	$2,355,700	Optional
Hospital DRG 20% for discharges (FFS)	$701,700	$6,741,700	$6,346,100	$757,500	$14,547,000	Optional
	$1,478,100	$78,259,400	$159,388,500	$59,837,100	$298,963,100	

Public Health Emergency Related Changes

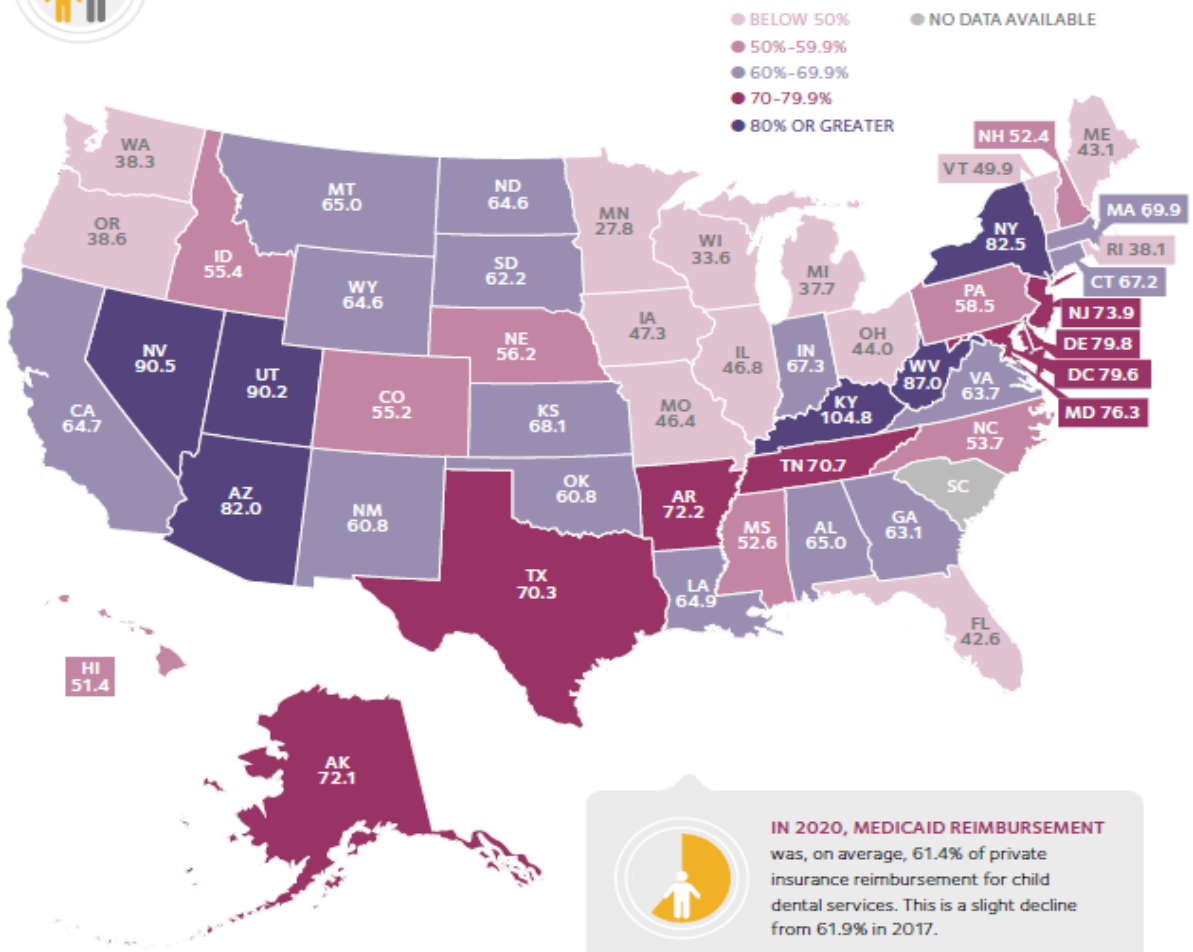
- Maintenance of Eligibility Effort (MOE) (mandatory)
  - Federal requirement that states maintain eligibility standards for Medicaid and the Children's Health Insurance Program (CHIP) to receive 6.2% enhanced federal matching funds
  - If eligibility is not maintained through the end of the public health emergency (PHE), the state would have to return all of the enhanced funds that were received for the entirety of the PHE
- Other flexibilities (optional)
  - Telehealth
  - Waived requirement on limit of inpatient beds to 25 for critical access hospitals
  - Waived face-to-face visit, new physicians order, and medical necessity documentation to replace durable medical equipment
  - Expanded settings for adult day training and adult day health to be provided in-home

Vision, Hearing, and Dental Benefits for Adults

Vision, Hearing, and Dental Adult Benefits

- Medicaid currently limits coverage of vision, hearing, and dental benefits for adults
- New services added to promote workforce participation and improve overall health
- Beginning January 1, 2023, Medicaid will cover:
  - One pair of glasses or contact lenses per year
  - Hearing aids
  - Two cleanings per year instead of one, root canals, crowns, and dentures
- Reimbursement for new adult dental benefits will mirror child-specific fee schedule for dental

MEDICAID REIMBURSEMENT AS A PERCENTAGE OF PRIVATE INSURANCE REIMBURSEMENT FOR CHILD DENTAL SERVICES, 2020



IN 2020, MEDICAID REIMBURSEMENT was, on average, 61.4% of private insurance reimbursement for child dental services. This is a slight decline from 61.9% in 2017.

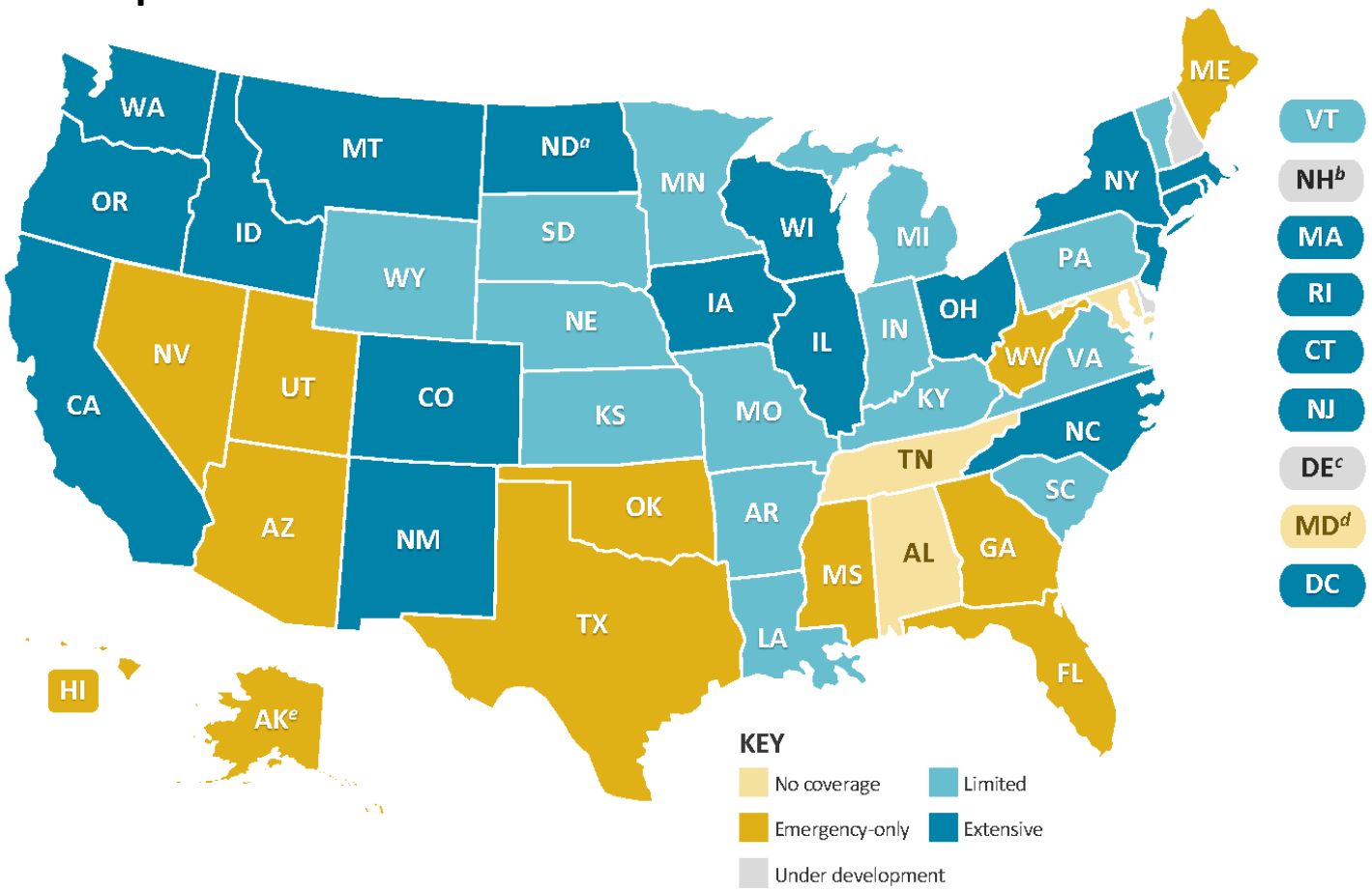
Ratios ranged widely by state, from 27.8% in Minnesota to 104.8% in Kentucky in 2020.

FOR DATA AND METHODS, and to view the reimbursement ratios for all states for 2017 and 2020, see this Data Table.

IN 2020, MEDICAID REIMBURSEMENT was, on average, 61.4% of private insurance reimbursement for child dental services. This is a slight decline from 61.9% in 2017.

Ratios ranged widely by state, from 27.8% in Minnesota to 104.8% in Kentucky in 2020.

State Medicaid Coverage of Adult Dental Benefits, September 2019



Covered Dental Services for Adults Includes:

- Oral Exams
- Emergency Visits
- X-rays
- Extractions
- Fillings

Source: Center for Health Care Strategies

What Dental Services do Kentucky Medicaid Beneficiaries Utilize?

Top Ten Dental Procedures Performed for Kentucky Medicaid Beneficiaries, Ranked by Total Spend (2020-2021)

Rank	Procedure Code	Procedure Description	Count of Beneficiaries	Total Spend per CPT Code
#1	D8080	Comprehensive orthodontic treatment of the adolescent dentition	11,421	$22,228,051
#2	D1120	Dental prophylaxis (child)	346,866	$22,174,888
#3	D0150	Comprehensive oral evaluation	468,606	$15,439,608
#4	D2392	Resin-based composite – 2 surfaces (posterior)	114,785	$13,975,123
#5	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	107,293	$12,139,854
#6	D2930	Prefabricated stainless steel crown – primary tooth	35,603	$11,734,956
#7	D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	50,955	$11,652,548
#8	D0330	Panoramic radiographic image	248,564	$10,037,261
#9	D1110	Dental prophylaxis (adult)	203,563	$9,996,626
#10	D8670	Periodic orthodontic treatment visit	9,956	$9,608,025
Total Spend on Top Ten Dental Procedures (2020-2021)				**$138,986,941**

These top ten procedures accounted for 56% of the total spend on dental services during the 2020-2021 period

Total Dollars Spent on Dental Care (2020 – 2021) = $248,287,212

Source: CHFS Office of Data Analytics

Vision, Hearing, and Dental Adult Benefits

- Funded through savings from increased savings generated by implementing SB50 related to single pharmacy benefit manager (PBM) through drug rebates
- Anticipated recurring savings of $38 million per year
- Cost:
  - $36,875,000
    - $31,268,700 federal
    - $5,606,300 state

Proposal to Transition Members with Third Party Liability to Fee-for-Service

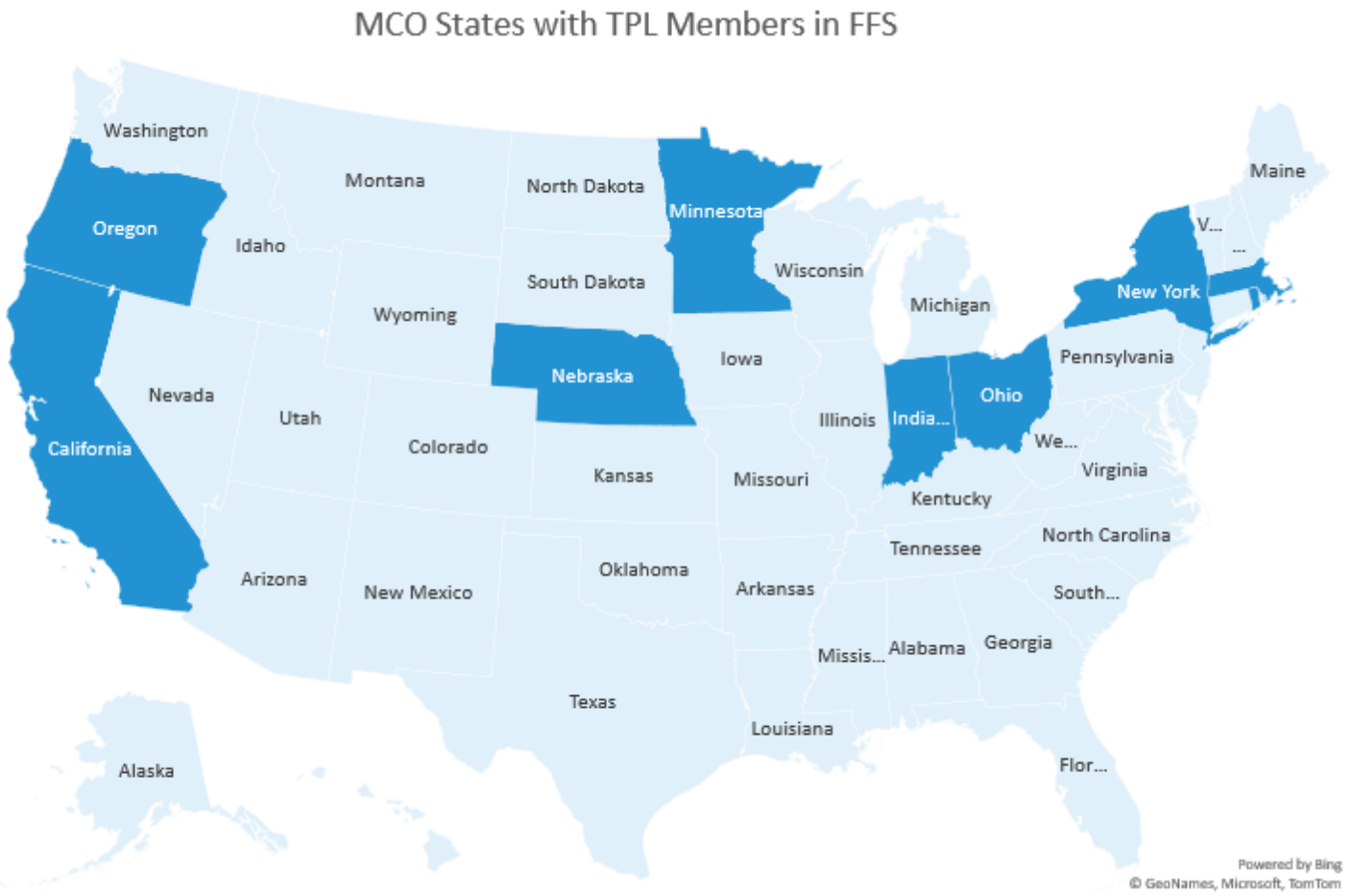
Transition of Members with Third Party Liability (TPL) to Fee-for-Service (FFS)

- Approximately 90,000 managed care organization (MCO) members with third party liability (TPL) identified in Medicaid information system
- MCO average capitation payment $6,535 per member/per year
- Proposal to move members with TPL to FFS based on:
  - Coordination of benefits compliance
    - MCOs required to report and verify TPL – current information and data file errors
    - FFS has robust and accurate system for identifying TPL
  - Reduce provider administrative burden
    - Commercial and Medicare Bypass Lists especially for behavioral health services
  - Cost savings
    - Capitation rate versus claim expenditure
    - Leverage Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program
  - Excludes members in SKY

Data as of March 2022

MCO States with TPL in Fee for Service (FFS)

The map below shows the MCO states which utilize the Fee-For-Service model for Medicaid members who are enrolled in Third-Party-Liability.



MCO states with TPL in FFS:
California
Indiana
Massachusetts
Minnesota
Nebraska
New York
Ohio
Oregon
Rhode Island

QUESTIONS