Kentucky Outpatient Behavioral Health Network Inadequacy

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ABA Advocates

Bluegrass Center for Autism

Intrust

Kentucky Health Resource Alliance

Kentucky United Methodist Homes

Key Assets

Maryhurst

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Kentucky Network Adequacy Standards

KRS 304.17A-515 Requirements for managed care plan

- (1) A managed care plan shall arrange for a sufficient number and type of primary care providers **and specialists** throughout the plan's service area to meet the needs of enrollees. Each managed care plan shall demonstrate that it offers:
- (e) A provider network that meets the following accessibility requirements:
  - 1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence or work, to the extent that services are available; or
  - 2. For areas other than urban areas…all other providers shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available.
- (3) A managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care.

Kentucky Network Adequacy Standards

907 KAR 17:015 Managed Care Organization requirements and policies related to providers.

- (7) Appointment Wait Times.
  - (a) ..an appointment wait time for a primary care provider, **behavioral health provider**, specialist, or dental, general vision, laboratory, or radiological service **shall not exceed thirty (30) calendar days** from the date of an enrollee's request for a routine or preventive service.

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Federal Network Adequacy Regulations

42 CFR 438.206

- Each State must ensure that **all services** covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a **timely manner**.

42 CFR 438.68 (New Compliance Standards)

- Standards must be established for routine appointments for the following services and within the specified limits: (i) If covered in the MCO's, PIHP's, or PAHP's contract, outpatient mental health and substance use disorder, adult and pediatric, within State-established timeframes but **no longer than 10 business days from the date of request.**
- At a minimum, a State must develop a quantitative network adequacy standard, other than appointment wait times, for the following provider types, if covered under the contract…(iii) **Mental health and substance use disorder**, adult and pediatric.

Centers for Medicare & Medicaid Services (CMS) Letter to Kentucky's ABA Advocates (August 2025)

- In managed care, federal regulations include requirements for states to "ensure that their contracted Medicaid managed care plans have the capacity to serve expected enrollment in their service area and maintain a sufficient number, mix, and geographic distribution of providers."

Network Inadequacy Realities

- The average wait time for outpatient mental health care has nearly doubled in just two years extending now to 77 days in 2025 (Children's Alliance Provider Survey)

- For vital intervention services such as applied behavioral analysis (ABA), average wait times stretch past several months–sometimes exceeding a year–and wait lists tower into the hundreds. (ABA Advocates Member Analysis)

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Network Adequacy Measure Discrepancies

How does MCO network adequacy methodology…

- Account for appropriate ratios for each provider type?
  - MCO Master Agreements specify that "enrollee to PCPs ratios shall not exceed 1500:1 FTE Provider" but do not provide a standard for other required provider types.
- Identify how much capacity a provider has available for each MCO's members
  - 100% of an in-network provider's capacity is not reserved for a single MCO
- Account for providers with an active license who are not practicing?
  - i.e. licensees in operational/management roles, licensees in educational roles, licensees in advocacy roles, etc.
- Account for the difference between a provider accepting new patients to be served immediately and accepting new patients to be placed on a waitlist?
  - Does a secret shopper asking "Are you accepting new patients?" make this distinction?

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Kentucky Outpatient Behavioral Health Rate Setting Regulations

907 KAR 15:015. Reimbursement provisions and requirements for behavioral health services

- Section 2. Reimbursement–(2) Except as provided by subsection (3) of this section, the rate per unit for a covered service shall be: (a) **Seventy-five (75) percent of the rate** on the Kentucky-specific Medicare Physician Fee Schedule for the service…
- Not all codes on the Kentucky Medicaid Behavioral Health and Substance Abuse Services Outpatient Fee Schedule appear on the Kentucky-specific Medicare Physician Fee Schedule. No standard reimbursement methodology exists for these codes, which include Targeted Case Management (TCM), Community Support Services (CSS), and Applied Behavior Analysis (ABA)

Behavioral Health Reimbursement Rate Adjustment Timeline

The Kentucky-specific Medicare Physician Fee Schedule is updated annually. Therefore the Kentucky Medicaid Behavioral Health and Substance Abuse Services Fee Schedule is also updated annually. Over time this has resulted in…

- Flat or minimal increases and occasional reductions due to changes in Medicare
  - Kentucky DMS has held harmless reductions in some behavioral health codes including the Individual Therapy code, which was slated for a reduction the past two years. That code did receive a minimal increase in 2025.
  - Some codes–mainly those NOT on the Medicare Fee Schedule–were increased by 4.6% based on a "healthcare cost index"
- An inefficient and fraught rate change implementation process.
  - Historically the updated fee schedule would be published sometime in February, March, or April with a January 1st effective date, creating significant rebilling burdens and costs, MCOs update their fee schedules on different timelines etc.
  - Moved to an April 1st effective date in 2024 which helped for one year - Posted March 11, 2024
  - In 2025 the fee schedule was posted in July with an April 1st effective date
- Labor and operational costs radically outpacing reimbursement rates
  - Providers report that labor costs have increased on average 30% since 2021 and year over year nearly double digit inflation for other costs

Reimbursement Rate Surrounding States Comparison

Kentucky's Outpatient Behavioral Health Rates are **below all seven border states**–some by as much as 40%–and do not sufficiently cover the cost of high quality care. Providers are unable to compete for, recruit, and retain the necessary staff to meet the demand for services, creating significant waiting lists.

- Individual Therapy
  - **KY - $89.91/hour ($29.74 lower)**
  - AVG border states - $119.65/hour
- Family Therapy
  - **KY - $60.71 ($34 lower)**
  - AVG border states - $94.71
- ABA Direct Service
  - **KY - $47.08 ($10.92 lower)**
  - AVG border states - $58
- ABA Supervision/Modification
  - **KY - $85 ($26.55 lower)**
  - AVG border states - $111.55

*Children Alliance Contiguous State Rate Analysis
**ABA Advocates Contiguous State Rate Analysis

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MCO Reimbursement Rate Setting Regulations

- 907 KAR 15:015. Reimbursement provisions and requirements for behavioral health services––Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to: (1) 907 KAR 15:010; and (2).

- MCOs are required to **negotiate rates with providers** in order to meet regulatory Network Adequacy Standards. However, providers most frequently experience MCOs referencing the KY traditional Medicaid Fee Schedule–which is woefully inadequate–rather than negotiating rates.

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Recommendations to Achieve Network Adequacy Compliance

1. Amend Kentucky Outpatient Behavioral Health Fee Schedule reimbursement rate methodology to prevent arbitrary and harmful automatic reductions of 25% from the Medicare Fee schedule.

2. Increase codes that are not on the Medicare Fee schedule by 25% for consistency and fee schedule integrity.

3. Perform the required analysis to determine the level of reimbursement needed to meet network adequacy standards set forth in federal regulations. **Adjust reimbursement rates accordingly**.

4. Hold MCOs accountable to federal regulations, state statutes/regulations, and DMS contract terms requiring the negotiation of rates to meet access standards.

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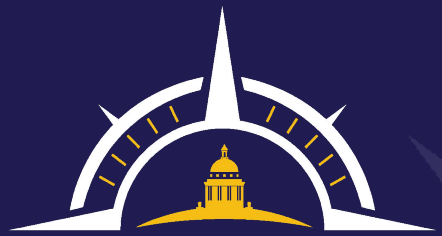

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