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Family Services

Advisory Council for Medical Assistance

Medicaid Update

July 13, 2020

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TEAM KENTUCKY

MANAGED CARE ORGANIZATIONS
EFFECTIVE 1/1/2021

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MCOs Beginning 1/1/2021*

- Aetna Better Health of Kentucky
- Humana
- Molina Healthcare
- United HealthCare
- WellCare of Kentucky

All current MCO contracts have been extended until 12/31/2020

*Subject to pending protest

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TRANSFORMING THE MEDICAID MANAGED CARE PROGRAM

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2021 MCO Contract

- One MCO for Supporting Kentucky Youth (SKY) serving foster children and dually committed youth

- Contract Term
  - Effective January 1, 2021
  - Four additional 2 year renewal periods
  - Must meet contract requirements by October 1, 2020

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2021 MCO Contract

- Subcontractors
  - Department can approve or deny delegation to any subcontractor
  - Must have appropriate training, education, credentials, experience, and liability coverage to fulfill responsibilities
  - MCO must share third party liability information with subcontractors that are responsible for payment of covered services
- Quality
  - MCO expected to support Kentucky's goals to transform Medicaid program
  - Expanded requirements for ongoing monitoring of performance to address outcomes and identify needed adjustments

2021 MCO Contract

- Utilization Management
  - Requires criteria will be transparent and based on scientific evidence
  - Incorporates telehealth requirements based on KRS 205.5591

- Pharmacy
  - Specifically requires compliance with SB5 requirements
  - Ensures state can claim and maximize rebates on physician administered drugs
  - Changes preferred drug list review from 3 years to annually
  - Removes the MCO/PBM ability to charge hidden fees
  - Implements a single pharmacy drug list
  - Requires pass through pricing vs spread pricing – creating more transparency with regard to Pharmacy Benefit Manger (PBM)
  - Anticipates modifications based on SB50 requiring single PBM

2021 MCO Contract

- Provider Services
  - Requires compliance with KRS 205.532 for credentialing verification organization
  - Adds topics to education requirements
- Provider Network
  - Updates accessibility requirements to comply with KRS 304.17A-515
  - Prohibits MCO from automatically enrolling providers in any other product offered by the MCO
  - Expands requirements for notice of provider termination to the Department and requires an exit survey
  - Improves provider network information for enrollees by timing notice of provider network changes to coincide with provider termination notices

2021 MCO Contract

- Case Management
  - Includes a Population Health Management (PHM) program to hold the MCOs accountable for addressing care needs
  - Specifies conditions and populations as priority based on the highest needs in the Commonwealth
- Reporting
  - Requires MCOs to participate with the Department to develop a reporting package that include comparable data across all MCOs
  - Requires specific telehealth reporting

2021 MCO Contract

- Remedies for Violation, Breach, or Non-Performance of Contract
  - Expands language to further define Department's rights and decisions in addition to MCO responsibilities
  - MCO must maintain a $30 million performance bond throughout the life of the contract

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COVID-19 UPDATE

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Medicaid Actions

- Beneficiaries
  - Waived all cost sharing
  - MCOs and FFS waived prior authorization requirements except for some pharmaceuticals
  - Expanded telehealth, including but not limited to:
    - Well childcare visits
    - Behavioral health
    - Substance use services
    - Case managers in Home and Community Based waivers
  - Allowed for care in alternative settings

Medicaid Actions

- Hospitals
  - Allowed hospitals to bill for administrative days
  - Increased DRG rates by 20% for treatment of COVID19 patients
  - Distributed DSH funds to hospitals in May rather than September

Medicaid Actions

- Long-Term Care Facilities
  - Increased reimbursement by $270 per bed per day for any COVID-19 patient they treat
  - Increased bed hold days from 14 to 30 days
  - Allowed self-attestation for Medicaid eligibility
  - Cabinet provided free testing for every facility - every patient and employee has been tested
  - Cabinet fulfilled PPE requests

Medicaid Actions

- Other Actions
  - Allowed temporary provider enrollment if the provider was enrolled in Medicare or was enrolled in another state Medicaid program
  - Suspended recoupment of overpayments upon request from provider
  - Received approval from CMS for the Cabinet to assign Presumptive Eligibility to ensure providers could receive reimbursement for services provided

Fiscal Impact

- Telehealth
  - Fee for Service
    - January, 2020 – billed $13,649
    - May, 2020 – billed $3.9 Million
  - MCO
    - January, 2020 – billed $370,000
    - May, 2020 – billed $19 Million
- DRG 20% increase - $483,000
- NEMT Increase – approx. $700,000

Fiscal Impact

- Prior Authorizations
  - Prior to COVID-19 with PAs – approximately 5,000 services provided per month
  - Since COVID-19 with no PAs – approximately 10,000 services provided per month
  - DMS has notified MCOs they may begin requiring PAs effective August 1, 2020, except for BH and SUD services

- Increase in Semi-Private room revenue code since COVID-19 is approximately $6 million per month.

Other Information

- Since 3/2/2020, Medicaid enrollment has increased by 182,878
  - 84,233 Presumptive Eligibility

- FMAP increase of 6.2%
  - Intended as a means of providing fiscal relief to state Medicaid agencies to offset the costs of increased enrollment and expenditures related to COVID-19
  - States must meet certain conditions to receive including, but not limited, to:
    - Maintaining eligibility (no disenrollments)
    - Waiving premiums
    - Covering all costs of COVID-19

POST COVID-19

- When the COVID-19 State of Emergency is over, DMS will be looking at ways to improve Medicaid. Some questions will include:
  - Which flexibilities do we want to continue beyond the pandemic?
  - How can we build a better healthcare system?
  - How can we better deliver care after the pandemic?

- We will be reaching out to our providers and beneficiaries as we begin to explore these, and other, questions.

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