

# TEAM KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

## STATE UNIVERSITY PARTNERSHIP POLICY BRIEF

### Quantifying Medicaid policies aimed at increasing health equity: A comparative study over time

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#### What is Known on This Topic?

The COVID-19 pandemic had a huge impact on the utilization of health care services and resources. A number of Kentucky Medicaid policies were implemented during the COVID-19 public health emergency (PHE) to help expand eligibility and health care access across the commonwealth.

#### What Did This Project Do?

Health care service utilization was used as a measure of effectiveness for PHE policies related to telehealth and continuous enrollment (CE). Longitudinal changes in utilization rates before and during the PHE period were analyzed and compared for different communities of beneficiaries.

#### What could Medicaid do with these findings?

This study's findings indicate that the utilization of many health care services increased during the PHE period, despite some initial decreases at the start of the pandemic. However, utilization of several services did differ across Kentucky Medicaid regions. Implementing targeted changes that address specific challenges and barriers to health care access within regions that underutilize services would improve health equity.

### Introduction

On March 6, 2020, Kentucky declared a state of public health emergency (PHE) in response to the outbreak of the COVID-19 virus. During this PHE, changes to Medicaid policies were permitted to address the needs of enrollees during the pandemic.<sup>1</sup> As a result, Kentucky expanded beneficiary eligibility, allowing hundreds of thousands of residents to gain health insurance. Several other Medicaid policies were also implemented during the PHE to help enhance patient care and ensure access to health care coverage and support.<sup>2</sup>

For many Kentucky Medicaid beneficiaries, the utilization of health care services was greatly impacted during the COVID-19 pandemic. However, the extent and severity of these impacts likely differed based on the race, ethnicity, and socioeconomic backgrounds of individuals. Therefore, the goal of this project was to examine whether the changes in health care service utilization before and during the PHE period were similar for different communities of enrollees. Using utilization rates as a measurement of effectiveness, two Medicaid PHE policy areas were assessed: telehealth and continuous enrollment (CE).

### Methods

Medicaid claims data were extracted between the period of January 1, 2018, to December 31, 2022. Subjects were included in the study cohort if they were between the ages of 19 to 64 years old and had a history of service claims for each year of the study.

The claims data was divided into three separate time periods as follows: pre-PHE (January 1, 2018 – December 31, 2019), start-PHE (January 1, 2020 – December 31, 2020), and intra-PHE (January 1, 2021 – December 31, 2022). Utilization was obtained based on ten health care service categories of interest: Home, Hospital Emergency Department (ED), Hospital Inpatient (IP), Hospital Outpatient (OP), Lab, Mobile Unit, Office, Pharmacy, Telehealth, and Urgent Care. Overall (total) yearly claim counts were summarized as "number of claims per 100 beneficiaries" and changes in yearly service utilization were compared longitudinally between pairs of time periods: either start-PHE minus pre-PHE (Start-Pre), intra-PHE minus start-PHE (Intra-Start), or intra-PHE minus pre-PHE (Intra-Pre).

### Results

The start-PHE period captures the initial impact of the COVID-19 pandemic. As displayed in Figure 1, six of the ten considered services had decreases in utilization from pre-PHE to start-PHE. While most of these utilization decreases were less than -50 claims per 100 beneficiaries, Office and Hospital OP services had larger declines of -166.0 and -331.7 claims per 100 beneficiaries, respectively. Home, Hospital IP, Lab, and Telehealth services all had increases in utilization during the start-PHE period. Telehealth had the largest growth of 292.9 claims per 100 beneficiaries.

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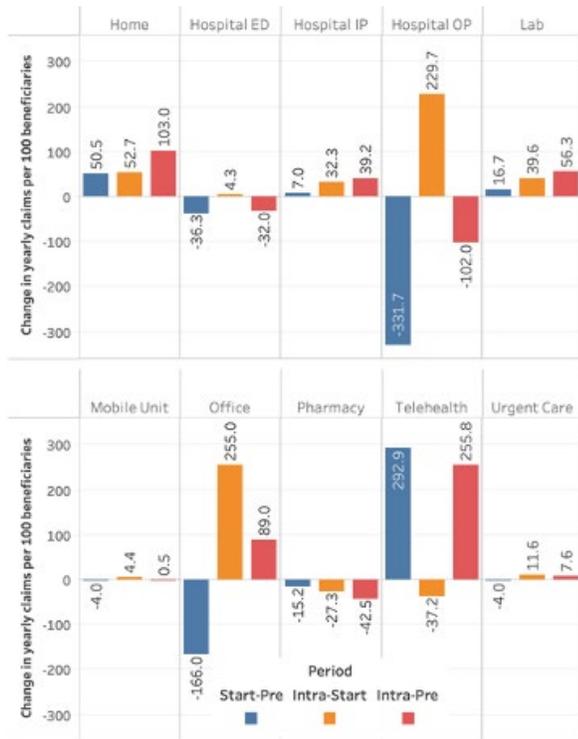


Figure 1: Changes in yearly service utilization.

The intra-PHE period provides insight into the recovery of the health care system after being impacted by the pandemic. Only three of the considered services continued to have lower utilization intra-PHE compared to pre-PHE (Figure 1): Hospital ED, Hospital OP, and Pharmacy. Service utilization rates for Home, Hospital IP, and Lab increased during the start-PHE period and continued to increase during intra-PHE. There was, however, a slight drop in the utilization of Telehealth from start-PHE to intra-PHE (-37.2 claims per 100 beneficiaries).

### Policy Implications

Most telehealth restrictions were dropped during the PHE to allow all beneficiaries the opportunity or option to access telehealth services. In this study, telehealth utilization increased drastically during the start-PHE period and continued to have high utilization throughout the intra-PHE period. These findings suggest that telehealth policies were effective in increasing overall access to health care services and resources. However, changes in telehealth utilization did vary by Medicaid region. Medicaid Regions 1 and 4 had the smallest uptakes in telehealth utilization during the start-PHE period (Figure 2). Only Medicaid Regions 3 and 8 continued to have increased telehealth utilization during the intra-PHE period, while Regions 1, 2, and 5 had the largest decreases in utilization from start-PHE to intra-PHE.

CE policy removed procedural barriers of the Medicaid renewal process to help ensure consistent access to care during the PHE. Therefore, CE may be one of the contributing factors to the increase in health care service utilization. To measure the potential effectiveness of CE, utilization of health services other than telehealth were evaluated. During the intra-PHE period, most of the considered services were

utilized at higher rates when compared to the pre-PHE period. Hospital ED, Hospital OP, and Pharmacy were the only utilization rates in this study that did not recover back to or exceed baseline rates prior to the pandemic. Some changes in service utilization differed across Medicaid Regions (Figure 2). During intra-PHE, Pharmacy utilization decreased in most Medicaid regions except for Regions 2, 4, and 8. While Office utilization increased for all Medicaid regions during this period, Regions 1 and 7 were still below pre-PHE baseline rates. Interestingly, when comparing Hospital OP utilization intra-PHE to pre-PHE, the decreases in rates were relatively similar across all Medicaid regions.

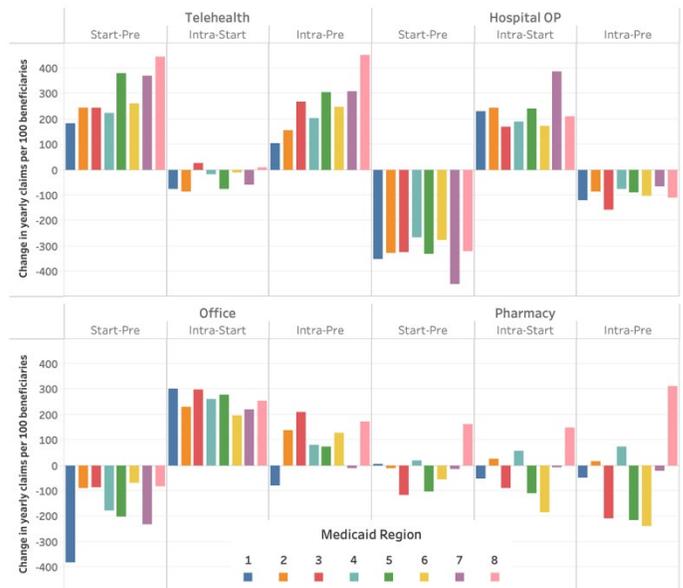


Figure 2: Changes in yearly service utilization by Medicaid Region.

### Conclusion

The significant changes to Medicaid policies during the COVID-19 PHE provide a unique opportunity to explore the impact of expanded health care coverage and provider availability. While most health services had initial decreases in utilization at the start of the COVID-19 pandemic, this project found that many services achieved higher utilization rates during the intra-PHE period compared to baseline pre-PHE period.

Changes in utilization for some services did vary considerably by different Medicaid regions. Areas with lower-than-average utilization rates should be examined to better understand the challenges and barriers that prevent an adequate infrastructure for health care services (e.g., lack of awareness and/or clarity of services, proper workflows, technology access). Targeting and addressing access to care issues in communities that underutilize services will help improve health equity within the Kentucky Medicaid population.

### References

- 1 Unwinding the COVID-19 Public Health Emergency. <https://ciswh.org/projects/the-catalyst-center/phe-resources>
- 2 Kentucky's Approach to Unwinding from the Public Health Emergency (March 2023). <https://khbe.ky.gov/Enrollment/Documents/KentuckyUnwindingApproach.pdf>