TEAM KENTUCKY

CABINET FOR HEALTH AND FAMILY SERVICES

STATE UNIVERSITY PARTNERSHIP POLICY BRIEF

Expanded Tele-Mental Health Services in Kentucky Behavioral Health Settings: Effect on Beneficiaries with Mental & Behavioral Health Challenges

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What is Known on This Topic?

Tele-mental health services enhance healthcare access for many people living with mental and behavioral health challenges. Facilities accepting Medicaid are less likely to offer tele-mental health. Recent availability of telehealth modalities is important considering the prevailing mental and behavioral healthcare workforce shortage. Further, tele-mental health delivery may be more cost-effective than in person visits and results in similar mental and behavioral health outcomes.

What Did This Project Do?

This project examined the effect of tele-mental health services expansion on the ability of Medicaid providers to deliver care to beneficiaries. The intent of this project was to advance translatable research in this area while providing important data to guide Kentucky State Medicaid regarding the impact of a telehealth expansion initiative on continuity of care for beneficiaries and the mental and behavioral health workforce among Medicaid providers.

What could Medicaid do with these findings?

Medicaid could use telehealth expansion as a way to improve access to and continuity of mental healthcare for beneficiaries. These findings could inform the importance of continued coverage of tele-mental health services especially for underserved areas.

Introduction

Tele-mental health services enhance healthcare access for individuals living with mental and behavioral health challenges. Mental health programs increasingly offer telehealth services, but facilities accepting Medicaid are less likely to do so. However, tele-mental health delivery may be more cost-effective than in person visits resulting in similar mental health outcomes.

The primary purpose of this project was to examine the effect of Kentucky's telehealth services expansion on treatment adherence, healthcare utilization, and patient and provider satisfaction. To achieve this purpose, we proposed three aims to examine:

Aim 1) Medicaid Data two years before and two years after March 2020 (month of 907 KAR 300E because of COVID-19), among Medicaid beneficiaries with a psychiatric disorder, to assess changes in treatment adherence, hospitalizations and emergency room visits, and healthcare costs.

Aim 2a) Satisfaction with tele-mental health services among Medicaid beneficiaries in Community Mental Health Centers,

Aim 2b) Satisfaction with tele-mental health services among Medicaid providers in Community Mental Health Centers

Aim 3: Opinions about the value of the tele-mental health expansion among managed care organizations.

Methods

For Aim 1a, we analyzed de-identified Kentucky State Medicaid data (2018-2022) of beneficiaries with psychiatric diagnosis, and aged 18 years or older. We obtained demographic information (including diagnosis), inpatient, outpatient, emergency department visits, healthcare costs (inpatient, outpatient and pharmacy), and telehealth use codes

For Aim 2a & 2b, we surveyed Medicaid beneficiaries and providers at community mental health organizations and within Managed Care Organization networks. We obtained demographic information (including diagnosis), residence, frequency of telehealth usage, trust in health provider scale (for beneficiaries), and telehealth usability questionnaire.

For Aim 3, we conducted informant interviews with managed care organizations using a semi-structured interview guide on questions regarding perspectives on the impact of telehealth on beneficiaries and providers

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Results

Changes in treatment adherence, hospitalizations and emergency room visits, and healthcare costs. Among 91,816 beneficiaries that met our inclusion criteria, we found that there were significant decreases in ***treatment adherence*** (assessed as ≥80% proportion of days covered) with 41.8% pre-COVID, 29.0% during COVID and 23.8% post COVID. In addition, when compared to 2018, we found significant decreases in both ***emergency department*** and ***outpatient visits***, but little change in ***inpatient hospitalizations***. We further found that overall pharmacy and outpatient costs increased post-covid, whereas inpatient costs decreased. Finally, we found that there was a significant increase in the usage of ***telehealth codes*** post-COVID compared to pre-COVID (0.8% vs. 0.3%)

Satisfaction with tele-mental health services among beneficiaries: Preliminary results from 73 beneficiaries responding to the survey indicated that 57.5% receive 50% or more of their mental healthcare through telehealth services. A greater proportion of those in rural areas receive tele-mental health care services 50% or more of the time compared to those in urban areas (68.2% vs. 51.1%). Finally, telehealth usability was most influenced by greater trust in healthcare providers.

Satisfaction with tele-mental health services among providers: Preliminary results from 176 providers responding to the survey indicate that 26.7% deliver tele-health services greater than 50% of the time. In addition, there is a higher proportion of providers who use telehealth services for 50% or greater patient encounters in urban versus rural areas (30.3% vs. 23.9%). Finally, **telehealth usability** is most influenced by being in the urban setting and proportion of patients seen by tele-health.

Opinions about the value of the tele-mental health expansion among managed care organizations: The Kentucky Medicaid team supported conversations with managed care organizations (MCOs) related to tele-mental health service provision. Despite variability among MCOs in perspectives regarding communication with tele-health, a consistency across all MCOs was the inherent challenge in providing behavioral health services throughout the state and especially in rural areas and pediatric services. Therefore, providers may increase online behavioral health care provision services to access these needed services which are not readily available in their areas.

Policy Implications

907 KAR 300E was the emergency regulation that allowed for the expansion of telehealth services during the COVID-19 public health crisis. Medicaid relaxed its rules regarding telehealth delivery of all appropriate types of health care services as outlined in 907 KAR 3:170 as a response to the COVID-19 public health crisis. Kentucky law requires the coverage of tele-mental health services to the same extent covered by in-person services. However, there is confusion over when to use G codes and when to use other visit codes and modify place of service to be telehealth. Therefore, there are discrepancies in the Medicaid data that make it challenging to identify the full use of tele-mental health services. Nevertheless, the impact on access to needed services as a result of telehealth availability and observed changes in overall health utilization pre- versus post-COVID, suggest the need for continued telehealth options for Medicaid beneficiaries based on expanded services mandate.

Conclusion

The telehealth expansion has supported access to and continuity of mental healthcare for Medicaid beneficiaries. However, it may be under-utilized for Medicaid beneficiaries. The use of telehealth for mental and behavioral healthcare has increased post-COVID, however, challenges persist in the appropriate coding of such services to properly identify service usage. More understanding is needed of the billing practices and appropriate use of billing codes for telehealth services among organizations that serve Medicaid beneficiaries. Clarifications regarding how a provider should mark place of service could also help provide a more complete picture of existing use of telehealth.

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