Medicaid HCBS and PACE Weekly Recap

August 2, 2024

National Policy Pulse Call. LeadingAge's members-only briefing and analysis call with our experts, "National Policy Pulse," happens every Monday at 3:30 p.m. ET. Register for the calls (registration required even if you were registered for the previous 3:30pm policy update calls) here. Your registration will keep you on the list for all calls in 2024, and we'll send a new registration link to members for calls in 2025 so you never miss a beat.

MACPAC Releases Issue Brief on Prior Authorization in Medicaid. The Medicaid and CHIP Payment Access Commission (MACPAC) analyzed prior authorization in Medicaid to assess for cost avoidance and barriers to beneficiaries accessing services. The brief reports that 69% of physicians surveyed indicated, "…prior authorization requirements led to ineffective initial treatments, and 68 [%] reported that prior authorization requirements led to additional office visits." The authors highlight the increased burden both on beneficiaries and providers. This burden is often exacerbated when payers make updates to prior authorization policy without notification to participating providers. In these instances, a provider may prepare a request for prior authorization for a service that has been transitioned to a standard covered service, while the inverse also promises problems. Without current federal regulations requiring the collection or reporting of prior authorization requests, approvals, and denials there is very limited and inconsistent data though there does seem to be significant disparity between services, plans, ethnic populations, and geographies experiencing high rates of prior authorization and rejection. There are no policy recommendations, though there is an expressed belief that changes imposed by the Final CMS Interoperability and Prior Authorization Final Rule may offer useful data and reporting. The full document is available here.

CMS Open Door Forum Focuses on Payment Adequacy Provisions in Medicaid Access Rule. On July 30, the Centers for Medicaid Services (CMS) Open Door Forum (ODF) was hosted by Alyssa DeBoy (director) and Melissa Harris (deputy director) from the Medicaid Benefits and Health Programs Group. This group oversees state waivers and programs related to home and community-based services. Ms. Harris reviewed a few slides providing high level requirements of states from the entire rule, then homed in on payment adequacy and related transparency provisions. The Medicaid: Ensuring Access to Medicaid Services Rule was finalized on May 10, with an effective date of July 9 with robust requirements on states ranging from revamping stakeholder processed and groups and critical incident management programs to developing payment rate reporting standards and holding providers to payment adequacy provisions. The most talked about provisions of the rule were the payment adequacy provisions; those that would require 80% of Medicaid payments for home maker, home health, and personal care services to be passed on to direct care workers through compensation. While there was no new policy guidance offered during the call, Harris was thoughtful and forthcoming with the work CMS is undertaking to develop and release a collection of additional sub-regulatory guidance around these provisions. She agreed with audience concerns and reiterated that CMS recognizes that states need more information on how to handle bundled services and how states should determine if specific services are covered under the rule since they may have multiple services in different waivers or programs that resemble the stated services. She also was careful to address that CMS does not have authority to direct states to raise provider rates, and believes they are using the

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levers available to them to compel states to bring providers and other stakeholders to the table in developing a compliance plan for the payment adequacy provisions. Harris made two useful clarifications:

- Regarding the exclusion of training from the calculations- costs associated with training of direct care staff such as developing training and hiring a trainer would not be included in the 80%, though wages of direct care staff while staff are being trained would be eligible for inclusion in the 80%.
- CMS has the ability to waive reporting requirements of states that implement small provider and hardship exemptions if the combined number of providers falling under both exemptions is less than 10% of providers offering that service in the state. Our prior interpretation was that either of these exemptions individually could see reporting requirements waived if covered providers comprised less than 10% in each exemption.

The transcript and Q&A will be posted on the CMS ODF page in a few days under the Long-Term Services and Supports drop down. Here is a LeadingAge serial post containing our summaries and comments on the rule.

Older Americans Act (OAA) Reauthorization Passes Out of Senate HELP Committee. On July 31, the Senate Health, Education, Labor, and Pensions (HELP) Committee passed the OAA reauthorization out of committee by a vote of 20-1. The reauthorization would permit Congress to appropriate more than $2.7 billion dollars in FY2025 and overall would increase funding for OAA programs by 44% over the 5 year reauthorization. These are authorizations – the amounts to be appropriated are still to be determined. The bill needs a vote on the Senate floor and then would go to the House. OAA funds a number of programs that LeadingAge members utilize, often through their area agency on aging partners, like respite care, community-based services like adult day, some home care, meals, transportation, and other important services.

Senator Casey Introduces the PACE Anytime Act. On July 25, Senators Bob Casey (D-PA) and Mike Braun (R-IN) introduced an act that would compel CMS to open enrollment of PACE to anytime of month. The one-pager describing the Act references how individuals attempting to access other long-term care services are not burdened with the same delays as PACE participants, who are required to wait until the first of the next month to enroll. The bill also addresses the statutory requirement that payment be prorated on a monthly basis to allow for payment of partial months. LeadingAge has been supportive of these provisions when included in other bills and will seek enactment of this bill.

The LTSS Gap is Real; States Have Options. In an article published in Health Affairs on July 24, authors explored opportunities for states to offer some long-term services and supports for individuals that are near Medicaid eligible. This term is defined as people with incomes between 138% and 221% of the poverty level. This population is less likely to have community supports or spouses to provide unpaid family caregiving. They also have higher rates of disability leading to significant unmet need. States can leverage existing programs through Older Americans Act funds, create new state-only funded programs, or leverage Medicaid demonstrations to mitigate adverse outcomes and avoid nursing home placement. The article highlights a significant weak spot in our healthcare system: the gap in coverage for long-term care services in conventional insurance or Medicare and offers options for states to consider in meeting their own aging population's needs. The full article is available here.

LeadingAge Shares Feedback with White House on Respiratory Virus Vaccine. In follow up to the Long-Term Care Leadership Summit 3.0, which LeadingAge attended at the White House on July 18, LeadingAge sent a letter to the White House Office of Pandemic Preparedness and Response Policy on July 25 outlining feedback from nursing home members regarding barriers to vaccination and strategies for increasing vaccine acceptance. Based on this feedback, LeadingAge shared three recommendations for increasing vaccine acceptance for the 2024/2025 respiratory virus season. Read more here.

Online Interactive Data Platform Examining Americans Views on Healthcare and Aging Launches. On July 31, the West Health-Gallup National Healthcare & Aging Data Dashboard launched. The dashboard examines how Americans view healthcare and the role it plays in the aging experience and explores trends and issues across various demographics including aging, gender, race, and income, drawing information from more than 17,000 respondents from 2021-2024. Key focus areas of the dashboard include healthcare affordability and its consequences, the intersection of aging and the healthcare system, the future of Medicare and Social Security, and the state of the country's readiness for a fast-growing aging population. The dashboard includes two unique indices: the Healthcare Affordability Index that measures Americans' ability to access and afford healthcare and the Healthcare Value Index that measures the quality people associate with the care they receive relative to how much they pay for it.

Last Week's Recap Update: Medicaid, HCBS, and PACE Weekly Update. Here is the July 26, 2024 Medicaid, HCBS, and PACE Update.