Medicaid Fill Rate Survey

National Alliance for Care at Home

Background

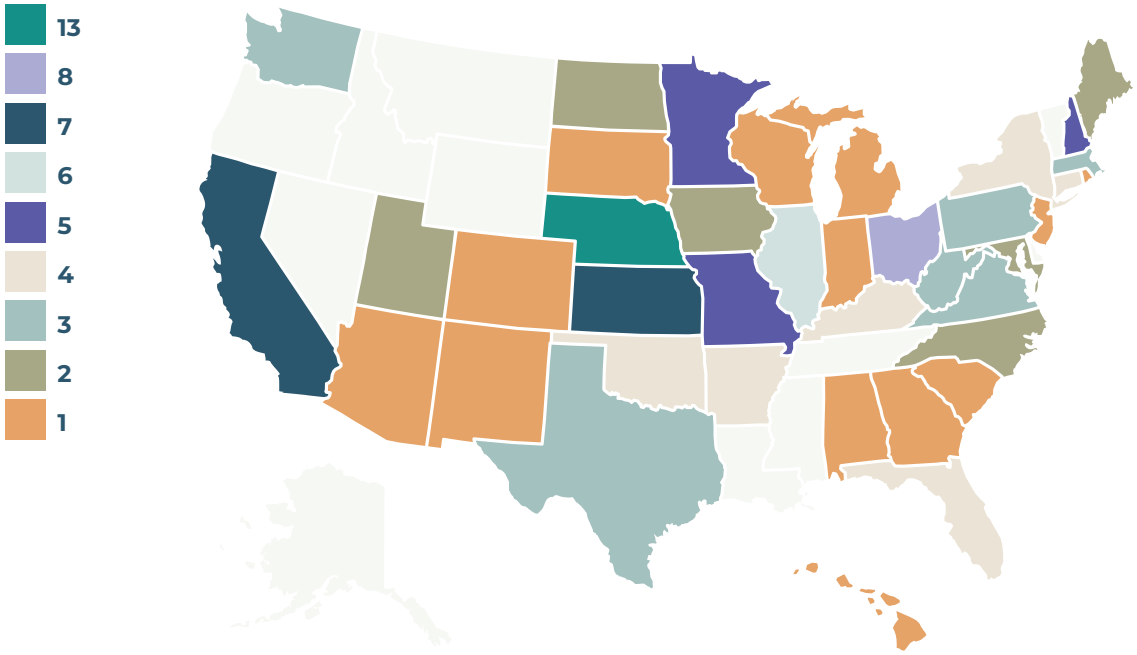
Medicaid coverage entitles enrollees to a wide range of primary, acute, post-acute, and long-term services and supports. However, participants often struggle to receive these supports due to a variety of factors such as inadequate reimbursement, caregiver shortages, and overly restrictive utilization management protocol. Unfortunately, though many states collect information regarding delivery of services, it is often not publicly available. As a result, national information on access to covered services is sparse.

In the summer of 2024, the National Association for Home Care & Hospice (NAHC) surveyed members to gather information about provider experiences with delivering covered Medicaid services. The survey was conducted via an online tool and was distributed to NAHC membership that provides Medicaid-funded home and community-based services (HCBS). It included questions regarding acceptance of referrals, disconnects between the amount of service authorized and the amount delivered, as well as the reasons for any gaps in care.

Respondent Characteristics

A total of 108 unique members responded from 39 states and the District of Columbia. Respondent providers represented a wide range of sizes and footprints, with the vast majority of (n=99) respondents serving only one state and the largest respondent serving 5 states. Figure one demonstrates the geographic diversity of responding entities.

Figure 1: ***Locations of Survey Participants***



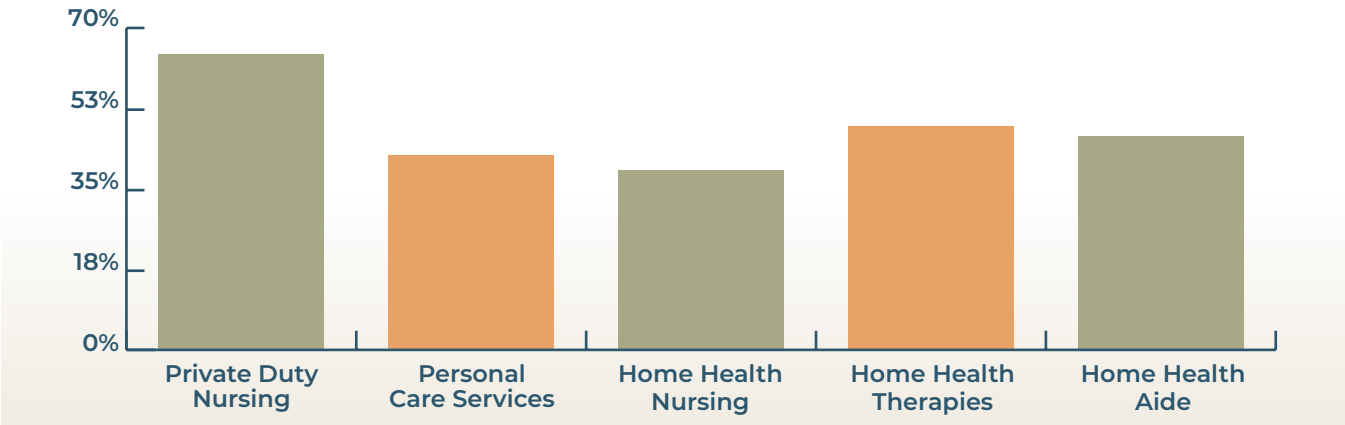
Responding providers were a wide range of sizes based upon annual revenue. The largest respondent reported approximately $120 million in annual revenue whereas the smallest respondent reported $180,000. Medicaid represented 100% of the revenue for some providers compared to 1% for others. Using the reported total revenue and percentage from Medicaid, we estimated the dollar amount received from Medicaid for each provider. The results ranged from $12,600 to $62.4 million.

	Total Revenue	Percent Medicaid	Estimated Medicaid Revenue
Average	$12,587,810.63	41.52%	$3,602,277.04
Median	$5,000,000.00	35.50%	$683,436.64
Count	90	101	85

Refusal Rates

For purposes of the survey, we defined "refusal rate" as the percentage of referrals for specific HCBS that are rejected by the provider. Referrals may come from a variety of sources, such as hospitals, case managers, nursing home transition planners, and other social or medical agencies. Rejection rates were highest for Private Duty Nursing (64%) and lowest for skilled home health services (i.e. Home Health Nursing) at 39%.

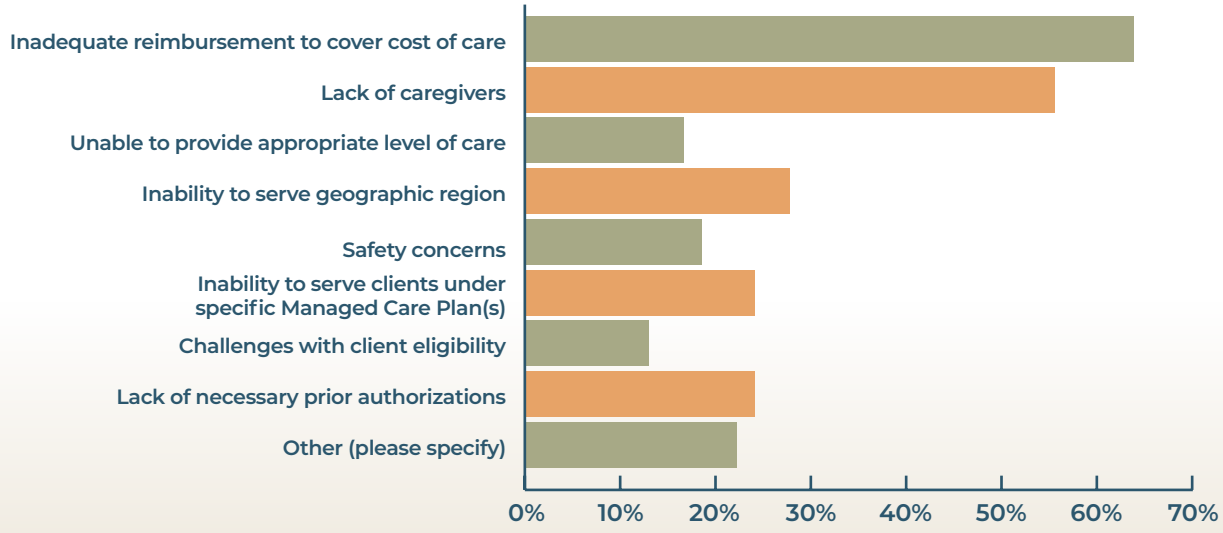
Figure 2: ***Provider Refusal Rate for Selected Services***



Reimbursement challenges, a longstanding issue in the Medicaid program, played a prominent role in decisions to reject a Medicaid referral. When asked to provide their top three reasons for referral rejections, nearly two-thirds of respondents (63.89%) reported low reimbursement rates. Caregiver shortages, which are related to the low pay and poor benefits resulting from inadequate reimbursements, was the second most commonly reported reason for a referral rejection (55.56%).

Twenty-two percent of respondents cited "other" reasons, which included challenges with EVV, authorizations being cancelled after issuance, and challenges contacting clients. Figure 3 provides summary data of the most common reported reasons for rejecting a referral.

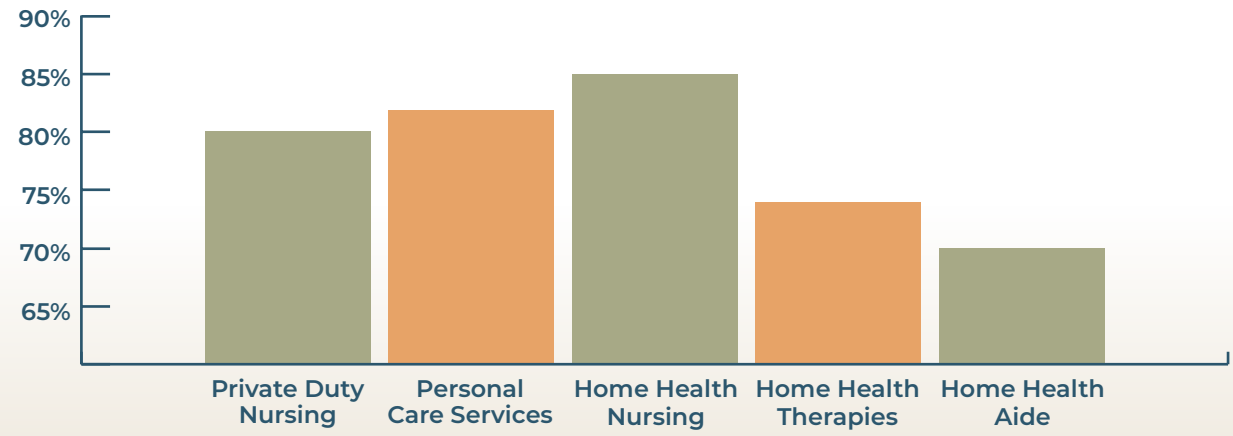
Figure 3: *Most Commonly Reported Reasons for Rejecting Referrals*



Medicaid Fill Rates

As part of Medicaid long-term care requirements, individuals are assessed to determine eligibility for services. After assessment, the clinician develops a plan of care that includes prior-authorization of necessary services. This process is different for state-plan services, such as Private Duty Nursing and Home Health, compared to personal care and other comprehensive HCBS, but general prior-authorization and service plan requirements still exist. For the survey, we defined the Medicaid "fill rate" as the number of hours authorized in the plan of care that were actually delivered to the individual. Challenges with staffing and reimbursement have created gaps in care when individuals cannot access the services that are authorized.

Figure 4: *Percentage of Authorized Hours that are Delivered to the Client*

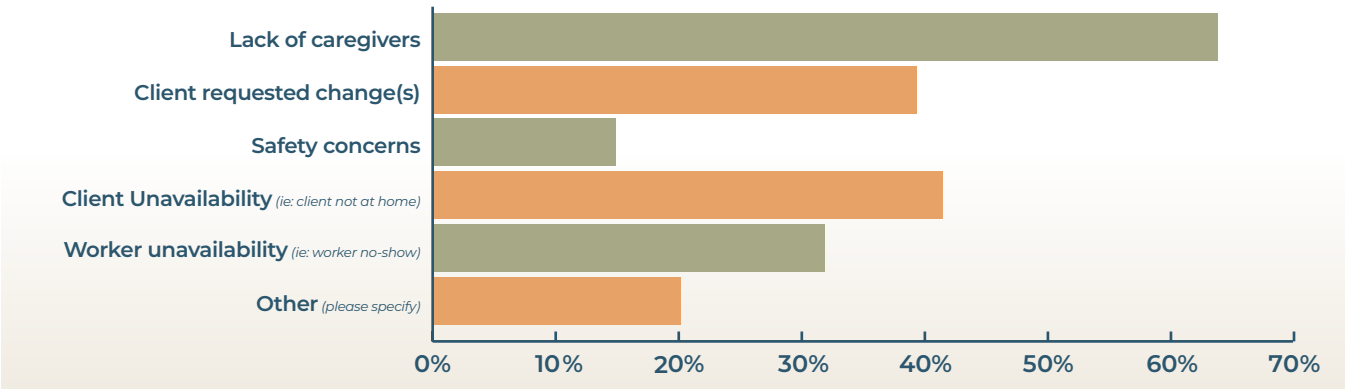


Medicaid fill-rates for selected home care services ranged from 71% for home health aide services to 85% for home health nursing services. The overall percentage of hours provided was significantly higher than the acceptance rate, suggesting that agencies use referral rejection as the primary process for aligning workload with available caregivers.

Similar to the rejection rate, the survey asked respondents for the top three reasons that hours went unfilled. Once again, lack of caregivers was a significant reason for unfilled hours (63.83% of

respondents). Other reasons included a client-initiated change in services, client unavailability, and worker no-shows, which are similar to but distinct from caregiver shortages. Twenty percent of respondents indicated an "other" reason, which included reimbursement challenges that led to an inability to provide hours that would result in worker overtime, client refusal, admission to an inpatient setting, and participants no longer needing services once they met their plan of care goals.

Figure 5: ***Reasons for Undelivered Authorized Hours***



Conclusions and Implications

Individuals seeking Medicaid HCBS face many barriers to receipt of care. These include byzantine financial eligibility requirements and processes, difficulties with clinical eligibility, assessment, and authorizations, and inability to access services once they are deemed eligible. The NAHC member survey provides additional context on some of the factors leading to the challenges that individuals face with services. The high referral rejection rates demonstrate that various structural issues, including low reimbursement, caregiver shortages, managed care complexities, and related issues are forcing providers to turn away eligible participants. Similarly, though the "fill rates" were relatively high due to providers managing capacity through admissions, providers still reported unfilled hours resulting from challenges with workforce shortages.

The Medicaid Access Rule, finalized in May 2024, will require states to report on the number of authorized hours that are actually delivered (i.e. the fill rate) and the amount of time that passes between a determination of eligibility for services and the delivery of those supports (which can serve as a proxy for rejection rate due to rejections creating delays in accessing care). These reporting requirements begin in 2027. Policymakers should carefully analyze the resulting data to identify policy changes that can increase the ability to serve all eligible individuals. As our survey demonstrates, there are significant gaps in accessing care that must be addressed to ensure that individuals are able to live in the most integrated setting appropriate to their needs and preferences.

Limitations

The data available is self-reported by providers and has not been independently verified. Further, there was not sufficient sample size to draw firm conclusions, nor could we stratify by state. Additional state-specific data, such as the reporting that will begin in 2027, can provide needed context to begin identifying state payment, coverage, and regulatory requirements that improve the ability of individuals to receive all HCBS to which they are eligible.