Home Health Weekly: Recap of LeadingAge Updates

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.

LeadingAge Home Health Member Network. The next meeting of the Home Health Member Network is on August 6, at 2p.m. ET. The agenda includes a review of LeadingAge's comments on the CY2025 Home Health Payment Proposed Rule and a LeadingAge launch a Data Collection Initiative on MA Prior Authorizations with the intent to provide CMS with recent data showing plan non-compliance and practices regarding prior authorizations. To join the Home Health Member Network, register here or contact Katy Barnett, kbarnett@leadingage.org.

Home Health, Hospice, DME Open Door Forum Scheduled for August 7. The next Home Health, Hospice & DME Open Door Forum is scheduled for August 7, 2 p.m. ET. The agenda for this forum includes information on the Home Health Value Based Purchasing First Annual Performance Report with Payment Adjustment, the Home Health CAPHS, hospice quality reporting updates, and home health quality reporting updates. Providers can register in advance for this webinar here.

July 2024 CMS Home Health OASIS Q&A. The Centers for Medicare and Medicaid Services (CMS) released the quarterly OASIS Q&As for July. These questions were received by CMS help desks, the responses may be time-limited and may be superseded by additional guidance by CMS at a later date.

a. CMS received a question regarding patients who may be confused and not responding appropriately and if clinicians are required to ask social determinants of health (SDOH) questions. CMS clarifies that each of the SDOH questions have responses for when a patient or proxy are unable to answer but notes that there should be documentation in the medical record of why they were unable to respond.
b. CMS received a question on M1306-M1324 regarding Kennedy Ulcers and whether they would be conserved for the purpose of coding pressure Ulcers. Kennedy ulcers, or terminal ulcers, resulting from organ failure are not considered pressure ulcers and are not reported on the OASIS pressure ulcer items.
c. Finally, CMS received a question regarding how to stage a pressure when the tissue damage is unknown. CMS clarified ulcers should be coded based on findings from the first skin assessment and provided details to when an ulcer could be restaged. This is valuable information to share with staff and ensure nurses are versed in coding requirements for OASIS.

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Home Health and Nursing Home Employees Likely to Have Educational and/or Medical Debt. A study published in JAMA Health Forum on July 26, 2024, analyzing medical and educational indebtedness among US health care workers found that 21% of home health care workers and almost 20% of nursing home employees carry medical debt. Analyzing the self-reported data from the Survey of Income and Program Participation(SIPP) from 2018-2021 researchers found that healthcare workers are more likely than those in other sectors to carry medical and educational debt, collectively amounting to over $150 billion. Medical debt was particularly linked to being female, having a lower income or education level, working in home health and nursing home care, lacking health insurance, and recent hospitalization. Critical components of the aging services workforce were particularly impacted by debt with over 23% of Certified Nurse Aides(CNAs) reporting educational debt, while 18.7% reported having medical debt. Registered Nurses(RNs) indicated a higher incidence of educational debt, with nearly 35% reporting an average debt of $11,939 and 12%, reporting having medical debt. Researchers noted "extensive training requirements may lead to high student debt among some healthcare workers, while nonprofessional health workers may be at risk for medical debt due to low wages and poor benefits". These findings indicate that US healthcare workers carry significant educational and medical debts, further research should focus the impact of debt on the healthcare workforce and patient care.

Recording of LeadingAge Explainer on MA Prior Authorization Data Collection Initiative and Tool. As part of our advocacy efforts, we are asking our SNF and home health members to submit data for one month on the prior authorization and re-authorization requests they make on behalf of the individuals they serve. This data will provide critical evidence to support our advocacy efforts seeking MA reforms and further clarifications to prior authorizations practices. On July 30, LeadingAge hosted a call to walk members through the data collection tool and corresponding guide. The recording is available here. Here are the data collection spreadsheets and guides: SNF Data Tool Spreadsheet, SNF Guide, Home Health Data Tool Spreadsheet, Home Health Guide.

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.

Change Healthcare Submits Initial Placeholder Breach Report, Updates Expected: The U.S. Health and Human Services Office for Civil Rights (OCR) has updated its "Change Healthcare Cybersecurity Incident Frequently Asked Questions" webpage (see Question #3) to reflect that, on July 19, Change Healthcare filed an initial breach notification report with OCR concerning the ransomware attack that occurred earlier this year. According to the OCR: "Change Healthcare's breach report to OCR identifies 500 individuals as the "approximate number of individuals affected". This is the minimum number of individuals affected that results in a posting of a breach on the HHS Breach Portal. Change Healthcare is still determining the number of individuals affected. … HIPAA breach reports filed on the HHS Breach Portal may be amended as the breach report form allows a filer to file an initial breach report or an addendum to a previous report." This initial report to OCR follows prior communications from the company. As we noted in our Change Healthcare Serial Post, the company started notifying providers and insurers on June 20 whether their patients' or members' data was compromised in the cyberattack and provided a link to a website that its customers can link to from their own websites to share with their potentially impacted individuals. Change

has also updated that website effective July 31. We will continue to monitor and report developments relating to this cyberattack.

CMMI Finalizes TEAM model. The Center for Medicare and Medicaid Innovation (CMMI) finalized its proposals for the Transforming Episode Accountability Model (TEAM) on August 1 and we expect it to impact care delivery patterns and expectations of post-acute care providers. This five-year, episodic model, unlike most CMMI models, will have mandatory participation for acute care hospitals in certain designated Core Based Statistical Areas (CBSAs). The model incentivizes coordination among providers during and for 30 days following a surgery. Covered surgeries include lower extremity joint replacement, surgical hip and femur fracture treatment, spinal fusion, coronary artery bypass graft and major bowel procedure. The model will begin January 2026. More details on the model can be found on the TEAM model page.

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.

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.

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 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.

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.

Last Week's Recap Update. Here is the July 26, 2024 weekly Home Health Update.