PUBLIC POLICY *ALERT*

AAHCM
AMERICAN ACADEMY OF HOME CARE MEDICINE

January 24, 2024

Academy Public Policy E-Briefing

Welcome to the Academy's Quarterly Public Policy E-Briefing**.** You will find this and all previous Public Policy E-Briefs on the Academy website. Please contact Joy Chen at jchen@healthsperien.com or visit the Academy's Education page on the Academy website for additional information. As well, if you are facing policy issues related to COVID-19, please contact us and/or visit our resources page here. Highlights in this quarterly e-brief include:

1. Centers for Medicare and Medicare Services (CMS) Releases Interoperability and Prior Authorization Final Rule
2. CMS Publishes New Model Advancing Integration in Behavioral Health
3. Department of Health and Human Services (HHS) Announces Regulatory Priorities for Fiscal Year 2024
4. Bipartisan Group of Congress Members Urge HHS Secretary Becerra to Extend Medicare Telehealth Services
5. HHS Releases Final Rule on Conscience and Religious Discrimination
6. CMS Publishes Medicare Telehealth Trends Report
7. Center for Medicaid and CHIP Services (CMCS) Bulletin Showcases the Benefits of Direct Support Worker Registries
8. Kaiser Family Foundation (KFF) Survey Highlights Stability and Challenges in Home- and Community-Based Services Waiting Lists

CMS Releases Interoperability and Prior Authorization Final Rule

On January 17, CMS published the Interoperability and Prior Authorization Final Rule, which requires Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs) to implement and maintain certain Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs) to improve the electronic exchange of health care data, as well as to streamline prior authorization processes.

CMS is requiring impacted payers to:

Add information about prior authorizations (excluding those for drugs) to the data available via that Patient Access API.
Implement and maintain a Provider Access API to share patient data with in-network providers with whom the patient has a treatment relationship.
Implement and maintain a Payer-to-Payer API to make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in the United States Core Data for Interoperability (USCDI) and information about certain prior authorizations (excluding those for drugs).
Implement and maintain a Prior Authorization API that is populated with its list of covered items and services, can identify documentation requirements for prior authorization approval, and supports a prior authorization request and response.
Send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests.
Provide a specific reason for denied prior authorization decisions, regardless of the method used to send the prior authorization request. Such decisions may be communicated via portal, fax, email, mail, or phone.
Publicly report certain prior authorization metrics annually by posting them on their website.

In response to public comment on the proposed rule, impacted payers have until compliance dates, generally beginning January 1, 2027, to meet the API development and enhancement requirements in this final rule. The exact compliance dates vary by the type of payer.

Bipartisan Group of Congress Members Urge HHS Secretary Becerra to Extend Medicare Telehealth Services

On January 19, a group of bipartisan members of Congress authored a letter to the Secretary of HHS, Xavier Becerra, urging him to work closely with Congress to ensure that all Medicare beneficiaries have continued access to telehealth services. Congress has already expanded coverage of these services before and after the COVID-19 public health emergency, most recently in the Consolidated Appropriations Act of 2023 which extended the waivers through December 31, 2024. The letter states that the group's goal is to enact permanent telehealth legislation that will require Congressional and HHS collaboration. Additionally, the letter suggests upcoming opportunities for communications between the two entities such as the President's Fiscal Year 2025 Budget, the Calendar Year 2025 Medicare Physician Fee Schedule, and testimonies before Congressional committees. The letter also encourages HHS to solicit information and feedback from stakeholders in regard to outstanding implementation questions stemming from the 2024 Physician Fee Schedule.

CMS Publishes Medicare Telehealth Trends Report

On January 10, CMS released their Medicare Telehealth Trends Report that analyzed Medicare beneficiaries who utilized telehealth services from January 1, 2020, to June 30, 2023. In response to the COVID-19 public health emergency, CMS expanded telehealth services to increase access to care. During the initial outbreak of COVID-19, the percentage of Medicare beneficiaries who utilized a telehealth service jumped from 7% to 47% between the first and second quarters of 2020. That same figure

has declined in a consistent manner since the public health emergency, with only 13% of Medicare beneficiaries utilizing a telehealth service in June of 2023. The telehealth data was also broken down into different demographics including race, ethnicity, gender, age, and whether the beneficiary is dually enrolled, aged, disabled, and live in a rural or urban area. These comparisons were relatively congruent, aside from the comparison between rural and urban beneficiaries which showed that urban beneficiaries are maintaining their telehealth services more than their rural counterparts.

HHS Releases Final Rule on Conscience and Religious Discrimination

On January 10, the HHS Office for Civil Rights (OCR) released a Final Rule, *Safeguarding the Rights of Conscience as Protected by Federal Statutes*, that partially rescinds a 2019 Trump Administration rule. Federal laws permit physicians to decline services according to religious beliefs during certain situations, and the 2019 Trump Administration rule would have broadened the implications of those federal laws. The 2019 policy aimed to give medical professionals more rights to abstain from providing health care services that may go against their religious or moral principles.

In 2019, three federal district courts found the Trump policy unlawful, and its execution has been blocked. This Final Rule repeals the part of the 2019 policy that would have withdrawn federal funding from health facilities that mandated health care workers perform services they opposed. This 2024 Final Rule focuses on protecting Americans against conscience and religious discrimination in health care and is the Department's most recent action supporting Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. Abortions, contraception, gender-affirming care, and sterilization are examples of services that health care workers could have refused under the Trump Administration 2019 rule. With this new Final Rule, the Department hopes to clarify and find a balance between physician conscience rights and patient health rights. The Final Rule will be effective March 11, 2024.

HHS Announces Regulatory Priorities for Fiscal Year 2024

On December 6, the Office of Information and Regulatory Affairs (OIRA) released its Fall Regulatory Agenda, which details additional actions that Federal agencies are considering over the coming months as well as recently completed actions. Key focus areas for the HHS Regulatory Plan for Fiscal Year (FY) 2024 include lowering costs and expanding coverage, reducing disparities and advancing equity, increasing public health preparedness, and supporting the wellbeing of families and communities. Specifically, HHS aims to:

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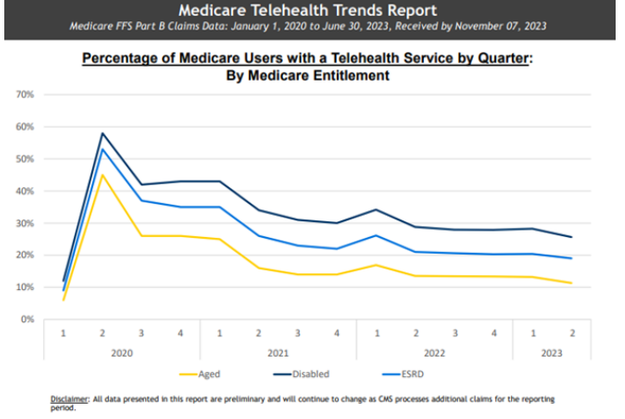

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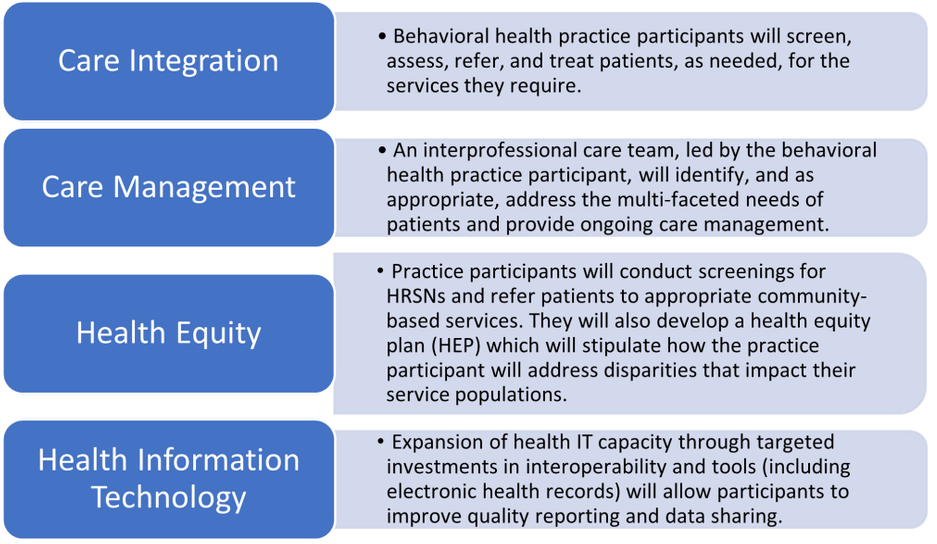
Expand access to affordable care and protect health coverage following the end of the COVID-19 public health emergency;
Strengthen federal early care and education programs that enhance quality of services to children and families, lower child care costs for working families, and provide needed support to early educators;
Advance health and safety across the health care delivery system through policies and programs that promote health equity;
Expand access to the full continuum of mental health and substance use prevention, treatment, and recovery;
Bolster the Department's ability to identify and prevent future public health threats;
Improve the Department's ability to identify foodborne illnesses and advancing work to improve consumers' ability to access nutritious food to prevent disease and protect public health;
Strengthen services for older Americans to allow them to remain in their communities;
Ensure that children and youth receive safe and appropriate care and support in order to thrive.

CMS Publishes New Model Advancing Integration in Behavioral Health

On January 18, CMS released a new model to test approaches for addressing the behavioral and physical health, as well as health-related social needs, of people with Medicaid and Medicare. The Innovation in Behavioral Health (IBH) Model aims to improve the overall quality of care and outcomes for adults with mental health conditions and/or substance use disorder by connecting them with the physical, behavioral, and social supports needed to manage their care.

The model works to improve care through four key program pillars:



Practice participants in the IBH Model will be community-based behavioral health organizations and providers, including Community Mental Health Centers, public or private practices, opioid treatment programs, and safety net providers where individuals can receive outpatient mental health and SUD services. IBH is a state-based model, led by state Medicaid Agencies, with a goal of aligning payment between Medicaid and Medicare for integrated services. The model will launch in Fall 2024 and is anticipated to operate for eight years in up to eight states and includes a pre-implementation period (model years 1-3). CMS will release a Notice of Funding Opportunity for the model in Spring 2024.

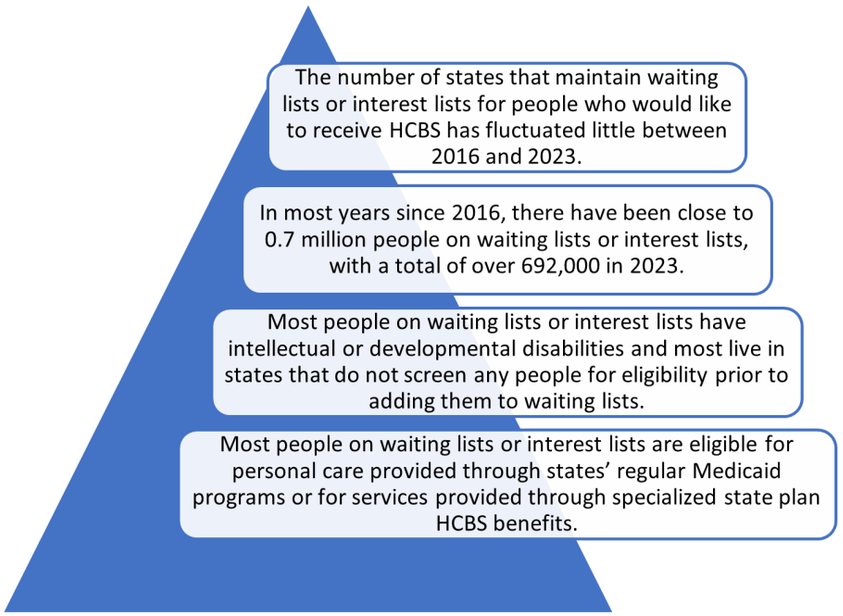
CMCS Bulletin Showcases the Benefits of Direct Support Worker Registries

On December 12, CMCS released an informational bulletin outlining the benefits of direct support worker management platforms—or registries—to connect home and community-based services (HCBS) beneficiaries with workers who provide services. In addition to briefly outlining how states have successfully leveraged registries as a part of their HCBS access and quality strategies, they also noted the potential for these systems to connect workers to their benefits, ongoing education and training, program integrity monitoring, and collect critical data on the workforce. States implementing worker registries can use the enhanced federal matching funds (FMAP) and the American Rescue Plan Act of 2021 temporary 10% FMAP to offset the costs of developing and maintaining these systems.

KFF Survey Highlights Stability and Challenges in Home- and Community-Based Services Waiting Lists

On November 30, the Kaiser Family Foundation (KFF) released results of a survey on HCBS waivers, which revealed that between 2016 and 2023, the number of states with waiting lists has fluctuated between 35 and 41, reaching 38 states in 2023. While HCBS waivers provide flexibility for states to determine services and eligibility, waiting lists are a consequence when demand exceeds available slots. The survey, which broadened terminology to include "interest" lists,

indicated that the number of people on these lists (692,000 in 2023) remained relatively stable over the years, with individuals with intellectual or developmental disabilities comprising a significant portion. Despite an average waiting period of 36 months for HCBS waiver services, individuals on waiting or interest lists are generally eligible for other HCBS through Medicaid state plans, residing in the community during the wait period. Key takeaways include:



The American Academy of Home Care Medicine has been serving the needs of thousands of home care medicine professionals since 1988, through an interdisciplinary team of HBPC care providers working with patients' community supports. Our members include home care physicians, nurse practitioners and physician assistants who make house calls, care for homebound patients, act as home health agency and hospice medical directors, and refer patients to home care agencies; home care organizations; medical directors of managed care plans; and administrators of medical groups interested in home care. Their specialties include internal medicine, family practice, pediatrics, geriatrics, psychiatry, and emergency medicine.

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