Understanding the Future of COVID-19-Related Medicare and Medicaid Flexibilities

WEDNESDAY, MARCH 30, 2022

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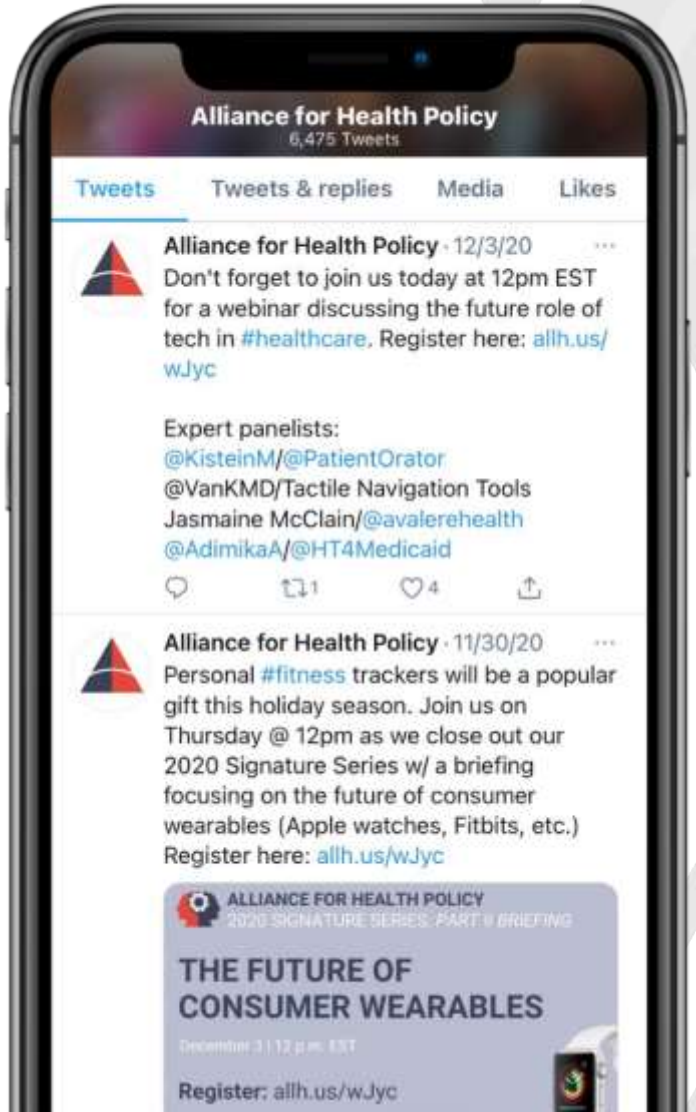

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Understanding the Future of COVID-19-Related Medicare and Medicaid Flexibilities

March 30, 2022

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Agenda

- Background
- Lessons Learned from the Pandemic
- Assessing Temporary Flexibilities for Permanence through a Person-Centered Framework
- Priority Flexibilities for Consideration

Background

Medicare and Medicaid Flexibilities Implemented During the PHE

Hundreds of temporary Medicare and Medicaid regulatory flexibilities were implemented during the public health emergency (PHE) to minimize administrative, clinical, and financial barriers to care.

Categories of Temporary Medicare and Medicaid Regulatory Flexibilities*

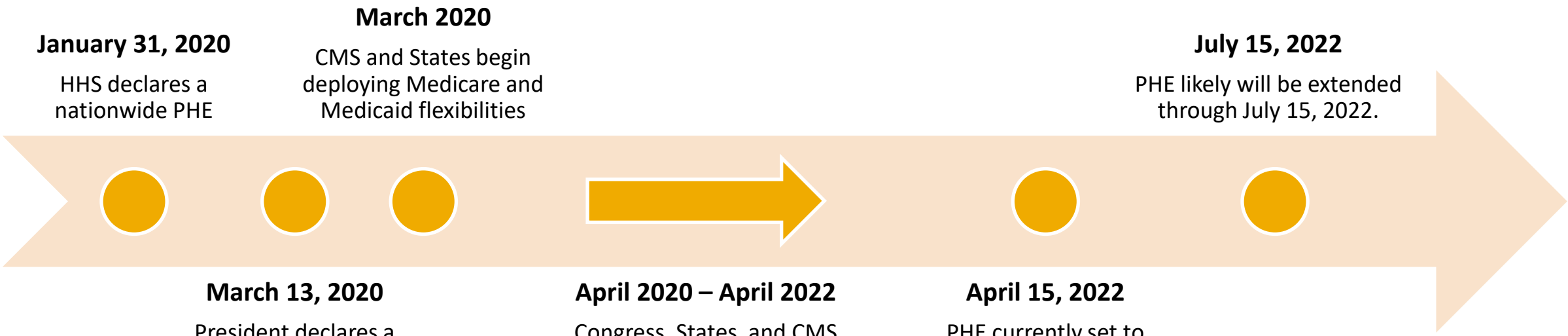
- Expanded program eligibility and enrollment
- Expanded benefits
- Modified care management policies
- Created alternate care sites
- Expanded provider capacity and workforce
- Expanded utilization of telehealth / remote care delivery
- Modified reporting and appeals requirements
- Modified conditions of participation

Recent Publications

- COVID-19 State Resource Guide: Leveraging Federal and State Authorities to Ensure Access to Long-Term Services and Supports for High-Risk Individuals (1st Edition: June 2020; 2nd Edition: February 2021; 3rd Edition: March 2022)
- Ongoing Regulatory Changes to Medicare in Response to COVID-19 (1st Edition: August 2020; 2nd Edition: January 2021)
- Which Medicare Changes Should Continue Beyond the COVID-19 Pandemic? Four Questions for Policymakers (May 2021)

*See Appendix and Recent Publications for detailed lists of flexibilities

Timeline of Medicare and Medicaid Flexibilities



Project Context

The disproportionate impact of COVID-19 on older adults and people with chronic conditions or disabilities underscored the need for person- and community-centered care that advances health equity.

Disproportionate Impact of COVID-19

Older adults (65) comprise nearly 75% of deaths due to COVID-19, and people with disabilities are more likely to be at higher risk of infection and mortality due to underlying medical conditions.

People with disabilities experience disparities in vaccine access.

There are significant and persistent disparities in COVID-19 cases and mortality across race and ethnicity, particularly for American Indian/Alaska Native, Black, and Latino/Hispanic populations. Trans, nonbinary, and other gender-expansive people are at higher risk of COVID-19 transmission and mortality.

Source: COVID-19 Mortality Overview, CDC (January 2022); Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Health Care Providers, CDC (October 2021); Disparities in COVID-19 Vaccination Status, Intent, and Perceived Access for Noninstitutionalized Adults, by Disability Status—National Immunization Survey Adult COVID Module, United States, May 30–June 26, 2021, CDC Morbidity and Mortality Weekly Report (October 2021); COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time, KFF (October 2021); COVID-19 Data on Trans and Gender-Expansive People, Stat!, Health Affairs (May 2021)

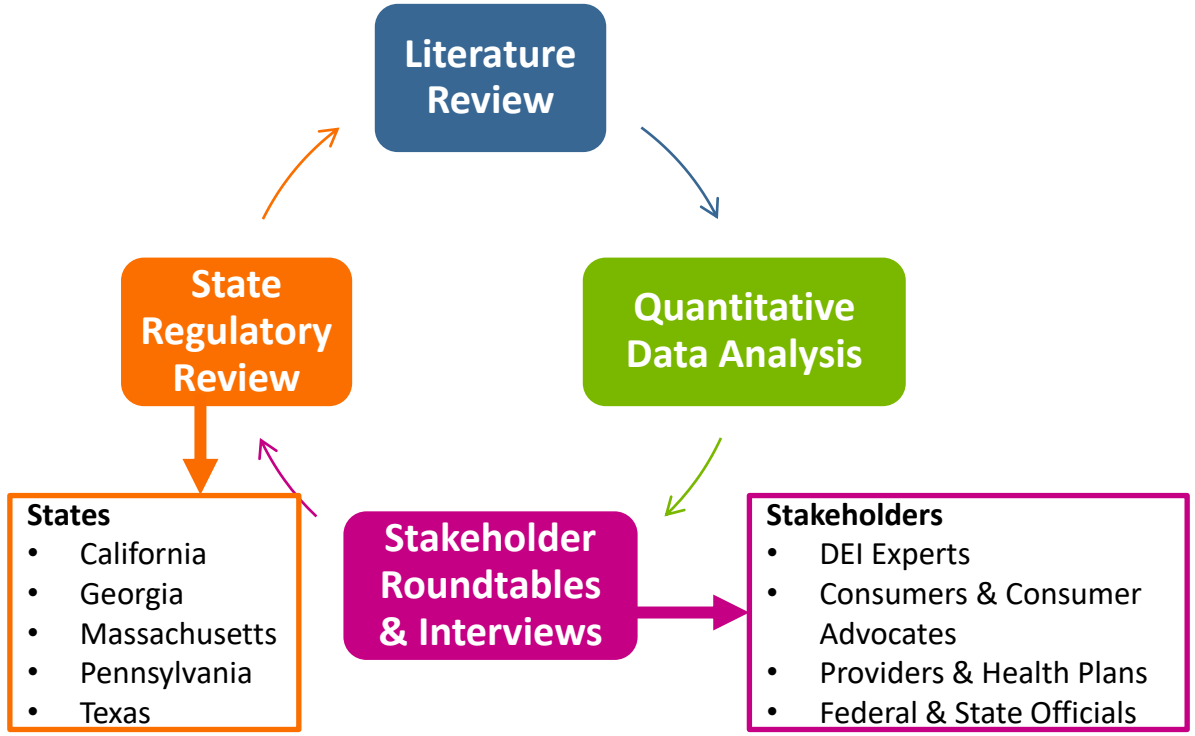
Project Objectives and Approach

HMA and Manatt Health, with the support of The SCAN Foundation:

- ✓ Identified temporary Medicare and Medicaid regulatory flexibilities that advance person- and community-centered care in the least intensive or least restrictive setting and better align Medicare and Medicaid policies and practices;
- ✓ Developed a person-centered framework for federal and state policymakers to assess the impact of flexibilities and make informed decisions about which should be considered for permanence, modification, or further evaluation; and
- ✓ Made initial recommendations on which flexibilities advance person- and community-centered care and advance health equity.

Methodology: Mixed Methods Analysis

The project approach, methodology, and research were guided by The Communications Network DEI framework, including a DEI expert roundtable and diverse voices, perspectives, and experiences.



Lessons Learned from the Pandemic

Lessons Learned: Uneven Data Collection and Reporting

There is growing, but incomplete, data on the impact of the flexibilities on consumers and providers.

- Medicare and Medicaid data demonstrate that **telehealth utilization increased** across all populations, at varying rates, and **additional telehealth visits helped to protect patients' access to care.**
- However, **minimal data exist** related to impacts of increased telehealth utilization **on quality of care and patient outcomes**.
- Stakeholders emphasized the importance of:
  - **Leveraging qualitative data** in the absence of quantitative data; and
  - **Extending flexibilities for further testing and establishing glide paths for permanent implementation** to enable policymakers to better understand budgetary, fraud, abuse, and other implications and incentivize investment by providers and health plans.

> "Absence of evidence is not evidence of absence."
>
> —DEI Roundtable Participant

Sources: Medicare and Medicaid: COVID-19 Program Flexibilities and Considerations for Their Continuation, GAO (May 2021); Stakeholder Roundtables and Interviews

Lessons Learned: Telehealth Enhanced Access to Care

An unprecedented drop in in-person Medicare and Medicaid visits in the early months of the PHE dramatically accelerated the use of telehealth.

Mitigated Disruption in Medicare Visits	Widespread Utilization in Medicaid
▪ Telehealth utilization increased 63-fold between 2019 and 2020 among FFS beneficiaries. The share of telehealth visits increased from <1% to over 5%. ▪ COVID-19 resulted in an unprecedented drop in Medicare visits between 2019 and 2020. – In-person clinician visits fell by 16.1%. – Telehealth partially offset the decline in visits so that *total* visits fell by 11.4% – In-person behavioral health visits fell by 43.8%. – Telehealth partially offset the decline in behavioral health visits so that *total* visits fell by 10.2%.	▪ Telehealth utilization increased more than 20-fold in the early months of the pandemic and continues to remain above pre-pandemic levels. Utilization was higher for behavioral health services than physical health services. ▪ Between February 2020 – April 2020: – Telehealth utilization rates increased from 6 to 150 telehealth services per 1,000 Medicaid and CHIP beneficiaries. – The number of states allowing Medicaid telehealth visits more than doubled for some types of services (e.g., LTSS). – Many states expanded telehealth modalities to include telephone-only and text-based communications and expanded originating sites to include people's homes.

Sources: Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location, ASPE (2021); Medicaid & CHIP and the COVID-19 Public Health Emergency, Preliminary Medicaid & CHIP Data Snapshot, Services through October 31, 2020. CMS.; Stakeholder Roundtables and Interviews

Lessons Learned: Opportunities to Align the Medicare and Medicaid Programs

In many cases, temporary Medicare and Medicaid flexibilities aligned previously misaligned policies. A return to pre-pandemic policies may be a missed opportunity to reduce programmatic and regulatory complexity for consumers and providers.

	Medicare		Medicaid		
	Temporary Flexibility	Permanent Policy	Temporary Flexibility	Permanent Policy	Policy Alignment Opportunity
Can patients use telehealth…					
in their homes?	✓	✗	✓	✓	Allow patients to use telehealth in their homes
in urban areas?	✓	✗	?	✓ ?	Allow patients in urban areas to use telehealth
without video?	✓	✗	✓	✓ ✗	Allow patients to use audio-only telehealth if they need or prefer to
for a visit with a new provider?	✓	✓	✓ ?	✓ ?	Allow patients to use telehealth for a first visit with a new provider
Can all types of clinicians who can bill the program provide services…					
using telehealth?	✓	✗	✓	✓	Allow all clinicians to use telehealth
without physician supervision?	✗ Added: • PAs	✗ Limited to: • NPs • PAs (added in 2022)	✗ Added: • APRNs • PAs (in more states)	✗ Limited to: • Mental health clinical specialists • NPs • Nurse anesthetists • Psychiatric nurses (in some states)	Allow mental health clinical specialists, NPs, nurse anesthetists, PAs and psychiatric nurses to treat patients without physician supervision
via telehealth (or in person) with out-of-state licenses?	✓	✗	✓ ?	✓ ?	Allow clinicians to provide care with out-of-state licenses

Medicaid policies in five states (CA, GA, MA, PA, and TX) are included as examples of the differences in policies across the country.

Key: ✓ Permitted (in Medicare or at least one example state) ✗ Not permitted (in Medicare or at least one example state) ? Regulation unclear (in at least one example state)

Assessing Temporary Flexibilities for Permanence through a Person-Centered Framework

Person-Centered Assessment Framework: Assessment Criteria and Instructions for Policymakers

The person-centered assessment framework is a user-friendly tool for federal and state policymakers to assess the impacts of temporary Medicare and Medicaid regulatory flexibilities. The framework was tested and refined through stakeholder input.

Assessment Criteria

1. Ability to advance person- and community-centered care by meeting the needs of people and communities based on who and where they are, and mitigating program obstacles to care created by or predating COVID-19.
2. Ability to facilitate care in the least intensive or least restrictive setting, based on a person's needs, goals and preferences.
3. Ability to better align Medicare and Medicaid program rules to enable people to seamlessly access care regardless of their insurance status and enable providers participating in both programs to deliver care quickly, nimbly and uniformly.

Instructions for Appropriate Use

- Policymakers can answer the following questions for each flexibility they consider for permanence, modification, or further evaluation.
- No single question or group of questions should determine whether a flexibility should be made permanent or extended.
- Policymakers may choose to weigh certain questions, such as consumer impact, more heavily.
- Policymakers should consider quantitative and qualitative data when answering the questions.

For more information, see "Moving Toward More Person-Centered Medicare and Medicaid Programs: A Policymaker Playbook".

Person-Centered Assessment Framework for Policymakers

Benefits and Risks

What is the impact on consumers, communities, federal and state programs, providers, and health plans?

1. What are the potential benefits and risks for consumers? Consider, for example, out-of-pocket spending, access to care, quality of care, health outcomes, consumer choice, risk of institutionalization.
2. How do potential benefits and risks for consumers vary based on an individual's social determinants of health? Includes but is not limited to race and ethnicity, language(s) spoken, gender or sexual orientation, age, ability or disability, geographic location.
3. What are the potential benefits and risks for communities? Consider, for example, provider stability, access to services, social determinants of health, population health, community resiliency.
4. What are the potential benefits and risks to the Medicare and Medicaid programs? Consider, for example, federal and state policy and payment goals, regulatory simplification and alignment between federal and state rules, program spending, risk of fraud and abuse by providers and health plans.
5. What are the potential benefits and risks to providers and health plans? Consider, for example, administrative workload, focus on care delivery, provider capacity, provider diversity, care management processes and activities, pay equity for workforces that are disproportionately comprised of women and/or people of color (e.g., direct care).

Informed Decision Making

What is the rationale for and feasibility of permanent reform?

1. Are there sufficient qualitative or quantitative data to assess the effects of the temporary flexibility?
2. Did consumers and providers commonly use the temporary flexibility and in what context?
3. Did the temporary flexibility directly impact the disparities and inequities faced by marginalized populations?
4. Could policymakers modify the temporary flexibility to ensure a more equitable impact?
5. Are there barriers to adoption among stakeholders and policymakers?
6. If needed, could policymakers modify the temporary flexibility to address barriers to adoption among stakeholders?
7. Is it necessary to continue evaluating the flexibility and gathering data after the PHE ends before deciding whether to make the flexibility permanent?
8. Are there other reasons not already identified to make this flexibility permanent?

Authority

Which entity has the authority and should be responsible for making the temporary flexibility permanent?

1. Which entities have the authority to make the temporary flexibility permanent (e.g., Congress, HHS, state legislature, state executive branch)?
2. What is the most feasible and effective vehicle or approach for making the temporary flexibility permanent?

Priority Flexibilities for Consideration

Priority Flexibilities for Permanence, Modification, or Further Exploration

Several flexibilities stand out for priority consideration based on their ability to advance person- and community-centered care in the least intensive or least restrictive setting and better align Medicare and Medicaid program rules.

Category*	Description
Expand Telehealth Benefits	Targeted and equitable expansion of remote care delivery opportunities, particularly telehealth, for all beneficiaries
Modify Provider Scope of Practice and Other Requirements	Modifications to provider licensure, scope of practice, qualifications and payment rates to strengthen and expand the workforce (clinical providers, direct care workers and paid family caregivers)
Modify Medicare Advantage (MA) Requirements	Modifications to MA requirements related to telehealth, risk adjustment and midyear benefit enhancements to support person-centered care
Other Temporary Flexibilities	Adjustments to other Medicare and Medicaid program requirements such as three-day prior hospitalization requirement for skilled nursing facility (SNF) stays, self-directed home- and community-based services (HCBS) and long-term services and supports (LTSS) financial eligibility rules

*See Appendix for more detail on priority flexibilities

Priority Flexibilities for Permanence, Modification, or Further Exploration: Medicare Example

Medicare Flexibility: Allowing Physicians and Nonphysician Practitioners to Provide Services in States in Which They Are Not Licensed	
Benefits, Risks, and Other Considerations	Potential Authority for Permanence

• **Benefits:**
  ○ Improves access to care in states and communities with limited participating providers
  ○ Advances person-centered care by expanding beneficiary choice in providers
  ○ Advances equity by enabling beneficiaries with fewer financial and other resources to access care at distant centers of excellence
• **Risks:**
  ○ An overreliance on out-of-state providers may perpetuate small provider networks in rural and other under-resourced areas
  ○ Greater disparities for rural and under-resourced areas with less access to broadband and technology required for telehealth visits
  ○ Fraud and abuse by providers and health plans
• **Other Considerations:**
  ○ Potentially significant political challenge from provider groups
	• Federal legislation and subsequent rulemaking is required to modify this Medicare policy
	• Similar legislation has been enacted for Veterans Administration (VA) health, Department of Defense (DOD) health, and Indian Health Service

Priority Flexibilities for Permanence, Modification, or Further Exploration: Medicaid Example

Medicaid Flexibility: Institute or expand opportunities for self-directed HCBS (e.g., personal support, transportation, personal care attendant, home-delivered meals), including expanding access to paid family caregiving	
Benefits, Risks, and Other Considerations	Potential Authority for Permanence

• **Benefits:**
  ○ Enables beneficiaries to tailor services and select caregivers according to their preferences
  ○ Financial support sustains families and communities and mitigates provider workforce shortages
• **Risks:**
  ○ Need to further evaluate impact on quality, outcomes, and person-centeredness
• **Other Considerations:**
  ○ 1915(c) HCBS waiver services must be furnished by qualified providers defined in the 1915(c) technical guidance
	• Medicaid authorities supporting self-directed services include 1915(c), 1915 (i), 1915(j), 1915(k), and 1115
	• 1915(c) is the most used authority to authorize self-directed services
	• During the PHE, most states made changes to self-direction through an Appendix K - states can reach out to their CMS state lead to begin the process of extending flexibilities

Where Do We Go From Here?

- More data collection and analysis is needed to fully understand how flexibilities advance person- and community-centered care and health equity.
- In the meantime, policymakers can use the person-centered assessment framework and priority flexibilities described in the Issue Brief and Playbook to begin assessing flexibilities for permanence, modification, or further evaluation.
- Stakeholders urged policymakers to consider a third option in their assessment of whether to unwind a temporary flexibility or make it permanent: extend flexibilities for further evaluation.
- Numerous grantees and researchers funded by The SCAN Foundation will continue to assess the impacts of temporary flexibilities to inform policymakers' assessments and decisions.

Understanding the Future of Covid-Related Medicaid and Medicare Flexibilities

Presenter: Lisa Hayes,

Executive Director, Rolling Start, Inc.
A Center for Independent Living

The Independent Living Network: NCIL

- The National Council on Independent Living (NCIL) is the longest-running national cross-disability, grassroots organization run by and for people with disabilities.
- NCIL represents thousands of organizations and individuals throughout the US including:
  - Individuals with disabilities
  - Centers for Independent Living (CILs)
  - Statewide Independent Living Councils (SILCs)
  - Other organizations that advocate for the human and civil rights of people with disabilities.

www.ncil.org

NCIL
National Council on Independent Living

The Independent Living Network: CILs

- Centers for Independent Living are consumer-controlled, community-based, cross-disability, nonresidential, nonprofit agencies designed and operated by people with disabilities;
- Funded to provide five (5) Core Services
  - I & R, Peer Support, Advocacy, Independent Living Skills & Transitions*
- All Ages
- Low Income, people living below the poverty level, undocumented;
- People managing chronic conditions;
- Utilizers of Medicaid, Medicare & Duals

* Services may vary based on community needs

NCIL
National Council on Independent Living

Wrap-Around Social Services

- Traditionally In-Person
- Goal Setting
- Person Centered/Independent Living Plans
- 1:1 Support
- Social / Group Support
- 30/60/90 Follow-Ups

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on Independent Living

Addressing Social Determinants of Health in a Pandemic

- Collaborations with health plans & other CBOs
- Addressing the Digital Divide
- Managing Fear
  - Social Isolation
  - Health care rationing
  - Getting infected – PPE needs of consumers, caregivers, family
- Gaps Identified
  - Consistent caregiving; back-up provider shortages;
  - Access to food, special diet needs;
  - Access to Assistive Technology to avoid NF placement
  - Rental Assistance, Utility Assistance;
  - Vaccine prioritization;
  - Home Health, In-Home Vaccinations

Recommendations:

- HCBS Funding is critical
  - Sustainable wages for Caregivers
  - Back-up Caregiver Registry's
  - Housing
  - Permanently authorization of MFP
  - Utilization of CHW's to support health education
  - LTSS
    - Broader lens
      - Emergency Preparedness
      - Bridging digital divide
      - Day Habilitation

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Understanding the Future of COVID-Related Medicare and Medicaid Flexibilities

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About NASHP

The National Academy for State Health Policy (NASHP) is a nonpartisan organization committed to developing and advancing state health policy innovations and solutions.

NASHP provides a unique forum for the productive exchange of strategies across state government, including the executive and legislative branches.

State Priorities in 2022

Health Care Workforce

Behavioral Health

Cost of Health Care

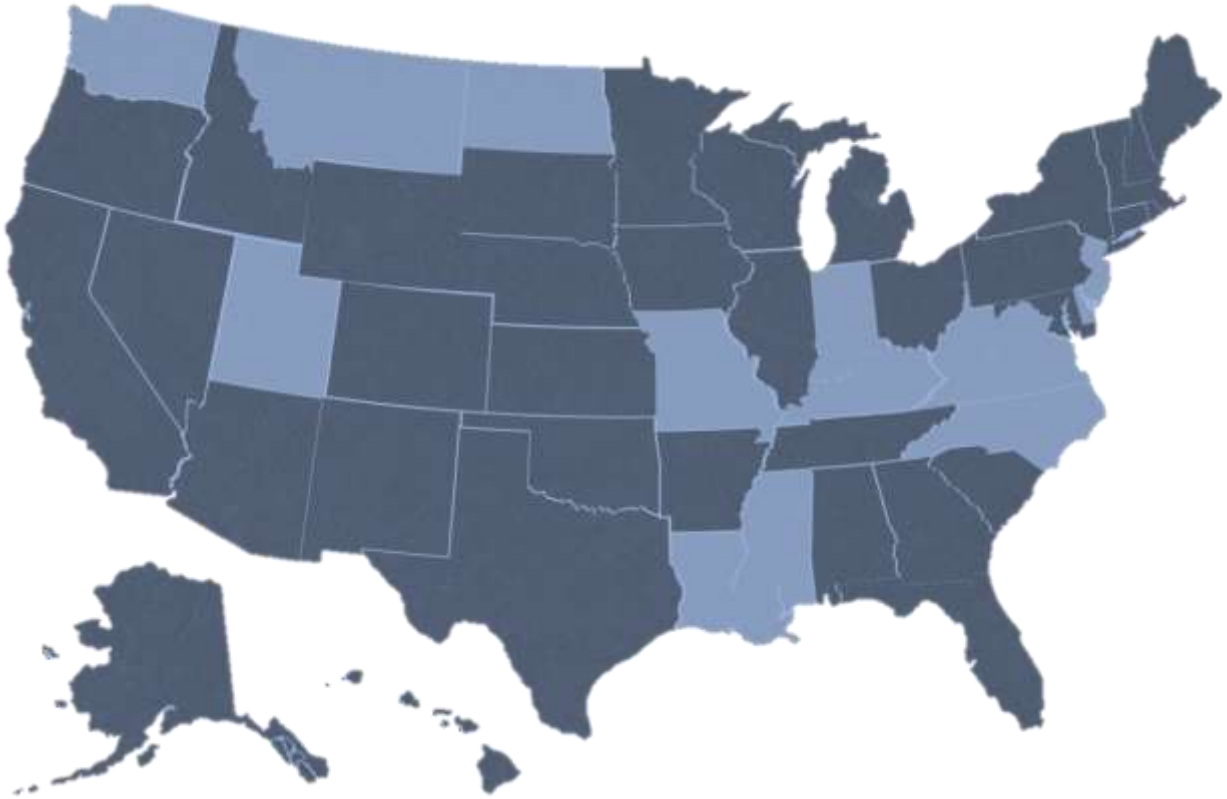
Public Health

Social Determinants of Health (SDOH) and Equity

Thirty-Six States Are Electing Governors in 2022

8 of these elections are guaranteed to result in a new governor

- 7 governors are termed out (AZ, AR, HI, MD, NE, OR, PN)
- 1 governor has announced he won't run again (MA)



Source: fivethirtyeight.com

Medicaid and CHIP COVID-19 Response Declarations and Flexibilities

- Section 1135 Waivers
- Medicaid and CHIP Disaster SPAs
- Section 1915(c) Appendix K
- Emergency Section 1115 Demonstration Waivers
- Enhanced FMAP and MOE/ Continuous Coverage
- Optional COVID-19 Eligibility Group

Eligibility and Enrollment

- Continuous Medicaid eligibility
- Coverage of the optional COVID-19 eligibility group
- Flexible approach to eligibility criteria
- Extend or expand presumptive eligibility
- Eliminate, waive, or suspend enrollment fees, premiums, and cost-sharing

Workforce

- Increased provider reimbursement and interim payments
- Relaxed provider licensure, expand out-of-state providers, and provider screening requirements
- Services provided by graduate clinicians
- Reduced supervision of physician or dentist for certain providers

Benefits and Service Provision

- Add new optional benefits or adjust existing benefits
- Exceptions and changes to preferred drug list
- Allow service provision in unlicensed facilities
- Allow services provided via telehealth, at homes, schools, outdoors, or other community locations
- Payment parity for telehealth

Administrative

- Suspend, waive, or extend prior authorizations
- Require providers to extend pre-existing prior authorizations
- Bypass health plan appeals for fair hearing
- Extend timeframe for requesting a fair hearing

Long Term Services and Supports

- Suspend PASRR for 30 days
- Extend settings for HCBS for continuation of services
- Allow verbal consent
- Adjust reassessment dates and requirements
- Reimburse for personal care services rendered by family caregivers

KFF Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19; SHVS Federal Declarations and Flexibilities Supporting Medicaid and CHIP COVID-19 Response Efforts

Preparing For The End of The PHE: Telehealth

Telehealth Flexibilities

- Licensure requirements
- Payment parity for telehealth and in-person services
- Modalities for delivery (from home, telephone-only, text-based, remote patient monitoring)
- Services and specialties eligible for telehealth (dental, maternity care, behavioral health, and long term services and supports)

State Considerations

- Assessing appropriate modalities of care delivery
- Avoiding creating disparities in standards or levels of access
- Assessing impacts on lowering costs, improving quality of care
- Addressing rapid spending growth, if implementing payment parity
- Impact on provider networks

National Law Review: COVID-19 State Law Telehealth Update; Manatt Executive Summary: Tracking Telehealth Changes State-by-State; NASHP 2022 State of the State Addresses; Learning from COVID-19 Related Flexibilities

Preparing For The End of The PHE: Workforce

Workforce Flexibilities

- Increased compensation and interim/ retainer payments
- Provider licensure and screening requirements
- Out-of-state providers and graduate clinicians
- Practicing at the top of license

State Considerations

- Balancing access and quality
- Costs of increased compensation
- Political implications
- Additional state workforce programs

National Law Review: COVID-19 State Law Telehealth Update; Manatt Executive Summary: Tracking Telehealth Changes State-by-State; NASHP 2022 State of the State Addresses

Preparing For The End of The PHE: Home and Community Based Services

HCBS Flexibilities

- Coverage of services in alternate settings (remote, temporary living situations, day services in homes, etc.)
- Coverage for nontraditional providers
- Increased payment rates or offered retainer payments
- Expanded eligibility or increased the number of participants
- Created or expanded opportunities for self-direction
- Added services (home delivered meals, medial supplies and equipment, assistive technology)

State Considerations

- Impacts on utilization, cost, and quality
- Impacts on waiver capacity
- Enrollee and family feedback
- Additional state programs (such as those implemented through the enhanced match for HCBS)

NASHP 2020 States Use Appendix Ks to Provide Innovative Flexibilities for Medicaid Enrollees and Caregivers during COVID-19 Brief and Map; SCAN 20221 COVID-19 State Resource Guide

Thank you!

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Please fill out the evaluation survey you will receive immediately after this presentation, or via email this afternoon!

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UPCOMING EVENTS

NEW THREE-PART SERIES!

The Future of Medicare

April 22, May 6, & May 20 | 10:00 am – 11:30 am ET

This series will provide foundational education about the mechanisms of the Medicare program to help decisionmakers and other stakeholders consider the tradeoffs of policy options to promote Medicare sustainability. Panelists will explore the implications of policy options for the delivery system, beneficiaries, and the overall financial health of the Medicare program.

https://www.allhealthpolicy.org/the-future-of-medicare-medicare-101/

THANK YOU FOR ATTENDING!

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Appendix

Temporary Medicare Regulatory Flexibilities

Policy Goals of Temporary Medicare Regulatory Flexibilities (Full Catalog of Flexibilities available here)
Benefits and Care Management
Expanding the definition of “homebound” status to include patients when a physician has determined that because of COVID-19 it is medically contraindicated for the patient to leave the home.
Waive the 3-day prior hospitalization requirement for SNF stays.
Allow MAOs to expand telehealth and other mid-year benefit enhancements.
Alternate Care Sites
Permit hospital expansion sites, including psychiatric hospitals and CAHs, and allow those sites to provide services in other healthcare facilities and to set up temporary expansion sites, if approved by the state.
Allow other entities, such as ASCs and independent licensed EDs, to provide hospital services and waive 24-hour nursing for these sites
Partially waive enforcement of EMTALA by permitting hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital’s campus, if the screening is not inconsistent with the state emergency preparedness or pandemic plan.
Allow Community Mental Health Centers' (CMHCs) to provide partial hospitalization services in an individual’s home and via telehealth.
Allow dialysis facilities to provide services in alternate locations, such as nursing homes, long-term care facilities, and assisted living facilities.
Provider Capacity and Workforce
Allow physicians and NPPs to provide services in states in which they are not licensed for individuals who meet certain conditions.
Reduce physician supervision requirements for certain services, so the supervising physician is not required to be immediately available.
Permit physicians in hospitals and SNFs to delegate any tasks to PAs, NPs, or CNSs acting within the scope of practice laws defined by state law and continuing to be under supervision of physician.
Waive requirements that Medicare patients be under the care of a physician to allow hospitals to use other practitioners, such as PAs and NPs to the fullest extent possible.

Source: Medicare Policy Tracker and HMA analysis of information from CMS.

Temporary Medicare Regulatory Flexibilities Implemented During the PHE (continued)

Policy Goals of Temporary Medicare Regulatory Flexibilities (Full Catalog of Flexibilities available here)
Telehealth/Remote Service Delivery
Allow multiple services to be provided by telehealth, including home visits, PT/OT/SLP visits, ED services, hospice routine care visits, and inpatient and nursing follow-up care.
Allow telehealth in urban locations and patients homes.
Permit audio-only telehealth services, including E/M services, for new and established patients.
Allow FQHCs and RHCs to use telehealth.
Set E&M payment rates equal for telehealth and in-person visits.
Permit physicians to provide direct supervision through virtual presence.
Permit remote physiological monitoring (RPM) services for both acute and chronic conditions.
Include diagnoses that MA organizations collect only by two-way AV telehealth for risk adjustment.
Conditions of Participation
Permit acute care hospitals to shift inpatients between distinct part units, e.g., rehabilitation, psychiatric.
Allow certain hospital services to be provided remotely, including in patients' homes.
Allow most hospitals to establish SNF swing beds.
Waive the IRF 3-hour rule that requires that a beneficiary be reasonably expected to actively participate in, and benefit from, an intensive rehabilitation therapy program at least 3 hours per day at least 5 days per week.
Waive some Stark Law provisions, such as permitting group practices to MRIs, CT scans, or clinical laboratory services from locations like mobile vans in parking lots that the group practice rents on a part-time basis.

Source: Medicare Policy Tracker and HMA analysis of information from CMS.

Temporary Medicaid Regulatory Flexibilities

Policy Goals of Temporary Medicaid Regulatory Flexibilities (Full Catalog of Flexibilities available here)
Eligibility and Enrollment
Increase the availability of HCBS in order to prevent a beneficiary from losing access to services or to minimize the number of individual receiving care in acute or institutional settings
Modify Medicaid eligibility determination requirements, including verification processes to reduce the number of uninsured individuals and expand access to HCBS
Benefits and Care Management
Provide beneficiaries with flexibility in how they access services, to prevent gaps in services if the traditional workforce is diminished
Expand available services to ensure individuals can remain in their homes during the public health emergency and stay-at-home orders
Suspend or modify administrative requirements to access care to prevent gaps in services when in-person visits are not possible due to stay-at-home orders or other social distancing requirements
Address financial barriers to accessing services that arise during the public health emergency
Alternate Care Sites
Segregate individuals with confirmed COVID-19 to minimize spread in nursing homes
Ensure individuals receiving care in the community continue to do so when certain HCBS settings are inaccessible
Provide care virtually to minimize exposure to COVID-19 for beneficiaries and providers
Provider Capacity and Workforce
Expand the number and types of people eligible to provide HCBS to prevent gaps in services
Ensure provider sustainability in light of lost revenue due to increased cost related to COVID-19
Reporting and Appeal Requirements
Monitor the impact on and risk of COVID-19 exposure for HCBS waiver participants
Reduce administrative burdens for providers and recipients

Source: COVID-19 State Resource Guide: Leveraging Federal and State Authorities to Ensure Access to Long-Term Services and Supports for High-Risk Individuals

Priority Flexibilities for Permanence and Further Exploration: Expand Telehealth Benefits

Priority Telehealth Flexibilities to Consider for Permanence or Continued Evaluation

Program	Flexibility	Authority
Medicare	Allow telehealth in urban locations	Federal legislation
Medicare	Allow telehealth in patients' homes	Federal legislation
Medicare	Permit audio-only telehealth services when these are needed or preferred by patients	Federal regulation or legislation
Medicare	Allow nonphysician practitioners to provide telehealth services	Federal legislation
Medicare	Set payment rates for evaluation and management visits equal for telehealth and in person	Federal regulation or legislation
Medicare	Allow physicians and nonphysician practitioners to provide services in states in which they are not licensed	Federal legislation
Medicaid	Expand utilization of state plan and HCBS waiver remote service benefits	State administrative or legislative action (option is available on a permanent basis outside of a PHE)
Medicaid	Expand remote service delivery to include audio-only modalities	State administrative or legislative action (option is available on a permanent basis outside of a PHE)

Benefits, Risks, and Other Considerations
• Advances person-centered care for consumers who prefer virtual visits or have difficulty attending in-person visits
• Connects communities with limited provider networks with specialty care
• Improves access to behavioral health – stigma prevents patients from accessing in-person services
• Significant regulatory and legislative momentum
• Strong potential for aligning Medicare and Medicaid programs
• Need to ensure equitable access given disparate access to broadband and technology, clinically appropriate care, and sustainable payment policies

Priority Flexibilities for Permanence and Further Exploration: Modify Provider Scope of Practice and Related Requirements

Priority Provider Scope of Practice and Related Flexibilities to Consider for Permanence or Continued Evaluation

Program	Flexibility	Authority
Medicare	Permit physicians to delegate tasks to nonphysician practitioners in hospitals and skilled nursing facilities	Federal regulation or legislation
Medicare	Waive physician supervision of certified registered nurse anesthetists at the discretion of the hospital, critical access hospital or ambulatory surgical center	Federal regulation or legislation
Medicare	Reduce requirement for physician supervision of nurse practitioners and physician assistants in federally qualified health centers and rural health clinics	Federal regulation or legislation
Medicare	Allow physicians to delegate SNF visits to a nurse practitioner, physician assistant or clinical nurse specialist	Federal regulation or legislation
Medicaid	Allow out-of-state providers to provide and receive payment for long-term services and supports (LTSS) through expedited licensing processes and modified requirements, or under special circumstances	State administrative or legislative action (option is available on a permanent basis outside of a PHE)
Medicaid	Expand the number and types of providers eligible to provide HCBS (e.g., authorizing nonphysician practitioners to order services without physician supervision)	State administrative or legislative action (option is available on a permanent basis outside of a PHE)
Medicaid	Temporarily increase payment rates for HCBS to maintain provider capacity despite service suspensions and volume reductions	State administrative or legislative action (option is available on a permanent basis outside of a PHE)
Medicaid	Provide retainer payments to LTSS providers to maintain provider networks despite reductions in service utilization	State administrative or legislative action (option is available on a permanent basis outside of a PHE)

Benefits, Risks, and Other Considerations

- Maintains continuity of care, provider capacity, and consumer choice, particularly for rural, under-resourced communities
- Enhanced provider payments and retainer payments helped mitigate service reductions and support women- and minority-led direct care workforce
- Strong potential for aligning Medicare and Medicaid programs
- Changes may not be politically feasible given implications for administrative burden and complexity of structural shifts in provider requirements, networks, and risk pools
- Need to further evaluate impact on quality of care, cost, provider capacity, and workforce
- Need to ensure any reliance on out-of-state providers does not inhibit growth of local networks or increase risk of clinically inappropriate services

Priority Flexibilities for Permanence and Further Exploration: Modify Medicare Advantage (MA) Requirements

Priority MA Flexibilities to Consider for Permanence or Continued Evaluation

Program	Flexibility	Authority
Medicare	Allow MA organizations to expand telehealth and other midyear benefit enhancements	Federal regulation or legislation
Medicare	Include diagnoses that MA organizations collect by two-way, audio-video and by audio-only telehealth for risk adjustment	Federal regulation or legislation

Benefits, Risks, and Other Considerations
• Ensures the ~40% of Medicare beneficiaries enrolled in an MA plan can use telehealth to the same degree as FFS enrollees • Improves access to care, continuity of care, and, and quality of care • Advances person-centered care for individuals who prefer telehealth visits for risk adjustment • Risk of increased program spending because MA risk adjustment system is more costly for MA than FFS enrollees. • Need to ensure equitable access given disparate access to broadband and technology, clinically appropriate care, and sustainable payment policies

Priority Flexibilities for Permanence and Further Exploration: Other Temporary Flexibilities

Other Priority Flexibilities to Consider for Permanence or Continued Evaluation

Program	Flexibility	Authority
Medicare	Waive three-day prior hospitalization requirement for SNF stays	Federal legislation
Medicaid	Institute or expand opportunities for self-directed HCBS (e.g., personal support, transportation, personal care attendant, home-delivered meals), including expanding access to paid family caregiving	State administrative or legislative action (option is available on a permanent basis outside of a PHE)
Medicaid	Apply less restrictive income or asset rules or counting methodologies for individuals most likely to use LTSS (e.g., eliminating resource tests for people with disabilities, not counting unemployment compensation)	State administrative action (option is available on a permanent basis outside of a PHE, as recently clarified in the "rule of construction")

Benefits, Risks, and Other Considerations

- Person-centered for individuals who require SNF services without a hospital admission and those with acute/post-acute needs
- Expanded enrollment for individuals who wouldn't normally be eligible for LTSS
- Need for federal legislation and rulemaking to modify Medicare policies; need for alignment with regulatory and statutory frameworks to modify Medicaid policies
- Need to further evaluate consumer impact and modifications to ensure person-centeredness
- Need to further evaluate effective income and asset rules to balance expanded access with cost

Additional Grantees of The SCAN Foundation Researching Care Delivery for Older Adults and People with Complex Care Needs or Disabilities in Medicare/Medicaid

- Milken Institute
- Duke Margolis Center for Health Policy
- Convergence Center for Policy Resolution
- Bipartisan Policy Center