



2021 FORUM

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*Transforming Medicare and
Medicaid Beyond COVID-19 for a
Person-Centered Future*



Highlights from COVID-19 State Resource Guide:

Leveraging Federal and State Authorities to
Ensure Access to Long-Term Services and
Supports for High-Risk Individuals

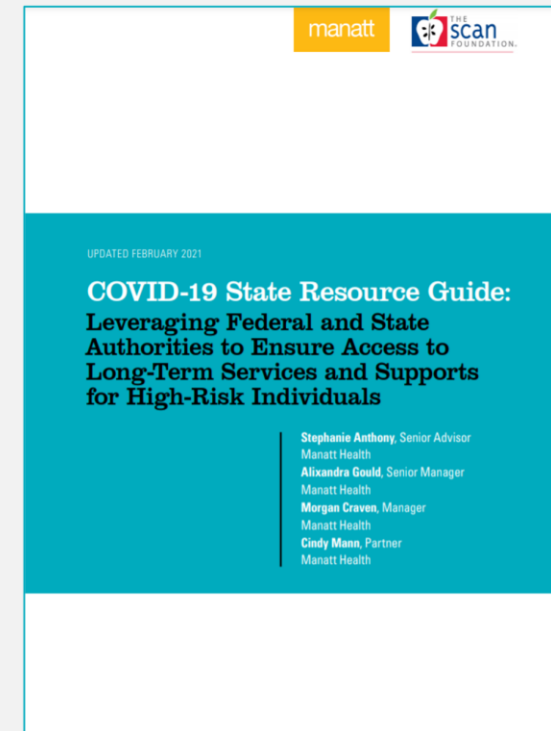
Update February 2021



COVID-19 LTSS State Resource Guide

In an updated and expanded [resource guide](#), prepared on behalf of The SCAN Foundation, Manatt identified federal and state Medicaid flexibilities available to state officials and other stakeholders to ensure access to long-term services and supports (LTSS). The guide reviewed:

- COVID-related regulatory flexibilities put in place by states since the beginning of the public health emergency.
- State implementation examples of how those flexibilities are being deployed.
- How states have leveraged federal funding to respond to the pandemic.



Available Federal and State Authorities

CMS provided disaster authority application templates and technical assistance to states applying for flexibilities. As a result, the types of flexibilities requested and approved across states is consistent with a few exceptions.

Federal Authorities Used for LTSS Regulatory Flexibilities

- **1915(c) Waiver Appendix Ks** are the primary vehicle for emergency LTSS flexibilities and apply to services authorized via 1915(c) or 1115 waivers.
- **Section 1135 Waivers** target a wide range of Medicaid, CHIP, and Medicare requirements and are often issued by CMS as “blanket waivers.” State-specific 1135 waivers targeting LTSS are limited, though many blanket waivers impact LTSS recipients and providers.
- **Disaster State Plan Amendments (SPAs)** are used to approve a wide variety of Medicaid flexibilities, including eligibility and enrollment criteria and reimbursement rates. Disaster SPAs target only state plan LTSS.
- **1115 Disaster Waivers** have been approved by CMS in small numbers -- 10 states to date. Most 1115 disaster waiver provisions extend HCBS-type flexibilities available under Appendix K to beneficiaries receiving LTSS under SPA authority.

Expiration dates for each of these authorities varies but are related to end of the public health emergency declaration, which is expected to last through the end of 2021.

State Authorities Used for LTSS Regulatory Flexibilities

- States are able to modify a variety of LTSS rules, including those pertaining to provider credentialing, licensure, oversight, worker pay, and service delivery modalities (including telehealth), providing the modifications or flexibilities don't conflict with federal rules.



State Priorities in Responding to COVID-19

States' COVID-19 responses focused on delivering LTSS remotely, removing barriers in access to care, and stabilizing providers and the LTSS workforce.



Maximizing remote service delivery to ensure access to care while protecting the health and safety of both beneficiaries and providers.



Expanding and stabilizing the provider workforce through modified credentialing, modified care management processes, and enhanced pay/rates.



Maximizing Remote Service Delivery

Delivering LTSS remotely has been a primary focus for state LTSS policymakers, with states supplementing in-person services with both telephonic and live video services.

How States Use Flexibilities

- Authorized **remote delivery of LTSS benefits** that previously could only be delivered in-person.
- Modified the **amount, scope, or duration of LTSS** that can be delivered remotely.
- Authorized **beneficiary assessments/reassessments and care planning** to be done remotely.
- Added **assistive technologies** that facilitate remote delivery of services as an available waiver service.

Some LTSS (e.g., assistance with daily care needs, such as bathing and dressing) cannot be delivered remotely. So states used emergency authorities to expand access to in-person supports or to provide care in alternative settings, with appropriate PPE and socially-distanced when possible.

State Examples

- **California** used Appendix K authority to add assistive technology as a waiver service to provide enrollees with equipment and training on remote technologies (e.g., computer monitors, video cameras, cell phone or tablet, software cost, maintenance, and installation).
- **Virginia**'s Governor extended an executive order from early in the pandemic to allow providers to use any available "non-public facing audio or remote communication product" to communicate with patients for any reason regardless of whether the communication is related to the diagnosis and treatment of COVID-19.

Sources: [https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-57-SECOND-AMENDED---Licensing-of-Health-Care-Professionals-in-Response-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-57-SECOND-AMENDED---Licensing-of-Health-Care-Professionals-in-Response-to-Novel-Coronavirus-(COVID-19).pdf)

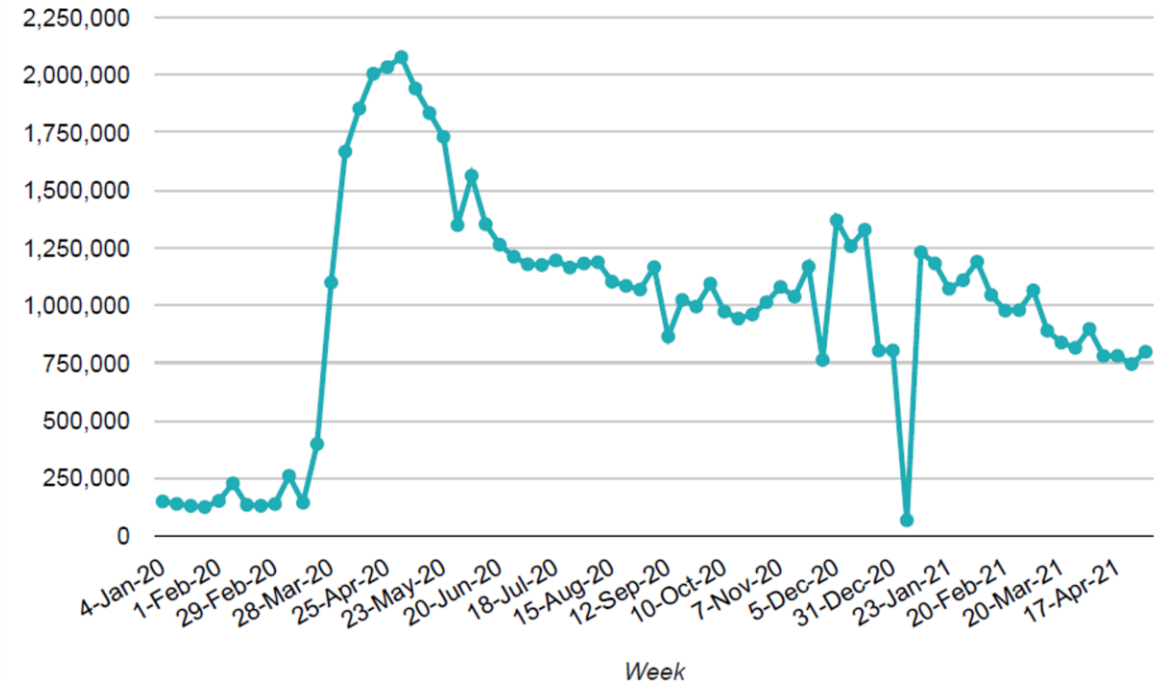


Expanding Access to Remote Care for Older Adults

- **Telehealth service volume for all payers increased dramatically in 2020**, enabled by significant new regulatory flexibilities introduced by CMS and due to safety risks that in-person care poses for older adults during the pandemic.
- However, research has found that **more than a third of adults over age 65 face potential difficulties** engaging in virtual care, with the greatest challenges experienced by older, low-income men in remote or rural areas, especially those with disabilities or poor health.
- **Telemedicine use has decreased after peaking in May 2020**. Despite the continuation of the pandemic, weekly telemedicine visits declined by 60% between May 2020 and April 2021. Concerns about provider reimbursement for telemedicine have slowed provider investment in technology platforms and

Source: UCSF, COVID-19 Pandemic Drives Telehealth Boom, But Older Adults Can't Connect, August 2020, <https://www.ucsf.edu/news/2020/08/418201/covid-19-pandemic-drives-telehealth-boom-older-adults-cant-connect>; Kaiser Health News, Technology Divide Between Senior 'Haves' and 'Have-Nots' Roils Pandemic Response, July 2020 <https://khn.org/news/technology-divide-between-senior-haves-and-have-nots-roils-pandemic-response/>

Telemedicine Visits by Week, January 2020 – April 2021



Data Source: "3 surprising trends in seniors' telemedicine use during the pandemic," STAT. August 30, 2021. <https://www.statnews.com/2021/08/30/three-surprising-trends-seniors-telemedicine-use-pandemic/>; <https://www.ucsf.edu/news/2020/08/418201/covid-19-pandemic-drives-telehealth-boom-older-adults-cant-connect>; Kaiser Health News, Technology Divide Between Senior 'Haves' and 'Have-Nots' Roils Pandemic Response, July 2020 <https://khn.org/news/technology-divide-between-senior-haves-and-have-nots-roils-pandemic-response/>



Expanding and Stabilizing the Provider Workforce

Stay-at-home orders and the risk of infection exacerbated pre-existing LTSS workforce shortages in both HCBS and institutional settings while service need among care recipients increased.

How States Use Flexibilities

- Expanded **opportunities for self-direction** to allow recipients to hire their own providers.
- Allowed **family members and other closer relations** to be reimbursed for providing personal care services.
- Authorized case management entities and other **alternative providers** to furnish direct care services.
- Authorized **providers licensed in other states** to provide certain services in-state.
- Altered **minimum provider qualifications** for certain services, including allowing unlicensed graduates to provide care.
- Modified **care management processes** (e.g., modalities for person-centered care planning) to ensure seamless access to care and alleviate workforce capacity issues.

State Examples

- **Missouri** used 1135 waiver authority to allow RN/LPN graduates who have not yet been licensed to deliver private duty nursing services.
- **Kentucky** used Appendix K authority to suspend potential financial conflict and pre-employment screenings specifically required for immediate family members to approve them to provide self-directed waiver services.
- **Maine** used Appendix K authority to allow relatives or spouses to delivery personal support and attendant care services to waiver participants when hired by the provider agency. Training and certification requirements may be completed after services begin but before the Appendix K end date.
- **Hawaii** used 1115 waiver authority to delay initial and annual assessments for up to one year for its QUEST Integration demonstration and delay annual eligibility redeterminations for state plan HCBS.



Post-Pandemic Planning

Next Steps for States

- Develop framework to plan for near-term changes (e.g., making certain temporary flexibilities permanent) and system-wide reform based on the lessons learned during the pandemic.
- Assess LTSS system need prior to the pandemic, identifying strengths to build on and challenges to address.
- ARP FMAP increase for HCBS can be leveraged to strengthen states' LTSS systems.
- Identify stakeholders, recruit system reform "champions," and map out process for reform.

CMS issued guidance on extending temporary flexibilities beyond the emergency a December State Health Official Letter: "Planning for the Resumption of Normal State Medicaid, CHIP, and BHP Operations Upon Conclusion of the COVID-19 Public Health Emergency."

Caring for Older Adults and People with Disabilities After COVID: A Person-Centered Framework for Transforming Temporary Emergency Medicare and Medicaid Regulatory Changes Into Permanent Reform

- With support from The SCAN Foundation, Manatt and HMA are developing tools for federal and state policymakers to assess the impact of Medicare and Medicaid regulatory changes implemented in response to the COVID-19 pandemic, and determining which of those regulatory changes should be made permanent features of the Medicare and Medicaid programs after the public health emergency ends.



Thank You!

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