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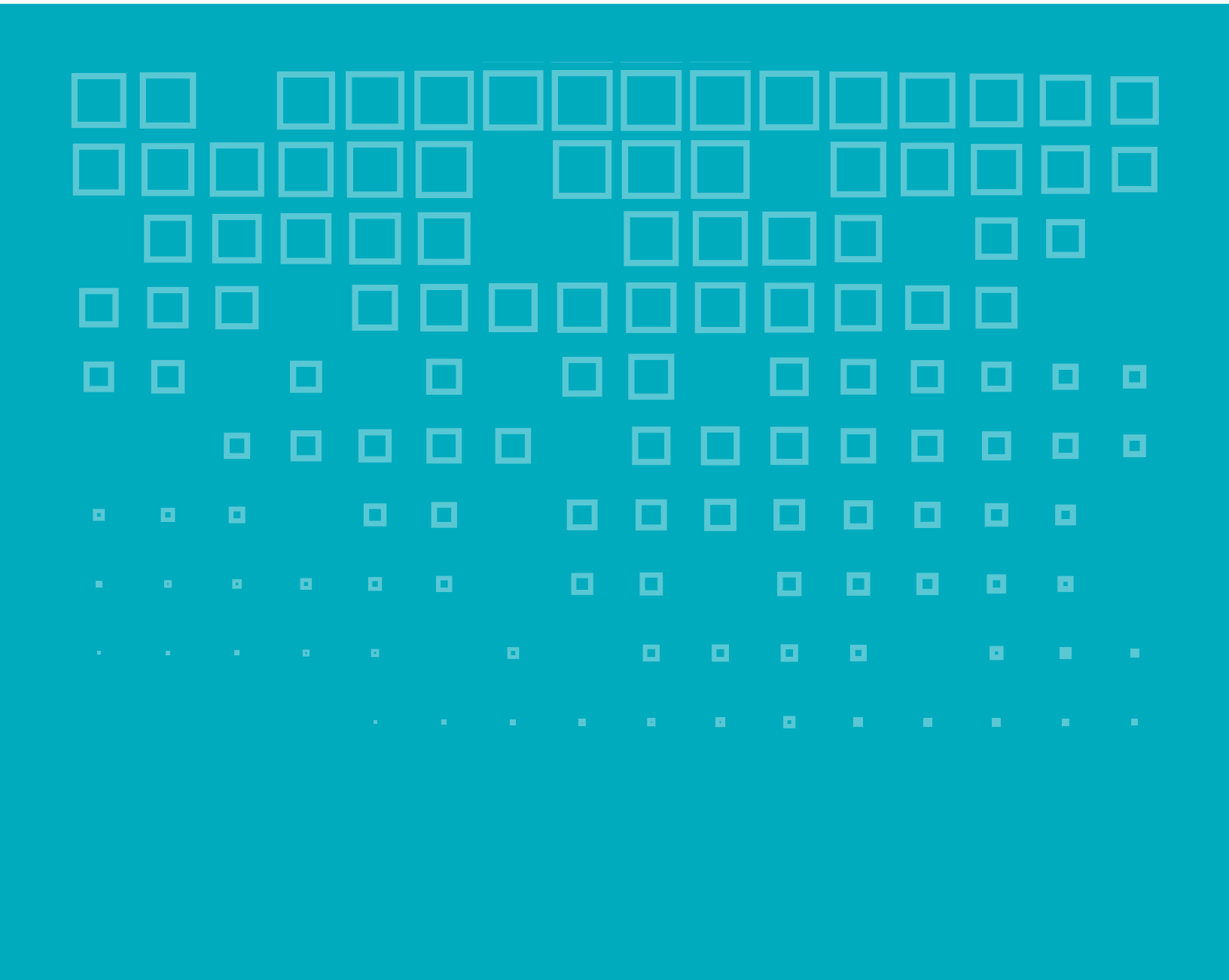
Learning From COVID-19-Related Flexibilities

Moving Toward More Person-Centered Medicare and Medicaid Programs



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Health Management Associates (HMA) is an independent, national research and consulting firm specializing in publicly funded health care and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

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Table 1. Roundtable and Interview Participants

Name	Organization
Maya Altman	Health Plan of San Mateo
Michael Anderson-Nathe	Anderson-Nathe Consulting, LLC
Bob Applebaum	Department of Sociology and Gerontology, Miami University
Shawntel Bush	California Department of Aging
Henry Claypool	American Association of People with Disabilities
Ayesha D'Avena	National Quality Forum
Nadia Glenn	Institute for Medicaid Innovation
Vicki Gottlich	Administration for Community Living
Dennis Heaphy	Massachusetts Disability Policy Consortium
Mary Hsieh	Transpectus Health
Catherine Kinnaman	Department of Social and Health Services, State of Washington
Melisa Lindamood	Johns Hopkins University
Christine Aguiar Lynch	Association for Community Affiliated Plans
Arielle Mir	Arnold Ventures
Sonja Nesbit	FTI Consulting
Sara Rosenbaum	Milken Institute School of Public Health, George Washington University
Emma Sandoe	Department of Health and Human Services, North Carolina
Gelila Selassie	Justice in Aging
Mary Sowers	National Association of State Directors of Developmental Disabilities Services
Emily Stewart	Community Catalyst
Piper Su	Mayo Clinic
Damon Terzhagi	ADvancing States
Wendy Trafton	Agency of Human Services, Vermont
Lisa Watkins	Anthem
Elizabeth Zirker	Disability Rights California

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Moving Toward More Person-Centered Medicare and Medicaid Programs

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Executive Summary

Over the course of the COVID-19 public health emergency (PHE), a series of Medicare and Medicaid regulatory flexibilities were implemented to help ensure access to care for older adults and people with chronic conditions or disabilities by minimizing administrative, clinical and financial barriers to using services. These temporary regulatory flexibilities expanded program eligibility and enrollment, enhanced remote service delivery options, authorized care delivery in alternative care sites, and much more. Although the federal PHE has been extended to April 15, 2022, these regulatory flexibilities are temporary and will inevitably end when policymakers terminate the PHE.[1]

As policymakers prepare for the unwinding of these temporary policies, they have the unique opportunity to assess the policies' impact on advancing person- and community-centered care and consider flexibilities for permanence through this lens. In this context, person-centered care means health care that is guided by an individual's personal values and preferences and is designed to help people achieve what matters most to them. Community-centered care is an approach to care that involves expanding care outside the walls of clinical providers and into communities in a way that helps individuals directly engage in addressing the factors contributing to their health status. Yet, policymakers and other stakeholders have only started to understand the impact of these flexibilities on health care consumers and the providers and systems that provide their care.

Uneven data collection and reporting across the Medicare and Medicaid flexibilities and populations during the pandemic inhibited a comprehensive analysis of the impact of the flexibilities on consumer access, service utilization and outcomes, and the provider and direct care workforce. The limited quantitative data that do exist indicate that telehealth flexibilities facilitate access to timely care in individuals' homes or communities. Qualitative data are more abundant and support the use of telehealth and provider workforce flexibilities to improve access to care but suggest that certain flexibilities may widen health disparities or harm patient care if not implemented with modifications designed to ameliorate these risks.

At the outset of the pandemic, regulatory flexibilities were implemented quickly to minimize disruptions in access to care. In many cases, the regulatory changes aligned Medicare and Medicaid program policies that were previously misaligned; for example, Medicare temporarily allows patients to use telehealth in their homes, similar to pre-COVID-19 policies in many states. Without further federal or state action to adopt temporary flexibilities as permanent policy, a return to pre-pandemic rules will result in a return to the complex regulatory web that consumers and providers had to navigate prior to 2020.

As policymakers consider which temporary regulatory flexibilities might improve the Medicare and Medicaid programs if continued as permanent policies, they are now faced with complex decisions weighing the impact on consumers and providers, the opportunities for programmatic alignment, the ability of modifications to address risks, and the possibility of additional evaluation before making a final choice.

Manatt Health and HMA conceptualized a person-centered assessment framework to facilitate these decisions. The framework assesses the potential for the regulatory flexibilities to:

- Advance person- and community-centered care
- Facilitate care in the least intensive or least restrictive setting
- Better align Medicare and Medicaid program rules

The person-centered assessment framework was tested and refined with a diverse group of stakeholders, including consumers and consumer advocates, experts in DEI, health plans and providers, state officials, and former federal officials, to ensure it would be an actionable tool for federal and state policymakers. The person-centered assessment framework is organized into the following three sections, each with probing questions for policymakers to consider as they deploy the tool:

 **Benefits and Risks**	 **Informed Decision Making**	 **Authority**
What is the impact on consumers, communities, federal and state programs, providers, and health plans?	What is the rationale for and feasibility of permanent reform?	Which entity has the authority and should be responsible for making the temporary flexibility permanent?

Using the person-centered assessment framework and informed by stakeholders, Manatt Health and HMA identified several priority COVID-19 temporary regulatory flexibilities to consider for permanence, additional modification or further evaluation. We intend these recommendations to be viewed through the lens of advancing person- and community-centered care for older adults and people with chronic conditions or disabilities. To that end, we identify flexibilities that should be considered for permanence if person- and community-centered care is the primary goal, recognizing that policymakers face numerous additional trade-offs when making policy decisions.

These flexibilities fall under four major categories and were selected based on their ability to promote person- and community-centered care in the least intensive or least restrictive setting and better align Medicare and Medicaid program rules and policies (Table 2).

Table 2. Categories of COVID-19-Related Temporary Regulatory Flexibilities That Enhance Person-Centered Care in Medicare and Medicaid

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 Related 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 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

The person-centered assessment framework and priority list of flexibilities for permanence or further evaluation are foundational tools for policymakers hoping to advance person-centered and community-centered care in Medicare and Medicaid. This report identifies and provides a rationale for elevating specific flexibilities among the hundreds that were implemented during the pandemic; discusses the benefits and risks for consumers, communities and other stakeholders; and identifies at a high level the authorities that would be needed to make the reform permanent or extend it past the PHE. However, this list is a starting point for policymakers' consideration and action. Federal and state policymakers can use the person-centered assessment framework, the priority list of flexibilities and an accompanying policymaker playbook to arrive at their own conclusions about which regulatory reforms they would like to pursue for permanence based on their ability to promote person- and community-centered care in the least intensive and restrictive settings and remove misalignments between Medicare and Medicaid programs that impact both consumers and providers.

Section I: Background and Context

COVID-19 has had a direct and severe impact on older adults, people with disabilities and the providers who care for them. Older adults (aged 65 and older) account for nearly 75% of COVID-19 deaths in the United States.[2] People with disabilities are more likely to live in long-term care facilities and have underlying medical conditions that put them at higher risk of infection and mortality.[3] While vaccine availability has become more ubiquitous (nearly 80% of the U.S. population aged 5 and older have at least one vaccination, and older adults are most likely to be fully vaccinated), older adults continue to experience higher mortality rates, and people with disabilities continue to face disparities in mortality and vaccine access.[4,5] Significant disparities in COVID-19 cases and mortality have also been observed among American Indian/Alaska Native, Black and Latino/Hispanic populations, compared with White and Asian populations. While some disparities based on race and ethnicity have narrowed over the course of the pandemic, they persist.[6] COVID-19-related data on trans, nonbinary and other gender-expansive people are sparse, but these populations are greatly impacted by social and structural determinants of health that would increase the risk of COVID-19 transmission and mortality, particularly among Black, Indigenous and people of color (BIPOC).[7] Persistent health disparities underscore the fact that our current health systems are not uniformly guided by principles of person-centered care and, therefore, are not meeting the needs of vulnerable populations and communities. It is imperative to implement policies that facilitate the delivery of high-quality, person- and community-centered care to improve health outcomes and advance health equity.

Key Terms and Guiding Principles

"**Person-centered care**" is defined by The SCAN Foundation as health care that is guided by an individual's personal values and preferences and is designed to help people achieve what matters most to them.

"**Community-centered care**" is described by several organizations as an approach to care that involves expanding healthcare outside the confines of hospitals, hospital systems and clinics into communities. According to one researcher, in this model of care health care providers can partner with community-based organizations to help individuals directly engage in transforming the root causes of their health challenges.

"**Health equity**" is defined by the Center for Disease Control and Prevention Office of Minority Health and Health Equity (OMHHE) as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

"**Health disparities**" is defined by OMHHE as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage other characteristics historically linked to discrimination or exclusion. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; or geographic location.

Sources:

The SCAN Foundation.

American Academy of Physicians.

Juliana E. Morris, When "Patient-Centered" is Not Enough: A Call for Community-Centered Medicine.

Centers for Disease Control and Prevention, Health Equity Style Guide for the COVID-19 Response: Principles and Preferred Terms for Non-Stigmatizing, Bias-Free Language, Centers for Disease Control and Prevention. Aug. 11, 2020.

In the early stages of the pandemic, federal and state policymakers acted quickly to implement a series of temporary Medicare and Medicaid regulatory flexibilities, often in alignment across programs, to facilitate seamless, timely and safe access to Medicare and Medicaid services; support providers impacted by shutdowns or COVID-19 surges; and bolster the workforce. The temporary flexibilities are tied to the federally declared COVID-19 PHE, which recently was extended to April 15, 2022, and end upon or shortly after the end of the PHE.[8,9] These flexibilities are described in recent publications by Manatt Health and HMA, supported by The SCAN Foundation, which catalog hundreds of temporary Medicare and Medicaid flexibilities implemented between April 2020 and January 2021.[10,11,12] The temporary flexibilities promote access to person- and community-centered care by:

- Expanding or minimizing disruptions to program eligibility and enrollment
- Enhancing or adding benefits
- Authorizing alternative care delivery sites
- Improving workforce capacity
- Expanding telehealth and remote service delivery options
- Relaxing Medicare and Medicaid conditions of participation (while balancing beneficiary protections)
- Modifying reporting and appeal requirements

Given that Medicare provides coverage to over 61 million older adults and younger people with disabilities and Medicaid provides coverage to over 76 million Americans, 12 million of whom are "dually eligible" and enrolled in both programs, these flexibilities had and continue to have far-reaching impacts on older adults and people with disabilities.[13,14,15]

Federal Efforts to Strengthen Medicare and Medicaid for Older Adults and People With Disabilities

American Rescue Plan Act of 2021 (American Rescue Plan)

The American Rescue Plan was enacted in March 2021 to provide comprehensive COVID-19 relief to federal, state and local programs and a broad array of stakeholders. Included in the $1.9 billion package is a provision providing a 10-percentage-point increase to the Federal Medical Assistance Percentage for specified Medicaid HCBS spending between April 1, 2021, and March 31, 2022. States enhance their Medicaid HCBS programs by reinvesting state funds through March 2024.

Consolidated Appropriations Act of 2021 (CAA)

The CAA was signed into law on December 27, 2020, and includes changes to Medicare telehealth rules that allow beneficiaries to receive telehealth services at Rural Emergency Hospitals and to receive BH care in their homes in any part of the country by telehealth, including by audio-only technology, subject to limitations.

2022 Medicare Physician Fee Schedule

Through rulemaking, the Centers for Medicare & Medicaid Services (CMS) extended certain temporary telehealth flexibilities and made others permanent. Select telehealth services will continue to be permitted through 2023 to allow additional time for evaluation. In addition to implementing the CAA, permanent changes include reimbursing rural health clinics and federally qualified health centers for mental health services provided by telehealth, including audio-only, and permitting opioid treatment programs to use audio-only telehealth.

These COVID-19-related temporary changes have also become catalysts for policymakers to consider more permanent health system improvements. Although the PHE continues, federal "PHE unwinding" guidance, originally released in December 2020 and updated in August 2021, provides states guidance on how to plan for the end of the PHE and return to normal Medicaid operations post-COVID-19, including ending temporary authorities and flexibilities or making some temporary changes permanent.[16] Other recent actions by the federal government reinforce its commitment to supporting older adults and people with disabilities through the American Rescue Plan enhanced federal Medicaid funding for HCBS. The federal government also permanently expanded telehealth coverage for behavioral health (BH) services, subject to limitations, in its 2022 Physician Fee Schedule. Additionally, several states have started to make permanent certain temporary Medicaid flexibilities, particularly around the expansion of telehealth and provider scope of practice.[17,18,19,20] Federal and state policymakers are well positioned to build on this regulatory momentum provided that they are able to understand and characterize the impact of temporary regulatory flexibilities on different populations and communities and identify which flexibilities should be made permanent parts of the Medicare and Medicaid programs.

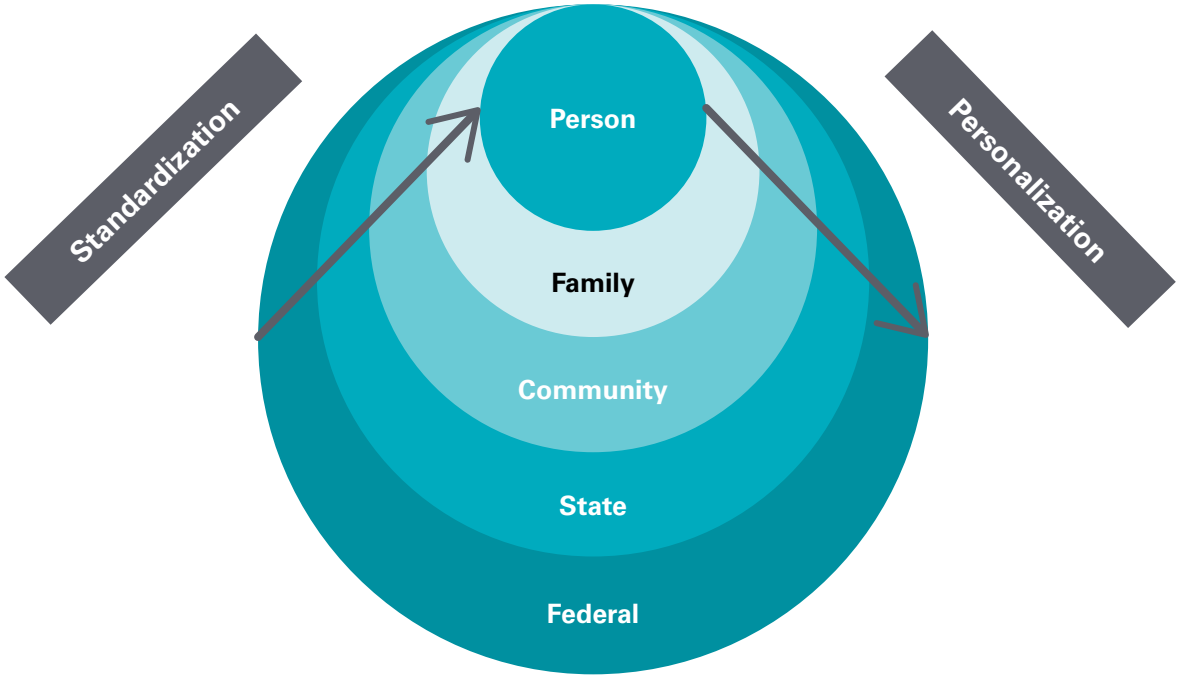
To that end, Manatt Health and HMA developed in conjunction with a group of stakeholders:

1. A person-centered assessment framework for federal and state policymakers to assess the impact of temporary Medicare and Medicaid regulatory flexibilities and consider which flexibilities should be made a permanent part of the programs
2. Initial recommendations for which flexibilities should be considered for permanence, as is or with modifications, or further evaluation.

The person-centered assessment framework and initial recommendations aim to promote person- and community-centered care in the least intensive or least restrictive setting appropriate to a person's or community's needs, and better align Medicare and Medicaid programs to promote clear policy and practice guidelines for providers participating in both programs and consistency in care experience for beneficiaries served by one or both programs.

The person-centered assessment framework and initial recommendations were informed by the person-in-environment model, which illustrates how the various levels of a person's environment contribute to their experience.[21] In this interactive person-in-environment model, each layer is linked by two dynamic tensions: standardization and personalization (Figure 1). Federal and state policy action, represented by the outermost circles, seeks to ensure standardization of laws, rules and regulations for health care. However, the outcomes of health care are best evaluated by assessing how they meet the needs of individuals; thus, the benefits of standardization are ideally balanced by personalization.

Figure 1. Interactive Model of Person-in-Environment



Source: Alkema, G. E. (2017). Bringing the pieces together: Person-centeredness is key to transforming policy and services. Generations, 40(4), 94–100.

Manatt Health and HMA were fundamentally guided in our project approach and research by The Communications Network DEI framework. This framework informed our methodology and the comprehensive process for conceptualizing and validating the person-centered assessment framework and initial recommendations, including creating a DEI-focused roundtable, our literature and data review approach, the diversity of voices on the roundtables, and our interview guide questions. Manatt and HMA conducted its research using a mixed-methods analysis of the temporary Medicare and Medicaid regulatory flexibilities to better understand their impacts on care delivery during the pandemic and identify those that should be considered by policymakers for permanence or further evaluation. The methodology included a literature review, quantitative analysis to the extent quantitative data were available, and a series of stakeholder roundtables and interviews with providers, health plans, state officials, federal officials and DEI experts. Roundtables and interviews also were used to pressure test and improve the person-centered assessment framework.

Manatt Health and HMA also conducted a regulatory review of select Medicare flexibilities and Medicaid flexibilities in five representative states to identify where federal and state laws and regulations either aligned or misaligned as flexibilities were implemented and to illuminate opportunities for better policy and program alignment across the two programs post-COVID-19. Regulatory misalignment between Medicare and Medicaid is a long-standing barrier to person-centered care for older adults and people with disabilities, particularly individuals eligible for both programs (dual eligibles) and the providers who serve them in both programs.

Section II: Lessons Learned From the PHE

Policymakers and researchers continue to learn about how the temporary flexibilities are impacting consumers, providers and other stakeholders and how they inform the development of long-term system improvements. Our literature, data review and roundtable discussions elicited the following preliminary findings about the implementation of the flexibilities and considerations for permanent reforms.

Uneven Data Collection and Reporting

There is growing but limited literature and data on the impact of the temporary Medicare and Medicaid regulatory flexibilities on consumer access, service utilization and outcomes, and on the provider and direct care workforce. At this time, beneficiary experience data and quantitative Medicaid data are particularly limited.

The primary exception is Medicare and Medicaid telehealth utilization data (see below). Medicare beneficiaries have confirmed that telehealth flexibilities facilitated access to timely care in the home.[22] While these data tell an important story about how telehealth flexibilities helped maintain people's access to health care, we await data on how telehealth services affected the quality of care delivered and people's health outcomes. Additionally, other than telehealth utilization, information is particularly scarce with respect to how the impacts of these flexibilities vary across populations, based on geography, race, ethnicity, income, gender and other characteristics. More comprehensive qualitative and quantitative research is needed to better understand how Medicare and Medicaid telehealth and other temporary regulatory flexibilities have impacted different populations and communities, so policymakers and other stakeholders can effectively advance and advocate for improved person- and community-centered care.

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

In the absence of comprehensive quantitative data on the impacts of the temporary flexibilities, however, qualitative data—including stakeholder experience and perspectives—are valuable and can be leveraged when applying the person-centered assessment framework. Targeted qualitative Medicaid studies exist and document some permanent HCBS provider closures, worker burnout across disciplines and gaps in incident reporting on pandemic-related measures, such as vaccination rates, and COVID-19 cases and deaths among Medicaid HCBS beneficiaries.[23] Several stakeholders who participated in the roundtables noted that policymakers should consider extending certain flexibilities or establishing glide paths for permanent implementation to gather additional quantitative and qualitative impact data. Extensions would enable policymakers to better understand budgetary impact, guard against fraud and abuse, and consider modifications for more equitable and successful implementation of permanent reforms. They would also signal continued federal or state interest in reform and incentivize greater investment and utilization by providers and health plans.

Telehealth Enhanced Access to Care, but Impacts Varied

Concerns about visiting health care facilities combined with health care providers redirecting their efforts to addressing COVID-19 resulted in an unprecedented drop in Medicare visits. The total number of times that Medicare fee-for-service (FFS) beneficiaries visited a clinician fell 11.4% from 2019 to 2020.[24] The availability of telehealth mitigated this decline as the share of Medicare FFS visits conducted via telehealth in 2020 was 5.3%, a significant increase from less than 1% in 2019. If people had not substituted telehealth for in-person visits to their clinicians, total visits might have fallen by 16.1%. The extent to which the decline in visits was offset by increased telehealth differed by groups of people. The decline was greater for people in urban areas than in rural areas, for people dually eligible for Medicare and Medicaid than people eligible for Medicare only, and for Hispanic and Asian Americans than for other racial and ethnic groups.

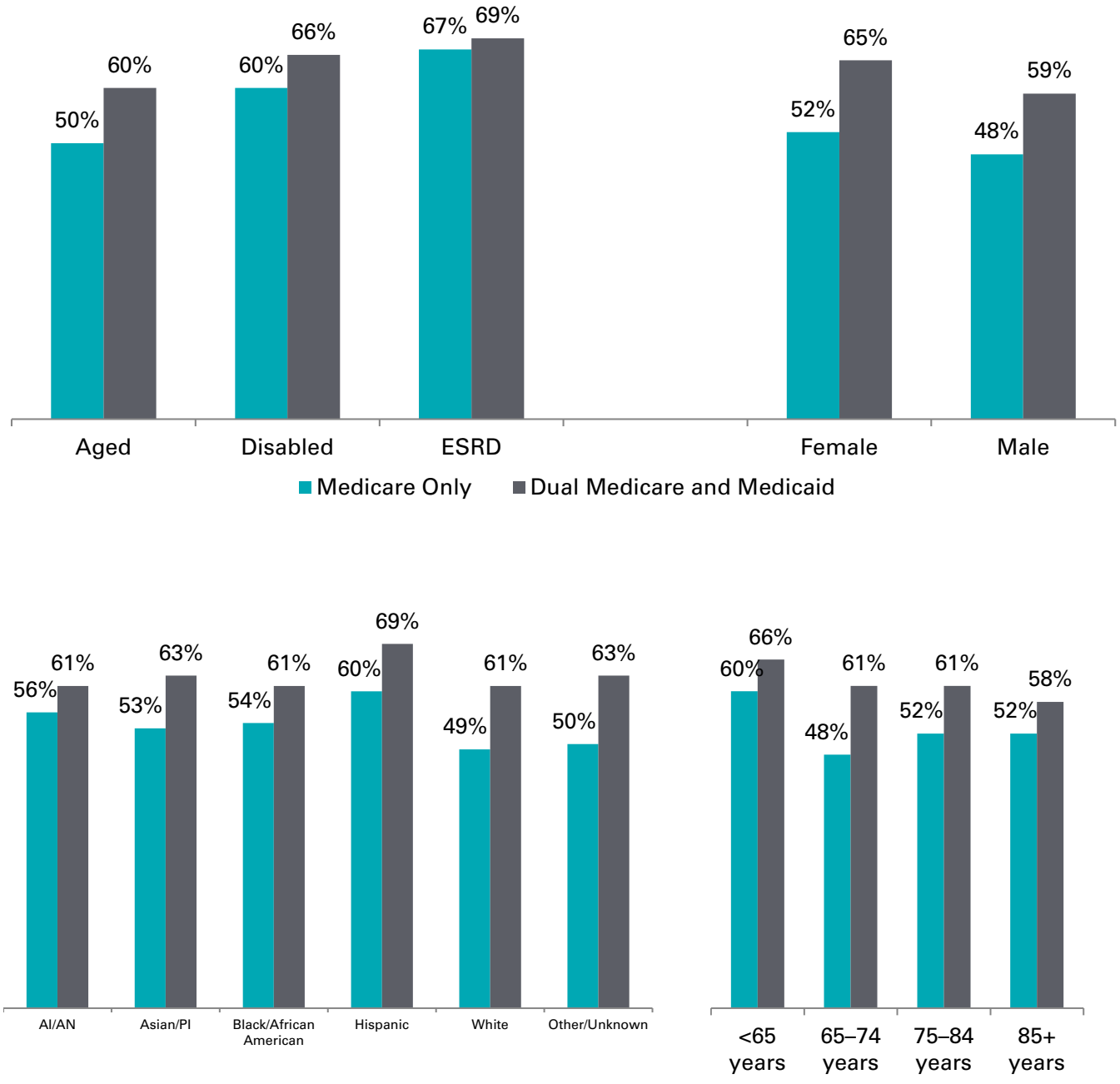
Key findings about the change in Medicare telehealth from 2019 to 2020:

- The share of telehealth visits grew from <1% to 5.3%.
- In-person clinician visits fell by 16.1%.
- Telehealth partially offset the decline in visits so that total visits fell by 11.4%.
- Telehealth partially offsetting the decline in visits particularly helped maintain access for:
  - People in urban areas
  - People dually eligible for Medicare and Medicaid
  - Hispanic and Asian Americans
- In-person BH visits fell by 43.8%.
- Telehealth partially offset the decline in BH visits so that total visits fell by 10.2%.

Telehealth was essential to maintaining Medicare beneficiaries' access to all types of clinicians: primary care, specialty care and BH care providers. This was particularly true for BH. Overall, there were 10.2% fewer BH visits in 2020 than in 2019, but there might have been 43.8% fewer visits if telehealth had not substituted for these in-person visits.[25]

While telehealth has provided an essential buffer to avoid potentially even greater disruptions in clinician visits, telehealth still accounts for a very small share of total visits. As noted above, the share of Medicare FFS visits conducted via telehealth in 2020 was 5.3%. Data that include the experience of people enrolled in FFS Medicare and MA suggest that this relatively small number of telehealth visits are somewhat evenly distributed across different groups of people but rather unevenly distributed by geography. These CMS data indicate that during the first 12 months of the pandemic, 53% of Medicare beneficiaries who saw a clinician had at least one telehealth service.[26] This rate ranged for various groups of people from 48% for men enrolled in Medicare only and for people aged 65 to 74 years old enrolled in Medicare only to 69% for women with end-stage renal disease (ESRD) enrolled in Medicare and Medicaid and for Hispanic people enrolled in Medicare and Medicaid (Figure 2).[27] The share of people with at least one telehealth service was consistently greater across all groups for people dually enrolled in both Medicare and Medicaid than those enrolled in Medicare alone. The rate ranged from 44% for people in rural areas to 55% of people in urban areas (Figure 3). The rate differed significantly by state, from 27% in North Dakota to 71% in California, the District of Columbia and Massachusetts. Again, across the 50 states and the District of Columbia, the rate of people with a telehealth service was greater for people dually eligible for Medicare and Medicaid than for those enrolled in Medicare alone. The difference averaged 13 percentage points and ranged from 1 percentage point in Hawaii to 24 percentage points in Iowa, Nebraska and North Dakota (data not shown).

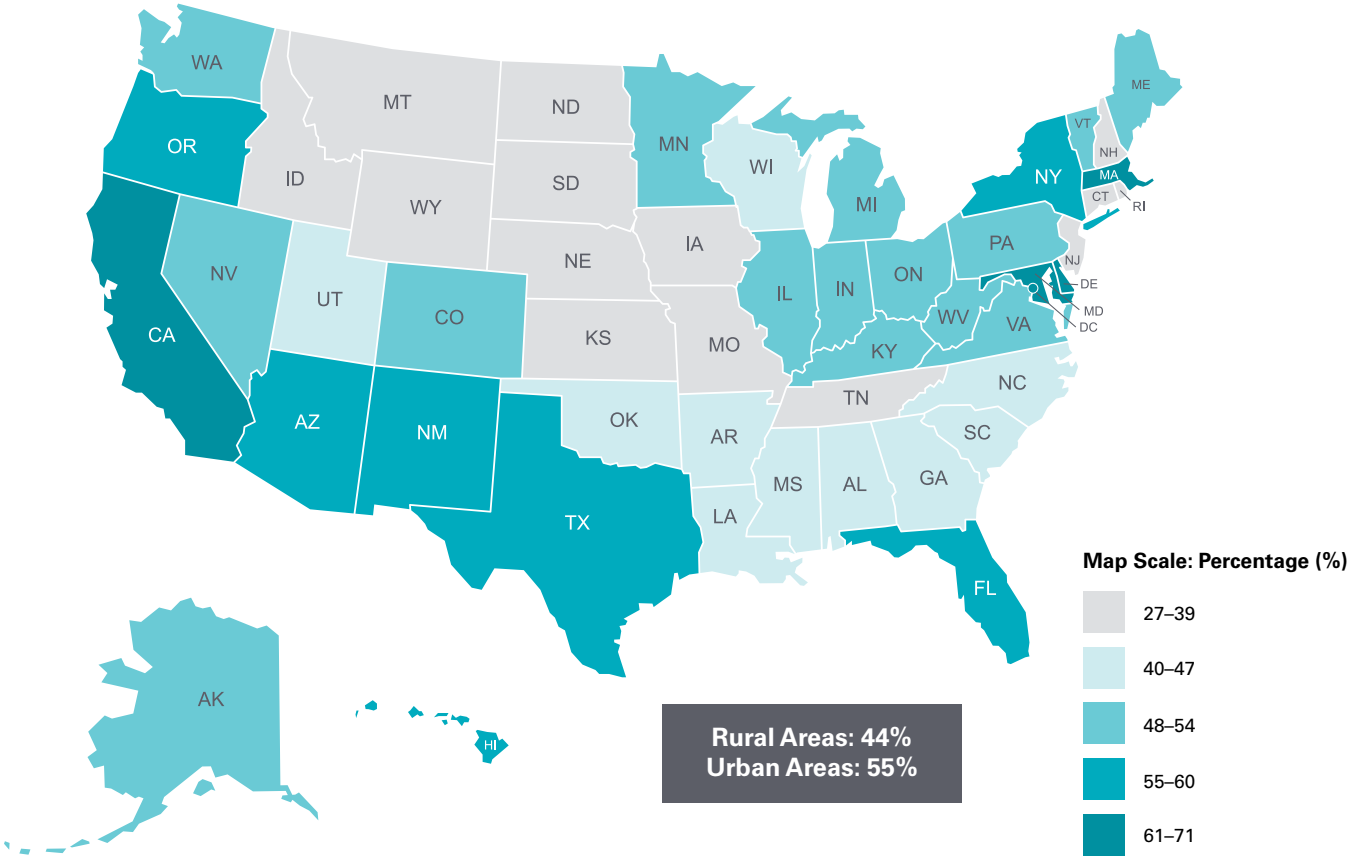
Figure 2. Share of Medicare Beneficiaries Who Saw a Clinician and Had at Least One Telehealth Service in the First 12 Months of the Pandemic, by Groups



Note: AI/AN (American Indian/Alaska Native), PI (Pacific Islander). Data include Medicare claims and encounter data for services from March 1, 2020, to February 28, 2021, that were received by September 9, 2021. Thus, data are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. The denominator excludes Medicare beneficiaries who received no services that could have been provided by telehealth (e.g., visits with clinicians).

Source: CMS. Medicare Telemedicine Snapshot.

Figure 3. Share of Medicare Beneficiaries Who Saw a Clinician and Had at Least One Telehealth Service in the First 12 Months of the Pandemic, by States



Note: Data include Medicare claims and encounter data for services from March 1, 2020, to February 28, 2021, that were received by September 9, 2021. Thus, data are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. The denominator excludes Medicare beneficiaries who received no services that could have been provided by telehealth (e.g., visits with clinicians).

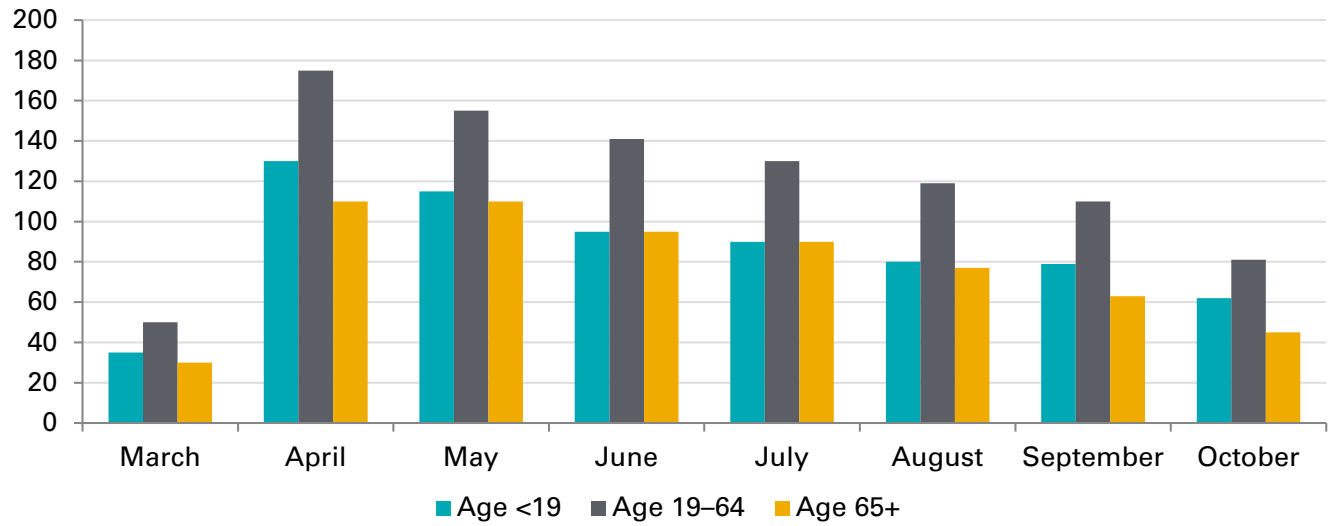
Source: CMS. Medicare Telemedicine Snapshot.

Similarly, telehealth utilization among Medicaid and Children's Health Insurance Program (CHIP) enrollees increased more than 20-fold in the early months of the pandemic.[28] Although Medicaid telehealth utilization nationally peaked in April 2020 and began to decline thereafter—due in part to the reopening of in-person services followed by the advent of vaccines—utilization rates remain above pre-pandemic levels (Figure 4).[29] Notably, utilization of mental health services has been higher than that of physical health services, partly attributable to the stigma associated with in-person visits.[30]

Key findings about the change in Medicaid telehealth from March to October 2020:

- Service utilization rates via telehealth increased from six telehealth services per 1,000 Medicaid and CHIP beneficiaries in February 2020 to over 150 per 1,000 in April 2020.
- The number of states allowing Medicaid telehealth visits more than doubled for some types of services, including dental, therapies, maternity care, and long-term services and supports.
- The number of states expanding the types of providers allowed to deliver services via telehealth also grew, particularly for advanced practice providers and dentists.
- Many states also expanded telehealth modalities to include telephone-only and text-based communications, and expanded originating sites to include people's homes.

Figure 4. Medicaid and CHIP Services Delivered via Telehealth per 1,000 Beneficiaries, March to October 2020



Source: Medicaid & CHIP and the COVID-19 Public Health Emergency, Preliminary Medicaid & CHIP Data Snapshot, Services Through October 31, 2020. CMS.

In aggregate, these data suggest that telehealth flexibilities can serve to maintain or potentially improve people's access to health care in the face of significant obstacles. This benefit is shared across many groups. Furthermore, the data indicate that even when faced with as significant an obstacle as the pandemic, providers and people appear to choose to substitute telehealth for some but not many of their in-person visits. Taken together, this should provide reassurance that permanent telehealth expansion would balance the widespread benefit to access to care against the risk that telehealth would replace a significant share of in-person visits, thereby potentially affecting the quality of care or program spending.

Considerations in Assessing Temporary Flexibilities for Permanence

As illustrated by the telehealth utilization data, where impact data do exist, they reveal some evidence supporting the positive effects of certain Medicare and Medicaid flexibilities on ensuring consumer access to care. However, stakeholders who participated in our roundtables and interviews noted that making permanent the temporary flexibilities that show potential to improve person-centered care is not the only option, nor the best one, given limited data available about all implications. They urged policymakers not to rush into making decisions about whether to make temporary flexibilities permanent or allow them to expire with the end of the PHE, citing persistent challenges that must be evaluated and addressed to ensure that the policies serve as person-centered solutions. They suggested a third option—selecting promising temporary flexibilities for extended evaluation following the end of the PHE. This option would avoid the risk of unforeseen negative consequences of making policies permanent that are not yet fully vetted while capitalizing on the investment of two years or more of evaluation for a select set of promising policies. The following examples illustrate the potential disparate impacts of the temporary flexibilities and highlight the need for policymakers to thoughtfully design permanent policies, which in addition to collecting more data may require modifying and enhancing how temporary flexibilities are implemented going forward to advance person-centered care.

> Stakeholders encouraged policymakers not to limit their choice to either making flexibilities permanent or allowing them to end. A third option—selecting promising temporary flexibilities for extended evaluation—would allow for additional data collection to support a more informed choice.

- **Telehealth flexibilities**, which include a wide range of activities, have been among the most impactful regulatory flexibilities, although the impacts vary across populations. Stakeholders who participated in roundtables and interviews were universally optimistic about the long-term potential for telehealth reforms to improve access to care, particularly due to the regulatory and congressional attention they currently command. A recent report by the Government Accountability Office (GAO) highlighted the ability for flexibilities such as virtual evaluations to facilitate access to care during the PHE.[31] However, if not implemented carefully, telehealth flexibilities do have the potential to widen disparities; both stakeholders and the GAO report recognized that older adults and rural communities with limited access to broadband or technology are often unable to fully benefit from virtual care.[32] Similarly, there are lower rates of telehealth utilization among older, non-English-speaking and Asian patients, and lower rates of video visits among older, Black, Latinx, lower-income and female patients.[33] At the same time, stakeholders acknowledged that these communities often experience barriers to accessing in-person services and have greatly benefited from audio-only telehealth flexibilities. If telehealth flexibilities were to extend past the PHE, Medicare, Medicaid and health plans would need to design policies to ensure appropriate access to both virtual and in-person

> "States focused on expanding access through telehealth should not overlook the need to expand access through in-person services."
>
> Consumer/Consumer Advocate Roundtable Participant

services, possibly by expanding access to specific types of services, to ensure that providers have the flexibility to tailor care plans that draw on combinations of these services to their individual patients so that they can have equitable access to clinically appropriate, person-centered services.

- **Provider and workforce flexibilities** have been critical to maintaining access to services for Medicare and Medicaid beneficiaries. Stakeholders were enthusiastic about flexibilities that allowed different types of providers to practice to the full extent of their licenses, allowed providers to practice across state lines, relaxed provider qualifications in specific situations, provided retainer payments for personal care workers, expanded reimbursement for informal caregivers and enhanced opportunities for self-directed services. According to a report by the U.S. Department of Health & Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE), flexibilities that provided or enhanced family caregiver payments and authorized nonphysician practitioners to order services were among the most helpful in alleviating strain on the workforce and restoring capacity.[34] Stakeholders also supported increasing payments to direct caregivers, such as home health workers, personal care attendants and certified nursing assistants, to strengthen the primarily low-income, immigrant and female workforce.[35] Despite some success in strengthening the provider workforce, data show that these flexibilities were unable to fully solve persistent HCBS provider capacity and workforce issues, which were made worse by the pandemic. Twenty-five states reported permanent closures of at least one Medicaid HCBS provider, and 16 states reported closures of more than one Medicaid HCBS provider type.[36] Adult day health centers, in-home service providers, group homes and supported employment programs were particularly affected. Further evaluation and modification of certain temporary provider and workforce flexibilities may enhance the impacts of reforms in this area, including on increasing provider capacity and improving health equity.

> "Equity should be a concern for the direct care workforce and caregivers, not just beneficiaries."
>
> State Official/Representative Roundtable Participant

Opportunities to Align the Medicare and Medicaid Programs

Telehealth, workforce and other regulatory flexibilities were implemented quickly across Medicare and Medicaid during the PHE to address challenges in caring for individuals during a pandemic. In many cases, regulatory changes aligned program policies that were previously misaligned. For example, Medicare temporarily allows patients to use telehealth in their homes, similar to a number of Medicaid programs (Table 3). In other instances, it is unclear whether temporary flexibilities resulted in greater alignment or misalignment, given the lack of visibility or clarity around certain state telehealth policies.

When the federal and state PHEs officially end, and policies revert to pre-pandemic standards, the Medicare and Medicaid programs will return to greater misalignment (absent actions to adopt temporary flexibilities as permanent policy). A review of select temporary Medicare flexibilities and Medicaid flexibilities in five states illustrates the potential misalignments and opportunities for alignment between the two programs when the PHE ends.[37] Notably, many of the temporary Medicare flexibilities are scheduled to cease. If this takes place, then consumers and their providers may once again face a complex regulatory web. For example,

Medicare does not allow audio-only telehealth for most services on a permanent basis, while some states like Massachusetts and Pennsylvania do. Similarly, Medicare does not allow providers with out-of-state licenses to provide care while certain states do under expedited licensing processes or other conditions.[38]

Table 3. Illustrative Opportunities to Align Medicare and Medicaid Policies After the End of the PHE

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

	Medicare		Medicaid		Policy Alignment Opportunity
	Temporary Flexibility	Permanent Policy	Temporary Flexibility	Permanent Policy	
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

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)

Note: PA (physician assistant), NP (nurse practitioner), APRN (advanced practice registered nurse). For more information about the policies in the five illustrative states, see Appendix A.

Section III: Assessing Temporary Flexibilities for Permanent System Reform

Guided by the research and stakeholder input, Manatt Health and HMA developed the following person-centered assessment framework and initial set of recommendations for which temporary COVID-19-related Medicare and Medicaid flexibilities should be considered by federal and state policymakers for permanence, or at least for further evaluation, once the PHE ends.

Person-Centered Assessment Framework for Policymakers

Manatt Health and HMA developed the Person-Centered Assessment Framework for Policymakers as a user-friendly tool to enable federal and state policymakers to assess the impacts of temporary Medicare and Medicaid regulatory flexibilities based on their 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.
- Facilitate care in the least intensive or least restrictive setting, based on a person's needs, goals and preferences.
- 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 respond to their full patient panel quickly, nimbly and uniformly.

The framework was tested with key stakeholders and refined based on their feedback. The framework is organized into three sections, each with probing questions for policymakers to consider as they deploy the tool (Figure 5).

Figure 5. Person-Centered Assessment Framework for Policymakers

Policymakers should answer the questions in the framework to help develop a priority list of temporary flexibilities for permanence. No single question or group of questions should be a deciding factor in whether a flexibility should be made permanent or extended for additional evaluation, though policymakers may choose to weigh certain questions, such as consumer impact, more heavily than others. In some cases, policymakers may choose to modify certain flexibilities based on lessons they learned during the pandemic or determine the need to continue evaluating the efficacy of certain flexibilities. Given the lack of comprehensive data across flexibilities and the lack of quantitative Medicaid data, policymakers should ensure that qualitative data is considered and make improvements to quantitative data reporting and management.

Initial Recommendations: Priority Flexibilities for Permanence and Further Exploration

Across the Medicare and Medicaid programs, standout regulatory flexibilities that are most likely to advance the above goals centered on four primary categories (Table 4). While the flexibilities in these categories can be implemented independently from one another to advance the delivery of person-centered care, together they more powerfully can help ensure that high-risk individuals can access care quickly, safely, and in a manner that best meets their needs and preferences.

Table 4. Categories of COVID-19-Related Temporary Regulatory Flexibilities That Enhance Person-Centered Care in Medicare and Medicaid

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 Related 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 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 SNF stays, self-directed HCBS and LTSS financial eligibility rules

We highlight below initial recommendations on which temporary changes should be considered for permanence or extended evaluation, either with or without modifications. We describe our rationale for choosing flexibilities within the four primary categories and discuss the benefits and risks for consumers, communities and others based on input from our research, stakeholders and person-centered assessment framework. We also identify at a high level potential vehicles to make the reform permanent or extend it past the end of the PHE, based on which federal or state entity has the authority to modify existing policies. For Medicare reforms, if the policy is in statute and can only be modified by enactment of law following passage

of new legislation by Congress, we list the authority as "federal legislation." If the policy is not detailed in statute and can be modified by agency rulemaking, we list the authority as "federal regulation or legislation," recognizing that change could be implemented either through CMS rulemaking or congressional legislation (followed by agency rulemaking). For Medicaid reforms, we list the authority as "state administrative or legislative action," recognizing that many COVID-19-related temporary policies can be made permanent outside of a PHE under existing Medicaid authorities, such as Medicaid state plan or waiver amendments, and that states vary on the authorities they use to operate their Medicaid programs. These authorities can be elected at the discretion of state executive leaders and/or at the direction of state legislatures. We recognize that Congress and CMS also can make permanent Medicaid changes through federal legislation or agency rulemaking, respectively, but focused the Medicaid authorities on those that states can make without federal intervention.

Ultimately, federal and state policymakers can use the person-centered assessment framework and accompanying playbook to arrive at their own conclusions about which regulatory reforms they would like to pursue for permanence. But this preliminary list elevates potentially high-impact flexibilities for priority consideration based on their ability to promote person- and community-centered care in the least intensive and restrictive settings and remove misalignments between Medicare and Medicaid programs that impact both consumers and providers. These flexibilities also improve system deficiencies made plain during the PHE, including equity in telehealth, provider workforce and capacity, Medicare and Medicaid misalignments, and long-standing health disparities based on race, ethnicity, gender, immigration status and more.

Expand Telehealth Benefits

Person- and community-centered benefits and risks: Consumers who prefer virtual visits or have difficulty attending in-person visits (e.g., people with disabilities or who face other barriers to accessing in-person benefits) can greatly benefit from expanded access to telehealth. Telehealth expansion has the potential to connect communities with limited, small provider networks of specialty care, such as BH. BH services also carry a stigma that often prevents patients from accessing in-person services but is mitigated in virtual visits. However, telehealth policies must be paired with policies that ensure equitable access to broadband and technology or include effective workarounds, such as coverage of audio-only care, to prevent widening existing health disparities. In some cases, virtual care may not be clinically appropriate, and an overreliance on virtual care and distant providers could perpetuate small provider networks in rural and other under-resourced areas. Providers and health plans may require more clinical and programmatic guidance from Medicare and Medicaid to ensure that beneficiaries are receiving the correct level of care and their networks maintain adequate access to in-person services when needed.

Other considerations: Telehealth expansion has experienced significant regulatory and legislative momentum, making its permanent and continued expansion politically feasible. The permanent expansion of telehealth benefits for both Medicare and Medicaid would result in greater program alignment and reduced administrative complexity for providers and health plans. It also signals to providers and health plans that they can safely invest in long-term capabilities and potentially develop innovative care models that capitalize on the widespread availability of telehealth. However, it also raises concerns about how the Medicare and Medicaid programs can balance competing demands and pay appropriately for telehealth services. Payment

policies that set high rates for granular services without sufficient protections carry the risk for rapid growth in use and program spending in an FFS payment system, as well as for fraud and abuse. Payment policies that set rates too low or that are paired with prohibitive requirements risk making providing telehealth services unachievable for small, under-resourced providers and health plans are shown in Table 5.

Table 5. 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)

Note: We recognize that Congress and CMS also can make permanent Medicaid changes through federal legislation or agency rulemaking, respectively, but focused the Medicaid authorities on those that states can make without federal intervention.

Modify Provider Scope of Practice and Related Requirements

Person- and community-centered benefits and risks: The expansion of and flexibility regarding which provider types are permitted to provide Medicare and Medicaid services have been critical to maintaining continuity of care, provider capacity and consumer choice during the PHE. For example, high-need beneficiaries (e.g., people with disabilities) had greater access to out-of-state specialty providers and culturally competent care, particularly in rural, under-resourced communities. Enhanced provider payments and retainer payments also helped mitigate service reductions and support the predominately women-led and minority-led direct care workforce. However, we lack data-informed insights into the effects of these scope-of-practice expansions on the quality of care that people received. In addition, the growing reliance on out-of-state providers may inhibit the growth of local provider networks and increase risk of beneficiaries receiving clinically inappropriate services by the wrong provider, widening health disparities over time. Furthermore, certain providers, particularly the direct care workforce, may still not receive enough in payments to ensure a livable wage.

Other considerations: The permanent modification of provider scope of practice and other requirements for both Medicare and Medicaid would result in greater program alignment, potentially address the ongoing shortage of some provider types (e.g., primary care physicians), support the strained workforce and enhance network adequacy. However, because of the lack of data-informed insights into the effects of these flexibilities on outcomes of care, it is unclear exactly how programs, plans and health systems can strike the right balance between expanded scope of practice and maintaining the status quo. Most notably, these changes are likely to face significant political feasibility concerns. In addition, the existing state licensing system is not optimized to address out-of-state providers; consequently, making this flexibility permanent could increase the administrative burden. Any provider payment increases would also increase programmatic costs, particularly if union workers are involved in negotiations. Permanent, structural shifts in provider requirements may also require costly and significant restructuring of provider networks and health plan risk pools. More evaluation may be required to ensure a reasonable impact on cost, provider capacity and the workforce. Specific priority flexibilities for policymakers to consider for permanence or continued evaluation are shown in Table 6.

Table 6. 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[39]	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)

Note: We recognize that Congress and CMS also can make permanent Medicaid changes through federal legislation or agency rulemaking, respectively, but focused the Medicaid authorities on those that states can make without federal intervention.

Modify MA Requirements

Person- and community-centered benefits and risks: Allowing MA organizations to expand telehealth and other midyear benefit enhancements ensured that the approximately 40% of Medicare beneficiaries enrolled in an MA plan had the opportunity to use telehealth like their FFS counterparts. It also reportedly permitted MA plan enrollees to receive enhanced benefits that were designed to maintain access to care, continuity of care and quality of care in the face of challenges to these that were introduced by the pandemic. Stakeholders reported that the ability to submit diagnoses collected during two-way, audio-video telehealth visits offered an equal playing field for clinicians and patients to choose between in-person and telehealth visits without affecting diagnosis collection. Continuing broader access to and use of telehealth in MA is associated with similar risks as continuing broader access to and use of telehealth in FFS Medicare. Excluding audio-only telehealth as an option for collecting diagnoses risks introducing inequity if clinicians and MA plans opt to use in-person visits due to risk adjustment concerns in situations where telehealth visits would better serve the needs and preferences of consumers.

Other considerations: Making these temporary MA policies permanent allows the Medicare programs to capitalize on the greater flexibility of MA plans compared with the traditional FFS program to deliver telehealth and other benefits to consumers. However, this flexibility comes at a cost as the MA risk adjustment system contributes to the Medicare program paying more for beneficiaries enrolled in MA than in FFS due to more robust diagnosis coding in MA than in FFS. Including diagnoses collected by audio-only telehealth may further increase this risk adjustment difference and, in turn, increase program spending.

Specific priority flexibilities for policymakers to consider for permanence or continued evaluation are shown in Table 7.

Table 7. 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[40]	Federal regulation or legislation

Other Temporary Flexibilities

Person- and community-centered benefits and risks: Allowing people to receive SNF services without first being admitted for a hospital stay has been tested by Medicare prior to the PHE as a way to make care more person-centered. States that expanded self-directed waiver services enabled beneficiaries to tailor their services and caregivers according to their preferences. Financial support associated with self-directed waiver services even helped sustain families, communities and provider networks by reimbursing family caregivers. States that applied less restrictive financial eligibility rules for individuals who require LTSS were also able to expand eligibility and enrollment to a greater subset of individuals who would benefit from LTSS. However, further evaluation of consumer impact or modification to ensure person-centeredness may be required before these flexibilities are made permanent.

Other considerations: The permanent modification of the three-day prior hospitalization requirement for SNF stays, expansion of self-directed HCBS and paid family caregiving, and income and asset rules for individuals who require LTSS would result in the possibility of more person-centered care for acute and post-acute care needs, more person-centered care for Medicaid members using HCBS with respect to the services they use and providers they hire to provide those services, and expanded eligibility and enrollment in Medicaid. However, permanent modifications to the Medicare policy would require federal legislation and subsequent rulemaking to design an effective policy, and permanent modifications to the Medicaid policies would need to align with existing regulatory and statutory frameworks. For example, HCBS waiver services may only be furnished by providers who meet all applicable qualifications for each relevant waiver service as described in the 1915(c) technical guidance. Further evaluation may also be required to assess effective income and asset rules to expand access to Medicaid services while balancing potential increases to programmatic, provider and health plan costs.

Specific priority flexibilities for policymakers to consider for permanence or continued evaluation are shown in Table 8.

Table 8. Other 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")

Note: We recognize that Congress and CMS also can make permanent Medicaid changes through federal legislation or agency rulemaking, respectively, but focused the Medicaid authorities on those that states can make without federal intervention.

Section IV: Moving Beyond the Pandemic

The COVID-19 pandemic has had a devastating and lasting impact on American society. It also has presented a unique opportunity for federal and state policymakers to evaluate Medicare and Medicaid policies designed to ensure access to care for older adults and people with chronic conditions or disabilities. The temporary regulatory flexibilities granted during the pandemic enabled people to safely obtain person-centered care in their homes and communities, expanded access to services, and bolstered an essential yet struggling provider and direct care workforce. While there is limited data available to date, existing evidence indicates that flexibilities positively affected consumers, providers and payers. More evaluation is needed to understand the impact of these flexibilities and to assess the impact of flexibilities that have yet to be measured, particularly with respect to how flexibilities advance person- and community-centered care and advance health equity.

This report provides federal and state policymakers a person-centered assessment tool to support these evaluations and—informed by the tool and input from diverse stakeholders—elevates select temporary regulatory flexibilities for priority consideration for permanence or continued evaluation based on their ability to advance person- and community-centered care and advance health equity. The person-centered assessment framework and the initial list of flexibilities are intended to contribute to a broader societal discussion about permanently strengthening and transforming care delivery for older adults and people with complex care needs or disabilities in the Medicare and Medicaid programs.[41] As the PHE comes to an end, federal and state policymakers will continue to work with the key consumer, provider and health plan stakeholders who underpin the Medicare and Medicaid programs to determine which reforms to pursue. The person-centered assessment framework, the priority list of flexibilities and an accompanying policymaker playbook are tools policymakers can draw upon to inform those decisions and help ensure selected reforms promote person- and community-centered care in the least intensive and restrictive settings and remove misalignments between Medicare and Medicaid programs that adversely impact consumers.

Appendix A: Opportunities to Align Medicare and Medicaid Policies

We selected five states to assess how federal and state laws and regulations could be synchronized: California, Georgia, Massachusetts, Pennsylvania and Texas. These states were selected for their representation of different geographic regions, population health needs and varying policy priorities. Many states implemented emergency policies that temporarily expanded access, lowered/eliminated cost-sharing and waived limits on out-of-state practitioners. Several states have considered making some of these policies permanent.

Table 9. Illustrative Opportunities to Align Medicare and Medicaid Policies After the End of the PHE

	Medicare		Medicaid		Opportunity for Policy Alignment
	Temporary Flexibility	Permanent Policy	Temporary Flexibility	Permanent Policy	
Telehealth Coverage					
Can patients use telehealth in their home?	Yes	No (except for substance use disorder (SUD)/ mental health, ESRD, renal dialysis)	Yes (CA, GA, MA, PA, TX)	Yes (CA, GA, MA, PA, TX)	Allow Medicare payment for telehealth in homes
Can patients in urban areas use telehealth?	Yes	No (except for stroke services, SUD/mental health, ESRD, renal dialysis)	• Yes (MA) • No reference in temporary policy (CA, GA, PA, TX)	• Yes (CA, MA, PA) • No reference in permanent policy (GA, TX)	Allow/clarify Medicare payment and Medicaid payment in more states for telehealth in urban areas
Can patients use audio-only telehealth?	Yes (in some instances)	No (except for BH, medical nutritional services, face-to-face prolonged services, advanced care planning)	• Yes (CA, GA, MA, PA, TX)	• Yes (MA, PA) • Yes under managed care (TX) • No (CA, GA)	Allow Medicare payment and Medicaid payment in more states for audio-only telehealth
Can patients use telehealth for a first visit with a new provider?	Yes	Yes	• Yes (CA, MA, PA) • No reference in temporary policy (GA, TX)	• Yes (MA, PA, TX) • No reference in permanent policy (CA, GA)	Allow/clarify Medicaid payment in more states for first visits with a new provider

	Medicare		Medicaid		Opportunity for Policy Alignment
	Temporary Flexibility	Permanent Policy	Temporary Flexibility	Permanent Policy	
Scope of Practice					
Which providers are eligible to bill for telehealth services (medical, allied health, BH)?	• Physical therapists • Occupational therapists • Speech language pathologists • Audiologists	• Physicians • Physician assistants • Nurse practitioners • Clinical nurse specialists • Nurse-midwives • Clinical psychologists • Clinical social workers • Registered dietitian • Certified registered nurse anesthetist	• Medicaid-enrolled providers (CA, TX) • Qualified providers (GA, MA) • Eligible providers (PA)	Medicaid-enrolled providers (CA, GA, MA, PA, TX)	Allow providers who can bill Medicare for their services to use telehealth
Which clinicians can provide services without physician supervision?	Physician assistants (subject to state law)	• Nurse practitioners • Physician assistants (beginning in 2022) • (Both subject to state law)	• Advanced practice registered nurses (MA) • Physician assistants and nurses when administering the COVID-19 vaccine (GA) • Physician supervision required (CA, PA, TX)	• Nurse practitioners, psychiatric nurse mental health clinical specialists, and nurse anesthetists (MA • Physician supervision required (CA, GA, MA - physician assistants, PA, TX)	Allow mental health clinical specialists, NPs, nurse anesthetists, PAs and psychiatric nurses to treat patients without physician supervision in Medicare and Medicaid in more states
Can providers provide care via telehealth (or in person) with out-of-state licenses?	Yes (subject to state law)	No	• Yes, if enrolled in Medicaid or through a temporary license (CA, GA, MA, PA) • No reference in temporary policy (TX)	• Yes, via expedited licensing through the Interstate Medical Licensure Compact or through a telemedicine license (GA) • Yes, if enrolled in Medicaid or through a temporary or extraterritorial license (PA) • Yes, except telehealth for mental health services (TX) • No (CA, MA)	Allow Medicare and more Medicaid providers to provide care with out-of-state licenses

Note: The temporary flexibilities and permanent policies pertain to the traditional Medicare FFS program and the Medicaid FFS and/or managed care program. Policies may differ across managed care programs, demonstrations, and other Medicare and Medicaid arrangements.

Sources: Manatt Health and HMA analyses of Medicare and Medicaid telehealth and scope of practice legislation and regulation (temporary and permanent).

[1] The Centers for Medicare and Medicaid Services (CMS) recently confirmed the Biden Administration's commitment to provide states with 60 days' notice prior to ending the PHE. Because such notice has not been given within the 60-day period prior to April 15, 2022, the PHE likely will be extended through July 15, 2022.

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[4] Demographic Trends of People Receiving COVID-19 Vaccinations in the United States, CDC (January 2022).

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[7] COVID-19 Data on Trans and Gender-Expansive People, Stat!, Health Affairs (May 2021).

[8] While the end of the PHE is unclear, HHS has committed to providing 60-day prior notice to its end.

[9] Federal Declarations and Flexibilities Supporting COVID-19 Response Efforts—Effective and End Dates, Manatt on Health (January 2022).

[10] Manatt Health recently provided a summary update of its COVID-19 State Resource Guide on March 1, 2022.

[11] HMA's publication was co-supported by The SCAN Foundation and The Commonwealth Fund.

[12] Which Medicare Changes Should Continue Beyond the COVID-19 Pandemic? Four Questions for Policymakers, The Commonwealth Fund (May 2021).

[13] Medicare Beneficiaries at a Glance, CMS (2021).

[14] Seniors & Medicare and Medicaid Enrollees, Medicaid (2021).

[15] June 2021 Medicaid & CHIP Enrollment Data Highlights, Medicaid (June 2021).

[16] December 2020 State Health Official letter; August 2021 State Health Official letter.

[17] Bill S.2984 (January 2021).

[18] PA Dept of Human Services, Medical Assistance Bulletin 99-21-06 (September 2021); PA Dept of Human Services, Office of Mental Health and Substance Abuse Services Bulletin OMHSAS-21-09 (September 2021); PA Dept of Human Services, Telemedicine Guidelines Related to COVID-19 (March 2020).

[19] HB1134 (March 2021).

[20] HB1135 (March 2021).

[21] Alkema, G. E. (2017). Bringing the pieces together: Person-centeredness is key to transforming policy and services. *Generations, 40*(4), 94–100.

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[24] Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location, ASPE (2021).

[25] Ibid.

[26] CMS. Medicare Telemedicine Snapshot.

[27] The denominator for these rates excludes Medicare beneficiaries who received no services that could have been provided by telehealth (e.g., visits with clinicians).

[28] State Medicaid Telehealth Policies Before and During the COVID-19 Public Health Emergency, ASPE (July 2021).

[29] Ibid.

[30] Ibid.

[31] Medicare and Medicaid: COVID-19 Program Flexibilities and Considerations for Their Continuation, GAO (May 2021).

[32] Ibid.

[33] Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic, JAMA Network Open (December 2020).

[34] COVID-19 Intensifies Home Care Workforce Challenges, ASPE (May 2021).

[35] PHI Releases New Annual Data on the U.S. Direct Care Workforce, PHI (September 2021).

[36] State Medicaid Home & Community-Based Services (HCBS) Programs Respond to COVID-19: Early Findings from a 50-State Survey, KFF (August 2021).

[37] The five states are California, Georgia, Massachusetts, Pennsylvania and Texas. See Table 9 for more detailed, illustrative list of opportunities to align Medicare and Medicaid programs.

[38] For example, the Interstate Medical Licensure Compact is an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states.

[39] Current COVID-19-related temporary flexibility applies only to nurse practitioners.

[40] Current COVID-19-related temporary flexibility applies only to two-way, audio-video telehealth.

[41] These topics are being explored by several other researchers, supported in whole or in part by The SCAN Foundation, including the Milken Institute, Duke Margolis Center for Health Policy, Convergence Center for Policy Resolution and the Bipartisan Policy Center.

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