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Learning From COVID-19-Related Flexibilities

Moving Toward More Person-Centered Medicare and Medicaid Programs

A Policymaker Playbook

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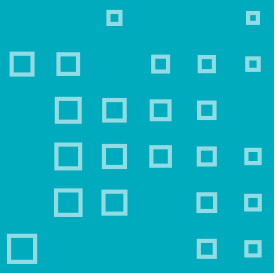

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Section I: Background and Context

The COVID-19 pandemic has reinforced that our health system does not fully meet the needs of older adults and people with chronic conditions or disabilities. These populations faced higher rates of disease and mortality, disparities in vaccine access, and barriers to accessing essential services and providers. There are many complex causes contributing to these realities, including health inequities and health disparities based on age, disability, race, ethnicity, socioeconomic status and other factors, and persistent challenges facing the provider and direct care workforce that delivers care to these populations.[1,2,3] To improve health outcomes and achieve health equity for older adults and people with chronic conditions or disabilities, the programs that shape their care—Medicare and Medicaid—must advance policies that facilitate the delivery of high-quality person- and community-centered care.

During the COVID-19 public health emergency (PHE), federal and state policymakers implemented hundreds of temporary Medicare and Medicaid regulatory flexibilities to ensure access to services and support the provider workforce. These flexibilities minimized clinical, administrative and financial barriers to care by expanding access to telehealth and remote care delivery, authorizing care delivery in alternative care sites, easing cost-sharing requirements, and more. As the temporary flexibilities will expire upon or shortly after the end of the PHE, policymakers must contemplate whether and which temporary flexibilities should be made permanent because they advance person- and community-centered care and promote health equity beyond the PHE.

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.

To aid policymakers, Manatt Health and Health Management Associates (HMA) developed:

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

Initial recommendations for which flexibilities should be considered for permanence, as is or with modifications, or further evaluation

These materials were conceptualized and refined through a mixed-methods analysis and a series of stakeholder roundtables and interviews with consumers and consumer advocates, experts in DEI, health plans and providers, state officials, and former federal officials. (For a full list of participants, see Acknowledgments.) They use a person- and community-centered lens to identify flexibilities that facilitate care in the least intensive or least restrictive setting and better align Medicare and Medicaid policies. 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 developing 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. For more information on the methodology for developing the person-centered assessment framework and initial recommendations, please see the issue brief.

Section II: Considerations for Assessing Temporary Flexibilities for Permanence

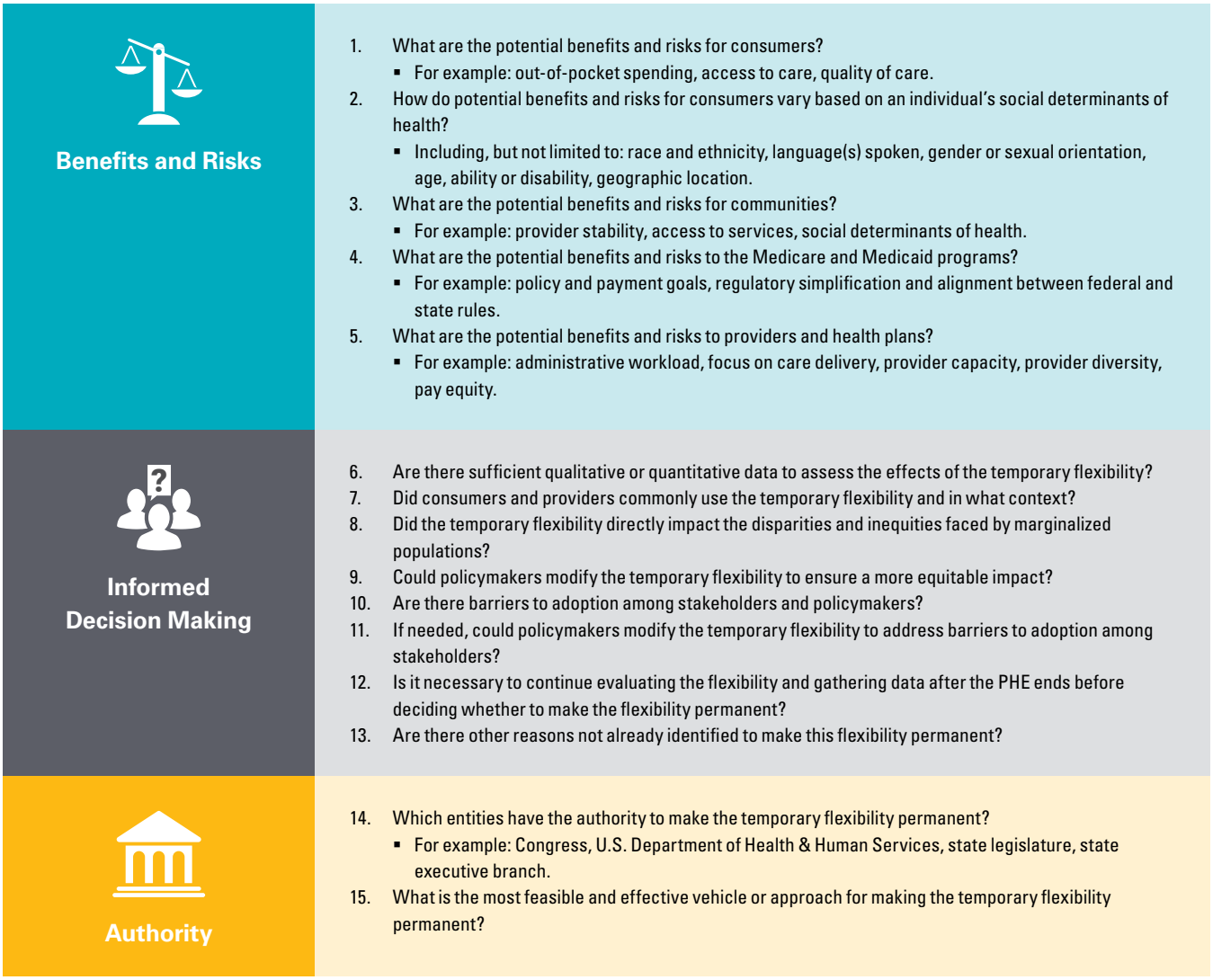
Although policymakers and researchers continue to learn about how the temporary flexibilities are impacting consumers, providers and other stakeholders, our analysis and roundtable discussions elicited preliminary findings and considerations that can help inform the development of long-term system improvements.

More Data Needed to Make Informed Decisions	Where data about the impact of the temporary flexibilities exist, they reveal the positive effects of certain Medicare and Medicaid flexibilities that indicate that these might be good candidates for permanent policy. One example is that expanded telehealth utilization in the Medicare program enhanced access to timely care in the home for many people.[4] However, we lack data on the impact of increased telehealth utilization on health outcomes, including whether they improved or exacerbated health disparities.
Extended Evaluation for Promising Temporary Flexibilities	Stakeholders 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. As such, stakeholders 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. As policymakers consider which temporary regulatory flexibilities might improve the Medicare and Medicaid programs if continued as permanent policies, they will be 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.

Section III: Person-Centered Assessment Framework for Policymakers

The person-centered assessment framework lays out a holistic approach to evaluating the temporary flexibilities (Figure 1) to support policymakers' complex decisions regarding the future of the temporary flexibilities. Policymakers are encouraged to answer the questions in each section for temporary flexibilities that they wish to consider for permanence, modification or further evaluation. To do so, they will need to draw upon both qualitative data and quantitative data and decide how to weigh each question.

Figure 1. Person-Centered Assessment Framework



Section IV: Priority Flexibilities for Permanence and Further Exploration

Four categories of Medicare and Medicaid flexibilities stand out among the many flexibilities implemented during the PHE, based on quantitative data and stakeholder experience (Table 1).

Table 1. 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 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

Within each of these categories, we list initial recommendations for high-impact flexibilities that policymakers may wish to consider for permanence, modification and/or further evaluation (Tables 2–5). We also identify at a high level which federal or state entity has the authority to extend each flexibility past the end of the PHE. For Medicare reforms, policies in statute that can only be modified by enactment of law are indicated as "federal legislation." Policies not detailed in statute that can be modified by agency rulemaking are indicated as "federal regulation or legislation." 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. For more information on the benefits and risks of extending these flexibilities, see the issue brief.

Table 2. 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)

Table 3. 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 SNFs	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[5]	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)

Program	Flexibility	Authority
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)

Table 4. 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[6]	Federal regulation or legislation

Table 5. 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")

Conclusion

This policymaker playbook and the accompanying issue brief are tools to support policymakers' decisions about the temporary Medicare and Medicaid regulatory flexibilities they wish to consider for permanence, modification or further evaluation. They are intended to help engage and guide ongoing discussions with policymakers and stakeholders about how to apply lessons learned from the impacts of temporary flexibilities to better equip the Medicare and Medicaid programs to advance person- and community-centered care for older adults and people with disabilities well beyond the end of the COVID-19 pandemic.

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

[2] 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).

[3] COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time, KFF (October 2021).

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

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

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

About Manatt Health

Manatt Health integrates legal and consulting services to better meet the complex needs of clients across the health care system.

Combining legal excellence, firsthand experience in shaping public policy, sophisticated strategy insight and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players.

Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions and lead health care into the future. For more information, visit https://www.manatt.com/Health or contact:

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About Health Management Associates

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 6. 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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