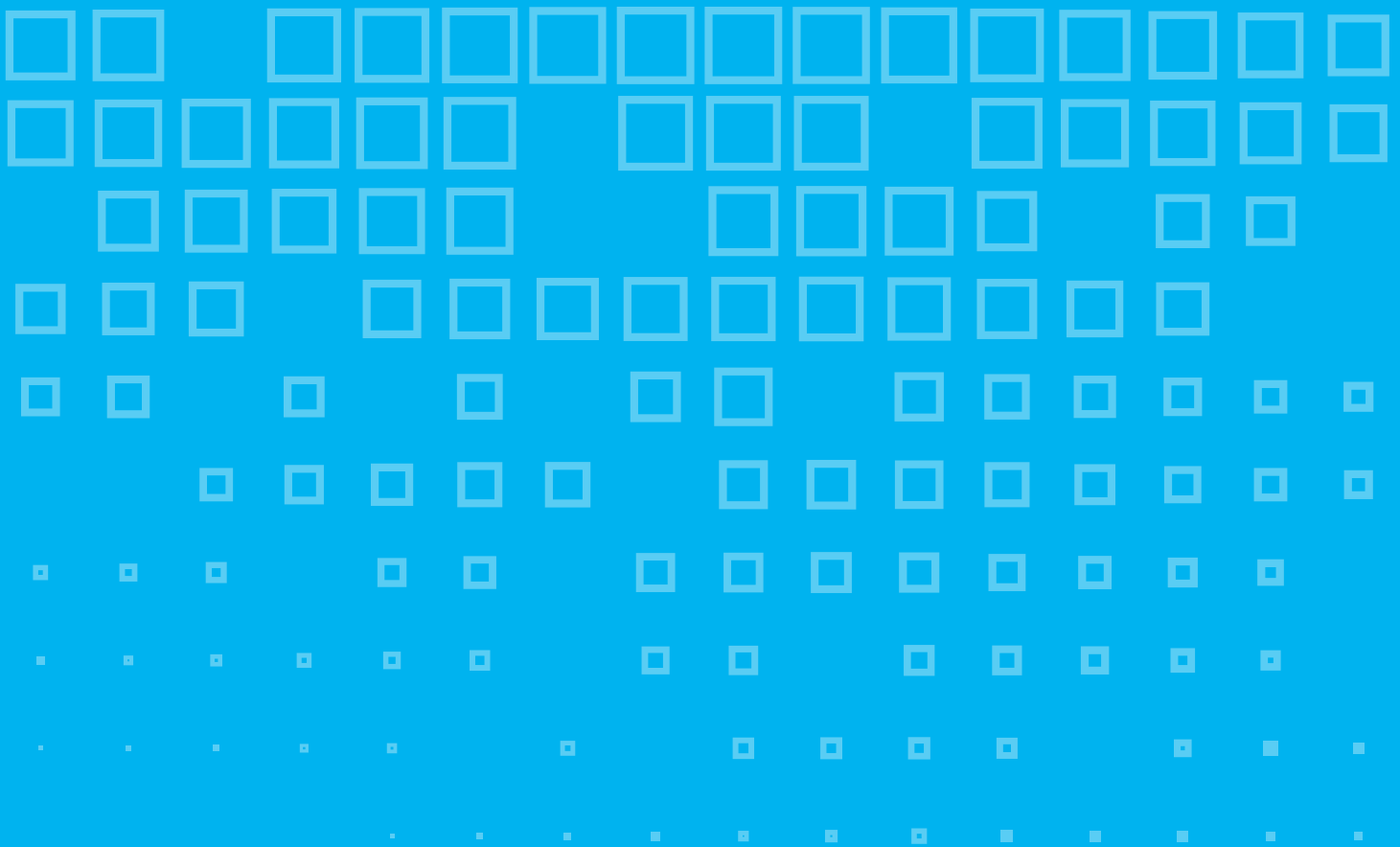


JANUARY 2023

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs **A Roadmap for Policymakers**



Letter to the Reader

The COVID-19 pandemic fundamentally changed Medicare and Medicaid health care service delivery. As stakeholders prepare for the eventual end of the COVID-19 public health emergency (PHE), federal and state policymakers will need to determine the path forward for the Medicare and Medicaid flexibilities that were implemented in response to the immediate needs of the pandemic. The SCAN Foundation supported several organizations to engage diverse stakeholders and subject matter experts ([COVID-19 Public Health Emergency Flexibilities Working Group](#))—including those with lived experience and on-the-ground perspectives—in dialogue on the PHE flexibilities that best represent person-centered and equitable care. “Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers” is a result of Working Group deliberations and provides an assessment of the future role of those flexibilities. The Roadmap provides guidance for federal and state leaders in their decision making on which Medicare and Medicaid COVID-19 PHE flexibilities may be worth continuing on a permanent basis and can be used to prepare for future emergencies.

The Working Group analyzed twenty-one of the hundreds of Medicare and Medicaid flexibilities—selected for their propensity to further person-centered care and equitable care—and came to consensus on continuing or discontinuing their use. As shown in [Figure 1](#) in the Roadmap:

- Flexibilities that the Working Group reached a broad consensus on making permanent are categorized as green.
- Flexibilities that the Working Group felt required further study or modifications are categorized as yellow.
- Flexibilities on which no consensus was possible would be categorized as red (however, the Working Group ultimately did not categorize any of the flexibilities as red).
- Flexibilities that the Working Group felt were useful in current or potential future emergencies but should not be made a permanent part of the Medicare or Medicaid programs were categorized as blue.

The Roadmap includes the full summary of these flexibilities, as well as the Working Group’s analysis and categorization ([Figure 3](#) and [Figure 4](#) in the Roadmap). The Working Group members approached their evaluation based on specific principles and inclusive of several important considerations.

Of the Medicare flexibilities the Working Group considered, the consensus opinion was that five merited permanence. These are generally telehealth-related flexibilities, and one related to removing the requirement for a three-day hospital stay before Medicare eligibility for skilled nursing services. Of the Medicaid flexibilities reviewed, an additional five were designated green. They fall under the telehealth, scope of practice, and self-directed home- and community-based services (HCBS) groupings. Another six flexibilities (five Medicare and one Medicaid) were designated yellow. The Working Group determined these flexibilities may need further analyses or data collection, and the Working Group gave some suggestions in the “Areas for Modification or Further Study/Monitoring/Evaluation” column of [Figure 3](#) and [Figure 4](#) in the Roadmap. The Working Group designated the remaining flexibilities blue and noted that these could be used in a tool kit by federal and state policymakers in the event of a similar future PHE.

The Roadmap summarizes the thoughtful deliberation and considerations that led to these recommendations. Please review the Roadmap in its entirety for the complete analysis of these PHE flexibilities. We hope that this consensus document will assist policymakers in the decisions necessary to administer more person-centered and equitable Medicare and Medicaid programs in the future.

Overview

In response to the COVID-19 pandemic public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) approved hundreds of temporary Medicare and Medicaid regulatory flexibilities to minimize administrative, clinical and financial barriers to care through expanded eligibility and enrollment, remote service delivery, alternative care sites, and more. In addition, Congress enacted flexibilities and funding to increase access to care over the course of the PHE.

As a result, unprecedented levels of change in Medicare and Medicaid coverage, payment and care delivery occurred in a short time frame. This in turn elevated new ways to deliver person-centered care to older adults, those living with complex care needs and family caregivers beyond what was previously provided. This also created a natural experiment to assess, among other things, what policies may best support person- and community-centered equitable care. Previous work by Health Management Associates (HMA) and Manatt Health Strategies (Manatt Health) identified the most promising flexibilities to achieve these goals in the [Learning From COVID-19-Related Flexibilities: Moving Toward More Person-Centered Medicare and Medicaid Programs](#) issue brief and policymaker playbook.

As policymakers and health care leaders prepare for the end of the COVID-19 PHE and plan for future emergencies, they must consider what flexibilities to continue, modify, evaluate further or end, possibly to be used again in a future PHE. Feedback from stakeholders, including those with lived experience and “on the ground” perspectives, will play a critical role in assessing the risks and benefits of the most promising person-centered PHE flexibilities.

To that end, The SCAN Foundation supported several organizations to engage diverse stakeholders and subject matter experts in dialogue, resulting in this Roadmap. The Alliance for Health Policy convened the COVID-19 Public Health Emergency Flexibilities Working Group (Working Group) (listed in [Table 1](#))—a group of expert stakeholders with diverse policy, practice and consumer perspectives. ATI Advisory facilitated these Working Group sessions. Health Management Associates (HMA) and Manatt Health provided technical guidance on their prior analyses and documented the recommendations of the Working Group in this Roadmap. Consultant Kristi Guillory Reid also contributed to this work by conducting a diversity, equity and inclusion (DEI) literature review and interviews with stakeholders to further assess the evidence of the impact of the flexibilities on equitable care.

Over a series of three interactive convenings during summer and fall 2022, the Working Group developed six principles (defined below) and identified which flexibilities could be made permanent, which would require modification, which would benefit from continued testing or which could sunset but be considered for future PHEs. This document outlines the results of the analyses and the Working Group’s recommendation for each flexibility.

The purpose of this Roadmap is to serve as an actionable tool and ready reference for policymakers when evaluating the impacts of select COVID-19 PHE flexibilities on person- and community-centered equitable care. The Roadmap can be used to inform policy deliberations and decision making on strengthening the Medicare and Medicaid programs.

Acknowledgments

The SCAN Foundation and its partners would like to thank the diverse group of stakeholders listed in Table 1 for their participation in the Working Group and thoughtful discussion on select Medicare and Medicaid flexibilities that can best advance person-centered, equitable care for older adults and individuals with complex care needs.

Table 1. COVID-19 PHE Flexibilities Working Group Members

Name	Organization
LaRae Cantley	Camden Coalition’s National Center for Complex Health and Social Needs
Josephina Carbonell	Independent Living Systems, LLC, and Florida Community Care
Lindsey Copeland, J.D.	Medicare Rights Center
Scott Cormier, CHEP, and Kelly Randall, Ph.D.	Ascension
Karen M. Dale, MSN, R.N.*	AmeriHealth Caritas
Robert Espinoza, MPA*	PHI
Allison Hamblin, MSPH	Center for Health Care Strategies
Brian Hasselfeld, M.D.*	Johns Hopkins Medicine
Calder Lynch*	Commonwealth Care Alliance
Michael Monson, MPP*	Altarum
Jennifer E. Moore, Ph.D., R.N., FAAN*	Institute for Medicaid Innovation
Sarah Hudson Scholle	National Committee for Quality Assurance
Hemi Tewarson, J.D., MPH*	National Academy for State Health Policy
Josh Trent, M.A.*	Leavitt Partners, an HMA Company
Sophia Tripoli, MPH*	Families USA
Kristal Vardaman, Ph.D., MSPH	Aurrera Health Group

* Denotes participation in this Working Group as an individual **only**. Their affiliation is listed here only as identification and does not reflect that their organization endorses, agrees with or supports this Roadmap.

This initiative is supported by a grant from The SCAN Foundation—an independent public charity devoted to advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. To learn more, visit www.TheSCANFoundation.org.

**Leveraging COVID-19 Public Health
Emergency Flexibilities to Advance
Person-Centered Care for Older Adults
and People with Complex Care Needs
A Roadmap for Policymakers**

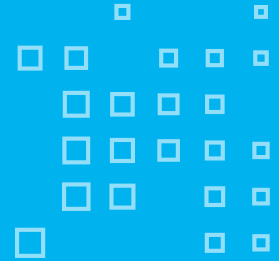


Table of Contents

Section I: Background	6
Section II: PHE Flexibilities Decision-Making Approach and Framework	8
Section III: Consensus Statement and Guiding Principles	10
Section IV: Assessing the Medicare Flexibilities	12
Section V: Assessing the Medicaid Flexibilities	17
Section VI: Conclusion	21
Appendix A: Person-Centered Assessment Framework for Policymakers	22
Appendix B: PHE Flexibilities and DEI Environmental Scan Conducted by Kristi Guillory Reid	23
Appendix C: State Examples of Medicaid Flexibilities	24

Section I: Background

In the early stages of the COVID-19 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 amid COVID-19 surges; and bolster the workforce. These temporary regulatory flexibilities expanded program eligibility and enrollment, enhanced remote service delivery options, authorized care delivery in alternative care sites, and much more. The temporary flexibilities initially were tied to the federally declared COVID-19 PHE. However, recent legislation modified and extended certain flexibilities past the end of the PHE.¹

As policymakers prepare for the eventual end of the PHE and many of the flexibilities sunset, it is important to assess and prioritize the flexibilities' impacts on advancing person- and community-centered care and promoting health equity. Persistent health disparities that predated and were worsened by the PHE 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. Conducting this exercise can help policymakers determine which flexibilities could be made a permanent part of the Medicare and Medicaid programs, modified, studied further, sunsetted or only used again in future emergencies.

Key Terms

Person-centered care: 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.^[1]

Community-centered care: An approach to care that involves expanding health care outside the confines of hospitals, hospital systems, clinics and skilled nursing facilities (SNFs) into communities. In this model of care, health care providers can partner with community-based providers and organizations to help individuals directly engage in transforming the root causes of their health challenges.^[2]

Health equity: 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 health care disparities.^[3]

Health disparities: A particular type of health difference that is closely linked with social, economic and/or environmental disadvantage [and] 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.^[3]

Sources:

^[1] American Geriatrics Society, <https://agsjournals.onlinelibrary.wiley.com/doi/pdf/10.1111/jgs.13866>.

^[2] American Academy of Physicians, <https://acpdecisions.org/the-vital-role-of-community-centered-care-during-a-pandemic/>; Juliana E. Morris, When "Patient-Centered" Is Not Enough: A Call for Community-Centered Medicine, <https://www.annfammed.org/content/annalsfm/17/1/82.full.pdf>.

^[3] 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. Aug. 11, 2020. Available here: https://ehe.jhu.edu/DEI/Health_Equity_Style_Guide_CDC_Reducing_Stigma.pdf.

In prior work supported by The SCAN Foundation, HMA and Manatt Health developed a person-centered assessment framework (see [Appendix A](#)) with broad stakeholder input that policymakers can reference as they consider how the PHE flexibilities might be used to improve person- and community-centered equitable care.²

Using the person-centered assessment framework, HMA and Manatt Health identified an initial list of temporary Medicare and Medicaid flexibilities that policymakers might prioritize for permanence or further evaluation after the PHE ends.³ Notably, these previously identified flexibilities are not fully representative of all the flexibilities that are available in Medicare and Medicaid during the PHE. They were selected based on their ability to promote person- and community-centered equitable care in the least intensive or least restrictive setting and better align Medicare and Medicaid program rules and policies. As a result, the Medicaid flexibilities for discussion are primarily focused on flexibilities that expand access to Medicaid long-term services and supports (LTSS) and home- and community-based services (HCBS) for populations with complex care needs, including people eligible for both Medicaid and Medicare (dual eligibles). However, many of the lessons here can apply to other Medicaid services, including primary care and behavioral health.

In addition, CMS has modified or ended certain Medicare flexibilities and Congress has amended some Medicare telehealth requirements since the waivers were initially implemented.⁴ To the extent these flexibilities helped better align Medicare and Medicaid program rules during the pandemic, there could be increased misalignment between Medicare and Medicaid after the PHE without further consideration and action by federal and state policymakers.

Section II: PHE Flexibilities Decision-Making Approach and Framework

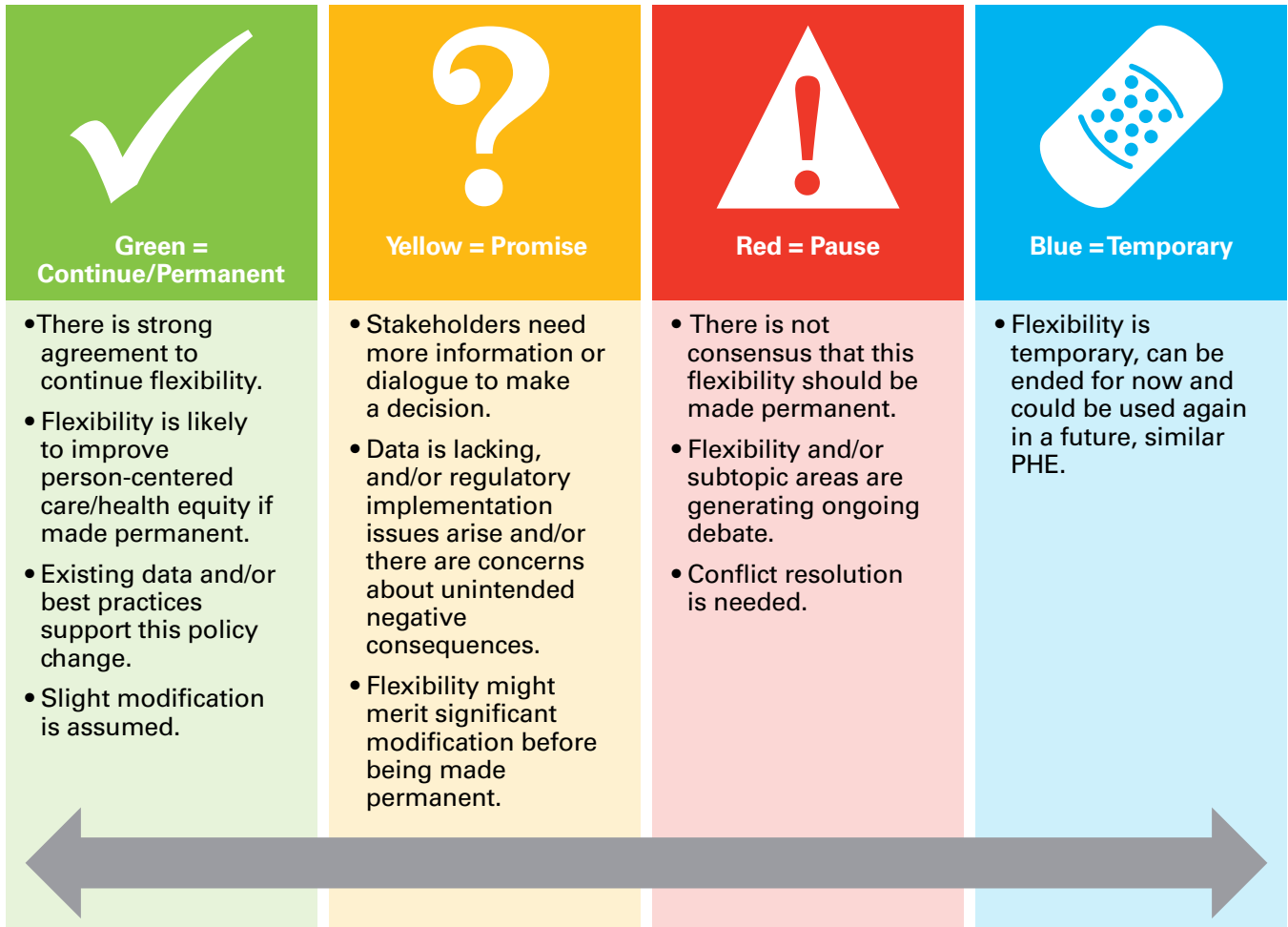
In summer and fall 2022, the project partners convened the Working Group to consider which flexibilities, among a select list of flexibilities, could be made permanent parts of Medicare and Medicaid programs. To do this, the Working Group broadly applied the person-centered assessment framework referenced above to the identified flexibilities and incorporated the DEI literature review and interview findings into their deliberations and assessment of the flexibilities. See [Appendix B](#) for a summary of the DEI environmental scan.

The Working Group had limited data with which to assess the impact of the Medicare and Medicaid flexibilities on consumer access, service utilization and outcomes as well as on the provider and direct care workforce. The limited quantitative data that does exist indicates that telehealth flexibilities facilitate access to timely care in individuals' homes or communities. Qualitative data is more abundant and supports the use of telehealth and provider workforce flexibilities to improve access to care but suggests that certain flexibilities may widen health disparities or harm patient care if not implemented with modifications designed to ameliorate these risks. Data on the quality and outcome effects on DEI impacts of all flexibilities is lacking.

The Working Group assessed each flexibility with the information available and voted on its future using a color-coded decision-making framework (see [Figure 1](#)).⁵ A green vote is a recommendation to continue the flexibility permanently with or without modification. A yellow vote is a recommendation that the flexibility has promise to meet the person-centered goal and should be evaluated after the end of the PHE. A red vote is a recommendation to let it sunset with the end of the PHE. Finally, a blue vote is a recommendation to consider this a true temporary flexibility that could be redeployed in future PHEs. The Working Group votes did not need to be unanimous but did need to represent consensus for the direction of the specific flexibility.

We note that CMS and states implemented these flexibilities quickly in response to the critical needs at the beginning of the PHE, and they were designed and implemented for rapid deployment. Many of these flexibilities would need to be examined and modified in certain ways if they were to be made permanent to ensure they are being implemented most effectively and efficiently within a non-PHE operating status.

Figure 1: PHE Flexibilities Decision-Making Framework



Section III: Consensus Statement and Guiding Principles

Based on the Working Group’s dynamic discussions over the course of the three working sessions, and their assessment of the future of the Medicare and Medicaid flexibilities under consideration, the Working Group agreed to the following consensus statement:

The members of the PHE Flexibilities Working Group affirm their support for this consensus Roadmap and agree that it reflects the deliberations of the Working Group.

As noted in Section II, this Roadmap represents a consensus of the Working Group about the future of specific temporary Medicare and Medicaid flexibilities. The votes on each flexibility were not unanimous in all cases. As the Working Group deliberated on their assessment of the temporary Medicare and Medicaid flexibilities for permanence or other action, they articulated personal biases, important policy goals or constraints, and other contextual considerations that they agreed would guide and impact their assessment and decision making across all the prioritized flexibilities. Working Group members acknowledged the lack of quantitative and qualitative data on the impacts of the temporary Medicare and Medicaid flexibilities on health care access, quality, equity and outcomes. They also discussed the potential impacts of the flexibilities on the lived experience of beneficiaries, particularly for individuals enrolled in and receiving services in both programs (i.e., dual eligibles), beneficiary protections (e.g., quality measurement or grievance and appeals rights) and program integrity (e.g., provider fraud and abuse).

Based on these considerations, the Working Group identified the following **six guiding principles** for their recommendations (see [Figure 2](#)).

Figure 2: Six Guiding Principles

1	Prioritize maintaining Medicare and Medicaid flexibilities that enable person-centered care: health care that is guided by an individual's personal values and preferences and is designed to help people achieve what matters to them most.
2	Prioritize health equity in programs and policies for the attainment of the highest level of health for all people.
3	Recognize that federal and state data collection, monitoring, oversight and transparent reporting are essential to support policymakers in monitoring access, quality of care and costs, and that the perspectives of people who are impacted by the policies must inform these processes.
4	Prioritize equitable access to health care regardless of the type of coverage or insurance status.
5	Recognize that state governments differ in the contexts guiding their considerations of certain flexibilities and that these differences also influence the effect of federal flexibilities across states.
6	Recognize that as policymakers advance person-centered and equitable care, they will need to consider multiple goals, such as beneficiary protections, program integrity and budget constraints.

The Medicare and Medicaid flexibilities prioritized for review and assessment by the Working Group fall into three overarching categories:

- **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).
- **Other Temporary Flexibilities.** Adjustments to other Medicare and Medicaid program requirements, such as the three-day prior hospitalization requirement for Skilled Nursing Facility (SNF) stays, self-directed HCBS and financial eligibility rules.

Given the fifth guiding principle, the Group opted to approach their assessment of the Medicare and Medicaid flexibilities across these categories separately while also considering opportunities to better align Medicare and Medicaid policies going forward. Most of the prioritized Medicaid LTSS flexibilities are available as policy options for states to implement under existing Medicaid authorities, including prior to the PHE.⁶ In recognition of this preexisting authority and the variation in state Medicaid program characteristics and covered populations, the Working Group assessed and voted on the Medicaid flexibilities slightly differently than the Medicare flexibilities (see [Section IV](#)), which are available and were granted only through PHE-related authorities (absent federal statutory or regulatory change) and implemented uniformly across the country.

Section IV: Assessing the Medicare Flexibilities

The Medicare flexibilities identified for the Working Group’s review represent a sample of the many dozens of flexibilities that CMS used during the PHE. Most of those flexibilities are designed to waive or modify requirements for the ways Medicare providers and suppliers deliver care and services.

In addition to the principles discussed above, the Working Group considered the operational feasibility of making the flexibilities permanent. The existing regulatory and programmatic infrastructure is not equipped to deliver the care provided through these flexibilities sustainably or at scale. Achieving these goals will require thoughtful and deliberate attention to identifying and adopting well-designed guardrails to ensure that these new permanent policies can operate seamlessly within the broader Medicare program. The Working Group members would like to see CMS make conforming changes to its operational structure, including provider enrollment, payment and beneficiary protection requirements for any flexibilities made permanent.

The Working Group also recognized that the discussions around these PHE flexibilities are occurring at the same time as broader policy debates about the future of Medicare, including financing issues, value-based care, workforce issues and initiatives to improve health equity. The Working Group also discussed the growing role of Medicare Advantage (MA) in the program and the impact the extension of any of the flexibilities could have on plan financing, risk adjustment, beneficiary access and other programmatic requirements. As previously discussed, there are dozens of additional flexibilities that were not prioritized for review. However, many of those flexibilities intersect with those the Working Group reviewed and can be used to further facilitate the delivery of care, such as provider enrollment and location requirements for telehealth services or the suite of waivers provided for use in SNFs. The Working Group recognizes that policymakers are faced with multiple complex considerations when administering the vast Medicare program. Trying to ensure policies align with Medicaid adds another level of complexity given the different statutory and administrative structures. However, the Working Group still believes it is important to focus on approaches to achieve person-centered care across Medicare and Medicaid.

See [Figure 3](#) for the Working Group’s recommendations on the Medicare flexibilities.

Figure 3: Medicare Flexibilities and Working Group Consensus Recommendations

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
Expanded Telehealth Benefits	Allow Medicare to reimburse for telehealth in urban areas.	Current law requires that Medicare only pay for telehealth from rural originating sites.		Congress and CMS should ensure telehealth is available in all geographic areas and without any in-person requirements, with a commitment to evaluate impact on the latter requirement.
	Allow Medicare to reimburse for telehealth from any location the patient prefers, including their home.	Current law requires that Medicare only pay for telehealth in certain rural locations, including physician offices, hospitals, rural health clinics (RHCs) and other health care settings. Patients' homes are only covered in very limited circumstances for end-stage renal disease patients and in rural and non-rural settings for mental health services. This last part was recently enacted by Congress.		Congress and CMS should ensure beneficiaries can access telehealth services from the most convenient location.
	Allow Medicare to reimburse for audio-only telehealth services when these are needed or preferred by patients.	In general, Medicare telehealth requirements are that services must be furnished using real-time audio and visual two-way interactive communication between the patient and distant site physician or practitioner.		Congress and CMS should recognize that continued access to audio-only telehealth is especially important for behavioral health services.
	Allow Medicare to reimburse for nonphysician practitioners to provide telehealth services.	Before the PHE, physician assistants (pAs), nurse practitioners (NPs), clinical social workers and others could bill for telehealth services from appropriate originating sites. This waiver allows all practitioners who can bill Medicare, such as occupational therapists, physical therapists and speech-language pathologists, to bill for telehealth services as well.		Congress and CMS should allow a full range of practitioners to deliver telehealth services.

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
	Set payment rates for evaluation and management visits equal for telehealth and in person.	Under current law, Medicare pays the facility rate to providers for telehealth services regardless of whether they were provided in a facility or non-facility setting.		Congress and CMS should monitor the utilization of telehealth services but implement policies to maintain beneficiary access to evaluation and management visits delivered via telehealth. Flexibility can be made permanent as long as it is monitored for the principles and evaluated over time to ensure each type of service is paid at a rate to reflect the appropriate resources needed to deliver the care.
	Allow Medicare to reimburse if the practitioner is allowed to practice across state lines, subject to state licensure flexibilities (enrollment, Medicare-based policies and payment, etc.).	Interstate provision of services was not allowed prior to the PHE. Both CMS and the U.S. Department of Health & Human Services (HHS) implemented flexibilities to allow this to occur to assist in the delivery of care during the PHE.		Congress and CMS should study the prevalence and impact of this policy. If the policy is made permanent, CMS will need to make conforming updates to its operational systems and enrollment framework to ensure providers can deliver these services as seamlessly as possible.
	Include diagnoses that MA organizations collect by two-way audio-video and audio-only telehealth for risk adjustment.	CMS expanded the set of codes to include certain telehealth services to be eligible to be used for risk adjustment under MA.		CMS should consider these changes in the context of broader non-PHE-related MA policy considerations. The extension of this flexibility should be evaluated for issues such as potential changes in risk adjustment scores, impact on health equity and overall access to services.

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
Modified Provider Scope of Practice and Other Requirements*	Continue federal flexibilities to permit physicians to delegate tasks to nonphysician practitioners in SNFs to the extent allowed by state licensure.	Regulations require that physician personally perform certain services in a SNF. This waiver allowed physicians to delegate those tasks to NPs, pAs or clinical nurse specialists under the supervision of the physician. CMS terminated this waiver and several other SNF-related ones on May 7, 2022, due to concerns about the impact of these waivers on patient care.		Congress and CMS should consider how this waiver functions within the context of other SNF regulations and flexibilities.
	Continue federal flexibilities to waive physician supervision of certified registered nurse anesthetists at the discretion of the hospital, critical access hospital or ambulatory surgical center to the extent state licensure or scope of practice allows.	Current regulations allow a state to opt out of the physician supervision requirements.		Congress and CMS should consider ways to improve access to services, make better use of the workforce, and allow physicians and hospitals to make decisions that are best for their local community.
	Continue federal flexibilities to reduce the requirement for physician supervision of NPs in federally qualified health centers (FQHCs) and (RHCs) to the extent state licensure allows.	Current regulations require physicians to supervise all FQHC or RHC staff. This waiver allows NPs to practice independently if allowed by state licensure.		CMS said it is considering ways to make this permanent. ⁷ Any future regulations addressing this policy should consider the impact of health equity and how it can improve person-centered care.
	Continue federal flexibilities to allow physicians to delegate SNF visits to an NP, a PA or a clinical nurse specialist to the extent state licensure allows.	Regulations require that a physician make the initial visit to a patient in an SNF. Physicians can alternate subsequent visits with NPs, PAs or clinical nurse specialists. CMS terminated this waiver and several other SNF-related ones on May 7, 2022, due to concerns about the impact of these waivers on patient care.		Congress and CMS should consider how this waiver functions within the context of other SNF regulations and flexibilities.

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
Other Temporary Flexibilities	Allow MA to enhance benefits midyear that were not included in the original bid.	Policy requires that these enhancements be included in the annual bid process.		Congress and CMS should consider the impact of this flexibility on the existing gap between MA and “original” Medicare benefits.
	Waive three-day prior hospitalization requirement for SNF stays.	Law requires this for Medicare to pay for SNF stays.		Changes to this provision will improve person-centered care and can help address health equity and disparity issues.

*Note: Working Group members suggested that the Medicare and Medicaid out-of-state provider flexibilities should be captured as Medicaid flexibilities. The Medicaid flexibilities in this report are focused on LTSS/HCBS, which are not typically covered by Medicare. However, the Working Group recommended that if covered, CMS enable Medicare to reimburse these providers to the extent a state allows. Also, out-of-state services could be relevant for other Medicare-covered services not highlighted in these flexibilities.

Section V: Assessing the Medicaid Flexibilities

As noted above, this report examines those Medicaid flexibilities that enabled older adults and people with complex conditions and disabilities to access LTSS seamlessly and safely throughout the pandemic, as prioritized in [Moving Toward More Person-Centered Medicare and Medicaid Programs](#).⁸ The Working Group recognized, however, that the guiding principles and considerations underlying their assessment of the Medicaid LTSS flexibilities apply more broadly to all Medicaid services (e.g., primary care, hospital and behavioral health services). For example, Working Group members emphasized that states expanded telehealth opportunities to new modalities, services and providers across **all** Medicaid-covered services, including LTSS and HCBS, and urged policymakers to continue to assess the impacts of and potentially pursue permanence for other Medicaid flexibilities adopted during the pandemic, such as those that broadly expanded access to telehealth services.

Ultimately, the Working Group assessed the Medicaid flexibilities based on their ability to address persistent challenges that people with complex care needs face in accessing person-centered, equitable Medicaid services—such as chronic workforce shortages and disparate access to telehealth—and to prevent misaligned Medicare and Medicaid policies when the PHE ends and temporary flexibilities unwind. As such, the Group’s votes on each of the Medicaid flexibilities represent a consensus recommendation on how states should consider the flexibilities as part of their Medicaid policy tool kit, if their goal is to advance person-centered, equitable health care. The Working Group recommended proceeding by recognizing that there may be policy decisions and adjustments specific to individual state circumstances. See [Figure 4](#) for a summary of the Working Group’s recommendations on Medicaid flexibilities.

For all Medicaid flexibilities, the Group recommended the following:

- To the extent states avail themselves of these temporary flexibilities on a permanent basis, they should consider the broader applicability of these Medicaid flexibilities across many Medicaid services, including but not limited to LTSS.
- To the extent states avail themselves of these temporary flexibilities on a permanent basis, they have the responsibility to evaluate and share the impacts of the policy changes on beneficiary health care access, quality and outcomes, as well as on providers and payers (to the extent possible).
- As Medicaid is a joint federal-state program, the federal government, including the administration and Congress—as advised by the U.S. Government Accountability Office’s Medicaid and CHIP Payment and Access Commission, the Medicare Payment Advisory Commission and other entities—has a responsibility to provide Medicaid oversight, federal financial contribution, quality monitoring, best practice sharing and additional research on and related to these Medicaid flexibilities.

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

Figure 4: Medicaid Flexibilities and Working Group Consensus Recommendations⁹

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
Expanded Telehealth Benefits	Expand use of state plan LTSS and HCBS waiver remote service benefits.	This set of flexibilities enabled providers (and more types of providers) to provide care virtually to minimize exposure to COVID-19 for beneficiaries and providers and to support beneficiaries in their ability to use remote service benefits. This flexibility was critical to ensure seamless and safe access to care and services as shutdowns and quarantines occurred.		States should consider the impacts on workforce shortages and equitable access to broadband and telehealth-enabling equipment, such as computers, by race, ethnicity, age, disability, geography and other measures.
	Expand remote service delivery to include audio-only modalities.	This set of flexibilities enabled providers (and more types of providers) to provide care virtually to minimize exposure to COVID-19 for beneficiaries and providers and to support beneficiaries in their ability to use remote service benefits. This flexibility was critical to ensure seamless and safe access to care and services as shutdowns and quarantines occurred.		
Modified Provider Scope of Practice and Other Requirements	Allow out-of-state providers to provide and receive payment for LTSS through expedited licensing processes and modified requirements or under special circumstances.*	This set of flexibilities expanded the number and types of people eligible to provide LTSS/HCBS during the COVID-19 pandemic to prevent gaps in access to and use of services.		States should build on their telehealth efforts to date and promote increased cross-state practice flexibility while measuring quality of care delivered via telehealth and ensuring provider qualifications and training requirements are met.
	Expand the number and types of providers eligible to order and provide LTSS/HCBS (e.g., authorizing nonphysician practitioners to order services without physician supervision).	This set of flexibilities expanded the number and types of people eligible to provide LTSS/HCBS during the COVID-19 pandemic to prevent gaps in access to and use of services.		

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
	Temporarily increase payment rates for HCBS to maintain provider capacity despite service suspensions and volume reductions.	Many states temporarily increased HCBS provider reimbursement rates to maintain provider capacity in the system. One report notes that HCBS providers in several states closed due to worker shortages and loss of revenues.		States should develop PHE-related provider or health plan contract clauses or addendums or develop a “playbook” with lists of flexibilities they can deploy based on the type of PHE (e.g., natural disaster, infectious disease pandemic).
	Provide retainer payments to LTSS providers to maintain provider networks despite reductions in service utilization.	Retainer payments enable states to ensure HCBS provider sustainability when there are interruptions in service delivery that could jeopardize the provider’s financial viability and, thus, access to care. Because Medicaid payments are typically tied to service use (versus lack of service use), CMS permits these payments under limited circumstances (e.g., types of providers, amounts) and for limited time periods.		
Other Temporary Flexibilities	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.	Self-directed HCBS opportunities provide beneficiaries with flexibility and personal choice in how they access services, which services they use and who can deliver those services. During the pandemic, this flexibility prevented gaps in services if/when the “traditional” direct care workforce was diminished.		There is wide variation across the states in the extent to which self-directed HCBS is used, the model of self-directed care delivery, the services that can be self-directed and the providers individuals can hire to provide self-directed services. CMS has signaled a desire for states to expand access to self-directed HCBS and has provided guidance for states interested in implementing this flexibility.

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

Category	Flexibility	Policy Context	Working Group Consensus Recommendation	Areas for Modification or Further Study/ Monitoring/ Evaluation
	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).	These changes, which states can adopt outside a PHE, as recently clarified in SMD# 21-004 re: Medicaid rule of construction , helped reduce the number of uninsured people and expand access to HCBS for people needing these services during the COVID-19 pandemic.		States should balance potentially competing goals of expanding access to Medicaid-covered LTSS in a way that enables people to preserve more of their assets for other life expenses that allow them to remain in the community, delaying or avoiding more costly institutional services, and acknowledging resource constraints and the need to meet state balanced-budget requirements.

*Note: Working Group members suggested that the Medicare and Medicaid out-of-state provider flexibilities should be captured as Medicaid flexibilities. The Medicaid flexibilities in this report are focused on LTSS/HCBS, which are not typically covered by Medicare. However, the Working Group recommended that if covered, CMS enable Medicare to reimburse these providers to the extent a state allows.

Section VI: Conclusion

This Roadmap represents a consensus among diverse national and state stakeholders, including people with lived experience and those with on-the-ground consumer, provider, health plan and state perspectives, and their assessment of the risks and benefits of the most promising person-centered temporary PHE flexibilities that promote health equity. The consensus-based input is an essential and actionable tool for federal and state policymakers considering making certain temporary flexibilities permanent and wanting to move toward more person-centered, equitable Medicare and Medicaid programs for older adults and people with complex care needs. This tool highlights which temporary Medicare and Medicaid flexibilities—previously identified in prior analyses as advancing person- and community-centered care and promoting health equity¹⁰—should be prioritized by policymakers for permanence, further study, sunseting or use in a future similar PHE.

The temporary flexibilities implemented during the COVID-19 PHE represent a unique opportunity to broadly assess the widescale implementation of Medicare and Medicaid policies, some of which have been tested, implemented or available on a smaller scale prior to the PHE. Much is unknown about the impact of some of these flexibilities, so in concert with these recommendations, more quantitative and qualitative data on their effects will be needed, and data analysis and decision making must take into account the perspectives of people who are most impacted by these policies. Discussions about the temporary PHE flexibilities, including those identified in this Roadmap, are occurring at the same time as broader policy discussions about the future of Medicare and Medicaid. Policymakers are addressing financing and sustainability issues, the role of managed care and value-based payments, performance and quality measurement, workforce capacity, and health equity, among other issues. The future of the Medicare and Medicaid PHE flexibilities should go hand in hand with these broader discussions about ways to strengthen these foundational programs that together cover 137 million Americans, including 12 million people enrolled in both programs.

Appendix A: Person-Centered Assessment Framework for Policymakers



Benefits and Risks

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

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



Informed Decision Making

What is the rationale for and feasibility of permanent reform?

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



Authority

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

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

Appendix B: PHE Flexibilities and DEI Environmental Scan Conducted by Kristi Guillory Reid

Kristi Guillory Reid was contracted by the Alliance for Health Policy to serve as a DEI consultant on this Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and Individuals with Complex Care Needs project. The objective of this work was to assess the current landscape of resources, research and best practices related to the use of the flexibilities during the PHE and their impact on DEI for older adults with disabilities and others with complex care needs. Below is a brief summary of the findings. The Working Group discussed these findings during their deliberations and considered equity as a factor in their consensus recommendations.

Health Care Data:

- Presently, there is a **paucity** of articles that examine the relationship and/or effects of PHE flexibilities on issues related to DEI.
- The importance of data **cannot** be overstated. We looked across multiple domains and the literature either lacks data or has poor-quality data.

Health Care Workforce:

- There is an **underrepresentation** of Black, Latinx and Native American licensed health care professionals in the health care workforce, despite advances in the educational pipeline to increase opportunities for these minority groups.
- Direct care workers and community health workers are important members of the health care workforce, and these health care professionals tend to be people of color. They can advance health equity and played a vital role during the pandemic, but issues related to **structural inequalities** persist.
- During the pandemic, Black physicians reported that they experienced **more discriminatory treatment** from their colleagues as compared with other racial groups.

Social Determinants of Health:

- There are increased state efforts to advance health equity using models involving social determinants of health either through state Medicaid **waivers** or through **nonmedical benefits** provided by MA.
- As COVID-19 infection rates have decreased, there still has been meaningful telehealth use across all patient populations. This represents an important way to access care, especially for people of color. Telehealth could become a **new** social determinant of health if issues related to digital literacy and broadband access are not addressed.

Medicaid:

- There are efforts underway to address issues related to equity in Medicaid, but **varying definitions** of race and ethnicity could hamper these efforts.

Appendix C: State Examples of Medicaid Flexibilities

The following state examples illustrate how different states implemented the Medicaid regulatory flexibilities during the COVID-19 pandemic to ensure continued access to LTSS. For more details on these examples and for examples from other states, see [COVID-19 State Resource Guide: Leveraging Federal and State Authorities to Ensure Access to Long-Term Services and Supports for High-Risk Individuals](#).

Expanded the use of state plan LTSS and HCBS waiver remote service benefits.

- Idaho allowed 1915(c) waiver participants to receive most waiver services (e.g., respite, supported employment, financial management, adult day care) remotely;
- Colorado allowed individuals to receive LTSS via telephone or live chat function and removed a requirement for an initial face-to-face visit prior to using telehealth;
- California added assistive technology (computer monitors, cameras, speakers, electronic devices that stream video, installation, repairs and participant training on the technology) as a 1915(c) waiver service to facilitate use of remote service delivery.

Expanded remote service delivery to include audio-only modalities.

- Colorado allowed residents to receive services, including LTSS, via telephone or a live chat function;
- Alaska expanded its definition of “telehealth” to include audio-only communications, such as telephone calls.

Allowed out-of-state providers to provide and receive payment for LTSS through expedited licensing processes and modified requirements or under special circumstances.

- Illinois allowed 1915(c) waiver participants to receive personal support services from providers in other states on a short-term basis if the participant’s family or regular caregiver is absent or requires respite;
- Wisconsin allowed 1915(c) waiver providers licensed in other states or enrolled in the Medicare program to provide the same or comparable services in the state.

Expanded the number and types of providers eligible to order and provide LTSS/HCBS (e.g., authorizing nonphysician practitioners to order services without physician supervision).

- Idaho allowed advanced practice registered nurses (APRNs) and PAs to order durable medical equipment and supplies;
- Missouri allowed APRNs and PAs to order, establish/review a care plan for and certify eligibility for home health services;
- California allowed certified nursing assistants to provide private-duty nursing services, in addition to registered nurses, licensed vocational nurses and certified home health aides.

Temporarily increased payment rates for HCBS to maintain provider capacity despite service suspensions and volume reductions.

- Alabama increased rates for residential habilitation waiver services by 19% to account for increased staffing and direct service delivery due to the suspension of day services;
- Maine increased rates by 10% for certain 1915(c) waiver services to account for additional staffing needs, infection control supplies and other unanticipated costs.

Provided retainer payments to LTSS providers to maintain provider networks despite reductions in service utilization.

- Arizona extended retainer payments to habilitation and personal care service providers;
- Delaware provided retainer payments across various state plan and HCBS waiver service providers when a participant is hospitalized or otherwise not using services, when the provider's overall attendance and use drop by 50%, or when the state deems it necessary to preserve its provider network;
- Washington D.C. provided retainer payments equal to 25% of the standard per diem rate to adult day care providers when a participant was unable to attend and the service was not delivered remotely.

Instituted or expanded opportunities for self-directed HCBS (e.g., personal support, transportation, personal care attendant, home-delivered meals), including expanding access to paid family caregiving.

- Florida expanded self-direction of personal support and transportation for 1915(c) waiver participants that previously existed only for 1915(j) HCBS;
- Iowa and Utah added more services that could be self-directed.

Applied 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).

- Washington did not count unemployment compensation in the Medicaid financial eligibility test for people eligible based on age or disability.

Leveraging COVID-19 Public Health Emergency Flexibilities to Advance Person-Centered Care for Older Adults and People with Complex Care Needs: A Roadmap for Policymakers

¹ Public Law 117-328. Available [here](#).

² Moving Toward More Person-Centered Medicare and Medicaid Programs. March 2022. Available [here](#).

³ Please refer back to the issue brief and policymaker playbook captured in [Moving Toward More Person-Centered Medicare and Medicaid Programs](#) for a thorough analysis of the flexibilities and underlying statutory or regulatory requirements that were waived to implement the temporary flexibilities.

⁴ <https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf>, Aug. 18, 2022 update.

⁵ This exercise was conducted with respect to the COVID-19 PHE in particular. Not all PHEs may call for the same policy or regulatory response based on the nature of the emergency being addressed (e.g., an infectious disease emergency may require a different response than the opioid crisis or a natural disaster, such as a flood or wildfire).

⁶ These authorities include Medicaid state plan amendments (SPAs), 1915(c) HCBS waivers and 1115 demonstration waivers. During the COVID-19 PHE, states used time-limited “Disaster Relief SPAs,” 1915(c) Appendix K Emergency Preparedness and Response authority, and 1115 demonstration authority to quickly implement temporary policy and regulatory changes.

⁷ <https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf>, Aug. 18, 2022 update.

⁸ A full range of Medicaid LTSS flexibilities were described in the February 2021 report [COVID-19 State Resource Guide: Leveraging Federal and State Authorities to Ensure Access to Long-Term Services and Supports for High-Risk Individuals](#).

⁹ See [Appendix C](#) for examples of how different states implemented these Medicaid regulatory flexibilities.

¹⁰ These analyses include a [COVID-19 LTSS State Resource Guide](#) and an issue brief and policymaker playbook, captured in [Moving Toward More Person-Centered Medicare and Medicaid Programs](#), supported by The SCAN Foundation, and an issue brief focused on pandemic-related Medicare flexibilities supported jointly by The SCAN Foundation and The Commonwealth Fund, available at <https://www.commonwealthfund.org/publications/issue-briefs/2021/may/which-medicare-changes-should-continue-beyond-covid-19-pandemic>.

About The Alliance for Health Policy

The Alliance for Health Policy is a nonpartisan, nonprofit organization dedicated to helping policymakers and the public better understand health policy, the root of the nation's health care issues, and the trade-offs posed by various proposals for change. We believe a better health care system begins with a balanced exchange of evidence, experience, and multiple perspectives.

For 30 years, the Alliance has helped to clarify and synthesize current issues for generations of policymakers and staff. But we do more than inform policymakers—we create a forum for dialogue by bringing together the health policy community to advance the conversation on tough issues. The Alliance has conducted hundreds of briefings on Capitol Hill, online, and around the nation on timely and important health policy topics. For more information, visit <https://www.allhealthpolicy.org/about-us/>.

About ATI Advisory

ATI Advisory is a healthcare research and advisory services firm dedicated to advancing innovation that fundamentally transforms the care experience for individuals, families, and communities.

ATI guides public and private leaders to success in scaling healthcare innovations. Its nationally recognized experts apply the highest standards in research and advisory services along with deep expertise to generate new ideas, solve hard problems, and reduce uncertainty in a rapidly changing healthcare landscape. For more information, visit www.atiadvisory.com.

About Health Management Associates

Founded in 1985, HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. Clients include government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. With offices in more than 20 locations across the country and over 500 multidisciplinary consultants coast to coast, HMA's expertise, services, and team are always within client reach. For more information, visit <https://www.healthmanagement.com/>.

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 180 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>.

© 2023

