



Long-Term Services and Supports and COVID-19: Ensuring Access to Services

MARCH 5, 2021



AGENDA & SPEAKERS

- Welcome and Overview
 - Samantha Scotti, NCSL
- Leveraging Federal and State Authorities to Ensure Access to Long-Term Services and Supports
 - Stephanie Anthony, Manatt Health
 - Alixandra Gould, Manatt Health
- Supporting the Direct Care Workforce
 - Kelsey Ruane, National Governors Association
- Legislative Examples
 - Kelly Hughes, NCSL
- Q&A



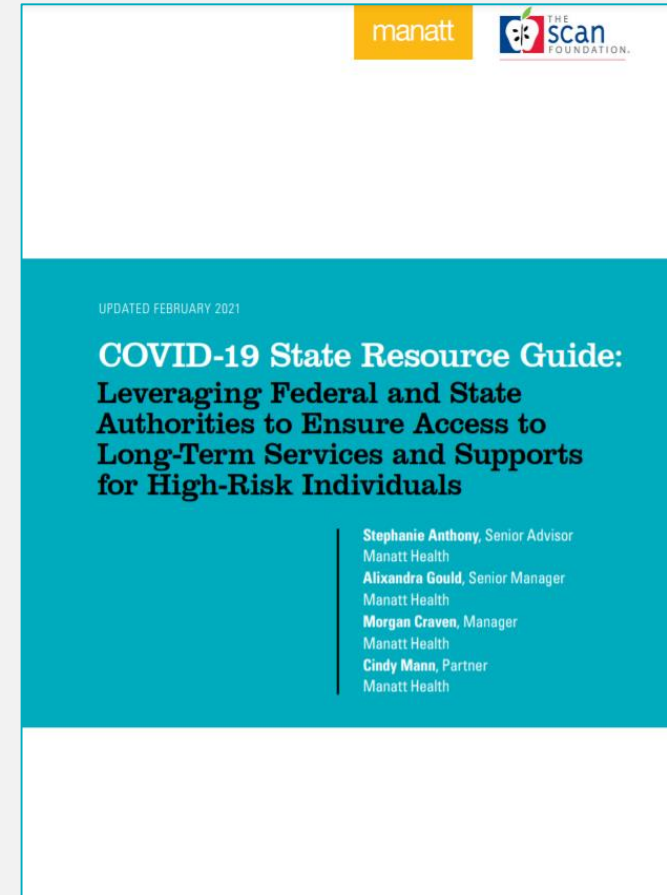
LTSS State Resource Guide for COVID-19 and Beyond

March 5, 2021

- **Impact of COVID-19 on LTSS**
- **States Responses to Ensure Access to LTSS**
- **Looking Ahead**
- **Discussion**

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

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

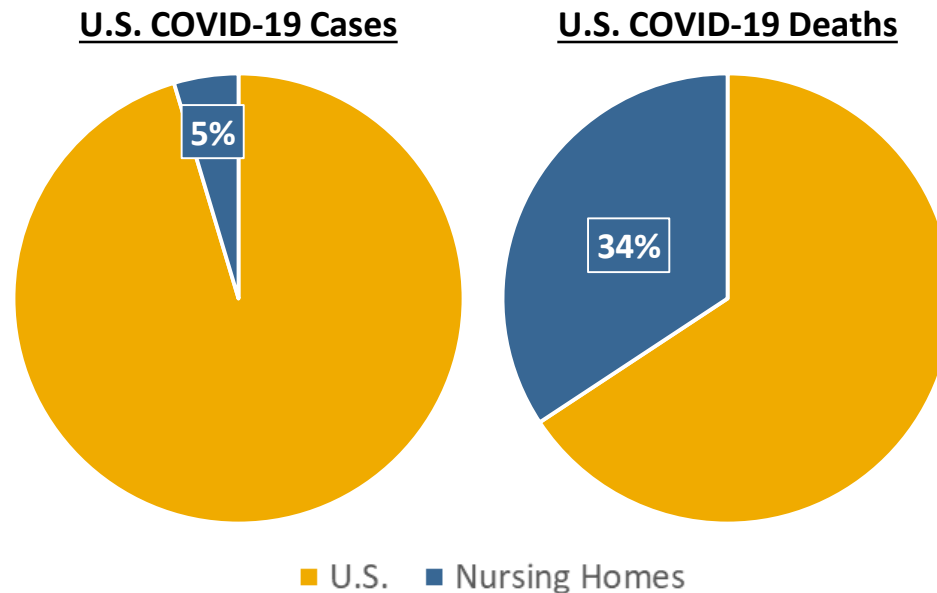


Impact of COVID-19 on LTSS

Impact of COVID-19 on Nursing Homes (1 of 2)

Residents in nursing homes and other congregate care settings have the highest risk for contracting COVID-19 and experiencing severe complications from the disease, including death.

- **Congregate Living.** Nursing homes have communal dining, shared bathrooms and often more than one resident living in a single room.
 - Residents *live* in nursing homes and as such typically have freedom of movement.
 - Many residents have cognitive impairments that make social distancing and independent infection control (e.g., washing hands, not touching face) difficult, if not impossible.
 - Some facilities have space and capacity to cohort residents and staff, but many do not.
- **Infection Control Deficiency.** Nearly 40% of nursing homes have previously reported infection control deficiencies, which are the most commonly cited deficiencies for nursing homes.



Less than 1% of the U.S. population lives in a nursing home.

COVID-19 didn't create the problem – it exacerbated the long-standing, underlying systemic issues affecting nursing home care.

Critical Themes

- Nursing homes **were largely underprepared for the threat of a widespread infection** and under-resourced due to long-standing staffing shortages or low staffing ratios. Many had previously been cited for infection control deficiencies.
 - A recent study found that nurses working in nursing homes saw an average turnover rate of greater than 100% in a given year. High turnover rates are often associated with poor quality.
- LTC facilities are **not adequately tied into the larger system of care** and generally do not have strong communications and consult relationships and protocols with emergency departments (i.e. admission and discharge protocol). Interoperability between nursing home and hospital electronic health records is a persistent issue.
- **Under-resourced state agencies** did not have sufficient staff to deploy to facilities and **conduct meaningful oversight** prior to COVID-19. Few states had LTC-focused **preparedness plans** in place prior to COVID-19.
 - Much of the oversight of nursing homes is **highly prescribed** by federal rules; the federal requirements are **rigid**, often resulting in **paper compliance and limited improvements**.
- The LTC industry and its regulatory agencies were not equipped with **the technological systems nor the practiced processes** to rapidly collect and share data in support of a state public health response.



Numerous major studies correlated widespread COVID-19 infection in the surrounding community with greater likelihood of COVID-19 in the nursing homes. Nursing homes are staffed by workers, disproportionately women of color, many of whom came from communities with large outbreaks.



Nursing homes with disproportionately higher numbers of racial and ethnic minority residents reported two to four times as many new COVID-19 cases and deaths per facility than other nursing homes.



Most studies found no correlation between Medicare Five-Star Ratings and likelihood of COVID-19 infections/outbreaks in nursing homes, although two state-specific studies did find that four and five star homes were likely to have fewer cases of COVID-19.

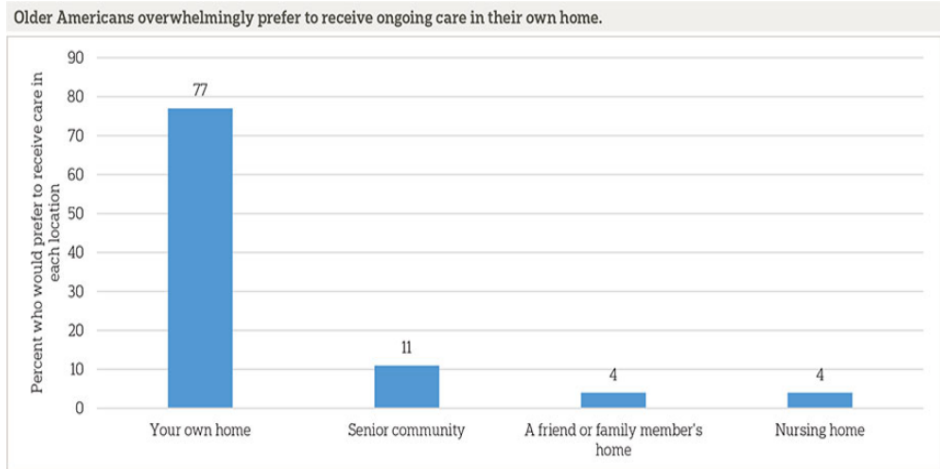
Sources: LeadingAge, *Health Disparities Highlighted by COVID-19 Data*, 2020, <https://leadingage.org/regulation/health-disparities-highlighted-covid-19-data>; PHI, *Workforce Data Center*, <http://phinational.org/policy-research/workforce-data-center/>; *Healthcarefinancenews*, *Minorities suffer most from COVID-19 in nursing homes and assisted living communities*, 2020, <https://www.healthcarefinancenews.com/news/minorities-suffer-most-covid-19-nursing-homes-and-assisted-living-communities>

COVID-19 also disrupted care for the 10 million individuals who receive assistance at home or in their communities.

Disruptions to home-based care were due to:

- Caregivers being subject to stay-at-home orders
- Caregivers having no access to childcare as schools shut down
- Caregivers not having adequate access to personal protective equipment (PPE) needed to provide care safely
- In some cases, caregivers having to enter isolation after becoming sick with or being exposed to COVID-19

- Even before COVID-19, Americans ages 40+ indicated a preference for receiving care in their own homes.
- 62% of respondents to a survey conducted in May 2020 reported having a worse opinion of nursing homes as a result of COVID-19.



Question: In the event that you need ongoing living assistance someday, if you could choose, what would be your first choice as to where you would receive that assistance? If you could choose, what would be your first choice as to where you would receive assistance right now?

States Responses to Ensure Access to LTSS

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

Federal Authorities Used for LTSS Regulatory Flexibilities

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

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

State Authorities Used for LTSS Regulatory Flexibilities

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

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



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



Expanding and stabilizing the provider workforce through modified credentialing and enhanced pay/rates.



Maintaining continuity of care by conducting virtual assessments, delaying reassessments, and extending prior authorizations.



Extending home care to new populations by modifying LTSS eligibility criteria and scope of services.

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

How States Use Flexibilities

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

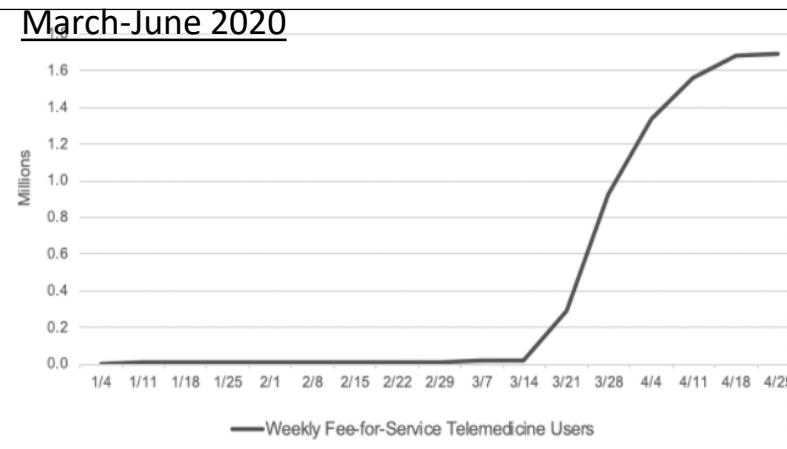
Some LTSS (e.g., assistance with daily care needs, such as bathing and dressing) cannot be delivered remotely. So states used emergency authorities to expand access to in-person supports or to provide care in alternative settings, with appropriate PPE and socially-distanced when possible.

State Examples

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

- **Telehealth service volume for all payers increased dramatically in 2020**, enabled by significant new regulatory flexibilities introduced by CMS and due to safety risks that in-person care poses for older adults during the pandemic.
- However, research has found that **more than a third of adults over age 65 face potential difficulties** engaging in virtual care, with the greatest challenges experienced by older, low-income men in remote or rural areas, especially those with disabilities or poor health.
- **As a result, health care payors and providers** have been focused on addressing barriers by providing devices and user support.

Number of Medicare FFS Weekly Telehealth Users,



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

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

How States Use Flexibilities

- Expanded **opportunities for self-direction** to allow recipients to hire their own providers.
- Allowed **family members and other closer relations** to be reimbursed for providing personal care services.
- Authorized case management entities and other **alternative providers** to furnish direct care services.
- Authorized **providers licensed in other states** to provide certain services in-state.
- Altered **minimum provider qualifications** for certain services, including allowing unlicensed graduates to provide care.

State Examples

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

Modifying in-person assessments and person-centered care planning requirements minimized physical contact with beneficiaries and alleviated workforce capacity issues while supporting access to and continuity of care.

How States Use Flexibilities

- Allowed **self-attestations or alternative verifications** of level of care (as well as income and assets)
- Delayed or modified requirements for completing **functional assessments**
- Modified deadlines and modalities for **person-centered care planning**
 - Allowed electronic signatures
 - Allowed services to be added to a care plan to respond to COVID-19 without convening care planning meetings
 - Waived requirement for face-to-face care planning meetings

State Examples

- **Hawaii** used 1115 waiver authority to delay initial and annual assessments for up to one year for its QUEST Integration demonstration and delay annual eligibility redeterminations for state plan HCBS.
- **North Carolina** used 1115 waiver authority to allow for self-attestation or alternative verification of individuals' eligibility and/or level of care to qualify for state plan LTSS. Verification can be delayed for up to one year.
- **Rhode Island** used Appendix K authority to allow level of care determinations for waiver services to be conducted via telephonic and/or video conference for new applicants and existing beneficiaries. Additionally, annual level of care reevaluations can be postponed for six months.

States built on existing home care infrastructure to accelerate the pre-pandemic shift away from institutional settings.

How States Use Flexibilities

- Prioritized **waiver services to individuals presumed COVID-19 positive** or quarantined, or to those in inpatient facility stays in COVID-19 hot spots
- Allowed **delivery of HCBS in alternative settings** (e.g. allow adult day to be provided in the home)
- Modified **eligibility criteria** for state plan LTSS, waiver enrollment, or specific waiver services
- Added **new services, medical supplies, and equipment** to waivers, including assistive technologies that facilitate remote delivery of services
- Modified **prior approval/preauthorization requirements**

State Examples

- **Texas** used 1115 authority to extend HCBS waiver-like services not available under the state plan to certain aged and disabled Medicaid enrollees who meet an institutional level of care.
- **Indiana** used Appendix K authority to create new priority categories for waiver enrollment for individuals who are COVID-positive or whose primary caregiver is COVID-positive, or who have been ordered to quarantine by the state.
- **Iowa** used Appendix K authority to add home-delivered meals, companion, and homemaker services to the list of waiver services that may be self-directed.

As the number of cases and deaths began to surge in nursing homes, states used both federal and state authorities and funding to direct resources—staffing, PPE, testing, and rate support—to those settings. As vaccines become more widely available, those same resources are being directed towards vaccinating residents and staff and resuming visitation to mitigate the impact of social isolation among residents.

State Examples

Michigan established “regional hubs” to treat individuals from congregate settings who are affected by COVID-19 but do not require hospital-level care. Michigan also activated an infection prevention resource and assessment team to train local health departments and facilities, review facilities’ infection control procedures and training protocols, assist with remote contact tracing, and provide remote facilitation of the CDC’s Tele-ICAR tool.

Iowa provided \$300 per day to nursing facilities for each Medicaid beneficiary residing in a designated COVID-19 isolation unit or in a COVID-19 designated facility who was discharged from a hospital to the nursing facility.

Maryland established “strike teams” comprised of the National Guard, state and local health department representatives, EMS clinicians, and doctors and nurses from local hospital systems. The strike teams provided on-site medical triage, supplies, and equipment to nursing homes. Strike teams were designated as “testing teams,” “assistance teams” (National Guard members who assessed sites, determined equipment and supply needs, and triaged residents), and “clinical teams” to provide medical triage and stabilize residents to prevent transport to hospitals.

States leveraged emergency federal funding to support various aspects of LTSS delivery during the pandemic.

- The primary sources of emergency funding directed towards state LTSS systems came from the CARES Act Coronavirus Relief Fund, FEMA, general state funds, and federal revenue for new Medicaid expenditures authorized through the emergency authorities (e.g., increased Medicaid provider rates).
- Examples of how states have used emergency federal funding :
 - Provider retainer payments and hazard pay for direct care workers
 - Supplemental reimbursement for newly authorized services or services with higher utilization
 - Funding for deployment of teams of temporary healthcare workers to facilities
 - Funding to cover costs associated with enhanced infection control, testing, and cost of caring for COVID-positive recipients
- The CARES Act Provider Relief Fund (PRF) was allocated to providers directly from the federal government (without state involvement), including \$4.9 billion that was distributed directly to nursing homes. However, some states provided technical assistance to providers applying for PRF dollars.

Looking Ahead

Next Steps for States

- Develop framework to plan for near-term changes (e.g., making certain temporary flexibilities permanent) and system-wide reform based on the lessons learned during the pandemic.
- Assess LTSS system need prior to the pandemic, identifying strengths to build on and challenges to address.
- Identify stakeholders, recruit system reform “champions,” and map out process for reform.
- For near-term changes (within one year):
 - Assess the impact of temporary changes made during the pandemic.
 - Determine timeline and authority needed for implementing new policies.

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

Anticipated State Priorities

- Maintaining remote service delivery options to address unmet need for services and workforce shortages, including remote “wrap around” services to supplement in-person delivery.
- Accelerating shift away from institutional settings towards HCBS (“rebalancing”).



State Strategies for Recruiting and Retaining the Direct Care Workforce



Organization

The NGA Center for Best Practices is a 501(c)(3) and part of our larger organization.

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Background

- The COVID-19 pandemic has put a spotlight on longstanding challenges in recruiting and retaining individuals in direct care/entry level health care jobs, particularly in the long-term care space.
- The pandemic has temporarily reduced demand for many other jobs, providing a pivotal opportunity to bring new entrants to the field.
- Due to federal and state flexibilities, there is an influx of individuals who have received training and clinical experience who could potentially be retained in the sector

State strategies to recruit and retain workers during COVID-19

NGA's new publication focuses on emergency action taken during the pandemic to expedite training for direct care workers such as CNAs and home health aides. Topics covered include

- Short-term federal and state flexibilities
- Ensuring adequate credentials and training for current workforce
- Longer-term recruitment and retention



Early insight: strategies for recruitment and sector retention of the direct care workforce



Cross-Sector
Collaboration



Career
Pathways



Fee
Structure
and Wages



Standardized
roles

LONG-TERM CARE STATE LEGISLATION DURING COVID-19

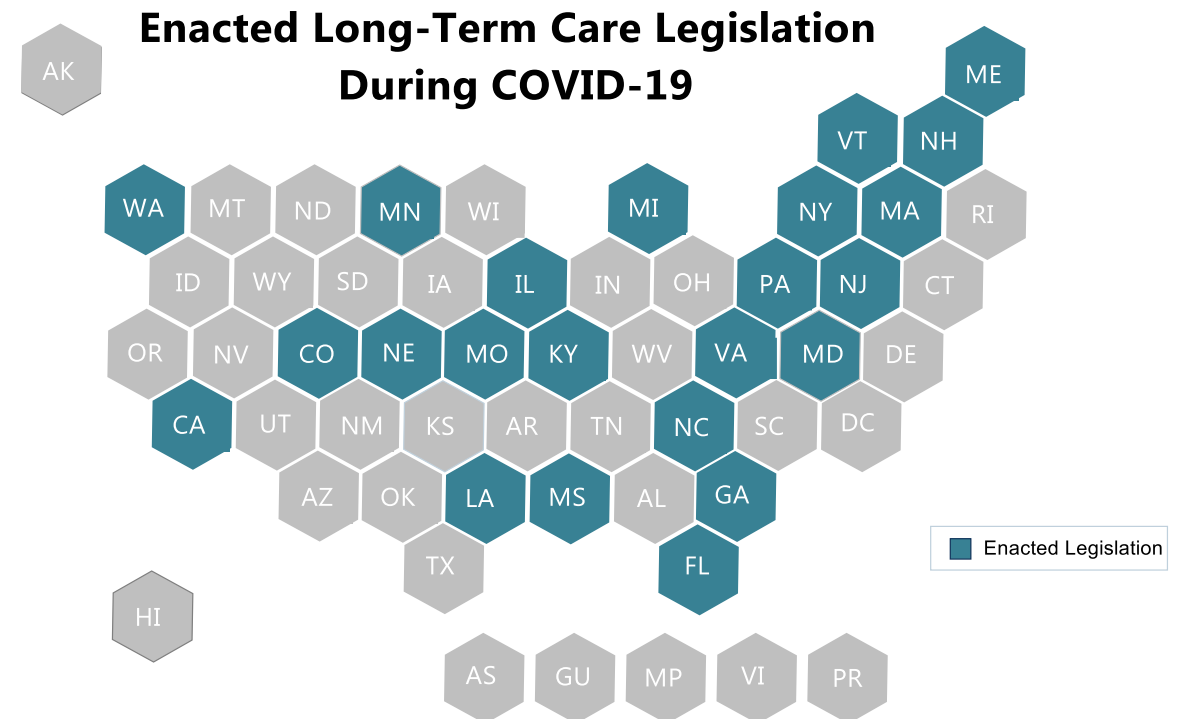
KELLY HUGHES, MPH

PROGRAM DIRECTOR, HEALTH CARE ACCESS, COSTS AND COVERAGE



OVERVIEW OF STATE ACTIONS

- At least 23 states enacted over 77 bills relating to long-term care during the pandemic.
 - Public Health Protocols
 - State Oversight
 - Provider Rate Increases
 - Additional Appropriations
 - Visitation Requirements



Source: NCSL State Action on Coronavirus Database

PUBLIC HEALTH PROTOCOLS AND STATE OVERSIGHT

Public Health Protocols

- CA SB 275—Establishes a personal protective equipment stockpile for health care workers.

State Oversight

- GA HB 987—Establishes COVID-specific reporting requirements, staffing requirements and increased fines for safety violations, among other provisions.



PROVIDER RATE INCREASES AND ADDITIONAL APPROPRIATIONS

Provider Rate Increases

- WA [HB 2965](#)—Authorizes increased Medicaid payment rates to nursing facilities.
- MN [HF 1](#)—Increases Medicaid payments rates to certain direct care workers. Establishes temporary compensation to certain family caregivers.



Additional Appropriations

- MI [HB 690](#)—Appropriates federal funds for direct care worker wage increases and to provide staff trainings on infection control strategies.

ADDITIONAL RESOURCES

- NCSL Resources
 - [State Action on Coronavirus \(COVID-19\)](#)
 - [COVID-19: State Health Actions](#)
 - [COVID-19 Health Policy Snapshots](#)
 - [Time Is Right to Examine Delivery of Long-Term Services and Supports](#)
 - [Ensuring Residents' Safety in Nursing Facilities](#)



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Q&A

Please type your questions into the chat box and we will get to as many as we can!



THANK YOU!

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