

# Continuing COVID-19 Policy Flexibilities Affecting Children and Youth with Special Health Care Needs: *Recommendations for States*

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Policy and regulatory changes enacted during the COVID-19 public health emergency (PHE) have significantly impacted children and youth with special health care needs (CYSHCN), their families, and their health care providers.

In an effort to ameliorate the negative consequences of the pandemic on access to and utilization of health care services, the federal government and state governments created temporary flexibilities through a variety of legislative, regulatory, and administrative mechanisms. With support from the Lucile Packard Foundation for Children's Health, Health Management Associates conducted a comprehensive review of these policy changes and identified those with particular implications for CYSHCN. We discussed these flexibilities and their impact on CYSHCN with frontline clinicians, legal and family advocates for CYSHCN, researchers, program leaders, and other public and private stakeholders.

**The study's findings, which can be found at [lpfch.org/COVID-19-HMA-Report](https://lpfch.org/COVID-19-HMA-Report) include the following:**

- Policies that expanded reimbursement for telehealth<sup>1</sup> have significantly affected and been largely advantageous to CYSHCN and their families. These included flexibility in services provided via telehealth, patient and practitioner location, technologies used, and types of providers.
- Expansions in telehealth also highlighted disparities, however, as many low-income and rural families face language barriers or lack broadband access, technologies required for telehealth, safe locations from which to conduct visits in private, or training on how to request or use telehealth. Further, states, health systems, and providers did not consistently adopt the flexibilities and make telehealth opportunities universally available, suggesting additional access challenges and inequities that warrant further study.
- To soften the pandemic's negative consequences on access to care, the federal government and state governments also relaxed provider enrollment, eligibility, and out-of-state licensure requirements for Medicare and Medicaid; broadened the scope of practice for certain health care workers; reduced administrative requirements for accessing specialty care and services; and expanded the ability of states to pay family caregivers for providing personal care to CYSHCN.
- The sudden and long-term school closures, isolation, cessation of many in-person clinical visits and home care visits (both home health and personal care/direct services), lack of child care and respite care, rampant unemployment, and social determinants of health (SDOH) that have been created or exacerbated by the pandemic have put tremendous strains on CYSHCN and their families. While use of telehealth for behavioral health services increased significantly during the PHE, there has been a dearth of policies or flexibilities focused on identifying and addressing the stressors on CYSHCN and their caregivers – many of which will continue beyond the PHE.

Given what has been learned so far, Health Management Associates developed recommendations about temporary policy changes that should continue or cease after the PHE, as well as new policies for consideration to best serve CYSHCN and their families and better prepare for future emergencies. ***This policy brief presents recommendations for state Medicaid agency and other state government actions.*** As more data become available, further assessment of how policy changes have affected quality, costs, and experiences of CYSHCN will provide additional guidance to policymakers.

## Recommendations for Retaining and Advancing Telehealth Policies

- Telehealth should be considered another modality for providing services. Medicaid telehealth flexibilities that should be maintained (or added) include:
  - *Payment parity* with in-person visits, noting that telehealth visits are not shorter and can be longer (and demand the same if not more documentation); parity rules should apply in all states
  - Reimbursement for *audio-only* telephone access (especially for behavioral health visits)
  - Coverage of *therapies as appropriate and care coordination* via telehealth
  - *Flexibility in and reimbursement for “originating” and “distant” sites* to include patient’s and practitioner’s home, without geographic or rural/urban restrictions
  - *Easing of out-of-state licensing restrictions* to allow out-of-state telehealth providers (including specialists and subspecialists), which leverages resources across state lines
- State Medicaid agencies should think creatively about encouraging *and incentivizing virtual check-ins* (for example, global payments) and reducing the pressure to do everything in one visit.
- State Medicaid agencies should *identify and expand reimbursement for school-based physical and behavioral health services that are appropriate for telehealth delivery*, and provide guidance to school districts on requirements and billing.
- State Medicaid agencies and departments of education should consider *reimbursing telehealth by specialized practitioners or assistants supporting children with medical complexity in schools and childcare settings*.
- States should consider piloting the expansion of telehealth modalities to include *texting*, especially for young people who may not have privacy for telephone calls.

## Recommendations for Other Access-Related Policies

### *Medicaid*

- States should coordinate with the federal government and the private health care sector on efforts to thoroughly *evaluate the impact of the temporary policy flexibilities* on access, utilization, child/family experience, physical and mental health, and developmental outcomes of CYSHCN and other at-risk populations.
  - State Medicaid programs should assess the impact of suspending prior authorizations, *modify authorization requirements* accordingly beyond the PHE (while continuing to monitor quality and cost-effectiveness) for fee-for-service Medicaid, and encourage or require Medicaid managed care organizations to do the same.
  - Many of the Medicaid *enrollment and eligibility flexibilities* affecting both consumers and providers should be retained beyond the PHE; for example, the benefits of continuous eligibility argue for changing this program feature from a state option to a mandatory feature, at least for children and pregnant women. States should consider continuing

- relaxation of Medicaid provider eligibility and enrollment requirements, revalidation, and personnel qualification requirements that address ongoing shortages if they do not sacrifice quality. However, documentation and medical record requirements and any provider qualification standards that resulted in compromised quality of care should cease.
- To further support critical *care coordination for CYSHCN* beyond the PHE, states should clarify that care coordination will be a covered benefit under EPSDT, secure and increase Medicaid reimbursement for care coordination services for CYSHCN, and consider covering care coordination by certain paraprofessionals and other service providers.<sup>2</sup>
  - Given that the pandemic highlighted disparities and unmet SDOH needs, Medicaid/CHIP *screening for SDOH, referrals, and interventions should become standard practice and incentivized*. Examples may include Medicaid managed care quality improvement requirements, pay-for-performance incentives, or as a requirement for state initiatives such as California's Advancing and Innovating Medi-Cal Enhanced Care Management or in lieu of services for children and youth with complex needs.
  - To build the Medicaid home care workforce, states should increase Medicaid reimbursement rates for home health workers (home health nurses, for example, consistently earn less than hospital-based workers), and implement or continue the (temporary, varies by state) home- and community-based services (HCBS) waiver program retainer payments to home-based caregivers while a beneficiary is temporarily institutionalized or unable to receive services for a short time.
  - Extending flexibilities, states should expand Medicaid *payment to family caregivers*, including legally responsible caregivers who provide personal care and health-related services to CYSHCN. States should develop communication channels to inform families of this benefit, design a user-friendly application process, and provide appropriate training and "guardrails" to help ensure quality and program integrity. (This may involve the use of waivers [e.g., HCBS or 1915(c)] to sidestep the legally responsible caregiver proscriptions.)
  - The need for identifying providers that are clearly accountable for the well-being of CYSHCN is heightened during emergencies such as the pandemic. States should *test and support value-based, comprehensive service and reimbursement models for CYSHCN*, which are currently not well developed for pediatric care; such models might include accountable care organizations, health homes, outcomes/value-based payment, and shared-savings.

#### *Additional State Government Access-Related Actions*

- Given some practice closures and provider retirements during the pandemic, states should reassess the workforce (specialists, therapists, etc.) serving CYSHCN and identify gaps. One option for states to consider in addressing shortages is *extending expanded scope of practice* for non-physician clinicians beyond the PHE (for example, the ability to order durable medical equipment) while maintaining or establishing new clinical and training standards.
- States and localities should implement school re-openings with special attention to assuring the *restart of quality, school-based therapeutic and other health services for CYSHCN*. Schools should be required to have plans in place to continue services in the event of another pandemic or other reasons for closing school-based health services.
- States should work with the federal government and the medical community to develop and fund creative solutions *addressing shortages in the home care workforce*, which were exacerbated during the pandemic. In addition to recommendations noted above (Medicaid), potential areas of

exploration include building a pipeline through education programs for both professionals and paraprofessionals, including family caregivers; this may include developing Certified Nursing Assistant training programs for legally responsible caregivers (e.g., parent and spouse).

- Given reports of home care workers lacking personal protective equipment early during the PHE, the federal government and state governments need to develop emergency preparedness plans that *ensure the availability of basic materials* required to continue delivering home care services.

### Recommendations to Support Behavioral Health Care for CYSHCN and Caregivers

- Given the reported toll the pandemic has taken and may continue to take on the mental health of CYSHCN and their caregivers, states should target resources and incentives to encourage more *routinized behavioral health screenings and services* for CYSHCN enrolled in Medicaid. Behavioral health screenings and basic services may be best positioned as a primary care responsibility (rather than a behavioral health responsibility) given the variable nature of behavioral health carve-outs in many state Medicaid programs.
- Medicaid reimbursement for *new telehealth modalities for behavioral health services for CYSHCN*, such as audio-only visits, should extend beyond the pandemic.
- If permitted by CMS, state Medicaid programs should reimburse for *screening of caregivers of CYSHCN for mood disorders*, beyond the current reimbursement for maternal depression screening (i.e., perinatal mood and anxiety disorders).



## 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 partner with government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations to improve health care and social services. Drawing knowledge from the frontlines of health care delivery and reform, we work with our clients to explore innovative solutions to complex challenges. HMA has 22 offices and more than 200 multidisciplinary consultants coast to coast. Learn more at [healthmanagement.com/](http://healthmanagement.com/).

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## About the Foundation

The Lucile Packard Foundation for Children's Health unlocks philanthropy to transform health for all children and families - in our community and our world. Support for this work was provided by the Foundation's Program for Children with Special Health Care Needs. We invest in creating a more efficient system that ensures high-quality, coordinated, family-centered care to improve health outcomes for children and enhance quality of life for families. The views presented here are those of the authors and do not reflect those of the Foundation or its staff. Learn more at [lpfch.org/CSHCN](http://lpfch.org/CSHCN).

## Endnotes and Citations

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<sup>1</sup> Telehealth or telemedicine refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health.

<sup>2</sup> States should consider proposed standards for care coordination for CYSHCN, such as: National Care Coordination Standards for Children and Youth with Special Health Care Needs, National Academy for State Health Policy, October 2020. <https://www.nashp.org/wp-content/uploads/2020/10/care-coordination-report-v5.pdf>