

# COVID-19 Pandemic Spurs Policy Changes Benefiting Older Adults

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## ABSTRACT

This article reviews recent federal and state policy changes in response to the COVID-19 pandemic that affect health care and quality of life for older adults. Specific regulations and guidelines issued at the state and federal level have increased access and provided additional funding for essential services and supports. Many of these changes are temporary and have the potential to improve care beyond the immediate crisis. This period of greater flexibility offers the opportunity to accrue evidence on quality and access to influence sustained change. [*Journal of Gerontological Nursing*, 46(6), 19-23.]

**T**he COVID-19 pandemic is a major disruptor for society and health care delivery. Older adults consume the majority of health care services in the United States across the continuum of care from community-based care to ambulatory care to acute hospital visits. Although adults older than 65 are 13.5% of the U.S. population, they account for 45.2% of health care

expenditures (Zayas et al., 2016). In the context of the pandemic, health systems are focusing on efforts to care for those who are infected with COVID-19, contain the spread of the virus, and be ready for potential surges in demand for specialized services (Young & Fick, 2020). Concurrently, older adults are experiencing acute and chronic illnesses, seeking care and support for these health

issues. Policy changes have been essential to meet these new demands and to continue to address usual care during this time of crisis. The current article summarizes significant federal and state policy changes and innovations that benefit older adults.

## FEDERAL POLICIES

Federal policies have expanded access, enhanced funding, and supported health professionals in a variety of ways. Major initiatives have included the National Emergency Declaration (Proclamation 9994, 2020); the Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020); and guidance from the Centers for Medicare & Medicaid Services (CMS; 2020). The implications of these actions for older adults are summarized in **Table 1**.

## National Emergency Declaration

In 1976, the National Emergencies Act was passed, allowing the President to take emergency action during a national crisis. On March 13, 2020, the White House proclaimed the COVID-19 pandemic a national emergency and specifically addressed emergency authority for the Secretary of Health and Human Services to temporarily waive requirements of Medicare and Medicaid (Proclamation 9994, 2020). This waiver opened the door for the CMS to address pressing health needs for older adults.

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TABLE 1

**Federal Policy Changes Related to Coronavirus Pandemic: Implications for Older Adults**

Regulation/Guidance	Implications for Older Adults
National Emergency Declaration	<ul style="list-style-type: none"> <li>Grants authority to the USDHHS Secretary and CMS to temporarily waive requirements</li> </ul>
Coronavirus Preparedness and Response Supplemental Appropriations Act	<ul style="list-style-type: none"> <li>Waiver removing restrictions on Medicare providers to allow telehealth services</li> <li>Emergency funding for COVID-19 response</li> </ul>
Families First Coronavirus Response Act	<ul style="list-style-type: none"> <li>Additional funding for the nutrition services programs authorized by the Older Americans Act of 1965</li> <li>Requires employers to provide paid sick leave to caregivers of persons with COVID-19</li> <li>Increases flexibility in telehealth delivery</li> </ul>
Coronavirus Aid, Relief, and Economic Security (CARES) Act	<ul style="list-style-type: none"> <li>Funding for home- and community-based supports for older adults/persons with disabilities</li> <li>Cash payments to individuals and families</li> <li>Insurance coverage of COVID-19 treatments and tests</li> <li>Funding to hospitals, community health centers, the CDC, Veterans Health Administration, for telehealth, medicine, and supplies</li> <li>Reauthorizes Title VIII Nursing Education Programs</li> <li>Allows nurse practitioners, clinical specialists, and PAs to order Medicare Home Health Services</li> </ul>
CMS – Telehealth Guidance	<ul style="list-style-type: none"> <li>Addresses originating sites for telehealth</li> <li>Allows reimbursement to a variety of providers</li> <li>Allows a variety of services</li> </ul>
USDHHS Secretary Azar letter to Governors (3/24/20)	<ul style="list-style-type: none"> <li>Interstate licensure compact</li> <li>Allows consumers direct access to APRNs</li> </ul>
CMS guidance (4/9/20)	<ul style="list-style-type: none"> <li>Access to APRNs and PAs for care in skilled nursing facilities</li> <li>Access to CRNA anesthesia services</li> <li>Eases access barriers in critical access hospitals</li> </ul>
Keep Americans Connected Pledge FCC Chairman Ajit Pai	<ul style="list-style-type: none"> <li>Encourages corporations to join to provide broadband and streaming services to rural communities</li> </ul>
CMS guidance (4/19/20)	<ul style="list-style-type: none"> <li>Reporting of new COVID-19 cases in skilled nursing facilities to health departments and CDC</li> </ul>

*Note.* USDHHS = United States Department of Health and Human Services; CMS = Centers for Medicare & Medicaid Services; PAs = physician assistants; APRNs = advanced practice RNs; CRNA = certified RN anesthetist; FCC = Federal Communications Commission; CDC = Centers for Disease Control and Prevention.

**Coronavirus Preparedness and Response Supplemental Appropriations Act**

This Act was to focus on the COVID-19 pandemic, signed into law on March 6, 2020, providing funding for the initial response to the looming crisis for research and public health activities (Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020). This Act also removed restrictions on providing tele-

health services by Medicare providers, an important action to enhance access to care for older adults and limit contagion associated with congregating at clinics for services.

**Families First Coronavirus Response Act**

This Act was signed into law on March 18, 2020, and addressed food security for older adults, providing additional funding for nutrition services

programs authorized by the Older Americans Act (Families First Coronavirus Response Act, 2020). In addition, the Act assures that caregivers who must miss work to care for someone with COVID-19 receive paid emergency sick leave. Importantly, this Act also expanded access to telehealth services, vital for older adults who need care and fear going to a clinic where they risk infection from other individuals who are already sick. This ac-

tion limits the potential of community spread of COVID-19. This flexibility also enhances access for older adults in medically underserved communities who lack regular access to specialty care, minimizing the need to travel distances. The provisions of the Act include routine health care visits as well as mental health and substance use disorder services.

### **CARES Act**

The CARES Act (2020) was signed into law on March 27, 2020, providing supplemental funding for programs authorized under the Older Americans Act of 1965 and the Rehabilitation Act of 1973. Specifically, approximately \$1 billion will support older adults and people with disabilities in their communities. The funding supports services from Home and Community Based Services to allow older adults to shelter in place, home-delivered meals, supports for persons with disabilities to stay safely at home, services from the National Family Caregiver Support Program and the Aging and Disability Resource Centers, and advocacy from the State Long-term Care Ombudsman programs.

In addition, the CARES Act provides direct funding to individuals and families and assures insurance coverage for COVID-19 related tests and treatments. The Act also provides supplementary funding to a variety of agencies responding to the COVID-19 pandemic, including hospitals, community health centers, the Veterans' Administration, and the Centers for Disease Control and Prevention (CDC). The Act funds additional supplies and equipment needed to provide care. The pandemic will have significant workforce implications and the Act reauthorizes Title VIII Nursing Education Programs, enabling vital education to continue and assure a pipeline of health care professionals to care for older adults. Importantly, the CARES Act considerably improves access for older adults to home health, by authorizing nurse practitioners (NPs) and clinical specialists to order

Medicare Home Health Services. This provision is a policy that policy makers and advocates have debated for more than a decade.

### **CMS Guidance**

As the above significant federal laws passed, the CMS issued guidance that has improved access to care for older adults in a variety of ways. Emergency declaration blanket waivers are summarized online (access <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>). An important, game-changing innovation occurred in early March when the CMS issued guidelines around telehealth (Medicare Learning Network, 2020). This guidance was vitally important to assure access for older adults through both video and telephonic contact with providers. The guidance addressed several key features: the originating site, reimbursement to an expanded array of providers, and the types of services permitted. Originating sites include clinics, hospitals, federally qualified health centers, skilled nursing facilities, renal dialysis facilities, and community mental health centers. The expanded list of providers includes physicians, advanced practice RNs (APRNs), physician assistants (PAs), certified RN anesthetists (CRNAs), clinical psychologists, clinical social workers, and registered dietitians. Services include consultations, self-management training, group interventions, pharmacological management, counseling, and wellness and prevention visits.

On March 24, 2020, Department of Health and Human Services Secretary Azar issued recommendations to governors to enter into an interstate licensure compact that temporarily waives CMS requirements that certain health care professionals hold licenses in the state in which they provide services, if they have an equivalent license from another state. This waiver enhances the ability of health professionals to cross state lines to deliver care in areas needing additional human resources and also enables providers

to deliver telehealth services in other states. However, this federal guidance does not supersede state or local licensure requirements; thus, state waivers are also required for enactment of this interstate compact. The National Council of State Boards of Nursing (NCSBN; 2020b) has announced that each state, territory, and Washington, DC has signed onto the Emergency Management Assistance Compact. This guidance also suspended state-level required physician contracts, allowing older adults to have direct access to APRNs for primary care and encouraging states to suspend supervision and collaboration agreements to avoid delays in access to services.

Secretary Azar issued further guidance on March 30, 2020, improving access for older adults. A significant advance was permanently allowing APRNs and PAs to order home health under Medicare and Medicaid. The guidance also removed barriers in Medicare that require supervision by physicians for CRNAs to provide pain management and anesthesia care. This is a significant improvement for older adults in rural and underserved communities who have difficulty gaining access to these services.

The CMS issued guidance on April 9, 2020, that improves access for older adults by waiving the requirements around physician physical assessment in skilled nursing facilities, allowing APRNs and PAs to perform admitting assessments and required monthly visits (for the first 90 days after admission and at least once every 60 days thereafter) for Medicare beneficiaries. The guidance also temporarily waives the requirement that a CRNA is under the supervision of a physician. CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, critical access hospitals (CAHs), and ambulatory surgical centers.

The April 9, 2020, guidance also addressed the needs of older adults in rural communities by waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically

present to provide medical direction, consultation, and supervision for the services provided in the CAH. Instead, the physician may be available “through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral” (CMS, 2020, p. 9) This waiver allows NPs and PAs to practice to the fullest extent possible in CAHs, while ensuring necessary consultation and support as needed.

With the alarming incidence of COVID-19 in skilled nursing facilities and the associated challenges with providing appropriate care, the CMS issued guidance on April 19, 2020, that reinforces requirements around reporting communicable disease to state and local health departments. Future rule-making will formalize requirements for reporting these data for residents and staff to the CDC. In addition, the CMS is refining requirements around notification of residents and their representatives regarding COVID-19 cases in the facility.

### **Federal Communications Commission**

The Federal Communications Commission (FCC) has also facilitated access for older adults by addressing internet capacity. On March 13, 2020, FCC Chairman Pai called on internet providers to remove data caps so there is enough bandwidth and speed to promote connectivity for Americans impacted by the disruptions caused by the coronavirus (FCC, 2020). To ensure that Americans do not lose their broadband or telephone connectivity during this crisis, he asked them to take the Keep Americans Connected Pledge (FCC, 2020). With funding from the CARES Act, the FCC established a \$200 million program to help health care providers provide connected care services to patients at their homes or mobile locations in response to the pandemic. The program provides immediate support to eligible health care providers responding to the pandemic by fully funding their telecommuni-

cations services, information services, and devices necessary to provide critical connected care services.

### **STATE POLICIES**

State governors have the power and responsibility to issue executive orders and take emergency actions to increase access to care during emergencies. States vary widely in consumers’ access to APRN practice and care, with 28 states restricting access to NP care (American Association of Nurse Practitioners, 2020,a,b; Brassard, 2015). Access to care provided by other APRN roles (e.g., CRNA, certified nurse-midwife, clinical nurse specialist) is also restricted in multiple states (NCSBN, 2020a). This restriction is despite uniformity in graduate education—master’s or doctoral degrees—and advanced clinical training that prepare APRNs to pass national certification examinations. Thus, in many states, older adults lack access to care when they need it because APRNs are held back from practicing to the full extent of their education, training, and national certification. Many advocates representing nursing, consumers (including AARP), and free market competition, encouraged governors to issue executive orders to remove state-specific barriers.

At the time of this writing, seven states—Kentucky, Louisiana, Massachusetts, New Jersey, New York, Virginia, and Wisconsin—have temporarily removed all state requirements for APRNs to contract with physicians (Quinn et al., 2020). In Massachusetts and Virginia, the waiver applies to APRNs with at least 2 years of clinical experience. The governors in these seven states have expanded access to care for 58.7 million people, decreasing wait times and expanding services. Several other states have lifted some or most restrictions that prevent direct access to APRN care. Louisiana and Kansas are examples of each type of regulation change.

#### **Louisiana**

In Proclamation Number 25 JBE 2020, the governor removed the re-

quirement that APRNs have a contract with a physician in response to the Secretary of the Louisiana Department of Health request that various requirements be temporarily suspended to increase health care providers’ ability to respond to the public health emergency (State of Louisiana, 2020). The governor also waived the requirement for a Louisiana RN license, as long as the RN is duly licensed in another state.

#### **Kansas**

Kansas is one of 15 states, at the time of this writing, that have temporarily removed selected aspects of state regulations that block access to APRN care (American Association of Nurse Practitioners, 2020a). Kansas Executive Order 20-26 temporarily suspends Kansas requirements for physician supervision “within a designated health facility...as determined by the facility in consultation with the facility’s medical leadership” (State of Kansas, 2020). Although beneficial for health systems, this temporary suspension does not apply to APRNs who practice outside the walls of a health care facility.

#### **Arizona**

The pandemic also prompted Arizona’s governor to make permanent a policy that will now allow the state’s CRNAs to provide care to Medicare beneficiaries without contracting with a physician to practice (State of Arizona, 2020).

#### **Licensure**

Many states have temporarily waived the requirement that RNs be licensed in the state where they practice. Allowing nurses to be licensed in one state and practice in multiple states is the aim of the Nurse Licensure Compact (NCSBN, 2020a), which has been supported by the Center to Champion Nursing in America (CCNA) and AARP state offices and enacted in many states. NCSBN’s website includes information about another compact—the Emergency Management Assistance Compact (EMAC)—that has been adopted by all states. EMAC authority

could be especially useful for expanding telehealth services. Licensure reciprocity could be granted to health care providers to allow them to provide telehealth services to individuals in their state no matter where the provider is physically located.

## DISCUSSION

These policy changes improve access to care for older adults, particularly through telehealth and by enhancing the capacity of providers to deliver services. Early responses to telehealth options are robust, with high adoption levels across health systems and satisfaction on the part of older adults who are able to access these services. However, telehealth remains inaccessible to some older adults who are not able to cross the digital divide, necessitating greater effort on the part of health systems to address technological challenges for vulnerable older adults.

Many of the changes discussed here are temporary yet have the potential to improve care beyond the immediate crisis. In fact, since the Institute of Medicine (2010) report *The Future of Nursing*, consumer groups, such as AARP and Americans for Prosperity, joined nursing leaders to advance state and federal policies to allow APRNs to practice to the full extent of their preparation (Quinn et al., 2017). These advocacy and education efforts have resulted in impressive improvements, but most states lag in modernizing nurse practice acts (Campaign for Action, 2020), despite recognition of the vital role of NPs by the National Governors Association (2012). Furthermore, with at least 40% of Medicare beneficiaries receiving billable care from NPs and PAs (MedPAC, 2020), it is smart policy for Congress and the Administration to modernize federal workforce policies.

This window of time, allowing such practice, offers an unprecedented opportunity to generate evaluative research to support ongoing policy enactment to improve access. Innovations in telehealth and nurse-led models of care

have the potential to improve access and quality of care for older adults, offering opportunities for practice expansion as well as research on the impact of these changes. Building the evidence base for innovation in practice is vital to continue progress in modernizing state and federal regulations.

## CONCLUSION

Although this nation and the globe will eventually recover from the pandemic, older adults will continue to require care and services. Unfortunately, the pandemic will most likely have a negative impact on the numbers of all clinicians, including APRNs, RNs, physicians, and others. With the combined increasing demand and diminished supply, it behooves policy makers to make permanent most, if not all, of the temporary policies described. Furthermore, Congress should consider updating other related policies in Medicare. Finally, evidence from states with less restrictive regulations can inform policy makers in those states that lag behind. With the complexity of care and the extent of delivery across state lines, movement toward national standards can only enhance quality and access for older adults.

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