Bipartisan Policy Center

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To the Biden-Harris Transition Team,

The Bipartisan Policy Center's health team has prepared the enclosed materials to aid and inform the Transition Team and help prepare President-Elect Biden, Vice President-Elect Harris, and their cabinet to address America's most urgent and complex health care and public health challenges starting on day one. The enclosed materials include one letter on each of the following topics:

- Access to Care and Coverage
- Cost Containment and Program Integrity
- Aging and Disability
- Rural Health
- Telehealth
- Behavioral Health and the Opioid Crisis
- Public Health and Preparedness
- Housing
- Nutrition

The Bipartisan Policy Center is a Washington, DC-based think tank that actively fosters bipartisanship by combining the best ideas from both parties to promote health, security, and opportunity for all Americans. BPC's health team strives to develop bipartisan policies that improve the nation's health outcomes, reduce preventable health care costs, and ensure equity and inclusivity.

Sincerely,

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Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Access to Care and Coverage

December 18, 2020

I. PRIVATE INSURANCE

These recommendations are highlights from BPC's report, Bipartisan Rx for America's Health Care. See the report for full policy recommendation explanations and rationale for change.

A. Marketplace Coverage

Recommendations

Legislation

- Establish a federally-funded, state-administered reinsurance program and authorize and appropriate $30-60 billion over three years for the program and create a federal fallback for states that do not administer it. The secretary of HHS should establish general parameters for the federal fallback.
- Allow states to auto-enroll subsidy-eligible individuals into Marketplace plans if premiums are equal to or less than their premium tax credit.
- Restore cost-sharing reduction payments and enact legislation to provide a permanent, mandatory appropriation for the payments.
- Expand the availability of premium tax credits to those between 400-600% of the Federal Poverty Level (FPL). The tax credit amount would be the greater of:
    - The current tax structure: an amount that would limit the premiums to 10% of the value of the second-lowest-priced Marketplace silver plan.
    - An advanceable minimum tax credit of $750 per individual in households with incomes between 100%-600% of FPL. The minimum tax credit would be indexed to grow commensurate with average premium growth nationwide for silver Marketplace plans.

Regulations

- Expand the following federal outreach and enrollment activities:
    - Restore the 90-day open enrollment period for individual and group markets.
    - Restore advertising/marketing funding to the original level of $100 million.
    - Increase funding for Navigators to $100 million annually and increase associated training and post-enrollment assistance.
    - Increase funding for consumer assistance programs to $100 million annually to reduce burdens on state resources.

Current Law and Policy

Enrollment in the total individual insurance market in 2016 was 17 million, including 10 million who purchased coverage through the Affordable Care Act (ACA) insurance Marketplaces, 4.8 million who purchased off-Marketplace ACA-compliant plans, and 2.3 million who were enrolled in non-compliant plans that were either grandfathered plans, short-term plans, or other plans.

Although the number of individuals receiving coverage through state and federal insurance Marketplaces has remained relatively unchanged since 2016, the percentage of new enrollees seeking coverage dropped by 16% from 2016-19. According to the Kaiser Family Foundation, the reasons include rising premiums for ACA-compliant coverage, an increase in the number of non- compliant off-Marketplace plans now available as a result of changes in regulation, the repeal of tax-penalties for remaining uninsured, and economic trends, such as decreased unemployment and a resulting increase in the availability of employer-sponsored coverage. However, this trend has reversed since onset of the COVID-19 pandemic. The Biden administration should take the following actions to stabilize insurance markets and reduce premium costs. Where legislation is required, as indicated below, the administration should seek congressional support for legislative action.

Cost-sharing reduction payments - Plans are required to waive cost-sharing for individuals with incomes below 250% of FPL. The ACA established CSR payments to reimburse plans for those costs. The Trump administration interpreted the language as requiring Congress to appropriate funds for CSRs, and because Congress did not directly appropriate the funds, stopped the payments in October 2017.

Silver-loading - To offset the loss of CSR payments, many states directed insurers to increase the premiums of silver-level plans, also known as silver loading. The ACA established premium tax credits for individuals with incomes between 100 and 400% of FPL. As individual market premiums have risen, silver loading resulted in a "cliff" for those who earned 400% of FPL or more (often termed middle-income) relative to those with slightly lower income who are subsidy eligible. When the Trump administration concluded that HHS does not have the legal authority to provide CSR payments to plans, the problem was exacerbated.

Risk corridors and Transitional Reinsurance Program (TRP) - To stabilize premiums in early Marketplace years, the ACA created two temporary programs (2014-2016): a two-sided risk corridor, and the TRP. The risk corridor limited insurer losses and gains to prevent unfair premium setting, and the TRP subsidized Marketplace plans enrolling higher-cost individuals.

Recent Action

- The Department of Health and Human Services (HHS) has reduced funding for the Navigator program and Consumer Assistance Programs (CAPs), which are designed to help people enroll in coverage and help resolve appeals related to coverage. Changes include:
    - A 90% reduction in spending on advertising for 2019 open enrollment ($10 million) compared to 2017 ($100 million).
    - Limiting funding for Navigators to $10 million for 2020, compared to $63.1 million in 2016, resulting in an average 84% funding reduction across states.

    - Shortening the open enrollment period from 90 to 45 days.
- In April 2020, the Supreme Court ruled that HHS is obligated to make risk corridor payments under Section 1342 of the ACA, and insurers are owed over $12 billion in unpaid risk corridor payments.
- In August 2020, a Court of Appeals for the Federal Circuit decided that insurers are owed CSR payments, but only to make up for the losses that were not covered by silver loading.
- Following repeal of tax penalties for those who did not obtain insurance coverage, Texas sued the federal government to invalidate the ACA arguing that the tax penalties upon which the Supreme Court upheld the ACA in *NFIB v. Sebelius*, were no longer law. California sued Texas to retain the ACA, and the Court heard the consolidated cases in November 2020. A decision on the future of the ACA is expected in spring 2021.

B. Employer-Sponsored Insurance

The Biden administration should seek legislation to reduce burden and provide flexibility to employers offering health insurance and reduce ESI premiums over time:

Recommendations

Legislation

- Repeal the tax penalty for employers that do not provide employees with qualified health insurance to relieve the burden of collecting and reporting data and payment of tax penalties.
- Rationalize the subsidization of employer-sponsored insurance by replacing the recently repealed tax on high-cost employer-sponsored insurance (ESI) plans with a more sustainable and progressive policy. This policy would limit the income tax exclusion for ESI at a dollar amount equivalent to the 80th percentile of single and family ESI premiums. The limitation would only be applied to expensive plans purchased by higher-income individuals.
- Monitor the impact of the current Health Reimbursement Account regulations and codify the rule that employers provide sufficient funds to cover 80% of the benchmark silver plan, as long as the policy does not increase Marketplace premiums.

Current Law and Policy

Employer tax penalty - The ACA contains employer shared-responsibility provisions that require certain employers to offer minimum essential coverage that is affordable and provide a minimum value to all full-time employees or to pay a tax penalty. The mandate applies to employers with more than 50 full-time or full-time equivalent employees that work 30 or more hours per week, or 130 hours per month, on average during a calendar year. This policy is similar to the ACA's individual mandate penalty. Together, the two policies were designed to maximize insurance coverage. Although Congress eliminated the individual mandate penalty in 2017, the employer penalty remains unchanged. Employers argue the penalty imposes a financial burden on some employers and poses an administrative burden to all employers, and there is some support on both sides of the aisle for repeal. Also, benefit managers for large employers and labor have raised concerns that with the repeal of the individual mandate, some

healthy employees will choose to remain uninsured, resulting in higher premiums for remaining employees.

Tax treatment of employer-sponsored insurance – Employer-sponsored insurance receives favorable tax treatment under current law; employer contributions towards ESI premiums are exempt from federal income and payroll taxes and employee premiums are excluded from an employee's taxable income. The ACA imposed a 40% excise tax on high-cost health insurance plans (i.e., insurance carriers or employers, in the case of self-funded plans), and prohibited insurers and employers from deducting the cost of the tax as a business expense. The excise tax—commonly referred to as the Cadillac tax— was intended to place downward pressure on health insurance premiums and lower health care costs as insurers and employers sought to avoid the tax premium. Congress amended the law reversing ACA policy and permitting insurers and employers to deduct the cost of the excise tax. Congress also repeatedly delayed the imposition of the tax, until it was fully repealed in December 2019.

Health Reimbursement Accounts – A Health Reimbursement Account (HRA) is a group health plan that allows employers to fund medical expenses for their employees on a pre-tax basis. Because HRAs are group health plans, previous rules have prohibited their use to pay for premiums in the individual insurance market. Under federal rules, HRAs were required to be offered in conjunction with an ACA-compliant group health plan to address non-compliance with ACA requirements prohibiting limits on essential health benefits and beneficiary cost-sharing for preventive services.

Recent Action

- In June 2019, HHS, the Department of Labor, and the Department of the Treasury issued a final rule permitting employers to provide an HRA that is offered in conjunction with an integrated individual health insurance plan.
- In December 2019, the Cadillac tax was repealed through the appropriations process.

Impact on Health Equity

The ACA's insurance market reforms and premium subsidies, along with Medicaid expansions, have reduced disparities in health insurance coverage and access to care. Nationwide, the uninsured rate fell from 20.5% in 2013 to 12.4% in 2018. The largest coverage gains were among Blacks (24.4% uninsured in 2013 compared to 14.4% in 2018) and Hispanics (40.2% uninsured in 2013 compared to 24.9% in 2018). Although progress has been made, Marketplace coverage is still unaffordable for many, especially those who are over 400% of FPL and fall into the "subsidy cliff." Building on and strengthening the ACA through policies, such as expanding the availability of premium tax credits, can eliminate the subsidy cliff and further reduce disparities. The impact of the repeal of the employer tax penalty is unclear. While it could result in the loss of employer-sponsored coverage, individuals would be eligible for coverage through Medicaid or marketplace plans with cost-sharing subsidies and/or premium tax credits unless individual income exceed 400% of FPL.

Challenges to Implementation & Cost

Many of the policies outlined would require up-front costs to the federal government. However, others are expected to result in long-term savings or reductions in overall health spending. For example, the Congressional Budget Office (CBO) estimated the silver loading that occurred to

offset the halting of federal CSR payments has resulted in a 10% increase in premiums above the level that would have occurred without the policy, and over time will increase premiums by as much as 20%. CBO has also commented extensively on the treatment of scoring CSRs, and projects that a permanent appropriation for the CSRs would eliminate the need for silver-loading and provide more stability in insurance market premiums.

The ACA's Cadillac tax was repealed because it lacked sufficient support among both Democratic and Republican policymakers. According to the CBO, repeal of the tax will result in a loss of $200 billion in federal revenue over 10 years. Although implementing a new tax policy would not be easy, there is a strong rationale for limiting the tax-preferred status of employer-paid premiums. The employer-sponsored insurance tax exclusion has been viewed by some health economists as encouraging higher spending on insurance premiums, which leads to increased health care costs. According to the Urban-Brookings Tax Policy Center, the exclusion will cost the federal government an estimated $299 billion in lost revenue in 2020.

Repeal of the employer penalty could reduce ESI, and a corresponding increase in premium subsidies in marketplace plans could increase federal costs. Codifying the HRA regulations is somewhat controversial. Opponents have expressed concern that employers would move high-risk employees into the Marketplaces, driving up premiums . Supporters are skeptical of that analysis. The impact of the HRA regulations should be closely monitored to determine their impact on Marketplace premiums.

II. MEDICAID EXPANSION AND IMPROVED ACCESS TO PRIMARY CARE

To promote access to Medicaid coverage for low-income populations and improve the availability of primary care services, the Biden administration should seek passage of legislation or issue regulations or guidance in the following areas. Full explanations of recommendations and the rationale for those changes are included in the following BPC reports: Bipartisan Rx for America's Health Care and Advancing Comprehensive Primary Care in Medicaid.

Recommendations

Legislation

- Incentivize Coverage Expansion - Permit non-expansion states to expand Medicaid coverage under one of these options:
    - Provide coverage to adults with incomes up to 138% of FPL with 100% Federal Medical Assistance Percentage (FMAP) phased down over five years to 90%; or
    - Provide coverage to adults with incomes up to 100% of FPL with 88% FMAP, provided they expand coverage within two years of enactment.
- Permit states to auto-enroll individuals eligible for coverage under Medicaid and the Children's Health Insurance Program (CHIP).
- Create a state option for 12-month continuous eligibility for adults.
- Improve Access to Primary Care:
    - Increase state FMAP to 100% for primary care services for 5 years for states that reimburse primary care services at Medicare rates.
    - Require preventive care coverage for adults in traditional Medicaid without cost-sharing.

    - Work with existing learning collaboratives and researchers to elevate primary care as a Medicaid priority and share primary care best practices among states.
    - Direct the secretary of HHS to work with states and other stakeholders to promote measurement and report of spending on primary care as a percentage of total health care spending.
- Seek congressional appropriations for the Primary Care Extension Program.
- Address Social Determinants - Provide the HHS secretary with authority to approve Medicaid coverage of non-medical services that address social needs if the secretary certifies the following:
    - Peer-reviewed evidence demonstrates the benefit improves or maintains health or function for the targeted population.
    - The CMS Office of the Actuary certifies coverage of the defined benefit for the defined population would result in no net increase in long-term Medicaid spending.
    - Additional benefits apply only to patients who are enrolled in Medicaid managed care or other health care payment or delivery models that include a comprehensive team-based approach to care management.

Regulation

- Provide guidance to states on defining and reimbursing community health workers, where evidence has demonstrated improved outcomes for those with chronic conditions and reduced health disparities.

Current Law and Policy

- The ACA provided increased FMAP for states during the 5 years following enactment, to offset costs to states. Those FMAP payments were set at 100% and phased down to 90%. States that failed to adopt the expansion during those first years, were ineligible for the increased FMAP.
- The ACA established the Primary Care Extension Program (PCEP) to support primary care practice transformation by adapting the successful model the U.S. Department of Agriculture. Congress authorized, but did not appropriate, the $120 million to the Agency for Healthcare Research and Quality (AHRQ).
- Medicaid managed care plans may offer additional non-medical benefits provided at plans' discretion. These "value-added services" might include such items as a portable crib to assure that a newborn has a safe place to sleep. These value-added services, unlike services provided in lieu of a covered benefit, may not be claimed for the purposes of federal matching dollars. Notably, these services must be provided out of the 15% of revenue that plans use for marketing, administration, and other costs under the medical loss ratio.

Recent Actions

- HHS secretary Alex Azar announced steps to provide more state flexibility under the Medicaid program to address social determinants. North Carolina is implementing a section 1115 waiver that permits reimbursement of non-medical interventions that

target certain social determinants of health: housing instability, transportation insecurity, food insecurity, and interpersonal violence and toxic stress.

- The Bipartisan Budget Act of 2018 permitted Medicare Advantage plans to offer certain non-medical services to patients with multiple chronic conditions, provided the services had a reasonable expectation of improving health or function.

Impact on Health Equity

While not the only answer, access to health insurance coverage can also help address racial disparities. According to the 2019 Census Bureau report, 26.1 million Americans—8% of the population—did not have health insurance at any point in the year. The uninsured were more likely to be non-elderly adults, low-income, employed, and people of color. The highest proportion of those without coverage were 18-64 year olds, primarily because they were less likely to be eligible for Medicare or Medicaid. Among non-elderly adults without coverage about, about 16% had incomes below, FPL ($25,750 for a family of 4). Three percent had incomes greater than 400% of poverty. About 88% of working-age uninsured Americans were employed either full-time or part-time for some portion of the year. People of color were more likely to be without health insurance coverage than whites. Only 5.2% of non-Hispanic whites were uninsured in 2019, compared to 6.2% of Asians, 9.6% of Blacks, and 16.7% of Hispanics. Rates of uninsured are higher in states that chose not to expand Medicaid to adults under the ACA.

A Robert Wood Johnson Foundation brief states the widely-reported statistic that these social determinants can drive up to 80% of health outcomes. The Centers for Disease Control and Prevention points out that discrimination and inequities in access related to these social determinants has placed certain racial and ethnic minority groups at higher risk of infection, hospitalization, and death from COVID-19. If Medicaid covered non-medical services that have been certified to improve health or function without increasing aggregate Medicaid costs and delivered in a value-based manner, racial and ethnic minorities that disproportionately make up the Medicaid beneficiary population would see lowered risks for adverse health issues. Given the number of children covered by Medicaid and the Children's Health Insurance Program as well, the provision of these non-medical services may produce benefits that will be felt over many years and reduce overall health care utilization and spending.

Challenges to Implementation and Cost

The biggest challenge to implementation of these proposals will be the federal costs of increased FMAP for both coverage and increased reimbursement. At least in the near-term, states are currently struggling to deal with the costs associated with the COVID-19 pandemic and the resulting economic downturn and are seeking ways to reduce Medicaid expenditures. Some will likely also oppose further Medicaid expansions.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Aging and Disability

December 18, 2020

The COVID-19 pandemic and associated recession has trained a spotlight on the fissures in the U.S. healthcare system that have always existed for people who are low income, who are disabled, and who have chronic disease and other illnesses. This includes hampered access to care, poorly coordinated and poor quality care, and a healthcare system that operates in siloes, oriented towards revenue generation rather than health.

As the Biden Administration envisions how it will "build back better," this population warrants particular attention. The recommendations below reflect the consensus of BPC's bipartisan groups of advisors as well as consultation with leading experts over the last several years. They focus on the following themes:

- Expanding access to care, particularly in outpatient and community settings,
- Reducing fragmentation in care financing and care delivery,
- Increasing flexibility to address beneficiaries' health related social needs,

They include regulatory and sub-regulatory actions, as well as legislative approaches the administration could consider including among its budget proposals. BPC's health policy teams are also actively building upon these reports and look forward to being a resources to Biden Administration officials and staff in the future.

I. MEDICARE: CARING FOR THOSE WITH COMPLEX NEEDS

Recommendations

A. Special Supplemental Benefits for the Chronically Ill

1. Promote the testing and evaluation of the provision of special supplemental benefits for the chronically ill (SSBCI) in MA. In particular:
    a. Direct the Centers for Medicare & Medicaid Services (CMS) to set standards for reporting and publishing MA plan information on SSBCI enrollment, utilization, and outcomes to hold MA plans accountable and contribute to the evidence base.
    b. Establish a CMMI demonstration to evaluate SSBCI.
        i. Incentivize evaluations of SSBCI by permitting MA plans to apply for CMMI funding to test certain non-medical benefits for those with chronic illness. Under the demonstration, CMMI would pay 50 percent of the cost of the intervention in the defined market. The demonstration would also fund data collection, including the cost of providing services and the impact on health costs, such as hospitalizations, hospital readmissions, emergency department visits and post-acute care costs, and such data as necessary to assure that plan participating providers refer eligible patients for supplemental benefits in a manner that guarantees equal access to benefits for racial minorities.

ii. CMMI should also collect data on well-being of MA enrollees which would allow for a richer evaluation of the impact of supplemental benefits on enrollee well-being.

iii. MA plans should provide all necessary claims and encounter data, cost of interventions, demographic information, and other data to CMMI to undertake an objective evaluation of the new benefit. Randomized trials should not be required, however, CMMI should design careful evaluation frameworks by comparing to comparable plans that do not incorporate these benefits. Data must be provided in a way to assure patient privacy.

iv. Evaluation results would be made publicly available to permit replication by MA plans, and to build an evidence base for consideration of coverage on non-medical benefits in Medicare fee-for-service.

v. Provide incentives to partner with community-based organizations in the provision of non-medical services.

2. Improve clarity around benefit eligibility and targeting criteria for SSBCI:
   a. Develop guidance on the definition of intensive care coordination, one of the three criteria for determining whether an individual is eligible for SSBCI. In developing this guidance, draw from Essential Attributes of high-quality care, developed by national experts committed to a person-centered framework for care coordination. (The SCAN Foundation, 2016).
   b. Require functional assessment in MA Health Risk Assessments to help better target SSBCI.
3. Improve marketing and education around SSBCI:
   a. Increase funding for State Health Insurance Assistance Programs.
   b. Require MA plans to develop materials to educate providers about SSBCI, so that providers can assess patient eligibility and refer patients to authorized suppliers.
   c. CMS should explore opportunities to encourage learning and sharing among plans, providers, and other stakeholders. This may be through a learning collaborative that allows for stakeholder discussion on impacts to beneficiaries, most effective interventions, and best ways to advance the policy field.
   d. CMS should improve the quality of information on non-medical supplemental benefits in the Medicare Plan Finder tool. Modifications may include redesigning the results page and increasing transparency on benefit eligibility and scope. For more information see Bipartisan Policy Center, "Next Steps in Chronic Care," July 2019.
4. Treatment of Certain Supplemental Benefits Provided by MA Plans During COVID-19
   a. Direct the secretary of the U.S. Department of Health and Human Services (HHS) to extend and improve special guidance to MA plans providing extra flexibility in the interpretation of regulations during COVID-19 and provide examples of items and services that plans may cover to promote the health and safety of MA enrollees during the COVID-19 outbreak. For example, while home delivered meals, grocery, produce, and non-medical transportation are explicitly listed in current guidance as examples, CMS might also consider offering special guidance around items and

services that will help people access those services from their homes, including internet provider service and mobile devices to the extent that they are not otherwise available. MA plans would not be limited to items identified in the guidance. However, they would be subject to audit.

b. Permit plans to count supplemental benefits provided to enrollees to protect health and safety during the COVID-19 pandemic to be counted as "incurred claims" for the purposes of calculating medical loss ratios in MA.

B. A Pathway for the Provision of Non-Medical Benefits in Medicare Fee-for-Service for those with Chronic Conditions

Seek legislation to create parity between Medicare Advantage and Medicare fee-for-service for those with multiple chronic conditions by:

a. Providing authority to the HHS secretary to identify and authorize coverage and payment of evidence-based non-medical benefits for patients with chronic conditions if:

i. Peer-reviewed evidence demonstrates that the benefit improves or maintains health or function for a specific subset of patients with certain chronic conditions and/or functional limitations.

ii. The CMS Office of the Actuary certifies that coverage of the defined benefit for the defined population would result in no net increase in Medicare spending; and

iii. The chronic condition is being managed by an ACO, a comprehensive primary care model, through CCM, or through another payment or delivery model that includes a care management component.

b. For any new evidence-based benefits for the chronically ill, the secretary should make available to Medicare providers a list of suppliers in the geographic area in which they provide services.

c. Eliminate the beneficiary co-pay for CCM services covered under Medicare, since the benefit covers provider-to-provider communications outside an office visit and are not obvious to the beneficiary.

d. Expand the list of qualified health providers that can bill for CCM services to include licensed clinical social workers practicing within the scope of their licenses.

e. Direct the HHS secretary to develop a uniform functional assessment tool and define the conditions under which providers would perform the assessment to facilitate eligibility determination for non-medical services, based on both chronic conditions and functional status.

f. Direct the secretary to establish criteria for organizations that would be eligible to provide non-medical services identified by the secretary in traditional Medicare FFS. The secretary should also establish monitoring programs to minimize fraud, waste, and abuse.

g. Direct the secretary to examine potential modifications to the risk-adjustment model to ensure more accurate predictions of medical expenses for Medicare beneficiaries with functional limitations. The secretary should consider the appropriateness of developing a tool that can determine eligibility and assess risk.

Current Law and Policy

Under the Bipartisan Budget Act of 2018, Congress provided authority for MA plans to offer special supplemental benefits for the chronically ill (SSBCIs) that are not primarily health-related beginning in January 2020. These benefits must have a reasonable expectation of improving or maintaining an individual's health or function (for example, the ability to perform normal activities of daily living, such as bathing and dressing). Under HHS guidance, plans may determine what benefits to offer, subject to approval by the secretary. SSBCIs are financed within existing Medicare payments to plans. As a result, there is no added cost to enrollees or to the federal government. Under agency guidance, plans may offer benefits such as medically-tailored, home-delivered meals beyond those already permitted in MA; non-medical transportation; fresh produce; and services supporting self-direction, home modifications, or other benefits. Under the BBA, Congress included a requirement that the General Accounting Office report on benefits offered and the impact of those benefits.

Recent Action

In 2017, CMS began testing the MA value-based insurance design model, providing insurers with the ability to offer beneficiaries diagnosed with select chronic diseases various incentives (e.g., reduced cost-sharing and additional supplemental benefits) for utilization of services that providers considered to be of high clinical value. The model was initially made available to seven states and covered seven chronic diseases; CMS then expanded it to plans in all 50 states and territories (Murphy-Barron et al. 2019).

In 2019, CMS *expanded* the definition of "primarily health-related" in traditional MA supplemental benefits to allow certain benefits typically provided through long-term services and supports (LTSS) programs. These include in-home support services (e.g., help with laundry, preparing meals, etc.), respite care to relieve a primary caregiver, and others.

In 2020, CMS expanded eligibility requirements for SSBCIs beginning in 2021. To be eligible for SSBCI, plan enrollees must meet specific criteria defined by the MA plan, including having a chronic condition. Eligible chronic conditions are no longer limited to those outlined in the Medicare Managed Care Manual.

In response to the pandemic, CMS has allowed MA plans *rare flexibility* to make midyear supplemental benefit changes to address the unique needs arising during COVID-19. Early lessons from plan experiences during the pandemic suggest MA plans can use supplemental benefits to meet member needs and enable home-based care. However, additional guidance to plans and allowing plans to include those COVID-19-related supplemental benefits as "incurred claims" will create additional incentives to plans.

Impact on Health Equity

Improvements in preventive services, care for chronic conditions, and access to care have led to a reduction and in some cases elimination of disparities in access to and receipt of care for some minority populations in areas such as receipt of mammography, timing of antibiotics, counseling for smoking cessation, and pediatric vision care. On the other hand, disparities in care continue to be a problem for some conditions and populations. For example, Blacks, Asians, American Indians/Alaska Natives, and Hispanics continue to lag behind whites in the percentage of the population over 50 who receive colon cancer screening, and this gap has widened in recent years. (AHRQ)

In 2019, CMS released a report on racial, gender and ethnic disparities in MA. According to a review of 2017 data, an estimated 69.5 percent of all MA beneficiaries were white, 13.8 percent were Hispanic, 9.9 percent were Black, 4.3 percent were Asians or Pacific Islanders (API), 2.1 percent were multiracial (not included in this report), and 0.4 percent were American Indians or Alaska Natives (AI/AN), compared with 76.1 percent, 8.5 percent, 8.9 percent, 3.6 percent, 2.3 percent, and 0.6 percent, respectively, in the general Medicare population. An estimated 56.3 percent of all Medicare Advantage beneficiaries were female, and 43.7 percent were male, compared with 54.1 percent and 45.9 percent, respectively, in the general Medicare population.

Although the analysis revealed few gender differences in care, it did reveal patterns in which (1) Black and Hispanic beneficiaries received worse clinical care than white beneficiaries on a large portion of the clinical care measures examined and (2) API beneficiaries reported worse patient experiences than white beneficiaries on almost all measures of patient experience. The results presented in this report lead to a conclusion that quality improvement efforts should focus on enhancing clinical care for Black and Hispanic beneficiaries and investigating differences between API and white beneficiaries' patient experience.

Challenges to Implementation & Cost

Actuaries have had difficulty modeling the real cost of providing discrete supplemental benefits, which has created an atmosphere of uncertainty and may partly account for the relatively slow and conservative rollout of such services. MA plans cautiously rolled out these new benefits in 2020, and experts anticipate a broader distribution of benefits across markets in the future will enable more reliable economic analyses. Despite uncertainties, there has been a substantial increase in the number of plans offering SSBCI, with 245 plans offering in 2020 compared to 920 plans in 2021 (Long-Term Quality Alliance and ATI Advisory, 2020).

CMS criteria for targeting supplemental non-medical benefits present implementation challenges. According to the rules, non-medical benefits can be targeted based on *clinical criteria* rather than *social needs*, and coding can vary significantly across providers, making eligibility criteria challenging to navigate. Due to issues related to licensing and payment, MA plans are also concerned about how to provide these new benefits across multiple states (Long-Term Quality Alliance 2018). Opportunities to expand MA supplemental benefits depend on the availability of rebate dollars which vary widely across geographic markets. Rebates, which average $107 per month in 2019 across the nation, can range from as little as $2 in North Dakota to $159 in Florida (Skopec et al. 2019).

SSBCI allow MA plans to make exceptions to the uniformity rule. While important for increased flexibility, MA enrollees should receive these benefits in a consistent, equitable, and non-discriminatory manner. MA plans should adopt specified criteria for eligibility that are administered consistently within a plan, based on chronic illness and functional impairment levels.

Critics of MA benefits expansion efforts note that SSBCI are not available everywhere in the U.S. MA plans have not penetrated rural areas and are found mainly in more densely populated markets. In six states (FL, HI, MN, OR, PA, and WI) and Puerto Rico, over 40 percent of Medicare beneficiaries are enrolled in an MA plan. By contrast, in two rural states (AK and WY), fewer than 10 percent of all beneficiaries are enrolled in MA plans (Jacobson et al. 2019).

II. MEDICARE & MEDICAID: INTEGRATION OF CARE FOR DUAL-ELIGIBLE INDIVIDUALS

Recommendations

Dual-eligible individuals are low-income disabled and aged beneficiaries who are enrolled in both Medicare and Medicaid. Those over age 65 were one of the most impacted populations by COVID-19. Navigating Medicare and Medicaid only exacerbated the challenges they faced during the pandemic. This population can be supported by promoting integration of Medicare and Medicaid services through:

Guidance and Technical Assistance

- Provide resources (i.e., grant funding if possible) and technical assistance to states to implement full integration of services.
- Require collaboration between CMS, the Administration for Community Living, and states to implement model standards for outreach and education.

Regulation

- Limit the Geographic Direct Contracting CMMI model to only geographic areas where existing integrated models are non-existent to avoid confusing beneficiaries (assuming CMMI moves forward with this model).
- Restrict further the availability of Dual-Special Needs Plans (D-SNPs) look-alikes beyond steps taken in 2020 regulation.

Legislation

- Ensure the availability of a model that integrates Medicare and Medicaid for all dual-eligible individuals. Integration should be defined as full financial alignment with a single set of benefits and a single point of contact. This should be achieved through the following models: (1) improved fully-integrated duals special needs plan (FIDE-SNP), (2) the program of all-inclusive care for the elderly (PACE), and (3) a flexible model negotiated between the secretary of HHS and a state, building on the managed fee-for-service implemented by the State of Washington.
    - States and territories should be able to make integrated coverage available for their residents and, if they do, should be eligible for guaranteed shared savings.
    - If a state or territory opts not to make an integrated coverage option available to all residents, a federal "fallback" integrated coverage option should be made available to all residents of that state or territory. These states would be subject to a recoupment or "claw back" payment similar to that used in Medicare Part D for the Medicaid portion of expenditures. Note: BPC is currently developing recommendations on how to operationalize the "fallback" program, with a final report expected in 2021.
- Provide the Medicare-Medicaid Coordination Office (MMCO) with direct funding and full regulatory authority for all programs serving dual eligible individuals—including integrated care models implemented by states and the federal fallback program and PACE. This would require increased staffing and resources.
- Establish general waiver authority to align administrative differences between the Medicare and Medicaid programs, excluding issues related to eligibility, benefits, access to care, Medicare freedom-of-choice protections, or beneficiary due process rights.

- Increase funding to the State Health Insurance Assistance Program to expand and improve information and counseling available for dual-eligible individuals.
- Provide resources and technical assistance to states for consumer, provider, and plan engagement and education about integrated care models, and encourage states to prioritize partnerships with community-based organizations and local governments.

Current Law and Policy

For more than 20 years, state and federal policymakers have tried to improve coordination of the Medicare and Medicaid programs for those eligible for both programs, with the most significant strides made as a result of demonstrations born out of CMMI's authority under the ACA. Within the last few years, Congress made additional progress toward improving integration as part of the Bipartisan Budget Act of 2018 (BBA), which granted authority to the MMCO to develop regulations and guidance related to D-SNPs. While the BBA legislation is broadly seen as a positive step toward future integration, it does not go far enough. Only one in ten dual-eligible individuals are enrolled in integrated programs today, and many dual-eligible individuals do not even have access to a meaningfully integrated program. While the MMCO has announced a second round of opportunities for states, HHS has also indicated the need for additional authority and resources to better align Medicare and Medicaid services (HHS, April 2019).

Recent Action

In April of 2019, CMS finalized D-SNP rules to implement some BBA provisions. This memo from MMCO summarizes the new regulatory requirements that take effect starting Plan Year 2021: D-SNPs have to meet new integration requirements that call for greater provision of long-term services and supports, behavioral health benefits, and information-sharing of admissions of high-risk individuals; to be designated as fully integrated Dual Eligible SNPs, highly integrated D-SNPs, or D-SNPs. Certain D-SNPs and their affiliated Medicaid managed care plans are also required to implement unified appeals and grievances processes for Medicare and Medicaid. All D-SNPs will have to meet coordination responsibilities as well.

In May of 2020, CMS further implemented BBA provisions in their final rule for changes in Contract Year 2021 to Medicare that phased out D-SNP "look-alikes," non-D-SNP plans that enroll very high numbers of dual-eligible individuals and market aggressively to them. CMS considered their growth as an obstacle to effectively implementing BBA's requirements. Starting in 2022, CMS will no longer contract with Medicare Advantage (MA) plans that project 80% or more of their enrollees will be entitled to Medicaid.

Impact on Health Equity

These recommendations would disproportionately benefit people of color given their disproportional representation among dual-eligible individuals. According to Justice in Aging, people of color account for almost half of all dual-eligible individuals but only 20% of all Medicare enrollees. Dual-eligible enrollees are also "almost 4 times more likely to be infected by COVID-19 and more than 4.5 times more likely to be hospitalized compared to Medicare-only individuals," with Black dual-eligible individuals more impacted than white dual-eligible individuals.

Challenges to Implementation and Cost

In addition to the heterogeneity of the population, which makes integrating care challenging, the differences in the Medicare and Medicaid programs are significant, posing barriers to program alignment. There are differences in eligibility, benefits, providers, reimbursement, how the programs are administered and by whom, and a host of other program rules. While both programs use managed care as a means of payment and delivery, there are significant differences in the way managed care plans are regulated under Medicare and Medicaid.

MA plans are regulated by CMS under federal rules, and Medicaid managed care plans are state-regulated. MA plans follow the calendar year with benefits starting in January, while Medicaid plans typically follow state fiscal years, the majority of which begin in July. Medicare and Medicaid plans have different network adequacy requirements, grievance and appeals processes, and rules and resources to address social determinants of health and risk factors. Outside federal demonstrations, the secretary does not have the authority to align many of these differences. For more information see: "A Pathway for Full Integration of Care for Medicare Medicaid Beneficiaries, Bipartisan Policy Center. July 2020.

III. MEDICAID: HOME AND COMMUNITY-BASED SERVICES

Recommendations

Legislation

Simplification, Alignment, and Expansion of Medicaid Home and Community-Based Services (HCBS). In 2016, BPC issued recommendations designed to create incentives for states to expand the availability of HCBS by:

- Streamlining and simplifying existing authorities under current law waivers (sections 1915(c) and 1115 of the Social Security Act) and state plan amendments Sections 1915(i) and 1915(k)).
- Extending existing enhanced federal matching to encourage states to take advantage of the new streamlined authority. For more information see Bipartisan Policy Center, "Initial Recommendations to Improve the Financing of Long-term Care," p. 17. February 2016. (*Note: In 2021, BPC will review and revise previous work and issue new recommendations. We welcome the involvement of CMS in that process*.)
- Incentivize states to continue shifting from institutional care to HCBS to begin to eliminate the institutional bias in Medicaid. Create financial incentives through enhanced FMAP to encourage states to eliminate waiting lists for HCBS and to begin to move populations from waiver to state plan amendments utilizing 1915(i) and 1915(k).

Current Law & Policy

While states are required to cover institutional LTSS services, HCBS are optional. In recent decades, there has been a shift away from institutional delivery of care to HCBS. In 2013, about half of Medicaid LTSS dollars were spent on institutional care, and half were spent on HCBS. The availability of HCBS varies significantly from state to state. In Mississippi, HCBS made up about 25 percent of the state's LTSS spending, while Oregon spent nearly 80 percent of LTSS dollars on HCBS.

A number of factors have driven the shift from facility-based services to HCBS. One of the more significant was a Supreme Court decision in 1999, Olmstead v. L.C., in which the Court held that requiring individuals with intellectual and developmental disabilities to live in institutions as a condition of receipt of services under Medicaid violated the Americans with Disabilities Act. The Court held that, where appropriate, and at the request of an individual, the state must make services available in the community. Recognizing the cost to states, the Court permitted states to maintain waiting lists for services, provided that waiting lists moved at a "reasonable pace."

Most individuals receive services through 1915(c) waivers, which give states predictability in spending by allowing states to offer limited services to specific populations, to set enrollment caps, and to expand income and asset limits. Individuals participating in 1915(c) waivers require an institutional level of care. In 2015, 47 states operated 265 separate waivers (KFF 2018). States also offer HCBS through section 1115 demonstration waivers.

States may also offer HCBS under specific benefit categories, such as home health services, rehabilitative services, personal care services, or other mandatory or optional services. In addition, states may offer HCBS through state plan options: 1915(i), which permits states to choose from among a broad array of services to provide care to specific populations who need less than an institutional level of care. Another state plan option includes 1915(k), also known as Community First Choice (CFC) attendant services and supports. Section 1915(k) must apply to all.

In fiscal year (FY) 2016, the last year for which state and federal data are available, Medicaid programs spent approximately $94 billion on HCBS compared to about $72 billion on institutional services, which represented a 10 percent increase in HCBS spending over FY 2015 (MACPAC 2020). Two recent studies (Kaye et al. 2009; Harrington et al. 2011) suggest that HCBS have a dampening effect on Medicaid cost escalation. These findings suggest that HCBS may be associated with overall improvement in efficiency of LTSS delivery by reducing non-productive expenses and waste such as, duplication of services, and excess capacity (Chattopadhyay et al. 2013).

In order to make costs more predictable for states, most limit the number of people receiving HCBS. In most states, those who wish to receive services may place their names on waiting lists. According to a 2018 survey, more than 800,000 individuals remained on waiting lists for HCBS (KFF 2018). Variation in the use of waiting lists suggest that the number could be fewer, since some states do not conduct eligibility determinations of those on waiting lists. States may have different waiting lists for each 1915(c) waiver, and people may place their names on multiple waiting lists (NASDDDS 2017).

Recent Action

In early 2020, Congress and the Trump Administration took a number of actions designed to ease provider restrictions and increase access to care during the COVID-19 pandemic. As hospitals continue to face surges and nursing facilities face significant spread of the virus, CMS outlined significant flexibility to increase access to HCBS as an alternative site of service. Among the flexibilities provided to states, were permitting states to increase the number of individuals served under 1915(c), the use of less restrictive income and resource methodology, an expansion of opportunities for self-directed care, an expansion of scope of services offered under 1915(c) waivers, and other flexibilities.

The administration also suspended enforcement of the "Community-Based Settings Regulation." This 2014 regulation required that home and community-based settings meet certain qualifications that ensure beneficiary choice and autonomy, as well as requiring person-centered planning for the development of service plans for individuals receiving care through certain HCBS waivers. The delay in the compliance date for these requirements is an obstacle to the improvement and enhancement of HCBS. available.

Impact on Health Equity

Expanding access to HCBS will be vital to improving care and quality of life for people of color who would otherwise receive care in nursing facilities. Compared to whites, racial and ethnic minorities disproportionately receive care in facilities with limited clinical and financial resources, low nurse staffing, and high care deficiencies (Yue Li, 2015). Rates of HCBS participation are also greater in higher income communities, compared to lower income communities and communities of color. This is often due to lack of awareness of eligibility and lack of outreach to those communities of color (AARP, 2018). To help address these disparities, the policy would also provide a modest grant program to do outreach and education in the aging and disability networks to encourage them to involve communities of color in all aspects of this work.

Challenges to Implementation

Eliminating the institutional bias in Medicaid will require congressional action. While most would agree on the need to create a level playing field between institutional care and HCBS, elimination of the bias would require a state mandate, 100 percent FMAP or both. Historically, states have used 1915(c) waivers, which not only allows them to expand coverage to discrete populations but also to cap the number of eligible individuals, guaranteeing predictability of the cost of individuals. Many states have waiting lists. However, these lists do not accurately reflect unmet need, because some states do not use waiting lists, while others have lists, but do not screen for eligibility for those on waiting lists (MACPAC, 2020). As a result, it is difficult to assess across states. The impact of COVID-19 on state budgets and the resulting surge eligibility have led states to explore how they can eliminate services to keep costs down. The cost of expanding services will likewise prove a challenge because it will be difficult to predict or limit the number of enrollees.

IV. MEDICAID: BUY-IN FOR WORKING INDIVIDUALS WITH DISABILITIES

Recommendations

Improving Medicaid Buy-in (MBI) for workers with disabilities will require both administrative and legislative action. In the near-term, providing additional agency guidance on the combined authorities, Section 4733 of BBA '97 and Section 201 of TWWIIA, and issuing regulations on the two programs will help clarify the range of flexibility available to states. Over the long-term, Congress should enact legislation to combine authorities to streamline and simplify the programs. Specific recommended actions include:

Issue an Executive Order that clarifies and simplifies the current Medicaid Buy-in for workers with disabilities. The order should:

- Direct CMS to issue agency guidance identifying the full range of authority available to states to design, improve, and expand MBI programs for workers with disabilities. Note: The Biden-Harris Campaign identified enhanced Social Security work incentives, MBI, and improving competitive integrated employment for people with disabilities. While BPC has yet to take a formal position on those issues,

addressing them through a combined Executive Order would underscore the president's commitment to expanding opportunities for workers with disabilities.

- Instruct CMS to change the name 'Medicaid Buy-In' to Medicaid for Workers with Disabilities (MWD). Note: The term "Medicaid Buy-In" has been applied more broadly across the Medicaid program in recent years. This has caused confusion and the need for more precise language when referring to Medicaid benefits provided to workers with disabilities.

Regulations on Medicaid Buy-in Programs

While CMS released informal agency guidance in the form of four separate State Medicaid Director's communications between 1997 and 2000, no regulations have been issued, nor has there been additional guidance in the last 20 years.

HHS/CMS should issue a Notice of Proposed Rule Making (NPRM) to give the agency the opportunity to address topics not addressed through informal agency guidance such as options for defining work, Medicaid enrollment stability when a beneficiary experiences a medical leave from work, adding workers with disabilities 65 and older, opportunities/interface with managed care, and treatment of assets for Medicaid eligibility post MBI enrollment. This process would solicit input from consumer organizations, states and other experts and require the Department to address relevant comments or questions arising from the NPRM, providing further clarification to help guide states.

Legislation

While it is possible to formulate MBI programs for the working disabled by combining multiple statutory authorities with waivers, it should be easier for states to implement these programs.

- Ask Congress to enact legislation to update, consolidate and streamline existing authorities into a single state option. This option should permit states to offer the full range of Medicaid benefits, or a subset of Medicaid benefits designed to supplement employer-sponsored or other private health insurance coverage.
- Improve and reauthorize TWWIIA-funded Medicaid Infrastructure Grants (MIG) to promote outreach and education about the MBI and successful employment outcomes for people with disabilities. The program should convene stakeholders to address barriers to earnings and employment experienced by people with disabilities, who often rely on HCBS to allow them to work. Services include addressing transportation barriers, skills training and employer outreach.

Current Law and Policy

In most states, individuals who are eligible for Supplemental Security Income (SSI) are automatically eligible for Medicaid. To be eligible for SSI, an individual must be between the ages of 16 and 64, must have a severe, medically determinable physical or mental impairment(s), and must meet income and resource standards. In 2020, the maximum income is $783 per month for an individual and $1,175 per month for a couple. Resource limits are $2,000 for an individual and $3,000 for a couple.

Eligibility for SSA is based on whether a person can engage in "substantial gainful activity" that, after deducting work expenses, cannot exceed $830 per month. If income exceeds that

amount, the individual will lose eligibility for SSI, and, because the two programs are linked in most states, Medicaid coverage. For more information see: https://aspe.hhs.gov/system/files/pdf/74111/handbook.pdf

In 2018, forty-four states and the District of Columbia had taken advantage of flexibility provided under BBA '97 and the TWWIA, as well as federal waiver authority to permit persons with disabilities who choose to work, to retain Medicaid eligibility.

According to state officials and advocates, states are not aware of the full range of options available to them because CMS has not issued comprehensive guidance on those options, nor has the agency issued regulations under section 4733 of BBA '97 or the TWWIA. Without this guidance, states are reluctant to take advantage of the full range of options available, given the ability of the federal government to withhold payment for services deemed not consistent with Medicaid law, also known as a Medicaid disallowance. In addition, states often do not have sufficient personnel to develop a program that requires combining both law and waiver authority to address the needs of a relatively low number of individuals.

The MBI-WDI is also challenging for enrollees to navigate. According to studies, program complexity is a significant barrier faced by current and prospective enrollees. Both anecdotal and statistical survey accounts from state evaluations strongly support a combination of program complexity and poor communication between states and enrollees and prospective enrollees.

By issuing guidance in the short-term and regulations in the mid-term, CMS would have the opportunity to clarify current law and provide opportunities for states, advocates, and other experts to comment on those regulations to help improve opportunities for working individuals with disabilities. Over the long-term, legislation to streamline and simplify MBI-WDI would address program complexity and encourage states to provide further opportunity for working people with disabilities.

Recent Action

During the Obama administration, CMS, the Administration for Community Living, the Department of Labor Office of Disability Employment Policy, and the Social Security Administration issued information on the options available to states, however, that information does not include the level of detail necessary to assist states in understanding the full range of options available to them through state plan options and waivers.

Impact on Health Equity

MBI-WID has resulted in increased incomes, improved health outcomes, and improved access to care for program participants relative to non-participants. An analysis of SSA earnings data by Mathematica Policy Research, Inc. determined that an average of 40% of participants increased their wages after enrollment in the MBI program and the median, inflation-adjusted increase from earnings in the year pre-enrollment, was $2,582. (Gavin et. al. 2011.)

Challenges to Implementation & Cost

MBI-WID enjoys broad bipartisan support, however, there is no recent data providing cost to states and the federal government, nor offsets associated with premiums or reduced state and federal costs associated with an individual no longer qualifying for SSI. Enactment of legislation may be challenging in the current environment.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Behavioral Health Integration and Opioids

December 18, 2020

I. BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

Recommendations

Behavioral health conditions are common, and when untreated can lead to high medical costs, and poor physical and behavioral health outcomes. These outcomes have worsened during the ongoing pandemic, which has increased existing mental health needs and coincided with a rise in anxiety and depression. BPC released a report in 2019 outlining challenges and opportunities to improve integration between primary and behavioral health care. BPC subsequently convened a Behavioral Health Integration Task Force that is currently considering a number of policy options, laid out below. The task force will release its recommendations in a report in Spring 2021.

A. Transforming payment and delivery to advance value-based integrated care

1. Establish cross-cutting standards within HHS for successful integration of behavioral health into primary care.

- Establish core care delivery elements. The secretary of HHS should define a set of core service elements necessary for behavioral health integration into primary care, which could include screening, care management, team-based care, measurement-based care, culturally adapted self-management of health conditions, patient information exchange between providers, links to social services and practice-wide systematic quality improvement.
- Standardize quality metrics. The secretary of HHS should work with stakeholders to identify a set of standardized quality and performance metrics for practices integrating behavioral health for use across all programs.
- Improve network standards. Update network performance standards across payers to ensure adequate specialty care for referrals and support for primary care providers. Standards must balance the need for sufficient providers participating in network who can accept new patients in a timely manner with the ability of health plans to meet those standards.

B. Driving behavioral health and primary care integration using existing federal payment platforms and practice-level incentives

1. Incentivize Behavioral Health Integration (BHI) in Medicaid Managed Care Organizations (MMCOs) through regulatory or legislative action

- Improve behavioral health integration measures in MMCOs. The HHS secretary should provide guidance and technical assistance to states and MCOs to help them prepare for upcoming mandatory state reporting requirements on Medicaid core measurement sets, which should include measures of BHI. CMS could include measures of BHI in the Medicaid managed care quality rating system;

recommend that states set a minimum rating for MCOs on the performance measures; and require states to describe in their managed care state quality strategy how the state will advance behavioral health integration.

- Improve network performance standards in MMCOs. CMS should consider requiring states to reevaluate time and distance to provider standards for Medicaid network adequacy requirements, taking into consideration changes in telehealth availability, and consider requiring states to establish additional quantitative measures.
- New funding opportunities for states to pursue integration. CMS should consider new Behavioral Health Integration initiative opportunities under Sec. 1115 waivers and CMMI to build state capacity for value-based payment initiatives that advance behavioral health integration.

2. Incentivize Behavioral Health in Accountable Care Organization Medicare Shared Savings Program
    - Update ACO MSSP participation requirements to include behavioral health. Congress could update the defined components of an ACO to require sufficient behavioral health professionals for the number of assigned beneficiaries; modify the core processes for ACOs for integration of behavioral health services and utilization of telehealth for care coordination; and require behavioral health screening and tracking to meet patient-centeredness criteria.
    - Improve behavioral health integration measures in ACOs. The secretary of HHS should utilize behavioral health performance measures for assessing quality in the Medicare Shared Savings Program.
    - Engage existing and new MSSP participants in Behavioral Health Integration. CMS should introduce a Behavioral Health Integration ACO track for the MSSP that offers an additional incentive for behavioral health and primary care integration.
3. Incentivize Behavioral Health Integration in Medicare Advantage.
    - Improve behavioral health integration measures in Medicare Advantage (MA). Revise components of the STAR rating system to include additional behavioral health integration measures. These changes would affect payment and incentivize plans to integrate care. Medicare Quality Improvement Organizations (QIO) could also focus on this area in their next scope of work.
    - Improve network adequacy in MA. Review MA network adequacy standards to ensure adequate performance standards, such as number of providers submitting claims, and taking new patients with an emphasis on mental health and substance use disorder.
    - Improve payment in MA. CMS should consider adding additional mental health conditions to the Hierarchical Condition Category risk adjustment process to incentivize screening for these conditions.
4. Incentivize Individual Providers to Participate in Integration
    - Reimburse integrated care in primary care practices. Congress could direct CMS to prioritize value-based payment models that reimburse for primary care and

behavioral health care together. These payment models should cover start-up costs associated with transforming a practice, and care coordination services that might not be reimbursable by traditional fee-for-service. These payment strategies should be accessible to primary care settings across practice-size and geographical location. Alternatively, CMMI could prioritize integrated health care payment strategies.

- Improve existing payments for integration. CMS should consider removing barriers to the adoption of the collaborative care model, which include insufficient reimbursement to cover start-up costs.
- Incentivize behavioral health providers to integrate care. CMS should consider payment models that align integrated care priorities between primary care and behavioral health providers. Payment should provide payment and accountability for activities such as sharing patient information, measurement-based care, and developing joint care plans.

5. Advance Health Equity

    - Improve reporting to highlight outcome disparities. For MMCOs, the secretary could review quality measurement initiatives and identify key measures that highlight outcome disparities and encourage integration for populations with mental illness. Certified Community Behavioral Health Clinics could be required to report behavioral health data by race, ethnicity and language.

C. Expanding and Training the Integrated Workforce

1. Expand Behavioral Health Workforce

    - Increase behavioral health workforce. Congress should pass legislation to include licensed mental health counselors and licensed marriage and family therapists in the list of covered providers. In addition, the secretary of HHS should clarify that peer support services can be billed in integrated care delivery and capitated payment models. To improve psychiatric consultation services for primary care providers, HRSA should increase grant funding for state-wide primary care-to psychiatric consultation services.
    - Increase care management services. CMS should allow licensed social workers to bill for chronic care management services.

2. Improve Training, Recruitment and Retention

    - Provide technical assistance to practices. Technical assistance (TA) is critical to aiding primary care practices in successfully implementing integrated models of care, as practice transformation requires significant time, expertise, and upfront investment. Congress could appropriate funding for the Primary Care Extension Program, or establish grant funding for TA for implementation and ongoing delivery of integrated care.
    - Improve integrated care education for new providers. Expand post-degree training for primary care and behavioral health professionals to prepare for work in integrated care settings.
    - Diversify the behavioral health workforce. Increase funding for the National Health Service Corps (NHSC) Loan Repayment Programs and expand the NHSC

Scholarship Program to include behavioral/mental health providers. NHSC scholarships are an important program for reducing financial barriers to increasing diversity in the behavioral health workforce.

D. Promoting Telehealth and Technology to Support Integrated Care

1. Expand Telehealth for Behavioral Health Integration

- Ensure data privacy standard for behavioral and wellness applications. All data collected by behavioral health and other wellness apps should be subject to privacy protections under HIPAA. In addition, privacy policies and permissions must clearly warn users when data leaves the protections of HIPAA and be easy to locate and understand. Individuals should also have the ability to select which information may be shared.
- Expand telehealth to increase access to care across technology platforms. Congress should remove site of service, geographic, and in-person visit restrictions for telehealth services; eliminate the video requirement for telehealth to allow the use of telephones; and expand asynchronous services to include written text, in addition to images.

2. Increase use of electronic health records and mobile health as tools for behavioral health integration

- Expand use of health information technology among behavioral health providers. To provide funding to support health information technology utilization by behavioral health clinicians, Congress could fund Section 6001 of the Support Act, or provide grants to independent behavioral health providers to cover licensing fees linked to accessing EHRs of neighboring health systems. CMS or SAMHSA should require EHRs to include common behavioral health terminology, and ONC could require that certified EHR technology include clinical decision support tools for behavioral health screenings.
- Improve mobile health apps (mHealth) effectiveness and interoperability. mHealth that enables access to or data sharing with EHRs should be recognized under the Promoting Interoperability (PI) category of the Quality Payment Program. ACOs, MA plans, Medicaid Managed Care Plans, and others providing integrated behavioral health care should be required to report on measures that capture mHealth and EHR interoperability. Moreover, Congress should require an independent third-party review of apps to ensure claims of effectiveness are legitimate. Apps should be evaluated in patient settings to define a minimum standard for claims of effectiveness and to aid in the development of clinical practice guidelines for use.

Current Law and Policy

The integration of mental health and addiction (commonly referred to as behavioral health) treatment with primary care is defined as an interdisciplinary team of providers, working together with patients and families to deliver a systematic and cost-effective approach to addressing behavioral health, and other behavioral issues that interfere with physical health or mental wellbeing.

Major legislation, such as the Mental Health Parity and Addiction Act, and the Affordable Care Act, have advanced mental health parity and coverage of mental health services, but have not

improved the integration of primary and behavioral health care. Our current system of care delivery, payment, workforce, and health information exchange enforces silos and does not support behavioral health integration. In 2018, CMS rolled out new CPT codes to cover behavioral health integration services based upon the evidence-based Collaborative Care Model. However, BPC stakeholder outreach indicates that the uptake by these codes by the primary care community has been low due in part to lack of reimbursement for start-up costs.

Momentum has been building among provider groups, such as the American Academy of Family Physicians, the American Medical Association, and the American Psychiatric Association; consumer groups such as the National Alliance for Mental Illness, National Coalition of Behavioral Health, and Mental Health America; and health plans represented by America's Health Insurance Plans and the Blue Cross Blue Shield Association, to advance integrated care. Policies that align across payment, workforce, and health information technology will be crucial to achieving that goal.

Recent Action

The response to COVID-19 has led to a dramatic increase in the authorization of and funding for telehealth options, including audio-only services. These changes have expanded access to behavioral health services; recent data show that behavioral health clinicians are utilizing telehealth services at higher rates than other specialties.

Beyond COVID-19, behavioral health care has not been a primary focus of House and Senate leaders, but many members of Congress have engaged on the issue and introduced legislation. These bills run the gambit, but there are some common themes: preventing suicide (particularly for veterans and children), expanding access to school-based services, treating SUDs, expanding workforce, enforcing parity laws, improving telehealth access, and reducing stigma. In this Congress, the Senate HELP Committee included parity provisions in The Lower Health Care Costs Act of 2019 (S. 1895) and the House Ways and Means Committee passed legislation to expand mental telehealth in Medicare (the Mental Health Telemedicine Expansion Act (H.R. 1301) as part of the BETTER Act (H.R. 3417). In addition to legislation, the House Mental Health Caucus, chaired by Reps. Napolitano (D-CA) and Katko (R-NY), does considerable work to educate other members and raise the profile of behavioral health policy.

Impact on Health Equity

A majority of patients seek help for mental health issues in the primary care setting, and this is true for children and adults from economically, racially and ethnically diverse communities. Integrated care has demonstrated improved quality of care and reduced costs, and also has the potential to reduce racial and ethnic disparities in mental health access and treatment. Importantly, the current make-up of the behavioral health workforce is predominantly white and could deter Black, Indigenous and people of color (BIPOC) populations from seeking care. Research shows that providers who are culturally and linguistically reflective of the communities they serve are more likely to meet the needs of those communities.

Challenges to Implementation & Cost

There is a renewed focus on mental health care given the effect that COVID-19 is having on existing mental health needs, along with a rise of anxiety and depression. Although integrated care has the potential to save money, it would still require upfront federal investment that would fully compensate for the start-up costs, health information technology, training, and technical assistance necessary for practice transformation. States, such as Washington, and

Colorado, have yielded cost savings from integrating care, but it is unclear how, and if, cost savings would be achieved with widespread implementation of integrated care.

Although behavioral health issues need to be addressed as part of the coronavirus response, Congress is currently more focused on time-sensitive issues such as economic relief and ensuring access to vaccines. This could limit the political will available to push for policies that advance behavioral health integration. Other challenges include reaching bipartisan support around the funding levels required to support integrated care and strengthening network adequacy standards to ensure there are behavioral health providers on insurance networks who are taking patients.

II. OPIOIDS

Recommendations

BPC recently released a report tracking FY2019 federal funding to combat the opioid crisis, and outlined recommendations based on federal analysis and state case studies. For more information see: "Tracking FY2019 Federal Funding to Combat the Opioid Crisis", Bipartisan Policy Center. September 2020.

1. Supporting sustainable funding and building the necessary infrastructure to reach at-risk populations
    - Increase SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG) funding for evidence-based programs. This block grant has been level funded at $1.85 billion since FY2016 and has not kept pace with inflation over the past decade, despite the startling increase in drug overdose deaths over this 10-year period.
    - Coordinate federal government harm reduction services. The enhanced coordination of harm reduction-related funding at the federal level would facilitate coordination at the state and local level and ensure services reach people most at-risk for overdoses. Congress should also remove the restrictions on purchasing syringes currently in federal appropriations language.
    - Evaluate programs and provide feedback. Since FY2017, the federal government has invested billions of dollars to curb the opioid epidemic. However, rates of annual overdose death are the sole public measure for the effectiveness of these expenditures. Given the size of this investment, publicly available evidence-based evaluations of each of the streams of federal opioid funding must be conducted. These evaluations should include information on whether the grant is going towards evidence-based interventions, and meeting the needs of at-risk populations as well as health equity goals.
2. Addressing overdose mortality of at-risk populations
    - Remove restrictive funding language. A recent BPC report found increasing rates of polysubstance use and overdose deaths across the country, as well as increasing rates of methamphetamine and cocaine availability and use. To the extent possible, federal grants should be revised to allow spending on substance use disorders generally, including emerging drug use trends such as methamphetamine and cocaine.
    - Reduce the treatment gap in diverse communities. Grant programs should focus on cultural competency to improve treatment access and retention. Evaluations of grant funds must address treatment gaps in communities of color.

- Coordinate criminal justice reform efforts. Reforms that seek to divert people away from arrest and incarceration, as well as efforts to expand access to medications for opioid use disorder in correctional settings and connect people to services upon reentry are critical. There should be greater coordination between the Justice Department's Bureau of Justice Assistance and SAMHSA to improve the efficacy of these programs and increase opportunities for funding coordination. In addition, efforts should be made to include housing first responses and increase HUD's focus on reentry and recovery supportive housing.

3. Removing legal barriers to treatment

   - Extend regulatory revisions made during COVID-19. The federal government should permanently extend the regulatory flexibilities that have expanded access to treatment via telemedicine. In addition, researchers should examine the effects that changes to other regulations (e.g., increased flexibility around take-home doses) have had on treatment retention and access. Upon completion, the federal government should immediately make permanent the most effective revisions and devise a plan for a comprehensive review of all restrictions on treatment access. The review and recommendations for change should include examining regulatory burdens on opioid treatment programs, or OTPs, and whether the regulatory revisions have made treatment more accessible to at-risk individuals and more equitable.
   - Remove the special licensing requirement (data waiver) for health care providers to prescribe buprenorphine. While removing the data waiver requirement requires legislative action, in the interim HHS has administrative discretion to lift the buprenorphine provider patient limit, thereby increasing access. These changes could expand the access to buprenorphine that is too often out of reach for many vulnerable populations, particularly communities of color.
   - Expand opioid treatment access through Medicaid. HHS should conduct a thorough review of all Medicaid practices that restrict access to treatment for people with substance use disorder, including people who are incarcerated but have not yet been sentenced. BPC also recommends states increase Medicaid coverage for 12 months post-partum and increase reimbursement rates to encourage additional providers to cover treatment services. In addition, the prior authorization for MOUD for opioid use disorder should be eliminated.

Current Law and Policy

Although overdose death rates decreased in 2018, preliminary data suggests that death rates climbed in 2019, and scattered reporting by states and counties suggests that this trend is continuing during the COVID-19 pandemic. In FY2019, total federal funding to address the opioid crisis was $7.6 billion. $5.3 billion of the funding was disbursed by the Department of Health and Human Services, with nearly two-thirds of that funding ($3.7 billion) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) primarily through State Targeted Response and State Opioid Response grants, while other grants went to agencies such as Indian Health Service, Centers for Disease Control and Prevention, and Heath Resources and Services Administration. These grants went towards expanding prevention initiatives, developing existing recovery activities, and bolstering community efforts to battle the crisis.

In 2019, the federal government implemented elements of The SUPPORT Act, legislation signed into law in October 2018. The SUPPORT Act included provisions to expand access under Medicaid, expand the list of providers who can prescribe buprenorphine, and provide funding for workforce development and programs established by the 2016 CARA Act.

Recent Action

The COVID-19 public health emergency prompted temporary revisions to SAMHSA, Centers for Medicare and Medicaid Services, and Drug Enforcement Agency regulations intended to minimize disruptions in substance use treatment. These changes included increasing access to telehealth and allowing take-home doses of methadone for people in early stages of treatment. In addition, Congress included funding in the Coronavirus Aid, Relief, and Economic Security (CARES) Act for SAMHSA and Federal Emergency Management Agency (FEMA) among others—to help states, territories and tribes tackle behavioral health conditions during the COVID-19 pandemic. This legislation also included a legislative change to align 42 CFR Part 2 regulations that govern confidentiality and sharing of SUD treatment data with the privacy rules of the Health Insurance and Portability Act (HIPAA) and initial patient consent.

In addition, the House Energy and Commerce Committee held a hearing in January 2020 on a number of bills aimed at addressing the opioid epidemic, but action on this issue has mostly stalled once legislative priorities shifted towards addressing COVID-19.

Impact on Health Equity

National data have shown increases in overdose death rates in the Black population, as well as in the Latino population, which are primarily driven by deaths involving synthetic opioids such as illicitly manufactured fentanyl. According to CDC, American Indian and Alaska Native groups highest rates for deaths involving stimulants such as methamphetamine and cocaine and had the highest rates of overdose deaths overall. Racial disparities in rates of overdose deaths can be indicative of stigma in communities of color, lack of access to culturally-responsive care, and underlying structural issues that can lead to income inequality or intergenerational drug use.

These alarming trends highlight the need for federal funding (e.g. SABG grants) that supports culturally-competent care and evaluates whether or not funding is evidence-based and reaching at-risk populations, including Black and Latino populations who are less likely to receive substance use disorder (SUD) treatment.

Challenges to Implementation & Cost

SAMHSA's substance abuse and treatment block grant will need to be funded at higher levels to contend with the rising drug overdose deaths in the last 10 years. Given the current legislative priorities to address COVID-19, it may be difficult to receive a higher level of federal funding for SABG.

Several states like Ohio and Washington have taken advantage of SOR supplemental awards that have been used to expand workforce capacity and workforce training for individuals impacted by opioid use disorder. However, additional funding for workforce and SUD treatment infrastructure is needed, and it may be difficult to agree on how much federal investment should go towards these programs given the federal investment and legislative action that has already taken place to address the opioids crisis, without a corresponding decline in overdose deaths.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Cost Containment and Program Integrity

December 18, 2020

The Bipartisan Policy Center's Future of Health Care Initiative offered several recommendations designed to improve the quality of health care delivery, lower costs, and introduce competition. Below are highlights of the recommendations. For a full explanation of recommendations and the rationale for changes, see: *Bipartisan Rx for America's Health Care* and *Confronting America's Rural Health Crisis*.

I. SYSTEM-WIDE HEALTH CARE COSTS

A. Hospital Consolidation

Lower system-wide health care costs across payers by promoting competition in non-competitive markets.

Recommendations

Legislation

- Permit hospitals in markets with a Herfindahl-Hirschman Index (HHI) score above 4,000 to enter into negotiations with the Federal Trade Commission (FTC) to bring the HHI score under 4,000, unless market consolidation was the result of a regulatory exception to the Department of Justice (DOJ) hospital merger guidelines.
- Direct the FTC to publish a list of markets with an HHI score of 4,000 or greater.
- Prohibit hospitals from using non-competitive contracting requirements, such as all-or-nothing requirements.
- Increase funding for FTC enforcement of hospital mergers and acquisitions.

Rationale

Market consolidation is increasingly common, in part because of federal payment policy that encourages more integrated care and incentivizes provider risk. However, studies demonstrate that hospital mergers can often lead to higher prices (Petris, 2018). In some concentrated markets, the purchase of specialty practices has resulted in a disincentive for providers to negotiate rates because they know that plans must contract with them in order to meet health insurance network adequacy requirements (Abelson, 2018). This lack of competition negatively affects health insurance premiums, particularly in non-group insurance markets.

B. Surprise Medical Bills

Protect consumers from unexpected out-of-network costs for services received at an in-network facility.

Recommendations

Legislation

- Require out-of-network providers to accept a benchmark payment that represents the insurer's median in-network rate, when provided to a consumer receiving services at an in-network facility.

Rationale

Despite widespread agreement on the need for patients to be protected from unexpected costs, Congress is divided over how reimbursement for these out-of-network payments should be settled. We support a policy that relies on private negotiations between insurers, physicians, and hospitals, backed by a limit on payments tied to a median rate, as recommended in the bipartisan proposal reported by the Senate HELP Committee. Arbitration is unnecessary in our view and risks increasing costs, which could drive up premiums for consumers. Further, arbitration benefits larger group practices that can afford to hire attorneys over small and independent physicians' practices (Kaiser, 2019).

C. All-Payer Claims Databases

Facilitate the use of all-payer claims databases (APCD) to improve transparency and uniformity in data collection and formatting.

Recommendations

Legislation

- Transition to a single APCD that builds upon those established by states and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Rationale

APCDs have been promoted as a tool for controlling health care costs by increasing transparency and helping inform decision-making. However, APCDs vary widely by state in terms of the standard data elements included, availability to researchers, price, and comprehensiveness. Further, the Supreme Court has held that the Employee Retirement Insurance Security Act (ERISA) precludes states from compelling employers to report data to APCDs. Development of a single database at the national level permits state access to data from plans that are exempt from state regulation under ERISA and provide a single data source for research.

D. Health Savings Accounts

Increase availability of health savings accounts (HSA) to engage beneficiaries in health spending.

Recommendations

Legislation

- Require insurers participating in the state and federal Marketplaces to establish and integrate beneficiary-owned HSAs for payment of deductibles and cost-sharing and require insurers to deposit any unused premium tax credits (above the cost of the premium) into an HSA owned by the enrollee.
- Require insurers to give enrollees the option of taking cost-sharing reduction (CSR) support in the form of a deposit to an HSA.
- Establish a state option under which states would be able to require insurers to establish HSAs, or similar tax-preferred accounts, into which the CSR payments would be

deposited on behalf of a qualified individual, rather than going to the insurer. The HSA could be used to pay out-of- pocket costs. If an individual has no out-of-pocket costs in that year, funds could be carried over and used for other health-related expenses.

- Allow HSA funds to be used to pay monthly fees for accessing direct primary care. States would not be allowed to consider these monthly fees as insurance premiums for purposes of state insurance regulation.
- Require the secretary of HHS to first test and then promulgate a system of posted and transparent pricing for standardized services that all HSA enrollees could pay when getting care. In developing pricing, the secretary would be required to:
    - Establish a list of services upon which selected providers would need to post a price (with age-adjustments) that all HSA enrollees would pay (as payment in full) for the service. The list of standardized services should include: monthly fees charged for a package of direct primary care services; high-volume procedures; other services that lend themselves to a bundled price for standardized care.
    - Require providers and organizations to post prices on the established list, including potentially all Medicare-participating providers. Accountable care organizations (ACO) and large systems would be required to post prices for all of the services; other providers, such as individual physician offices, would be required to post prices relevant to their practice.

Rationale

Proponents argue that HSAs encourage beneficiaries to be more engaged in and cost-conscious in making health care decisions. As insurance costs rise, one-way insurers and employers are keeping premiums down is by increasing enrollee out-of-pocket costs, often in the form of high deductibles. As high deductibles become more commonplace, many policymakers are seeking to improve the availability and usefulness of tax-preferred savings accounts from which individuals may make withdrawals to cover out-of-pocket expenses.

E. Prescription Drugs

Increase generic drug availability by preventing brand pharmaceutical manufacturers from engaging in anti-competitive practices and determine the value of government funding in the costs of new drugs brought to market.

Recommendations

Legislation

- Urge Congress to pass legislation that prohibits brand name drug and biologic manufacturers from compensating generic and biosimilar manufacturers to delay market entry of a generic drug or biosimilar.
- Closely monitor the implementation of the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2019, which increases access to brand drug samples needed for generic development.
- Quantify the government's contribution toward the intellectual property of the patent holder in terms of total market value. Congress should require the secretary of HHS to convene an expert panel to quantify the value of government-financed research (i.e.,

National Institutes of Health) provided during a drug's development relative to the overall market value of the patent and exclusivity provided to the drug manufacturer and have such quantified values verified by a neutral third-party.

Rationale

Generic competition is often delayed through anti-competitive behavior, leading to higher cost prescriptions (Vokinger et al, 2017). Brand companies limit access by offering patent settlements that pay generic companies to delay the launch of lower-cost alternatives in the market, refusing to sell drug samples to generic companies for testing, and exploiting rules requiring agreement with generic manufacturers for shared Risk Evaluation and Mitigation Strategies (REMS).

The government makes financial contributions to drug research and development. However, the value of those investments is not regularly quantified or considered in the federal government's costs to buy those drugs once available. Understanding the value of federal research would provide additional information to policymakers as they seek to address the costs of development relative to prices charged.

II. MEDICARE

The BPC's Future of Health Care Initiative offered several recommendations designed to improve quality and choice, and lower Medicare costs. Below are highlights of the recommendations. For a full explanation of recommendations and the rationale for changes, see: *Bipartisan Rx for America's Health Care* and *Confronting America's Rural Health Crisis*.

A. Post-Acute Care

Correct overpayment of post-acute care in certain settings.

Recommendations

Legislation

- Develop and implement a unified post-acute care (PAC) payment system that reimburses providers based on patient characteristics, rather than site of service.

Rationale

Post-acute care payments for skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH) incentivize the selection of lower-acuity patients, who are less likely to need high-cost services and Part B drugs. According to the, Medicare Payment Advisory Commission (MedPAC, 2019), patient selection has provided SNFs, HHAs, and IRFs with Medicare margins greater than 10%, on average, for most of the last 10 years. In contrast, hospitals were likely to operate at a -9.9% Medicare margin in 2019.

B. Prescription Drugs

Improve incentives for competition, reduce beneficiary out-of-pocket (OOP) costs, and reduce federal liability for increasing drug costs.

Recommendations

i. Part D

Legislation

- Authorize the secretary of HHS to modify cost-sharing for Low-Income Subsidy beneficiaries who select clinically appropriate generic and low-cost brand drugs.
- Require all Medicare Part D plans to offer an option that bases beneficiary cost-sharing on actual cost, net of manufacturer rebates.
- Reform the Medicare Part D Drug Rebate Structure by decreasing federal reinsurance payments to 20% of costs from current law 80%.
- Increase Medicare direct subsidies and decrease individual reinsurance subsidies above the catastrophic out-of-pocket (OOP) threshold.
- Prohibit Medicare Part D plans from including brand name pharmaceutical manufacturer rebates provided in the Part D coverage gap (i.e. the "donut hole") when calculating the catastrophic OOP threshold
- Create an OOP cap by eliminating the 5% beneficiary coinsurance over the catastrophic threshold.

ii. Part B

Legislation

- Replace the Average Sales Price (ASP) add-on percentage payment for Part B drugs with a flat rate add-on amount for each therapeutic class.
- Lower the wholesale acquisition cost (WAC) add-on payment to 3% for single-source drugs, biologics, and biosimilars.
- Direct the secretary of HHS to establish a voluntary Drug Value Program (DVP) through which private vendors negotiate prices for Part B products.

Regulation

- Require all drug manufacturers to submit ASP data to CMS for use in Medicare.
- Establish significant penalties for failure to report ASP data.
- Require manufacturers to pay a rebate to Medicare or adjust beneficiary cost-sharing amounts when price increases exceed an inflation benchmark, such as the CPI-U
- Use a common billing code to pay for a reference biologic and its biosimilars.

Rationale

Pharmacy benefit managers (PBM), Part D plans, and manufacturers do not bear sufficient accountability for drug spending under the current Part D rebate structure. Manufacturer discounts to PBMs and plans support the use of high-cost drugs to propel beneficiaries into the catastrophic phase, at which point Medicare assumes 80% of costs (MedPAC, 2016). Moreover, price reductions do not directly lower beneficiary OOP costs at the point of service (Antos and Capretta, 2019).

Part B drugs are also reimbursed in a manner that rewards the utilization of higher-cost drugs (MedPAC, 2019). Providers receive an add-on payment, based on ASP or WAC, which does removes incentives to use lower-cost generic drugs, preferred multisource drugs, and biosimilars. Until ASP data is available, physician reimbursement for Part B drugs is based on the WAC. Because the WAC is generally higher than ASP, there is an incentive for manufacturers to delay ASP reporting.

The DVP would introduce price negotiation for Medicare Part B drugs and offer an alternative to the current ASP add-on payments. It would provide opportunities for sharing savings among DVP vendors, providers, the Medicare program, and Medicare beneficiaries, in the form of reduced cost-sharing.

C. Value-based Payment

Accelerate the move from volume-based to value-based care.

Recommendations

Legislation

- Exempt chronic care management services from beneficiary cost-sharing requirements.
- Extend bonus payments for new advanced APM participants in the Quality Payment Program.

Regulation

- Require all Accountable Care Organizations (ACO) to bear down-side risk and expand the use of patient engagement tools, including financial incentives for seeking in-network services.
- Establish a two-tiered, risk-based monthly payment for providing a standard set primary care services and allow reduced copayments for beneficiaries who self-align with a primary care provider.
- Increase rural health, maternal health, and behavioral health integration CMMI demonstrations and expedite national expansion of promising models.

Rationale

Evidence has shown a reduction in costs when providers bear financial responsibility for overspending (Avalere, 2019). Many providers cite administrative burden and upfront implementation costs for their unwillingness to participate in newer payment models. Others feel unable to influence the behavior and spending patterns of other providers or patients, despite transforming their own practice patterns. Cost-sharing for high-value, non-face-to-face services and an inability to target incentives limit patient engagement efforts. The Medicare program should increase opportunities for transitioning to value-based payment models.

D. Medicare Enrollment

Streamline Medicare enrollment to enable greater comparison and choice.

Recommendations

Legislation

- Develop a uniform annual enrollment pathway to facilitate comparison of coverage options and total cost-sharing estimates for traditional Medicare fee-for-service (FFS), Medicare Advantage (MA) plans, alternative payment models (APM), Part D prescription drug plans, and supplemental benefit (Medigap) plans.

Rationale

Medicare.gov provides a process for enrolling in MA plans and provides options on Medicare Supplemental Insurance. However, enrollment periods for Medicare FFS and MA prevent a comparison of options. Beneficiaries are not currently provided a simple process that allows them to fully understand all options available to them, including premiums, copays, beneficiary incentives, and enrollment-based ACOs. Beneficiaries should also have a transparent process that provides incentives to select higher-value care within two-sided risk models.

E. Medicare HI Trust Fund

Take action to increase public accountability and oversight over Medicare and Social Security trust funds and ensure long-term sustainability to avoid the need for ad-hoc, short-term fixes. When facing insolvency in the Social Security Trust Fund in 1986, Congress passed bipartisan legislation to address the insolvency.

Recommendations

Nominations

- Fill the two vacancies for Public Trustees on the Board of Trustees of the Social Security and Medicare trust funds to ensure public confidence in both programs.

Legislation

- Propose legislation to address the long-term insolvency issue in the Hospital Insurance Trust Fund and the increasing dependence of the Supplemental Medical Insurance Fund on general revenues. The legislation should contain a blend of policies, including changes in provider payments, revenues, and beneficiary incentives. These policies should reduce cost growth, preserve current and future benefits, and reflect the impact of COVID-19 on employers, employees, health care providers and health insurance carriers.

Rationale

The Social Security Act established the Medicare Board of Trustees to oversee the financial operations of the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trust Funds. The Board consists of four federal government officials, including the Secretaries of Treasury, Labor, Health and Human Services and the Commissioner of Social Security. The board also includes two additional members of the public nominated by the president and confirmed by the Senate. The two non-government trustees have not been confirmed since 2015. More than 100 former lawmakers, administration officials, and experts spanning the political spectrum, including BPC leadership and fellows, signed a letter urging the administration and Senate to do so.

According to the trustees' April 2020 report, in 2019, HI expenditures exceeded income by $5.8 billion. The trustees projected deficits in all future years until the trust fund becomes depleted in 2026, unless Congress takes action to increase revenues or reduce outlays. For the purposes of calculating HI Trust Fund revenue, payroll taxes are attributed to the Hospital Insurance (HI), or Medicare Part A trust fund. Expenditures under Part A include inpatient hospital, skilled nursing, hospice and certain home health services.

While 2020 numbers are not yet available, increased unemployment will result lower-than-expected HI Trust Fund revenue. In addition, the CARES Act authorized and CMS provided $106 billion in advance payments to Medicare providers and suppliers to alleviate the financial burden

on providers in the early days of the pandemic. Those advances must be repaid, so should not have an impact on the HI Trust Fund. CMS also increased inpatient reimbursement or COVID-19 patients by 20% for the duration of the public health emergency, a change that CBO estimates will increase Medicare spending by $3 billion. The increased payments to Medicare will have an impact on trust fund solvency. The Congressional Budget Office, working from a different methodology, published a 10-year budget outlook in September of 2020 factoring in COVID19's economic disruption that projects the HI Trust Fund will be depleted in 2024, two years earlier than the trustees' projections, with deficits every year until 2030.

If the HI Trust Fund is exhausted, Medicare payments will be reduced by nearly 17 percent. The Social Security Act does not address actions to be taken if the trust fund becomes insolvent but it is estimated that expected benefits would be reduced by up to 20 percent if reserves are depleted.

III. MEDICAID

A. Prescription Drugs

Lower Medicaid spending on prescription drugs, while continuing to provide necessary treatments to beneficiaries.

Recommendations

Legislation

- Seek legislation permitting states to use the same tools available to private and Medicare part D plans to limit coverage of drugs for which there is inadequate evidence of clinical effectiveness. In developing standards, which would apply to both Medicaid fee-for-service and managed care, the secretary should:
    - Develop guidelines under which a drug would be considered to have limited or inadequate evidence of clinical effectiveness.
    - Enable states that choose to exclude drugs under this standard to continue to be eligible for rebates for drugs that are covered under the state program.
    - Guarantee that Medicaid beneficiaries are afforded the same protections guaranteed to enrollees in Medicare part D, Section 1860D-4(3)(B-G) of the Social Security Act, establishing requirements for formularies, inclusion of drugs in all therapeutic categories and classes, provider and patient education, notice before removal of a drug from a formulary, periodic evaluation of protocols, and required inclusion of drugs in certain categories and classes.
    - Prohibit states from making coverage decisions on the basis of diagnosis or disability.
    - Require pharmaceutical manufacturers to provide the Average Manufacturer Price and "best price" to state Medicaid directors 90 days prior to the launch of new medicinal therapies, so that states may initiate any state administrative processes for covering new drugs prior to the launch of the drug.

Rationale

Federal law requires drug manufacturers to enter into a rebate agreement with the secretary of HHS, in order for states to receive federal Medicaid funding for the manufacturers' drugs

(MACPAC, 2018). Under the federal Medicaid Drug Rebate Program, states offering Medicaid prescription drug coverage must cover almost all FDA-approved prescription drugs in exchange for the drug rebates. States may, however, exclude coverage for off-label use, utilize prior authorization and preferred drug lists, or limit the number of prescriptions provided each month. Rebates under the Medicaid Drug Rebate Program are shared between states and the federal government based on federal medical assistance percentages (FMAP); rebate formulas differ for brand-name and generic drugs. Most states also negotiate supplemental rebates from drug manufacturers in exchange for placing certain products on the state's preferred drug list, which typically include a list of drugs that do not require prior authorization (MACPAC, 2018).

B. Supplemental Payments

Improve fiscal integrity related to Medicaid supplemental payments through greater transparency and reporting requirements.

Recommendations

Legislation

- Require state reporting of upper payment limit (UPL) supplemental payments.
- Review distribution of UPL supplemental payments and submit recommendations to Congress on ways to phase out these payments over five years, while incentivizing states to increase the base rate providers are paid for serving Medicaid patients.

Rationale

Many states make payments to providers to supplement low FFS base payment rates. Supplemental payments are typically made as a lump-sum payment, filling in the gap between the Medicaid base payment rate and what Medicare would pay for a comparable service delivered by a particular class of facilities (MACPAC, 2014). Like all Medicaid payments, states and the federal government share the cost of the payments, which are subject to an upper payment limit (UPL). UPL payments have been subject to scrutiny because they lack transparency and increase in the federal share of Medicaid spending (MACPAC, 2017). In light of these criticisms, CMS has proposed changes to constrain the financing mechanisms that support these payments, an approach that can have broader implications for state finances and access to care. Reforms related to UPL supplemental payments need to be coupled with initiatives that do not unduly constrain a state's ability to finance the Medicaid program and that ensure access to care for Medicaid beneficiaries.

C. Quality and Fiscal Responsibility

Improve quality outcomes and ensure fiscal responsibility in the Medicaid program.

Recommendations

Legislation

- Direct the secretary of HHS to work with states to establish a set of core outcomes measures and establish shared savings initiatives to further improve Medicaid program outcomes.
- Direct the secretary to define the guardrail in section 1115A that requires federal deficit neutrality to permit the requirement to be applied across programs waived when combined with a section 1115 waiver (i.e., tax credits and Medicaid), provided waivers

assure full and affordable coverage for lower-income individuals before providing assistance to those with higher incomes.

- Codify budget neutrality as a requirement of 1115 Medicaid waivers for states and also the inclusion of certain cross-program effects, including the waiver's budgetary effects on other federal mandatory programs. For example, if a Medicaid 1115 waiver results in Medicare savings or costs, those savings or costs would be considered in the budget neutrality calculation as part of the waiver application process.

Rationale

In recent years, states have moved to improve Medicaid payment and delivery to focus more directly on outcomes. Although there has been some recent progress identifying a core set of measures for children and adults, more are needed. Disability and aging advocates support revising outcomes measures to better incentivize a non-medical, person-centered framework for home and community-based services (DREDF and NSCLC, 2013). Critical to the success of this outcomes- based effort, is the commitment of financial resources to help policymakers better understand how state and federal dollars are invested to improve outcomes. CMS and the states—in collaboration with health providers, beneficiary groups, and quality experts—should establish a set of core outcomes measures for use across federal programs, providing a standard for private insurers. CMS should be required to invest new federal dollars into a robust data reporting and outcomes measurement initiative and establish shared savings initiatives with states.

Under Section 1115 of the Social Security Act, states may request waivers allowing the use of federal funding for "experimental, pilot, or demonstration" projects that the secretary of HHS determines are "likely to assist in promoting the objectives of" the Medicaid program. Although not in statute, longstanding federal policy requires Section 1115 waivers to be budget neutral for the federal government (CMS, 2018). However, budget neutrality calculations do not account for potential costs or savings related to other federal programs.

Section 1115A of the Social Security Act (Section 1332 of the ACA) gives states the opportunity to redesign health care delivery by permitting states to request waivers of certain provisions of law related to the structure of their health insurance markets. These waivers must adhere to four constraints, or guardrails, required by federal law. States must demonstrate that the waiver will:

- Provide coverage that is at least as comprehensive as would be provided absent the waiver.
- Provide coverage that is at least as affordable as would be provided absent the waiver.
- Provide coverage to at least a comparable number of residents of the state as would be provided coverage absent a waiver.
- Not increase the federal deficit.

Similar to Section 1115 waivers, the secretary of HHS and the secretary of the Treasury are prohibited from approving 1115A waivers that increase the federal deficit. Under current federal guidance, when Section 1115 and 1115A waivers are submitted as part of a coordinated waiver application, savings accrued under one waiver are not factored into the assessment of deficit neutrality under the other waiver. By failing to take into account potential combined savings, states have less flexibility in designing coverage, and the full fiscal impact of the proposed

waivers are not being considered.88 In considering these combined waivers, the secretary must assure that priority in coverage is given to lower-income populations.

Current Law and Policy

A full explanations of policy recommendations and the rationale for those changes can be found at *Bipartisan Rx for America's Health Care* and *Confronting America's Rural Health Crisis*.

Impact on Health Equity

According to the US Census, 8% of Americans did not have health insurance in 2019. While whites were near the mean at 7.8%, 16.7% of Latinos and 9.4% of Blacks were uninsured. In addition, HHS' Office of Minority Health reported almost 15% of Native Americans were uninsured in 2017. Blacks are also less likely to have supplemental insurance coverage (Brundt 2017). Although federal health insurance provides access to care for children, the elderly, low-income individuals, and those with disabilities, persistent health inequities warrant further scrutiny and highlight the need for quality reporting by race, ethnicity, and language.

According to the Kaiser Family Foundation, half of American adults say they or a family member delayed or neglected to seek care over the last year because of costs. Providers have also raised cost-sharing as a significant barrier to high-value chronic care management services (Mathematica, 2017). In addition, most value-based care models utilize technology to increase patient engagement and provide information for continuity of care. However, older people, persons of color, and those of lower socioeconomic status disproportionately lack access to technological devices, digital literacy, or reliable internet coverage (Yoon, et al 2018). When compared to younger and white patients, older and Black patients are much less likely to be digitally literate (USDOE, 2018). Approximately one quarter of Blacks, Latinos, and Native Americans do not have traditional high-speed internet access (FCC 2020). These findings highlight the ongoing need for audio-only telehealth services, which are not traditionally reimbursed under Medicare.

Challenges to Implementation & Cost

The most significant challenges to the implementation of this section will be opposition from provider organizations and manufacturers who will be financially impacted by these policies. Many of these recommendations will reduce Medicare spending. The COVID-19 pandemic has created additional challenges for adoption, in terms of shortages of medical professionals, supplies, equipment and capacity to serve high volume of patients. Once a vaccine has been widely distributed and the high volume of COVID-19 patients has abated, admissions for elective care will start returning to previous numbers and help improve providers' financial position.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Housing and Urban Development
December 18, 2020

I. PANDEMIC-RELATED HOUSING PRIORITIES

BPC released a report in September 2020 outlining first-order priorities for the administration and Congress to quickly and cooperatively address housing needs resulting from the pandemic.

Recommendations

Executive Action

- Extend and augment regulatory flexibilities and waivers to reduce administrative burdens on HUD grantees, including public housing authorities and mission-driven service providers.
- Coordinate with HHS to develop and execute a testing, surveillance, and vaccination strategy for residents in federally assisted, congregate housing.

Legislation

- Secure $15 billion, at minimum, in funding for a federal emergency rental assistance program to prevent a wave of devastating evictions. According to the latest estimates, nearly 12 million renter households will owe almost $6,000, on average, in unpaid rent, utility bills, and late fees by January. Extended emergency unemployment insurance benefits and another round of direct payments would further ensure there are fewer gaps in assistance or prevent evictions. While strengthening and extending the CDC's nationwide ban on evictions would temporarily help to keep families housed, small landlords in particular will come under increasing strain from rent nonpayment if struggling residents do not receive emergency rental assistance, supplementary unemployment benefits, or another direct payment.
- Request at least $3 billion in funding to cover emergency pandemic-related needs in federally assisted, congregate housing and address COVID-19 detection.
- Request at least $11.5 billion in funding to meet the housing needs of those experiencing homelessness.
- Prioritize additional funding for USDA and tribal housing assistance alongside key HUD programs. This could be coupled with bipartisan legislation—such as H.R. 4029/S. 2282—to improve tribal access to HUD assistance programs.

Current Law and Policy

Once the health and financial ramifications of COVID-19 became clear, and to their credit, the administration, Congress, federal agencies, states, and local governments stepped up to keep mortgage credit flowing, help renters and homeowners stay housed, and assist those experiencing homelessness. However, the sheer breadth of these actions—from temporary regulatory waivers to overlapping legislative, administrative, and multijurisdictional eviction

moratoria—has unintentionally left the public confused about the resources available and the scope of protections. Policy disagreements remain over the need for additional household financial and rental assistance and stronger eviction/foreclosure prevention measures as initial actions expire and resources dwindle.

Recent Action

In H.R. 6800, the "HEROES Act," House Democrats proposed new spending on a wide range of priorities—including direct assistance to individuals, state and local government aid, and supplemental HUD funding—and added protections and resources for renters facing eviction and homeowners facing foreclosure. The HEALS Act—a series of COVID-19 response and relief bills packaged and proposed by Senate Republicans (S. 2733, S. 4317, S. 4318, S. 4319, S. 4320, S. 4321, S. 4322, and S. 4324)—similarly included an additional round of direct payments to households but comparatively modest supplemental HUD funding. A bipartisan, bicameral group of congressional leaders more recently proposed $25 billion in rental housing assistance in a COVID-19 relief framework intended to spark renewed negotiation and move a package forward. While work is ongoing to bridge the divide between House Democrats, Senate Republicans, and the administration on relief priorities, lost jobs and crucial household wages will leave many households unable to pay their rents, mortgages, and other bills in the coming months and beyond. Absent a sustained federal intervention, these families will likely stay precariously housed or could be evicted and become homeless, a devastating and potentially deadly outcome for these families during a pandemic.

Impact on Health Equity

While nearly all communities nationwide have experienced economic hardships as a result of the pandemic, minority households have disproportionately borne the brunt of the impact. Black and Hispanic households have experienced higher job losses and pay-cuts, have been more likely to tap into emergency savings, and have been more likely to miss household payments—including mortgage, credit card, utility, or rent payments—in response to COVID-19. These disproportionate impacts are critically important considering that people of color already faced disproportionately high housing cost burdens, housing insecurity, eviction, and poverty.

Housing modalities and conditions also have a direct relationship with disproportionate COVID-19 transmission. People of color are more likely to live in housing situations, such as multigenerational family units, overcrowded housing, or federally assisted housing, that, when coupled with a lack of health care insurance or limited provider access, make it difficult to socially distance, self-isolate, and prevent transmission. Blacks, Latinos, and other people of color are also more likely to be homeless, which makes it more likely that they are forced into circumstances that would increase susceptibility to COVID-19, circumstances in which it is more difficult to follow CDC-recommended preventative measures.

Challenges to Implementation & Cost

While the executive actions recommended would come at relatively low cost, those associated with the outlined legislative recommendations are significant and a key obstacle to congressional action. See estimates in the table below.

Policy Recommendation	**Estimated Cost**
Extension of UI benefits (with a weekly federal supplement equivalent to $400 per worker) and another round of direct payments	$400-500 billion
Emergency rental assistance to prevent eviction	$15+ billion

Emergency homeless assistance grants	$11.5 billion
Emergency funding for public housing authorities and other federally assisted housing providers	$3 billion
Additional USDA and tribal assistance	$300 million

For additional detail, see BPC's report, "Providing Stable, Healthy, and Affordable Rental Housing Through the COVID-19 Crisis."

Should Congress overcome these differences and deliver on these key recommendations, overarching implementation challenges will include quickly and equitably disbursing funds to meet the most urgent needs and helping capacity- and resource-strained state, local, territorial, and tribal governments navigate new funding streams without adding to administrative burdens. In our view, the combination of emergency rental assistance, another round of direct payments, and extended UI benefits, with a compromise federal weekly benefit supplement, offers the greatest likelihood that assistance reaches families that need it the most with the greatest relative speed and effectiveness.

II. CONNECT HEALTH AND HOUSING

BPC has worked extensively to highlight housing as a platform for other services, particularly health care, and the potential of cross-sector partnerships, including a 2015 report from BPC's Senior Health and Housing Task Force, a report connecting LIHTC and health, and an extensive review of partnerships opportunities between HUD and HHS.

Recommendations

A. Promoting Healthy Aging at Home

1. Executive Action

- Make ending homelessness among older adults a national priority by directing the U.S. Interagency Council on Homelessness to explicitly adopt a goal to prevent and end homelessness among older adults, requiring the collection of more granular age and demographic data on people experiencing homelessness, and launching and evaluating new interventions focused on older adults.
- Review and update Consolidated Plan requirements to more explicitly assess health and housing needs, including the availability of age-friendly housing and community services.
- Work with CMS to launch a large-scale demonstration program that coordinates health care and long-term services and supports for Medicare beneficiaries living in federally assisted housing (e.g., Section 202, LIHTC, USDA's Section 515, and other congregate housing sites where older adults predominate) to test the potential of improving health outcomes and reduce health care utilization and associated costs.
- Coordinate closely with HHS to ensure Medicare and other federal programs and policies support the prevention of older adults falls.
- Support Medicaid's Innovation Accelerator program in its efforts to bring together state Medicaid and housing agencies to identify affordable housing options for beneficiaries ready to be transitioned from institutionalized settings.

2. Legislation

- Work closely with members of the Senate Aging Committee to enact the bipartisan policy recommendations they outlined for reducing the risk of older adults.
- Create and fund a new program for senior-supportive housing that uses project-based rental assistance and Low-Income Housing Tax Credits to support new construction and attract funding for services from health care programs.
- Provide dedicated funding for service coordinators in HUD-assisted housing, while piloting and evaluating effective service coordination models.

B. Fostering HUD-HHS Partnerships

1. Executive Action

- Commit to regularly occurring meetings between the HUD and HHS secretaries to prioritize ongoing departmental collaboration and align programmatic and policy goals.
- Designate departmental liaisons at HUD and HHS, supplied with adequate staff and resources, to advance interdepartmental health and housing collaborations.
- Setup a joint planning and development office between HUD and HHS to provide a high-level and systematic platform for the articulation, budgeting, and organization of health and housing initiatives.
- Better align and connect local housing data with state Medicaid data to enable data-driven decision-making and target at-risk populations with available services, while continuing other HUD-HHS data matching efforts.
- Jointly pilot, evaluate, and support recovery housing interventions with HHS in communities with high rates of opioid use disorder, while working to promote innovative state initiatives and strategies identified by HHS in accordance with Section 1017 of the SUPPORT Act.
- Study the feasibility of a pilot program with HHS in which patients with severe mental illness at federally qualified health centers are screened for housing insecurity and prioritized for housing vouchers, consistent with federal fair housing requirements.
- Work with CDC to improve surveillance of housing conditions across all 50 states to better target geographic areas and types of housing with high lead home contamination and elevated blood lead levels.
- Launch a public-private partnership to replace lead-contaminated windows in pre-1940 housing, blending and leveraging funding streams from HUD, HHS, other federal departments, and the private sector.
- Task HUD's Office of Lead Hazard Control and Healthy Homes with improving coordination with CDC and CMS on the surveillance of asthma exacerbation "hot spots" and targeted remediation of homes to reduce environmental triggers.
- Coordinate healthy home grant funding with local public health and state Medicaid program efforts to reduce asthma and related environmental triggers.

- Preemptively standardize data and sign MOUs to enable HUD, HHS, and FEMA to share data during emergencies and natural disasters, increase preparedness and mutual understanding, shorten disaster response times, and limit administrative burdens on state, local, tribal, and territorial grantees.
- Relaunch HUD's ConnectHome initiative to expand broadband access to households living in HUD-assisted housing.

Current Law and Policy

There are many ongoing and productive partnerships at the nexus of health and housing. Generally, these collaborations—particularly between HUD and HHS—help the departments break down their siloed decision-making, more fully capitalize on their respective expertise, maximize limited funding, and more efficiently and impactfully fulfill both their missions. Yet this work is far from finished. The pandemic has elevated the importance of safe, stable, healthy, affordable housing, making continued and close collaboration between the two departments during the Biden administration more important than ever. In particular, the new HUD team will inherit two recent efforts that should be improved and expanded:

EnVision Center Demonstration: In 2017, Secretary Ben Carson introduced the EnVision Center Demonstration, a government-sponsored one-stop shop that offers social services for low-income residents. The purpose of the initiative is to encourage public-private partnerships to increase self-sufficiency in hopes of those being served to become homeowners or renters in the private market so HUD programs can be directed to help other low-income residents. Currently, 17 pilot centers across the country have been set up since the 2017 June rollout.

Supportive Services Demonstration. HUD launched the Supportive Services Demonstration/Integrated Wellness in Supportive Housing (IWISH) to test a housing plus services model that features an onsite team consisting of a wellness nurse and a wellness director who serves as an enhanced service coordinator. The demonstration will document participants' health care utilization and costs. Initial findings were first released in November 2020. BPC's Senior Health and Housing Task Force previously called for a larger initiative, funded through the health care system, to demonstrate how such an approach helps to prevent or delay health and functional declines in older adults and results in savings to public health insurance programs.

Impact on Health Equity

Expenditures to improve access to safe, affordable housing can materially improve population health. Studies have clearly demonstrated the positive health effects of many housing-based interventions, including those, for example, that improve insulation and energy efficiency, modify homes to reduce older adult falls, reduce mold and dampness, eliminate pest infestations, and abate lead.

Challenges to Implementation & Cost

Though addressing the lack of affordable housing supply is the most pressing challenge at the nexus of health and housing, partnership opportunities between health and housing policymakers and practitioners are more important than ever. The upside of a more integrated approach to health and housing is significant: by more tightly linking the two, policymakers can work to improve health outcomes and quality of life for vulnerable Americans, while more efficiently allocating limited federal resources. Yet in any administration, given limited resources, limited time, and a host of pressing challenges, only certain priorities can rise to the

top. In particular, we have found that successful health-housing collaborations require broad buy-in from participating agencies and programs as well as high-level engagement, support, and direction from HUD's political leadership. Blending funding streams across federal departments, along with private sources, continues to be a challenge despite the potential benefits of more integrated models and interventions.

III. A BIPARTISAN AGENDA ON AFFORDABLE RENTAL HOUSING

BPC's Housing Commission in 2013, Senior Health and Housing Task Force in 2015, and discrete efforts since have sought to build consensus and outline bipartisan affordable rental housing policies. Five overarching principles are foundational to this work:

- A healthy, stable housing market is essential for a strong economy and competitive America.
- The nation's housing finance system should promote the uninterrupted availability of affordable housing credit and investment capital while protecting American taxpayers.
- The United States should reaffirm a commitment to a providing a decent home and a suitable living environment for every American family.
- The primary focus of federal housing policy should be to help those most in need.
- Federal policy should strike an appropriate balance between homeownership and rental subsidies.

Recommendations

Executive Action

- Empower the White House Council on Eliminating Regulatory Barriers to Affordable, established by Executive Order 13878. Direct it further review recommendations on regulatory barriers to affordable housing development; more meaningfully engage the public, advocates, and congressional leaders; and work to educate and assist local governments and communities in removing prohibitive land-use restrictions and regulatory barriers.
- Assess and outline opportunities to overhaul the incentives structure for HUD rental assistance program to better align funding with desired outcomes, including rewards for high-performing housing providers and opportunities for competition-based funding.
- Continue to experiment and evaluate the effectiveness of using Small Area Fair Market Rents, mobility counseling services, landlord participation programs, housing voucher portability, and other innovative ideas to disrupt entrenched segregation and concentrated poverty and help low-income families move to higher-opportunity neighborhoods.

Legislation

- Make federal rental assistance available to all eligible households with incomes at or below 30 percent of area median income who apply through a reformed housing voucher program.
- Increase annual Low Income Housing Tax Credit allocations by 50 percent and provide $2 billion in gap funding for LIHTC developments.

- Overhaul the public housing system and address the capital backlog and ongoing accrual needs, including through the careful expansion of the Rental Assistance Demonstration program.
- Reward states and local communities for removing barriers to the development of rental housing, particularly in high-opportunity neighborhoods.
- Create a permanent federal short-term emergency rental assistance program to help families with financial shocks and prevent evictions.

Current Law and Policy

Low Income Housing Tax Credit. The Tax Cuts and Jobs Act, passed in 2017, had the unintended consequence of devaluing LIHTC by, among other provisions, lowering the corporate income tax rate from 35 percent to 21 percent, thereby weakening the tax relief that the credit offered. Notably, Congress expanded LIHTC in the omnibus appropriations bill for Fiscal Year 2018, providing a 12.5 percent increase in LIHTC allocations, starting in 2018 and lasting until 2021. While this increased support will boost affordable rental housing production and preservation, it will not fully offset the tax reforms that diminished LIHTC's value. Importantly, H.R. 3077/S. 1703 would increase the amount of tax credits allocated to each state by 50 percent over current levels (as recommended by BPC) along with other policy changes like reforms to stabilize the value of the 4% LIHTC and expand the "recycling" of multifamily housing bonds.

Emergency Rental Assistance. Senators Michael Bennet (D-CO) and Rob Portman (R-OH) recently introduced S. 3030, the "Eviction Crisis Act." The bill would establish a competitive grant program to bolster emergency assistance programs as well as evaluate how different interventions work in providing timely assistance to those who need it the most and have no other options. The HEROES Act and a host of other coronavirus relief proposals have similarly called for new funding for emergency rental assistance given the growing number of American families experiencing housing insecurity as a result of the pandemic and its economic impact.

Landlord voucher program participation. HUD officials held a series of listening forums in late 2018 with landlords across the country to hear suggestions for improving voucher program participation. They also convened a task force to make recommendations based on information gleaned in these sessions, with plans to report their findings.

Small Area Fair Market Rents. HUD previously studied the impact of switching to SAFMRs in a demonstration program with seven public housing authorities. The Trump administration suspended the Small Area Fair Market Rents rule, though their efforts were subsequently overturned in court, and has not pushed to more regularly require their use.

Mobility voucher expansion. In 2017, BPC laid out the possible parameters of a consensus plan on affordable rental housing that included support for mobility housing vouchers coupled with counseling. That idea gained traction with the introduction of H.R. 5793/S. 2945, the "Housing Choice Voucher Mobility Demonstration Act" in 2018, which proposed a limited demonstration program. A limited pilot eventually came to fruition with the bipartisan budget deal for FY 2020, which included $25 million for a mobility housing voucher demonstration. Most recently, Sens. Todd Young (R-IN) and Van Hollen (D-MD) introduced S. 3083, the "Family Stability and Opportunity Vouchers Act," to create 500,000 new Housing Choice Vouchers over 5 years for families with young children experiencing homelessness or housing instability.

Rental Assistance Demonstration Program. Established in 2011, HUD's RAD program was established to incentivize public-private partnerships and facilitate access to private sources of capital by public housing authorities to support the revitalization and modernization of public housing. The initial number of rental units allowed to participate in the program was capped at 60,000, but soon, demand exceeded this number. As the first wave of conversions demonstrated overwhelming success at leveraging private sector resources, the cap was lifted to 185,000 and then to 225,000. In 2018, the RAD cap was lifted for a third time, to 455,000 units, effectively eliminating the existing waitlist. Overall, the program has received widespread bipartisan support in Congress because it funds necessary renovations and is nearly budget neutral. Each time HUD has asked to lift the cap, Congress has voted to do so. in 2017, BPC released a paper noting that RAD was promising model to preserve affordable housing and cited two policy proposals that warrant consideration: (1) eliminating the cap on the conversion of public housing projects to RAD, and (2) allowing nonprofit owners of Section 202 properties to participate in RAD (which has since been done by HUD administrative action).

Recent Action

See Section I.

Impact on Health Equity

See Section I.

Challenges to Implementation & Cost

In 2013, BPC modeled the potential costs and impacts of many of these recommendations—summarized in the table below.

Policy Recommendation	**Estimated Annual Costs**	**Estimated Number of Units Produced/Preserved or Households Served**
Rental assistance to households with incomes at or below 30% AMI	$22.5 billion	2.5 million
Short-term emergency rental assistance and eviction prevention	$3 billion	2.4 million
LIHTC expansion	$1.2 billion	35,000 – 40,000
Gap financing to support LIHTC developments	$1-2 billion	N/A
Public housing capital backlog and ongoing accrual needs	$4 billion	110,000

The collective cost of these proposals is a key impediment to them becoming law, despite the broad, bipartisan support such policies can garner in Congress. Recognizing this, in 2017, BPC outlined a relatively more modest package of housing policies, costing around $8.5 billion annually in new spending commitments, to (1) increase the supply of affordable rental homes by as much as 400,000 units, (2) reduce homelessness among families and chronic homelessness to *de minimis* levels, and (3) provide mobility counseling and targeted housing vouchers for more than 500,000 additional low-income families (including 1.2 million children) to promote access to high-opportunity neighborhoods.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Agriculture: Nutrition

December 18, 2020

Mitigating Increased Rates of Food Insecurity and Ensuring Consistent Access to Healthy Foods

Recommendations

The Bipartisan Policy Center has long been a leader in advocating for bipartisan policies to address poor nutrition and food insecurity in the U.S. In 2012, BPC provided a comprehensive set of policy recommendations to Congress and key government agencies in our *Lots to Lose* report on the obesity crisis. In 2018, BPC convened a task force focused on opportunities to improve the Supplemental Nutrition Assistance Program (SNAP). The SNAP task force issued 15 policy recommendations to prioritize nutrition in SNAP, strengthen SNAP-Education, align SNAP and Medicaid, and coordinate federal and state agencies and programs. BPC continues to remain engaged in influencing federal legislation and regulations related to nutrition and food security.

Legislation

- Work with Congress to increase SNAP maximum benefit levels by 15 percent
- Suspend SNAP time limits for able-bodied adults without dependents
- Extend all child nutrition waivers for the remainder of the 2020-2021 school year
- Ensure pandemic-related WIC waivers remain in place for the duration of the economic downturn

Regulations

- Reverse regulatory changes that would reduce or cut benefits for SNAP beneficiaries including restrictions on Broad-Based Categorical Eligibility
- Strengthen and align school nutrition standards with 2020-2025 Dietary Guidelines for Americans

Technical Assistance to States

- Provide technical assistance to support schools in meeting evidence-based nutrition standards, particularly with respect to remote or partially remote learning models.

Current Law and Policy

Every five years, Congress is expected to reauthorize critical child nutrition and school meal programs, including the National School Lunch Program (NSLP), School Breakfast Program (SBP), Child and Adult Care Food Program (CACFP), Summer Food Service Program (SFSP), Special Milk Program (SMP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). However, the last Child Nutrition Reauthorization (CNR) took place in 2012 with the Healthy, Hunger-Free Kids Act. An attempt to reauthorize these programs through the Child Nutrition Integrity and Access Act of 2016 was unsuccessful due to an inability to reach a

bipartisan consensus. In the 116th Congress, Senate Agriculture Committee Chair Pat Roberts prioritized work on CNR; however, legislation was never advanced.

In 2019, the Trump administration proposed regulatory changes to SNAP, the nation's largest federal nutrition assistance program. These changes reduced access to SNAP and were inconsistent with the bipartisan history of support for the program. For example, the Trump Administration proposed a revision of categorical eligibility in SNAP, which USDA projected that, if implemented, would remove 1.7 million households and 3.1 million individuals from SNAP eligibility, and almost 500,000 children from free school meals. These unintended consequences ultimately go against the will of Congress, as a similar provision was not included in the 2018 Farm Bill, which passed with bipartisan support. Currently, many of these regulatory changes are stalled through the duration of the public health emergency. When the emergency declaration ends there could be an opportunity to strengthen access and benefits within SNAP beyond prior levels.

Recent Action

In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act, which allowed the U.S. Department of Agriculture (USDA) to provide states with operational and administrative flexibilities in SNAP to manage growing need. This legislation also created the Pandemic Electronic Benefit Transfer (P-EBT) program, which provides critical assistance to households with children who have lost access to free or reduced priced meals due to school closures. The act also provided $500 million to the WIC and $250 million for senior nutrition programs. Congress later passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which temporarily lifted work and work training requirements. It also included $15.8 billion to help manage and fund increased participation.

Congress and USDA have continued to prioritize food assistance. For example, in August USDA extended waivers for the Summer Food Service Program and Seamless Summer option, which enables students to receive meals even when they are not physically at school. A continuing resolution allowed USDA to issue nutrition program waivers through fiscal year 2021 and extend and strengthen the P-EBT program.

Congress and the Trump administration have implemented temporary, emergency flexibilities to address the growing need for food assistance. Unfortunately, the economic and health impacts of the pandemic will likely extend long past the end of the public health emergency. Consequently, additional federal action is required to protect access to healthy foods.

Impact on Health Equity

Prior to the COVID-19 outbreak, many special populations including older adults and undergraduate students relied on meal services in congregate settings. In response to increased risk of transmission, some schools and universities have converted to all remote or partially remote learning to adhere to social distancing guidelines. Unfortunately, this has limited access to healthy meals for low-income students who are already more likely to experience food insecurity. Similarly, seniors who used to receive federally subsidized meals in group settings may have lost access as a result of COVID-19. Though some congregate settings have found ways to adapt to physical distancing requirements, states need more federal support to ensure low-income Americans safely receive food assistance.

Low-income pregnant women are another special population that is uniquely impacted by COVID-19. Income loss associated with the pandemic has led to a significant spike in WIC enrollment as families struggle to provide food for women who are pregnant, postpartum,

lactating, and infants and children up to five years old. The importance of a nutritious diet during and after pregnancy for both mom and baby cannot be overstated. A healthy diet during pregnancy is linked to decreased low birthweight and still births, reduced hospitalization time, and decreased risk of chronic health conditions for both mom and baby.

Challenges to Implementation & Cost

The November 2020 election results will affect future nutrition and food security as the incoming Biden Administration has created an opening for new priorities and policies. While President-elect Biden is likely to reverse many of the outgoing administration's actions, the political make-up of the 117th Congress has not yet been fully determined, which leaves room for a politically-divided Congress that could present significant challenges to passing critical legislation and implementing policy changes.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Responding to COVID-19 and Improving Public Health and Preparedness

December 18, 2020

Support Investments in Public Health to Address the COVID-19 Pandemic and Improve Long-Term Community Health Outcomes

Recommendations

- Develop and implement a national COVID-19 vaccine plan.
- Work with Congress to pass a short-term COVID-19 relief package which provides regulatory authority and financial resources to states, and includes funding to address the following health areas: develop and implement a national system for testing and contact tracing; support vaccine production, distribution, and monitoring; augment school COVID-19 safety measures; provide nutrition and rental assistance; aid health care providers serving disproportionately vulnerable populations; and dedicate adequate financial relief to states.
- Encourage Congress to establish a Public Health Infrastructure Fund, a mandatory appropriation that can fill the estimated $4.5 billion/year gap between what we currently spend on public health and what we need to spend as a nation to provide sufficient funding for all communities to provide certain foundational public health capabilities – like surveillance, lab capacity, and all-hazards preparedness.
- Conduct and publicly release a transparent gap analysis of the material and equipment which modeling suggests we will need over the remainder of this pandemic. This will provide Congress, the American people, and the private sector with better visibility into what exactly is required, such as the specifications, quantities, regulatory approvals needed, and timelines. It will reveal if the current industry supply chain will not be able to meet these targets in the necessary timeframe and if the Defense Production Act (DPA) needs to be invoked.
- Support investment in global health and strengthen global health security leadership capacity.

*Note: The Bipartisan Policy Center's Future of Health Leaders will be coming out with additional bipartisan recommendations for improving the immediate U.S. response to the COVID-19 pandemic in the next several weeks. Later in the spring, the group will focus on long-term issues including augmenting the public health infrastructure, bolstering health care capacity, improving federal interagency coordination during public health emergencies, reviewing federal health care coverage policies during a pandemic, and enhancing safety in congregate living facilities and transitions to home and community-based services.

Current Law and Policy

Congress has passed four emergency relief bills in response to the COVID-19 pandemic, providing trillions of dollars for both the health and economic response effort. This includes:

- $26 billion for COVID-19 testing, including funding for state and local governments and federal agencies such as CDC, BARDA, and NIH.
- A 6.2% increase in the federal Medicaid match rate for states (if they meet certain maintenance of eligibility and continuous coverage requirements). This increase is in place until the end of the quarter in which the Public Health Emergency (PHE) ends.
- $6.5 billion for the CDC, with $2.4 billion available directly for states, localities, and territories to carry out surveillance, epidemiology, laboratory capacity, and other vital functions in their preparedness and response efforts.
- $500 million for public health data surveillance and analytics infrastructure modernization.
- $600 million for the Infectious Diseases Rapid Response Fund, which was created to prevent, prepare, and respond to infectious disease emergencies, both domestically and internationally.
- $340 million from the CDC for states for COVID-19 and flu vaccine planning and distribution.
- $175 billion to the Provider Relief Fund for grants to support hospitals and health care providers for expenses or lost revenues that are attributable to the pandemic and $1.98 billion in emergency grant funding for Community Health Centers, including funding specifically to support testing capacity.

Recent Action

In addition to the ongoing conversations on Capitol Hill around the continued need for federal action to address the COVID-19 pandemic, members of Congress have been looking at long term investments to improve our public health system to respond to COVID-19 and better prepare the country to deal with future challenges. Among these efforts, Senator Patty Murray (D-WA) has introduced the Public Health Infrastructure Saves Lives Act (S.4740) which would establish a $4.5 billion Public Health Infrastructure Fund to support state and local public health departments. In addition, Sen. Lamar Alexander (R-TN) introduced, the Preparing for the Next Pandemic Act (S. 4231), which would provide $10 billion over 10 years to assist in creating and maintaining state stockpiles of medical supplies and improving the federal Strategic National Stockpile by allowing the Federal government to work with companies to maintain supplies and manufacturing capacity.

Impact on Health Equity

Though COVID-19 continues to impact Americans nationwide, Black, Indigenous, and people of color (BIPOC) communities bear the burden of COVID-19 cases, hospitalizations, and deaths. As of November 2020, the COVID Tracking Project found that Black Americans are dying at two times the rate of their white counterparts. The disproportionate impact of COVID-19 on BIPOC communities has been attributed to a variety of factors including those that existed prior to the COVID-19 outbreak: structural racism, systemic inequities, and poverty, all of which have been recognized as drivers of health inequities. Immediate and long term investments in strengthening public health will help communities not only combat the COVID-19 pandemic and prepare for future pandemics, but provide the resources needed to improve health equity.

Challenges to Implementation & Cost

There remains general partisan disagreement over how much federal funding should be spent to address the COVID-19 pandemic. For most of these proposals, the amount of funding can be adjusted to address both the need and the political reality. The creation of a Public Health Infrastructure Fund as proposed would cost $4.5 billion per year, but has faced resistance from some Republican lawmakers who are concerned about creating new mandatory funding streams.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Rural Health

December 18, 2020

I. STABILIZE AND TRANSFORM RURAL HEALTH CARE INFRASTRUCTURE

Recommendations

Offer short-term stabilization for rural hospitals and clinics and provide them with transformation pathways for lasting change that will meet the needs of individual rural communities (See BPC Rural Health Task Force April 2020 report, page 19):

1. Provide immediate financial relief to rural hospitals to stem closures (See BPC Rural Health Task Force April 2020 report, page 19)
    - Provide rural hospitals with two years of relief from Medicare sequestration payment reductions and Medicare bad debt payment reductions.
    - Increase Medicare reimbursement for Critical Access Hospital (CAH) services by 3%.
    - Re-establish the CAH necessary provider designation process.
    - Make available capital infrastructure grants or loans that rural hospitals could use to modify service lines or improve structural or patient safety.
2. Establish rural hospital and clinic transformation models with flexible payment options (See BPC Rural Health Task Force April 2020 report, page 26)
    - Establish a process for rural facilities and communities to develop a Hospital Transformation Plan that fits the needs of the community by bringing together all stakeholders as a first step in the transformation process.
    - Establish a new Rural and Emergency Outpatient Hospital designation that recognizes the shift away from inpatient centric care. Certain rural hospitals could transform into entities that exclude most inpatient care and maintain such services as emergency and outpatient care. Transforming hospitals could choose from the following payment options:
        - Cost-based reimbursement of 110% percent of reasonable costs.
        - Medicare outpatient prospective payment reimbursement for emergency and outpatient services combined with a fixed grant payment option to cover other costs and services.
        - Medicare Outpatient Prospective Payment System (OPPS) reimbursement for emergency and outpatient services combined with a per patient per month payment based on the number of anticipated patients in an expected catchment area.
        - Global payment model that combines the funding of all federal payers.

- Establish an Extended Rural Services Program that would allow Federally Qualified Health Centers, Rural Health Clinics and other entities to add emergency and other services and receive a new type of payment for them.
- Advance new multi-payer, global budget models.

Current Law and Policy

Congress created the CAH designation in the Balanced Budget Act of 1997 to stem hospital closures. This designation provides additional financial security; these hospitals receive cost-based payments of 101% of reasonable costs. CMS may provide this designation to rural hospitals that have no more than 25 inpatient beds and are located 35 miles from another hospital. CAHs must provide 24/7 emergency care and maintain an average inpatient length of stay of 96 hours or less.

Congress created the special designations of CAHs, Sole Community Hospitals (SCH) and Medicare Dependent Hospitals (MDH) and implemented new payment adjustments for low-volume hospitals. Currently, there are roughly 1,300 CAHs, 402 SCHs, 138 MDHs, and about 500 hospitals receiving low-volume payment assistance.

Still, a wave of recent rural hospital closures suggests that ongoing financial pressures resulting from Medicare payment reductions (e.g. Medicare sequestration and bad debt), shifts in health care delivery away from inpatient care, and dwindling rural populations have once again placed rural hospitals on shaky financial footing. According to the Medicare Payment Advisory Commission, rural hospitals, including CAHs, on average, had a negative (-4.9%) Medicare operating margin in 2018.

For outpatient care, rural residents rely heavily on the more than 4,500 rural health clinics (RHC) and 1,362 Federally Qualified Health Centers (FQHC), many of which are rural. They must meet certain statutory criteria related to serving underserved or rural areas, among other qualifications, and are subject to unique reimbursement structures. RHCs are paid an all-inclusive, per visit rate under Medicare. FQHCs are paid the lesser of 80% of charges or the FQHC prospective payment system rate.

Many RHCs have revised their structure from lower-paid independent clinics to higher-paid, provider-based models, and nearly 400 have closed since 2012. Many closures have been independent, physician-owned RHCs that currently receive capped Medicare payments at a rate of $86.31 per visit, compared to hospital-owned RHCs that received an average uncapped rate of $206 per visit in 2020.

Recent Action

While Congress did not pass rural hospital transformation legislation in 2020, committees of jurisdiction in both houses and on both sides of the aisle created working groups and conducted major stakeholder outreach and research into the scope and nature of the problem Members of Congress have introduced several bipartisan bills to help rural hospitals, including the Save Rural Communities Act (H.R. 5808), which would allow rural hospitals to transform into stand-alone emergency departments and the Rural Hospital Sustainability Act (S. 2157 and H.R. 6962), which would provide a financial backbone for struggling rural health systems by allowing states to voluntarily implement a global budget for rural hospitals in lieu of the existing fee-for-service model. Separately, in response to COVID-19, Congress has provided significant financial resources to hospitals, including rural facilities, to help address the financial shortfalls caused by

the pandemic, though there is concern that these resources remain insufficient to meet the need.

Impact on Health Equity

Since January 2010, 126 rural hospitals have closed, and an additional 557 are currently at risk. Of those that closed from 2005 through 2017, 43% were more than 15 miles away from the next closest hospital and 15% were more than 20 miles away. According to the Government Accountability Office, rural residents delay or neglect to seek care if they must travel longer distances to access services after a local hospital has closed. This is particularly problematic for those who are geographically isolated, elderly, or have a low income.

Indeed, rural residents tend to be older and sicker, and to have lower incomes, on average. Rural hospitals and clinics serve as anchors to keep health care providers in the area. When rural hospitals close, clinics are at greater risk of closure.

A BPC/American Heart Association poll conducted in early 2020 by *Morning Consult* found:

- More than half of rural residents (54 percent) said access to medical specialists is a problem in their local community, compared to 33 percent of non-rural residents; and more than one-quarter (27 percent), said it is difficult to access behavioral health professionals, compared to 16 percent of non-rural residents.
- Forty-seven percent of rural residents agreed quality health care is a challenge in their community, compared to 34 percent of non-rural residents.

Challenges to Implementation & Cost

Rural hospital transformation, in general, has bipartisan support. The costs of care are higher in rural facilities due to the mismatch between high overheads and lower volume. In maintaining cost-based reimbursement for hospitals electing the REO model, the BPC task force proposed increasing reimbursement from 101% to 110% of reasonable cost. (Other proposals have recommended higher reimbursement.) Any new RHC attached to a REO would not get the average uncapped rate of $206 per visit, but a rate between that amount and the $86.31 capped amount.

There are no currently available cost estimates on the REO proposal. However, in its June 2018 report, MedPAC suggested a bare-bones version of the proposals to shift CAHs to Medicare outpatient payment system reimbursement – as outlined in Payment Paths B and C above – would cost roughly $5 million per year to operate and would increase Medicare spending by less than $50 million per year. In addition, beneficiary out-of-pocket costs would likely decline if a facility shifted from a cost-based CAH model to an outpatient, prospective payment model. This would occur because beneficiary copayments would no longer be tied to the often higher, cost-based charge and instead be based on a percentage of the lower, prospective payment rate.

II. IMPROVE ACCESS TO QUALITY MATERNAL CARE IN RURAL AREAS

Recommendations (See BPC Rural Health Task Force April 2020 report, page 47):

- Increase reimbursement rates for rural hospital obstetric units.
- Enhance the Federal Medical Assistance Percentage rate for rural hospital obstetric units.
- Increase funding of maternal health training programs for primary care providers.
- Direct the Centers for Disease Control and Prevention to improve rural maternal mortality data surveillance.

Current Law and Policy

Between 2004 and 2014, 9% of rural hospitals closed obstetric units, leaving more than half of rural counties in the United States without hospital-based maternal care. In response to the maternal health crisis, the 115th Congress enacted Preventing Maternal Deaths Act of 2018. The bipartisan law directed HHS to establish a federal program to accomplish five key goals:

- Review all maternal deaths
- Establish and sustain a Maternal Mortality Review Committee in every state
- Develop state plans for ongoing health care provider education to improve the quality of maternal care
- Distribute Maternal Mortality Review Information to every state Maternal Mortality Review Committee
- Provide public disclosure of information found in review committees in the form of state reports.

HHS received $35 million over five years to do this work.

Recent Action

The 116th Congress has continued to focus on the issue. Members of Congress have introduced several bills to try to improve maternal health care including the Rural MOMS Act (S. 2373 and H.R.4243) which would increase funding by directly providing HRSA with $15 million over five years to provide grants for rural obstetric clinical training and coordinated maternal care regionalization. In addition, the House passed the Helping MOMS Act of 2020 (H.R.4996) by voice vote, which would give states the option to provide one year of postpartum coverage under Medicaid and the Children's Health Insurance Program. This legislation could be included in an end of year funding package.

Impact on Health Equity

Women in rural areas are more likely to die from pregnancy-related deaths than urban women, although two-thirds of deaths are preventable. (See op-ed from BPC task force members and former governors Tommy Thompson and Ronnie Musgrove.) Mortality rates have doubled over the past two decades, from 10.3 deaths per 100,000 births in 1991 to 20.7 deaths per 100,000 in 2017. The rates are 29.4 deaths per 100,000 in rural areas, compared to 18.2 deaths in urban areas. As of 2014, only 45 percent of rural counties had obstetric services, and this has left many rural women needing to travel up to 65 miles to receive necessary care. And, according to the American College of Gynecologists, only 6% of ob-gyns practice in rural areas.

Pre-term births in rural areas increased by 5% between 2004 and 2014 – likely relating to inadequate prenatal care – and deliveries occurring in hospitals without obstetrics services increased 2-3%, according to one study.

Overall, the national birth rate has declined 19% since 2007. This decrease has an additive effect with other characteristics that have lowered birth volume in rural communities, such as the smaller size and older age of the population. Evidence clearly links lower birth volume to decreased clinical competence and poor maternal and neonatal outcomes.

Challenges to Implementation and Cost

A major challenge to keeping obstetric care in rural areas is low Medicaid reimbursement. While a lower maternal volume in rural areas translates into lower revenue, Medicaid rates are a

major factor. Medicaid is the dominant payer for maternal care, covering 50-60% of all rural births. However, the National Rural Health Association estimates that Medicaid reimbursement for obstetric services is approximately one-half the rate of commercial insurance.

III. ENSURE ADEQUATE RURAL HEALTH CARE WORKFORCE (See BPC Rural Health Task Force April 2020 report, page 52):

Recommendations

1. Improve utilization of currently available workforce.
    - Evaluate the potential effect of expanding reimbursement to additional types of providers in rural and Native communities.
    - Add marriage and family therapists and licensed mental health counselors to the list of Medicare-covered providers.
    - Remove regulatory and legislative barriers that prevent non-physician providers from practicing at the top of their license.
    - Direct CMS to assign a medical specialty to advanced practice nurses and physician assistants.
2. Expand federal rural workforce recruitment and retention initiatives.
    - Exempt Indian Health Service loan repayment funds from federal income tax.
    - Establish a federal tax credit for providers practicing in rural areas.
    - Reauthorize the J-1 visa waiver program and increase caps to 50 for rural doctors.
    - Direct HHS to evaluate and develop recommendations for interagency coordination.

Current Law and Policy

Federal policymakers have made some progress in recruiting clinicians to rural areas through investments in rural graduate medical education (GME), and a variety of workforce development programs, although the problem is far from solved. Medicare is the major funding source for GME. However, the Balanced Budget Act of 1997 capped Medicare GME funding and it has not kept pace with the workforce deficit. HRSA administers additional federal programs, the majority of which broadly address Health Provider Shortage Areas (HPSA). Although 60% of these shortage areas are in rural regions, there is far greater provider participation in urban settings. Despite targeted grant funding, loan repayment programs, and technical assistance, rural communities are not recruiting a sufficient health care workforce, nor are they retaining those who do initially come.

The Conrad 30 program has helped by providing each state with up to 30 J-1 visa waivers to authorize international medical graduates to stay in the U.S. for an additional three years to practice in shortage areas. Between 2001 and 2010, 41 states gave a waiver priority to primary care slots. However, the need for primary care continues to increase and the current workforce is insufficient, particularly in rural areas. State waivers should increase to 50 waivers, with priority given to rural areas. The Conrad State 30 & Physician Access Reauthorization Act (S.948) would reauthorize the program until 2021 and increase state waivers from 30 to 35.

Long-term solutions will require flexibility and a greater focus on pipeline and training programs that have been demonstrably effective in the sustainable development of a rural workforce. It

will also require a financial incentive, such as the task force's proposed tax credit, to keep providers in rural areas. Two states have already achieved success with such tax credits.

Many providers in rural areas are nurse practitioners and physician assistants, but it is difficult to determine the extent of the shortage, as Medicare categorizes them as primary care workers regardless of their actual specialty.

Recent Action

Members of Congress have introduced many bills to help address the provider workforce shortage in rural communities including the Conrad State 30 & Physician Access Reauthorization Act (S.948), which would reauthorize the J1 visa program until 2021 and increase state waivers from 30 to 35. They have also introduced the Strengthening Our Rural Health Workforce Act (S. 2902), which would help improve recruitment of providers in rural communities and train more primary care physicians.

Impact on Health Equity

Urban areas have an average of 53 primary care physicians per 100,000 people, while rural areas have 40. The disparity for specialists is greater: urban areas have an average of 263 specialists per 100,000 people, compared to only 30 in rural areas.

Challenges to Implementation & Cost

A federal rural practitioner tax credit would aid in the retention of rural clinicians. A 5-year annual federal tax credit should be offered to physicians and advanced practice clinicians choosing to work in rural HPSAs. Under this model, federal dollars would only be spent if providers practiced in rural HPSAs. The federal tax credit, for example $10,000, $15,000, and $20,000, should be tiered based on provider type.

Also, increasing state waivers does not necessitate more federal funding.

IV. BREAK DOWN BARRIERS TO TECHNOLOGY IN RURAL COMMUNITIES TO EXPAND ACCESS TO CARE (For additional details, please see BPC Telehealth Transition Memo. Also see BPC Rural Health Task Force April 2020 report, page 59):

Recommendations

- Create a centralized office for the advancement of telehealth, health information technology, and mobile health applications.
- Expand patient data privacy protections for behavioral and wellness applications.
- Evaluate telehealth utilization to ensure beneficiaries continue to receive high-quality care.
- Congress should remove site of service, geographic, and established patient restrictions for telehealth services.
- Eliminate the video requirement for telehealth to allow the use of telephones, with guardrails to prevent overutilization, fraud, and abuse.
- Expand asynchronous services to include written text, in addition to images.
- Expand broadband and collect accurate broadband data in rural and tribal areas.
- Expand the list of authorized sites of service for telehealth.
    - Include the home of an individual in the list of authorized originating sites.

- Streamline licensure requirements.
- Authorize licensed clinicians to provide inter-state services for Medicare.

Bipartisan Policy Center

Memorandum to Biden-Harris Transition Team
Department of Health and Human Services: Telehealth

December 18, 2020

Break Down Barriers to Telehealth to Expand Access to Care (See BPC Rural Health Task Force April 2020 report, page 59):

Telehealth was first introduced to the Medicare program in 1997 to increase access to providers for beneficiaries in rural health professional shortage areas. Telehealth has remained largely unchanged since that time, despite advances in technology and changes to how health care is delivered. As a result, Medicare telehealth services are far more restrictive than the broader range of telemedicine services outside the program.

Recommendations

- Create a centralized office for the advancement of telehealth, health information technology, and mobile health applications.
- Expand patient data privacy protection for behavioral and wellness applications.
- Evaluate telehealth utilization to ensure beneficiaries continue to receive high-quality care.
- Congress should remove site of service, geographic, and established patient restrictions for telehealth services.
- Eliminate the video requirement for telehealth to allow the use of telephones, with guardrails to prevent overutilization, fraud, and abuse.
- Expand asynchronous services to include written text, in addition to images.
- Expand broadband and collect accurate broadband data in rural and tribal areas.
- Expand the list of authorized sites of service for telehealth to include the home of an individual as an originating site and rural health clinics and federally-qualified health centers (FQHC) as distant sites.
- Streamline licensure requirements for health professionals and authorize clinicians to provide inter-state services to Medicare beneficiaries.

Current Law and Policy

Outside of the COVID health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must be in a rural area and treated by a distant provider, with whom there is an established relationship. and with whom they still have periodic face-to-face visits. With few exceptions, patients must be in a clinical setting, the distant provider cannot be located in a rural health clinic or federally qualified health center, and the patient must continue to have periodic in-person assessments.

Despite the use of telehealth services across settings, the office tasked with the prioritization of telehealth is currently located in the Federal Office of Rural Health Policy. Congress could improve coordination by directing the HHS secretary to remove the Office for the Advancement

of Telehealth from HRSA and create a centralized office for the advancement of health information technology, mobile health applications, and telehealth.

Statute requires Medicare telehealth services to be provided as a live, two-way video interaction between a beneficiary located in a certain type of health care facility and a provider at a distant site. CMS has supplemented telehealth with other technology-assisted communication services, including remote patient monitoring, certain telephone calls, and review of images sent by text message and email. However, audio-only and asynchronous services are not reimbursed outside of specific demonstrations.

CMS reimburses virtual check-ins to enable audio-only communication using the telephone. Virtual visits are short, 5- to 10-minute check-ins do not meet the video criteria for Medicare telehealth services. The 2021 Medicare Physician Fee Schedule Final Rule introduced additional virtual visits for up to 30 minutes. However, these services are reimbursed at much lower rates than in-person and may not see measurable adoption.

Recent Action

Congress and the Trump administration introduced flexibilities to expand coverage of telehealth services for the duration of the COVID pandemic. The site of service, geographic, and established patient requirements were removed, allowing beneficiaries to safely receive care. Early Medicare data showed over 1.7 million beneficiaries received telehealth in the last week in April – up from an average of 13,000 beneficiaries before the pandemic. However, the temporary flexibilities that expanded the eligible sites of service will disappear at the end of the public health emergency unless policymakers extend them.

Congress introduced multiple pieces of legislation in the 116th Congress that would permanently add the patient's home to the list of originating sites of service and allow Rural Health Clinics and Federally Qualified Health Centers to serve as distant sites. The Senate Republican-introduced bill, American Workers, Families, and Employers Assistance Act, would extend the telehealth flexibility through the end of 2021. The bill would also require MedPAC to examine the impact of extending the telehealth flexibilities.

Several other bills have specifically targeted telehealth for mental health. The Telehealth Expansion Act (S. 4230), the Mental and Behavioral Health Connectivity Act (S. 3999), the Mental Health Telemedicine Expansion Act (H.R. 1301), the CONNECT for Health Act of 2019 (H.R. 4932), and the Telemental Expansion Act (H.R. 5201) would remove the geographic and site of service restrictions.

Sens. Angus King (I-ME) and Todd Young (R-IN) introduced the Mental and Behavioral Health Connectivity Act (S.3999) in June 2020 to permanently remove the requirement for the use of two-way video for telehealth and allow additional forms of audio-only electronic communication. This would address access disparities for those without broadband or video technology.

Impact on Health Equity

Outside of the health emergency, telehealth is limited to live, two-way video. Older people, persons of color, and those of lower socioeconomic status disproportionately lack digital literacy, access to technological devices, and reliable internet coverage. When compared to younger and white patients, older and Black patients are much less likely to be digitally literate. Approximately one quarter of Blacks, Latinos, and Native Americans do not have traditional high-speed internet access. A 2019 Pew research study also found income, education, race, and

ethnic disparities between those using traditional broadband internet and smartphone internet access. Half of those without traditional broadband internet state cost as the reason; one-third cite the cost of a computer. Approximately one quarter of Blacks and Hispanics do not have traditional high-speed internet access and rely solely on their smartphones.

A recent *JAMA* study assessing telehealth readiness among Medicare beneficiaries during COVID-19 found 38% of elderly adults were not ready to participate in telehealth visits because of unfamiliarity with technology and physical or cognitive difficulties. Another study found 41.4% lacked access to a desktop or laptop computer with a high-speed internet connection at home, and 40.9% lacked a smartphone with a wireless data plan.

Audio-only and asynchronous services enable those without computers or sufficient wireless data to use telephones and text messaging for connecting with health providers.
We believe there are instances when exemptions from the face-to-face requirement are appropriate, provided the primary care clinician has documented seeing the patient within the previous 90 days. This conforms to the Medicare home health services' face-to-face requirement established through the ACA. These services may engage patients that would otherwise not receive care. For instance, Blacks are 20% more likely to experience mental health issues, yet less likely to receive services when compared to whites. The lower use of digital communication modalities among this population may exacerbate access disparities. These findings highlight the ongoing need for audio-only telehealth services, which are not traditionally reimbursed under Medicare.

Challenges to Implementation and Cost

CBO estimates the full extension of all flexibility introduced during the pandemic through 2022 would cost $490 million. The CBO estimate does not account for any substitution of in-person visits, reduction of avoidable hospitalizations, or unnecessary emergency services when estimating costs. Congress should consider the potential for downstream savings and pass legislation to make permanent the telehealth flexibilities that Congress and HHS introduced during the pandemic.

BPC estimates permanently eliminating geographic, site of service, and established patient restrictions solely for behavioral health services would cost $145 million over 10 years. We estimate reimbursing services provided only for behavioral health services through audio-only visits would cost Medicare $66 million over 10 years. Updating asynchronous services to include the sharing of written information is expected to have negligible federal impact of under $1 million over 10 years.