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Bridging Health and Health Care

September 2021

Bipartisan Policy Center

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ACKNOWLEDGMENTS

BPC would like to thank the Robert Wood Johnson Foundation for its generous support.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

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Executive Summary

In 2017, the Bipartisan Policy Center launched the Future of Health Care Initiative with a bipartisan group of leading national policy experts to create a consensus approach to improving our nation's health care system, increasing access to affordable insurance coverage, improving quality of care delivered to patients, lowering costs for all Americans, and creating competition throughout the health care sector. In response to the COVID-19 pandemic, the leaders turned their attention to improving the nation's public health infrastructure and preparing for the next pandemic.

In January 2021, the Future of Health Care leaders released a report outlining high-priority immediate actions that the administration and Congress should take in combating COVID-19, and in June 2021, the leaders released recommendations to ensure that our public health system is well-prepared to respond to and mitigate the consequences of a future pandemic. These recommendations provide a strategic approach to bolstering our nation's public health infrastructure. However, to fully address our vulnerability to health threats, we must confront the underlying challenge of the poor health status of the U.S. population.

Compared with many other industrialized nations, the United States invests significantly less in disease prevention and social services. Rather, health care spending is directed toward the delivery of health care services to treat chronic conditions. As has been noted in previous reports, early investments in programs and services that address social determinants of health could help avert the onset of chronic conditions. Some of our leaders would like to see federal health insurance programs, such as Medicare and Medicaid, play a role in preventing the onset of chronic conditions resulting from social needs. At the same time, a number of our leaders have concerns about using health insurance programs to address shortfalls in funding for social services. This report seeks to strike a balance between those two competing interests.

Recognizing the need to better bridge the divide between the often-siloed worlds of health and health care, these policies are designed to better integrate, coordinate, and ultimately improve the performance and outcomes of both. Our recommendations focus on two key areas: 1) improving access to and coverage and financing of nonmedical and preventive services; and 2) the health care workforce, with a focus on increasing access to care through improvements in the supply and distribution of key practitioners who are needed to improve the health status in underserved communities.

RECOMMENDATIONS

Specific recommended actions include:

Improving Access to and Sustainable Financing of Nonmedical and Preventive Services

A. Coverage of Nonmedical Services in Medicaid

- Provide the secretary of Health and Human Services (HHS) with the authority to expand Medicaid coverage of nonmedical services that address social needs and community-based interventions. For individuals participating in value-based payment models, including fully capitated managed care, accountable care organizations, or health homes:
 - The secretary could authorize coverage of nonmedical services where evidence demonstrates the benefit improves or maintains health outcomes for a defined population.
 - The secretary could authorize Community Preventive Services Task Force (CPSTF) recommended interventions that have either “strong” or “sufficient” evidence, are cost-effective, and are appropriate to be covered under Medicaid (e.g., not room and board). Examples include:
 - Various cancer screening interventions that engage community health workers
 - Community-wide physical activity campaigns
 - HHS should provide funding for ongoing studies by the Congressional Budget Office (CBO) and Government Accountability Office (GAO) on the cost and benefit of such services.

B. Expanding Access to Preventive Services in Medicaid

- Require coverage of clinical preventive services without cost-sharing in Medicaid for the non-expansion population. *From BPC’s [2020 Advancing Comprehensive Primary Care in Medicaid](#) report*
- Direct the secretary of HHS to provide CMS guidance to states on defining and reimbursing community health workers within their Medicaid programs, where evidence has demonstrated improved outcomes. *From BPC’s [2020 Advancing Comprehensive Primary Care in Medicaid](#) report*

Increasing the Capacity of the Health Care Workforce to Support Integration

- Waive the federal requirement for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) providers to be licensed in the state where a patient

receives services, when the provider is licensed in another state; and issue FBI guidance to states drafting interstate licensure compact legislation.

- Use technology to enable greater integration of clinical and community-based services.
- Improve Medicaid reimbursement for primary, prenatal, and postpartum care. Congress should increase state Federal Medical Assistance Percentages (FMAP) to 90% for five years for primary, prenatal, and postpartum services for states that reimburse those services at certain minimum rates; states must reimburse primary care services at Medicare rates and reimburse prenatal/postpartum services at average commercial rates to receive the enhanced FMAP. Congress should also direct GAO to study and report on the impact of the increased reimbursement rates on access to care.
- Appropriate funding for the National Health Care Workforce Commission to perform a comprehensive evaluation of the current workforce landscape, develop policy recommendations to ensure federal education and training programs meet critical needs, and provide oversight of federal workforce programs.

Introduction

The COVID-19 pandemic has made evident a truth that public health experts and officials have long known: The underlying health status and disease burden of a country has tremendous impact on the need for acute and chronic care services. A study examining COVID-19 hospitalizations found the risk of hospitalization was “robustly linked to cardiometabolic health.” Of the almost 1 million hospitalizations examined, researchers attributed 30% to obesity, 25% to hypertension, 20.5% to diabetes, and 11.7% to heart failure. Jointly, 63.5% of hospitalizations could be attributed to these four conditions.¹ Poor health has not only left the U.S. population more vulnerable to COVID-19, but the demands on the public health system will increase due to the significant effects of the pandemic on population health in areas such as mental health and opioid addiction.²

Effective public health interventions would have resulted in fewer deaths and cases of serious illness caused by COVID-19, as well as fit into a larger strategy to help people live longer, healthier lives. Public health challenges will only continue to grow beyond COVID-19. Six in 10 Americans now live with chronic diseases such as diabetes and cancer, and account for 90% of total health care expenditures.³ By 2030, almost half of Americans are expected to be obese. Obesity is “associated with increased rates of chronic disease and medical spending... [with] negative consequences for life expectancy.”⁴ Other population health challenges include the increased prevalence of sexually transmitted diseases, an increase in nicotine addiction with the rise of vaping, and a widening health gap between the rich and the poor.⁵ In light of these projections, the country has a choice: It can continue trying to build up an overburdened “sick care” system that takes a reactive approach to treat illness, or it can reorient the health care system to build on prevention and primary care; use incentives to keep Americans healthy; and invest in community supports, programs, and policies that reinforce healthy behaviors and care plans as part of an overall effort to bridge health and health care.

A prevention-oriented approach within and outside the health care setting can realize considerable health care savings and better outcomes. A study from UnitedHealth Group, the second largest health care company in the country, found that two out of every three emergency room (ER) visits to their facilities were “avoidable,” “not an actual emergency,” or treatable through primary care. The average cost of visits for conditions that can be treated through primary care was calculated to be 12 times lower at a physician office (\$167) than a hospital emergency department (\$2,030).⁶ These avoidable ER visits are one of the significant drivers of the astounding amount of money spent on health care each year.

Historically, the United States has focused most of its efforts on improving population health within the health care system. For example, instead of investing in social services, such as supportive housing, that could prevent negative health outcomes, recent efforts to improve health have focused on insurance coverage so individuals can access care after health problems arise. Compared with other high-income countries that spend more on social services and public health interventions, the U.S. spends a higher percentage of its GDP on health care, yet does not experience better health outcomes.⁷

In response to these trends, there has been a recent push to address “upstream” factors that impact health before an individual interacts with any medical professional.⁸ Social determinants of health (SDOH), sometimes also referred to as “drivers of health,” are the conditions in places where people live, learn, work, and age that affect an individual’s health and quality of life.⁸ SDOH refers to a wide range of factors, including experiences of racism and discrimination, access to healthy food, safe housing and transportation, and education and employment opportunities, among others. Recent research suggests that up to 80% of an individual’s health outcomes can be attributed to SDOH, while only 20% is attributed to clinical care.⁹ Many of the chronic diseases these SDOH contribute to are preventable through health promotion and disease prevention. Health care professionals, especially those in primary care, have a key role to play in this process, as they can develop trusting relationships with patients that can facilitate discussions and referrals to services addressing the social conditions affecting health status.

Of the social determinants of health, access to nutritious food—or food security—has an especially large impact on health outcomes and, as such, interventions to help secure access to better nutrition pays dividends to patients and purchasers alike. Dietary habits have been identified as the leading driver of death and disability in the United States,¹⁰ with poor nutrition contributing to diseases like diet-related obesity, Type 2 diabetes, and various cardiovascular diseases and cancers.¹¹ The U.S. Department of Agriculture defines “food insecurity” as, “the limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.”¹² Research has shown that beyond the burdens food and nutrition challenges have on health and productivity, diet-related diseases place “tremendous strains on productivity, health care costs, health disparities, government budgets, U.S. economic competitiveness, and military readiness.”¹³ According to a recent study, food-insecure adults had annual health care expenditures that were, on average, \$1,834 higher than food secure adults.¹⁴

a Addressing SDOH has been one of the recent focuses of federal agencies including the [Agency for Healthcare Research and Quality](#), and the CDC through various initiatives, including [Healthy People 2030](#). In summer 2021, the [Congressional Social Determinants of Health Caucus](#) formed with the goal of advancing services that address social factors that negatively impact health. [Various](#) multisector [coalitions](#) have formed to advance similar goals. Additionally, academia and advocacy groups have been contributing to research that links SDOH with health outcomes.

Health professionals and health plans have the opportunity to work with the public health sector to prevent diet-related illnesses, especially in light of the greater level of need resulting from COVID-19. In 2019, more than 35 million people (including 11 million children) were food insecure.¹⁵ The economic downturn associated with COVID-19 exacerbated these trends; Feeding America projected the number of food-insecure individuals to be 42 million people, including 13 million children, in 2021.¹⁶ Like many other SDOH, poor nutrition disproportionately affects minorities in the United States. In 2019, 8.1% of white individuals lived in food-insecure households, compared to 15.8% of Latino, 19.3% of Black, and 23.5% of Native American individuals.¹⁷ If plans uniformly covered services such as intensive, multicomponent behavioral interventions, medical nutrition therapy, and medically tailored meals, health care professionals—especially primary care providers—could have a greater impact on improving health outcomes through referring patients to these services. While this report focuses on improving access to preventive services more broadly, BPC has [ongoing work](#) related specifically to nutrition and access to healthy foods.

Addressing social determinants of health is an important step to improve health equity in the United States. CDC has named “the absence of systematic disparities in health between and within social groups that have different levels of underlying social advantages or disadvantages—that is, different positions in a social hierarchy” as one of the definitions of health equity.¹⁸ These social groups include racial/ethnic minorities, the LGBTQ community, people with disabilities, older adults, and rural populations. Additionally, Healthy People 2030—an HHS initiative that sets data-driven national objectives to improve health over the decade—includes an increased focus on SDOH as compared to past iterations. One of the five overarching goals is to “create social, physical, and economic environments that promote attaining the full potential for health and well-being for all,” with many of the objectives directly related to addressing upstream factors.¹⁹

The U.S. can improve population health and health outcomes by integrating social services with the health care system and addressing SDOH before they lead to or exacerbate chronic illness. To do so, BPC believes it is necessary to both improve the coverage of and access to primary care and preventive services. We recommend a multifaceted approach that improves insurance coverage of preventive and nonmedical services in the Medicaid program and strengthens the primary care workforce through an independent evaluation of workforce shortages, greater use of telehealth and technology, and higher reimbursement rates for select services in Medicaid. Health care providers are increasingly looking for ways to engage with community-based organizations and local and state public health officials to advance health outside of the clinical setting, and these recommendations will have a meaningful impact on promoting that collaboration.

Recommendations and Policy Rationale

SECTION I: IMPROVING ACCESS TO AND SUSTAINABLE FINANCING OF NONMEDICAL AND PREVENTIVE SERVICES

Coverage of Nonmedical Services in Medicaid

The World Health Organization defines social determinants of health as “the conditions in which people are born, grow, live, work and age.”²⁰ These determinants include, among many other factors, housing, food access, and nutrition insecurity and are responsible for up to 80% of population health outcomes.²¹ Social needs are defined as an individual’s perception of their own needs, based on negative social determinants of health they face in their lives.²² Although addressing social needs is not a panacea for overutilization and high spending in the health care system,²³ there is growing recognition that this challenge needs to be addressed as part of a strategy to improve population health.

While social needs are not limited to Medicaid beneficiaries, they often have the most serious needs that lead to poor outcomes and higher Medicaid expenditures. The Medicaid program is a health insurance program for lower-income individuals, administered by states under federal rules, and jointly financed by states and the federal government. Medicaid-covered services include both mandatory and optional services, and range from traditional medical services, such as hospital and outpatient services, to targeted case management services, to long-term services and supports. Eligible individuals receive care through fee-for-service or through Medicaid managed care plans; today over two-thirds of Medicaid beneficiaries are enrolled in managed care plans nationwide.²⁴ States receive federal matching dollars for expenditures provided to Medicaid-eligible individuals, and unless states obtain a waiver, they may only receive matching funds for mandatory services and optional services.²⁵

In January 2021, CMS issued guidance clarifying that certain services designed to address SDOH may be considered a Medicaid-covered service, including the rehabilitative services benefit, when provided through rural health clinics and federally qualified health centers (FQHCs), home and community-based services options, Medicaid health homes, and managed care.²⁶ While some services had

been considered covered services under previous guidance, or in some cases by statute, CMS further clarified as covered services:

- housing-related services and supports other than room and board^b
- nonmedical transportation
- home-delivered meals
- educational services
- employment services
- community-integration and social supports
- case management services

Federally qualified health centers are especially well-positioned to address the social needs of Medicaid beneficiaries. FQHCs are community-based health centers that receive federal funding to provide culturally competent preventive and primary care in underserved areas.²⁷ The majority of individuals served by FQHCs have low incomes; in 2020, nearly 91% of the 29 million people served by FQHCs had incomes at or below 200% of the federal poverty level, and Medicaid beneficiaries made up 47% of the population served.²⁸ In addition to basic health services, FQHCs also provide nonmedical services, such as transportation, language interpretation services, and health education programs, that can address an individual's social needs and bridge the gap between SDOH and the health care system.²⁹

Current Law Coverage of Nonmedical Services in Medicaid

The 2021 regulatory clarification built on the 2016 Centers for Medicare and Medicaid Services updated Medicaid managed care [regulations](#). It outlined how plans can address SDOH through “in lieu of” and “value-added” services. Subject to state approval, plans may offer services in lieu of a Medicaid-covered service.³⁰ For example, cab fare may be offered in lieu of non-emergency medical transportation. These services may be included in the plan's capitation rate—the fixed monthly payment states give to plans to cover all services for a Medicaid enrollee. The Affordable Care Act (ACA) required insurers to report their medical-loss-ratios (MLRs), which calculate the percentage of collected premiums on covered services or fraud prevention/quality improvement initiatives.³¹ Like Medicare Advantage and plans on the marketplaces, the MLR is 85% for Medicaid managed care plans.³² Costs for in-lieu-of services can therefore be included as “covered services” or incurred claims when calculating the MLR.³³

b Federal law generally prohibits federal Medicaid dollars from covering the cost of room and board, except in a facility as part of institutional long-term care and in two limited circumstances: 1) temporary, short-term out-of-home respite care services; and 2) for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver. 42 U.S.C. §§ 1396r, 1396n. See also 42 CFR §§ 440.182, 441.310, 441.360. See also Center for Medicaid & CHIP Services, “Coverage of Housing-Related Activities and Services for Individuals with Disabilities,” CMCS Informational Bulletin, June 26, 2015. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.

Value-added services are extra services that plans may provide but are not Medicaid-covered services. These services often are preventive, promote health, or advance health education. Examples include nutrition classes or peer support programs for individuals with substance use disorder.³⁴ Unlike in-lieu-of services, value-added services cannot be included in the plan's capitation rates, but plans may include value-added services in calculating MLR.³⁵ While these benefits can be counted toward the 85% MLR requirement, plans must pay for these additional services with their profits, disincentivizing coverage in many cases.

Nonmedical services that address social needs, such as access to nutritious food or support groups, can often be considered preventive services, as they can mitigate the effects of chronic conditions. In addition to nonmedical services that address social needs, there are community-based preventive interventions that advance population health. While most clinical preventive services are required to be covered by insurers without cost-sharing, most community-based interventions are not. The Community Preventive Services Task Force (CPSTF) provides evidence-based findings and recommendations about community-based preventive services and interventions that improve population health. Recommended services receive either “strong” or “sufficient” evidence ratings and are displayed on the [Community Guide](#) website along with the task force's findings and considerations for implementation.

While many of these interventions, such as tobacco-free policies, would not be appropriate to be covered by insurance, others could be considered appropriate Medicaid-covered services. Appropriate services could include interventions that address [cardiovascular disease](#), [diabetes](#), and other chronic conditions. For example, in April 2019, the CPSTF found there was strong evidence to engage community health workers in [interventions that promote cervical cancer screenings](#). The recommended intervention includes activities such as group education sessions and the removal of structural barriers that prevent people from accessing screenings. Studies included in the systematic review found that when community health workers are involved in these interventions, cervical cancer screening rates increase, and that the interventions are cost-effective. Additionally, these interventions are often implemented in underserved communities and advance health equity.

RECOMMENDATION

Improving Access to and Sustainable Financing of Nonmedical and Preventive Services

Coverage of Nonmedical Services in Medicaid

- **Provide the secretary of HHS with the authority to expand Medicaid coverage of nonmedical services that address social needs and community-based interventions. For individuals participating in**

value-based payment models, including fully capitated managed care, accountable care organizations, or health homes:

- **The secretary could authorize coverage of nonmedical services where evidence demonstrates the benefit improves or maintains health outcomes for a defined population.**
- **The secretary could authorize CPSTF-recommended interventions that have either “strong” or “sufficient” evidence, are cost-effective, and are appropriate to be covered under Medicaid (e.g., not room and board). Examples include:**
 - **Various cancer screening interventions that engage community health workers**
 - **Community-wide physical activity campaigns**
- **HHS should provide funding for ongoing studies by the CBO and GAO on the cost and benefit of such services.**

While much of the current evidence base for the provision of nonmedical services is limited to high-need populations (i.e., home-delivered medically tailored meals for those with multiple chronic conditions), ideally, future research and demonstrations will explore the impact of access to nonmedical services among those with social needs or those at risk of developing a chronic condition, to allow for their coverage as well.

For example, the National Diabetes Prevention Program (DPP) began as a demonstration but is now widely covered by insurance. The National DPP is a public-private partnership established in 2010 by CDC to prevent diabetes through evidence-based, cost-effective interventions.³⁶ CDC recognizes organizations that offer the National DPP lifestyle change program, a year-long structured program designed for those with prediabetes or at risk for Type 2 diabetes with a trained lifestyle coach, a supportive group environment, and CDC-approved curriculum.³⁷

Since its establishment, numerous studies have demonstrated the positive impact the National DPP has had on health outcomes and proven the program cost-effective or cost-saving, including when delivered via telehealth or online.³⁸ In 2016, CMS finalized a [rule](#) to expand coverage of the National DPP under the Medicare program. Today, the program is covered by commercial health plans, public and private employers, Medicare, and 17 states through their Medicaid programs.

Expanding Access to Preventive Services in Medicaid

Preventive services like screenings, vaccines, and counseling are part of routine health care that help reduce the risk of diseases, disabilities, and death.³⁹ Non-grandfathered private health insurance plans, Medicare plans, and Medicaid expansion plans must

cover, without cost-sharing, clinical preventive services that receive an A or B rating from the U.S. Preventive Services Task Force (USPSTF), vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), services recommended by the Health Resources and Services Administration's (HRSA) Bright Futures Program, and women's preventive services.⁴⁰ States have the option to cover recommended preventive services in their traditional Medicaid plans without cost-sharing in exchange for a 1 percentage point bump in FMAP for those services. All plans also have the option to cover other preventive services without cost-sharing.

Community health workers (CHWs), also referred to as community health advisors, outreach workers, peer counselors, and patient navigators, are public health workers who are trusted members of a community or have close understanding of the communities in which they serve.⁴¹ CHWs serve as a link or liaison between underserved communities and the hospitals and clinics located within them.⁴² According to CDC, CHWs have improved health, reduced disparities, and enhanced health equities in minority and underserved communities.⁴³ Studies have shown CHWs improve outcomes for underserved populations in the areas of prevention and control of chronic disease, including managing asthma and increasing cancer screening.⁴⁴

Notably, many of the services recommended by the Community Guide to improve population health involve CHWs, because of their strong ties to the communities they serve. The Community Guide recommends cancer screening interventions (for breast, cervical, and colorectal cancer) that engage CHWs, because they lead to higher screening rates in underserved communities. CHWs are also effective in addressing other chronic conditions. For example, to prevent cardiovascular disease, the Community Guide [found](#) there is strong evidence that including CHWs in team-based care models to improve blood pressure and cholesterol are both effective in improving health outcomes and are cost-effective. The Community Guide specifically found, based on 22 studies evaluating programs serving underserved groups, that this intervention addressed health disparities and improved minority health.⁴⁵ The Community Guide released similar findings for certain [diabetes prevention](#) activities, such as education and outreach for those at risk of developing Type 2 diabetes, as well as for some [diabetes management](#) activities. Researchers found that a CHW model addressing Hispanic health disparities related to cancer and cardiovascular disease was successful in increasing use of preventive services and changing behavior.⁴⁶

CHWs have also demonstrated net-savings in some areas. For example, in West Baltimore, using CHWs as part of the care team resulted in cost-savings of \$2,000 per enrollee with diabetes, and \$2.6 million net savings through outreach to those in need of home and community-based services.⁴⁷ While there is no national standard for training, certification, and licensure for CHWs, some states have established their own training and certification requirements to support reimbursement through Medicaid.⁴⁸

CHW services are not directly financed as Medicaid-covered services, though states can pay for these services through managed care, through state plan amendments using CHWs as part of health homes, and by including CHWs in the state preventive service and targeted case management benefits.⁴⁹ About half of states with managed care require managed care organizations (MCOs) to employ CHWs.⁵⁰ States have also financed CHWs through 1115 waivers and through grant funding.

RECOMMENDATIONS

Improving Access to and Sustainable Financing of Nonmedical and Preventive Services

Expanding Access to Preventive Services in Medicaid

- **Require coverage of clinical preventive services without cost-sharing in Medicaid for the non-expansion population.** *From BPC's [2020 Advancing Comprehensive Primary Care in Medicaid](#) report*

The ACA requires the coverage of clinical preventive services without cost-sharing across all payers; however, the traditional Medicaid population was excluded from this requirement. To incentivize states to cover preventive services without cost-sharing for this population, the ACA included a permanent 1% increase in FMAP for states that choose to expand access to these services. Today, most states have not elected to cover these services without cost-sharing; as of 2017, only nine states covered the full list of federally recommended preventive services without cost-sharing.⁵¹ States should still receive the 1% increase in FMAP after expanding coverage.

This would ensure certain services like nutrition screening and counseling services that are currently accessible to the Medicaid “expansion” population could also be accessed without cost by the traditional Medicaid population.

- **Direct the secretary of HHS to provide CMS guidance to states on defining and reimbursing community health workers within their Medicaid programs, where evidence has demonstrated improved outcomes.** *From BPC's [2020 Advancing Comprehensive Primary Care in Medicaid](#) report*

Coverage of CHWs has proven to be effective in addressing health care disparities in minority and underserved communities, improving outcomes, and reducing Medicaid costs for some populations and conditions. However, states and their representatives have indicated that CMS has not put forth adequate clarifying information on each of the pathways states can take to cover CHWs. For example, states have to specify in state plan amendments the education, training, and credentialing requirements of CHWs, even though no federal standards exist, and the limit on the CHW-provided services that CMS will reimburse is also unclear.⁵² CMS has already taken a step in this direction in 2021 by including

community health workers as possible members of care coordination teams in its discussion of managed care plan contracting strategies that states can leverage.⁵³ In developing guidance, the secretary of HHS should consider the numerous studies to determine how best to include CHW services to provide primary care and preventive services. Many of the interventions recommended by the CPSTF are provided in the community by CHWs, including various cancer screening interventions, team-based care to prevent cardiovascular disease, and interventions to prevent and manage Type 2 diabetes.

SECTION II: INCREASING THE CAPACITY OF THE HEALTH CARE WORKFORCE TO SUPPORT INTEGRATION

COVID-19 highlighted many of the inadequacies of the current health care system. The higher disease burden among Black, Latino, and other disadvantaged populations demonstrated clear racial and cultural disparities.⁵⁴ Broad integration of clinical and nonmedical services is necessary to address the behavioral, cultural, and social factors affecting health outcomes.⁵⁵ However, the ability to integrate services is dependent on a health care workforce facing critical shortages.

Primary care, maternal health, and behavioral health clinicians may be best-positioned to coordinate with the public health workforce because of ongoing patient relationships and established trust. Yet only 30% of physicians provide primary care services, and that number continues to decrease.⁵⁶ Nurse practitioners (NP) and physician assistants (PA) have historically practiced in primary care settings, but are shifting toward higher-paying specialties.^{57,58} Half of U.S. counties do not have an obstetrician, and 30% of Americans live in an area with a shortage of mental health professionals.^{59,60} Primary care providers are often the first line of care for expectant mothers and those with mental health conditions or substance use disorder, creating additional stress for an already overburdened group. This is particularly true in rural parts of the country, where staff recruitment and retention are tied to social factors, such as a spouse's ability to assimilate into the community.

The cause of provider shortages in these areas is complex. Job satisfaction and income potential are certainly key factors impacting the selection of one clinical discipline or setting over another. More than half of primary care physicians report experiencing burnout, according to the [Agency for Healthcare Research and Quality](#).⁶¹ Higher rates of burnout are seen in fee-for-service settings, while value-based models are linked to improved professional satisfaction.⁶² Moreover, operating as part of a team reduces emotional exhaustion and positively affects well-being.⁶³ The fee-for-service reimbursement structure has been criticized for underpaying primary care and other cognitive specialties, while rewarding

procedure-based specialties with higher payment rates. However, traditional reimbursement practices may have less influence on practice selection in the current workforce landscape, as more than half of all physicians are now salaried employees of a hospital or medical group.⁶⁴ Nevertheless, medical school graduates facing mounting debt may be less likely to enter into lower-paying disciplines.

HHS administers more than 70 discrete programs to expand the workforce pipeline, increase training opportunities, and support interprofessional mentorships through telehealth. It is difficult to determine which programs have been most successful in meeting national workforce needs, as they are funded and evaluated independently.⁶⁵ However, it is likely that recruitment and retention initiatives will continue to offer modest results without strategic application of available resources and a more holistic approach to the panel of federal programs.

Long-term solutions for tackling workforce shortages will require the adoption of team-based care models and judicious use of telehealth and other technology to expand the capacity of the currently available workforce. Here, we present immediate options for addressing the most critical workforce shortages.

RECOMMENDATIONS

- **Waive the federal requirement for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) providers to be licensed in the state where a patient receives services, when the provider is licensed in another state; and issue FBI guidance to states drafting interstate licensure compact legislation.**

State scope of practice and licensure requirements are often cited as impediments to interstate telehealth services. According to a 2018 report by the Federal Trade Commission (FTC) Economic Liberty Task Force, the associated administrative burden, extended application periods, and additive costs of multistate licensure prevent full use of the currently available workforce.⁶⁶ The task force recommended improving licensure portability by incentivizing state participation in voluntary professional licensure compacts or adoption of a mutual recognition model with a single license for member states.⁶⁷ While the role of states cannot be overstated, federal barriers exist.

Federal law requires providers be licensed in the state in which services are provided, as a condition of reimbursement under Medicare, Medicaid, and CHIP. In response to COVID-19, the HHS secretary used 1135 waiver authority to temporarily suspend the federal in-state licensure requirement, when a provider is licensed in another state.⁶⁸ Although licensure remained under the purview of the states, all 50 states and the District of Columbia subsequently waived similar requirements for the duration of the public health emergency. Notably, the CMS has issued guidance recognizing licensure compacts for meeting federal licensure requirements.⁶⁹

Interstate licensure compacts offer a streamlined and expedited licensure process for providers located in member states. Compacts are currently available for six health professions—medicine, nursing, physical therapy, psychology, audiology and speech language pathology, and emergency medical services. In March 2021, the Department of Defense announced a series of grants for the development of additional compacts, including for social workers and massage therapists, to assist military spouses with licensure portability.⁷⁰ In 2019, HRSA awarded the Federation of State Medical Boards a five-year grant to support the work of the Interstate Medical Licensure Compact, including funding to raise the profile of compacts through education and outreach. The grant also assists member states with the costs of conducting provider background checks. Despite incentives and funding, only 35 states are currently participating in compacts.⁷¹

Although licensure compacts are established through state legislation, federal law requires criminal background checks on all applicants within the compact. The FBI reviews the statutory language for each compact to ensure compliance with federal law before granting State Identification Bureaus the authority to perform the background checks. The FBI has withheld approval for a variety of reasons, including concerns regarding privacy and fingerprinting processes. The Interstate Medical Licensure Compact Commission has determined the specific concerns cited are expressly obviated by state legislative language. Moreover, denials have been issued for compacts with statutory language that is identical to that of previously approved compacts. The commission has requested greater transparency and guidance, as the inconsistency has resulted in administrative roadblocks to participation for some states.

To promote the provision of telehealth services across state lines, federal policy should build on the COVID-19 1135 waiver authority to remove federal barriers to licensure portability. Congress should either eliminate the federal in-state licensure requirement for practitioners licensed in another state or expand the HHS secretary's authority to waive the requirement outside of a declared emergency. While continuing to defer to the states of jurisdiction on licensure requirements, this would enable the secretary to improve access to providers in shortage areas. In addition, the U.S. attorney general should direct the FBI to issue additional guidance for State Identification Bureaus regarding federal requirements for authorization to perform background checks. Alternatively, the FBI could approve sample legislative language, which it deems compliant with Public Law 92-544, for use by state lawmakers when drafting compact legislation.

- **Use technology to enable greater integration of clinical and community-based services.**

Various types of technology are currently used across health care settings to improve care delivery and address widespread access issues. Electronic health records (EHR) are an important tool for ensuring the provision of coordinated, patient-centered care; telehealth connects patients with distant providers and enables interprofessional consultation and telementoring; and remote patient monitoring and mobile health applications offer additional touchpoints for patient engagement.

Recent advances in technology have led to significant fluidity across the different modalities. For instance, personal smartphones can now be used for accessing telehealth, health IT, and mobile health apps. Nevertheless, these platforms are regulated by disparate administrative divisions. The Office for the Advancement of Telehealth is currently located in HRSA's Federal Office of Rural Health Policy, while the Office of the National Coordinator for Health Information Technology (ONC) develops standards for EHR interoperability and data-sharing, and the Food and Drug Administration oversees patient monitoring tools and mobile applications. The agility required to keep pace with technological advancements is limited by this siloed structure.

Optimization and use of health technology should be undertaken to expand the capacity of the health care workforce and create a bridge to community-based services. To support these goals, policymakers should:

- Create a centralized office, within ONC, for the advancement of all forms of health information technology, telehealth, and mobile health applications, including technology solutions for the unique needs of rural communities.
 - Ensure that EHRs are able to support and simplify the integration of services, such as through inclusion of clinical decision support tools to assist with behavioral and social determinants of health screening and referral.
 - Provide additional funding for the HHS Office of the Inspector General to modernize capabilities to track fraud, waste, and abuse for telehealth and other health technology.
 - Ensure the protection of patient privacy across platforms.
- **Improve Medicaid reimbursement for primary, prenatal, and postpartum care. Congress should increase state FMAP to 90% for five years for primary, prenatal, and postpartum services for states that reimburse those services at certain minimum rates; states must reimburse primary care services at Medicare rates and reimburse prenatal/postpartum services at average commercial rates to receive**

the enhanced FMAP. Congress should also direct GAO to study and report on the impact of the increased reimbursement rates on access to care. *The Congressional Budget Office estimated that the ACA's two-year payment increase for primary care would cost \$8.3 billion over 10 years.⁷² BPC staff estimates the cost of this proposal to be at least \$20 billion over 10 years.*

The American Rescue Plan Act of 2021 established a Medicaid state plan option, available to states for five years beginning on April 1, 2022, that allows states to extend Medicaid postpartum coverage from 60 days to 12 months.^{c,73} However, coverage does not guarantee access to care. A wide range of challenges, including workforce shortages, can make it difficult for beneficiaries to access covered services.

Inadequate reimbursement is one of many barriers contributing to workforce shortages in Medicaid primary, prenatal, and postpartum care. Medicaid providers are generally reimbursed at lower rates than Medicare and private insurance providers. On average, Medicaid primary care providers are reimbursed at about 67% of Medicare rates, and Medicaid obstetric care providers are reimbursed at 80% of Medicare rates.⁷⁴ Medicaid is a predominant payer for maternal care, covering more than 40% of all births in the U.S.⁷⁵ However, the National Rural Health Association estimates that Medicaid reimbursement for obstetric services is approximately half the rate of commercial insurance and falls short of covering costs.⁷⁶ This has led to closures of rural hospital obstetric units, resulting in a loss of providers.⁷⁷

Providers are also less likely to accept new patients insured by Medicaid (74.3%) than those with Medicare (87.8%) or private insurance (96.1%), according to a 2021 Medicaid and CHIP Payment and Access Commission (MACPAC) study.⁷⁸ Across payers, primary care providers are generally reimbursed at lower rates than other providers, which has potential implications for access. Physicians in states with higher-than-average Medicaid-to-Medicare payment ratios (indicating Medicaid rates closer to average Medicare rates) are more likely to accept new Medicaid patients than those in states with lower-than-average payment ratios (indicating Medicaid rates further below average Medicare rates).⁷⁹

A new policy that builds on lessons learned from the ACA payment increase for primary care providers could improve access to care and inform future policy by providing better data on the impacts of increased reimbursement on access to care. For 2013 and 2014, the ACA required states to increase Medicaid rates for primary care providers to 100% of Medicare and provided 100% FMAP to cover the cost of the increase for those services.⁸⁰ The

^c Under the American Rescue Plan Act of 2021, if a state elects this new state plan option under Medicaid and covers, through CHIP, low-income pregnant women or low-income children who are pregnant, then the state must also extend postpartum coverage in CHIP. Also, while states may cover a narrow set of pregnancy-related services for the 60-day postpartum period, states electing this new state plan option must cover the full range of state plan benefits.

payment increase applied to eligible providers in both Medicaid fee-for-service and managed care.⁸¹ The intent had been for states to continue the higher payments following 2014, but that mostly did not happen. As of July 2016, 19 states continued to pay primary care providers at an increased rate, although not all continued at Medicare rates.⁸² Fourteen of those states maintained primary care payment rates above 80% of Medicare rates for eligible providers.⁸³

Evaluations of the impact of increased reimbursement on access to care found the higher reimbursement had only a modest effect, if any, on enrollment of new Medicaid providers.^{84,85} However, appointment availability increased among existing Medicaid providers, and availability grew most in states with the largest reimbursement increases, resulting in expanded access to care.⁸⁶

Several factors may have been barriers to recognizing the full potential impacts of the policy. For example, states had little time to prepare for implementation of the payment increase, since CMS released the final rule less than two months before the provision went into effect.⁸⁷ States and other stakeholders have suggested operational challenges may have delayed state implementation of the policy⁸⁸ by six to eight months in most states, and the short duration of the increased reimbursement may have contributed to the challenges in recruiting new Medicaid providers.⁸⁹ Also, many providers—particularly independent providers and those in small groups—may have been unaware of the payment increase,⁹⁰ and the eligibility criteria caused confusion among some providers.⁹¹

One study produced for HHS' Office of the Assistant Secretary for Planning and Evaluation examined nine states that represented a mix of criteria, and found that the main reasons for not continuing the payment increase was the pressure on state budgets, inability to find state-level funding for the increase, or lack of evidence of the policy's impact on access to care.⁹² The main reason other states maintained the payment increase was to continue improving provider participation and patient access.⁹³ Also, the greatest facilitator to continuing the payment increase was the ability to identify novel sources of state funding for it.⁹⁴

Some states that continued the payment increase modified it to fit within their budgets. For example, Connecticut and Nebraska revised the list of eligible codes by removing several of the expensive inpatient codes that were not reflective of outpatient primary care (e.g., intensive resuscitation in the emergency department), which helped both the states fund the continued payment increase.⁹⁵ When Florida implemented a similar payment policy for pediatricians and obstetricians, it required MCOs to fund the payment increase using cost-savings from enhanced care coordination.⁹⁶

The report recommended that future similar policies include longer lead time prior to implementation; clearer program requirements from federal agencies;

greater flexibility in state program design, such as allowing states to include nonphysicians practicing independently or linking enhanced payments to existing pay-for-performance programs; clearer, consistent communication with stakeholders; better targeted outreach to specific stakeholder groups; simpler electronic submission and attestation processes; better sequencing of provider eligibility determinations and payments to avoid claims reprocessing; and longer duration of payment increase.⁹⁷

Additionally, while the ACA limited the Medicaid payment increase to primary care physicians, CMS clarified in regulation that the payment boost applied to nonphysician practitioners practicing under the personal supervision of an eligible physician.⁹⁸ In line with lessons learned from the earlier payment increase, this policy option would also extend the enhanced match rate to services provided by nonphysician practitioners practicing independently, as long as they are practicing within the scope of their state license. This policy would also give states greater flexibility in their program design, allowing them to link payments to value-based payment initiatives.

Increasing Medicaid provider payments for primary, prenatal, and postpartum care for a longer duration to additional provider types, ensuring sufficient time for implementation, studying the impacts on access to care, and incorporating other lessons learned would help to address the earlier challenges and provide better data on impacts of the payment increase. As mentioned above, other important workforce challenges that are not addressed by this proposal but should be explored range from high medical malpractice insurance costs and other malpractice concerns to access disparities across race, ethnicity, and geography, to volume-based payments and fragmented or nonintegrated care across safety net providers, and to state policy choices around telehealth coverage, among other challenges.

Relevant Legislation - [H.R.1025 - Kids' Access to Primary Care Act of 2021](#), bipartisan legislation sponsored by Rep. Kim Schrier (D-WA) with 19 co-sponsors, including Rep. Brian K. Fitzpatrick (R-PA). Introduced February 11, 2021 and referred to Subcommittee on Health on February 23, 2021.

This legislation would renew and make permanent the ACA's payment increase for primary care providers, expand the list of eligible providers to include obstetrics and gynecology, and require the HHS secretary to conduct a study of Medicaid provider enrollment and payment rates. For the study, the legislation would authorize to be appropriated \$200,000 for fiscal year 2022, to be available until expended. While the ACA extended the payment increase to practitioners working under the personal supervision of a qualifying physician, this legislation would further extend the payment increase to advanced practice clinicians working under the supervision of a nurse practitioner, physician assistant, or certified nurse-midwife who is working in accordance with state law. The legislation also extends to rural health clinics,

federally-qualified health centers, or other health clinics that receive reimbursement on a fee schedule applicable to the providers mentioned for services furnished by those providers.

In March 2021, 26 organizations and advocate groups sent a [letter](#) to Reps. Kim Schrier (D-WA), Kathy Castor (D-FL), and Brian Fitzpatrick (R-PA) in support of the legislation.

A similar bill, [S.1833 – Ensuring Access to Primary Care for Women & Children Act](#), was introduced by Sen. Sherrod Brown (D-OH) on May 26, 2021. The bill has nine co-sponsors, including eight Democrats and one independent. The bill was referred to the Committee on Finance.

- **Appropriate funding for the National Health Care Workforce Commission to perform a comprehensive evaluation of the current workforce landscape, develop policy recommendations to ensure federal education and training programs meet critical needs, and provide oversight of federal workforce programs.**

An independent panel of experts should be convened to ensure federal health care workforce interventions effectively address the most critical workforce shortages. The National Health Care Workforce Commission was established and authorized under the ACA, but Congress has never appropriated funding. The panel should:

- Perform an analysis of the national health care workforce, in coordination with HHS and other relevant departments and agencies within the federal government, to identify the most critical workforce gaps.
- Quantify the comparative effectiveness of federal workforce recruitment and retention programs to reverse critical shortages and create sustained improvements for meeting future demands.
- Consider how the nonphysician and public health workforce as well as technology and telehealth can expand workforce capacity, provide ongoing training for providers, and facilitate the integration of health and health care.
- Recommend actions to address high-priority workforce shortages, ensure adequate training faculty, and consolidate the currently siloed federal workforce programs.
- Review and recalibrate workforce priorities every five years.

Conclusion

The COVID-19 pandemic has highlighted and exacerbated vulnerabilities created by poor health status in the United States, including the impacts of high rates of chronic disease, nutrition insecurity, and insufficient access to care. To improve our collective resistance to new health hazards, policymakers must take action to invest in a prevention-oriented approach to health care, address upstream social determinants of health, and enhance both coverage of and access to primary care and preventive services.

BPC's recommendations represent a bipartisan step toward bridging public health and health care, starting with the expansion of Medicaid coverage of services that enhance health and actions to bolster the workforce and empower providers to address social determinants of health. These proposals aim to increase access to services that prevent the onset of chronic conditions, stem disease progression and, therefore, lead to better health outcomes and drive down health care costs.

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