Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Health Policy Priorities for the Biden Administration

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The experience of the coronavirus disease 2019 (Covid-19) pandemic will shape the new administration's health care policies and impact health care for years to come, specifically in 2 ways. First, the pandemic widened disparities in access, quality, and outcomes, disproportionately affecting low-income and minority populations and demanding a greater focus on equity and a more comprehensive approach to care delivery. Second, the pandemic highlighted the benefits of shifting to a more resilient, innovative health care system. Many providers struggled to adjust to the new Covid realities such as decreased procedural revenue and increased reliance on non–face-to-face care; in contrast, many participants in alternative payment models shifted quickly, using more flexible financing and new virtual technologies to provide care that patients needed.[1]

These experiences support the administration's key policy goal: to strengthen primary care and bolster infrastructure to help more practices deliver accessible, equitable care. We outline how these experiences are influencing the administration's policies in the following areas: (1) Covid-19 response, (2) value-based payment, (3) telehealth, and (4) access and equity.

Continuing Focus on the Coronavirus Disease 2019 Pandemic: The American Rescue Plan Act

The American Rescue Plan Act (ARPA) was a $1.9 trillion economic stimulus bill signed by President Biden into law in March of 2021. Although the bill was designed in part to provide short-term pandemic relief, it also may have significant long-term impact on health care policy. For example, the legislation expands subsidies for 2 years to consumers who purchase health insurance on state exchanges and caps premium payments at 8.5% of income. Expanded subsidies will benefit all exchange participants, but particularly older adults with higher incomes. Affordable Care Act rules previously did not allow for subsidies beyond 400% of the federal poverty level. Now, under ARPA, a 60-year-old with an income of 430% of the federal poverty level would see more than a 50% reduction in premiums for gold or silver plans.[2] The administration hopes to make these increases permanent in the pending reconciliation legislation.

In addition, ARPA provides $350 billion in total funding to states for Covid-19 recovery and vaccination efforts, and public health and economic initiatives. States have opportunities to invest funds into economic recovery, health care infrastructure, and safety net programs. North Carolina, for instance, plans to put some relief funds toward health research innovation, health and wellness promotion, and food security programs for at-risk residents.[3]

The Value-Based Payment Agenda

A Center for Medicare and Medicaid Innovation (CMMI) review found that payment models that delivered substantial savings tended to have broader population focus with greater shifts from fee-for-service.[4] In that context, the emerging strategy of the Centers for Medicare and Medicaid Services (CMS) emphasizes moving to a streamlined set of payment reforms that prioritizes patient-centered models in which providers are accountable for quality and total cost of care, aligns quality measures with patient goals, advances health equity through better data analytics, and an enhanced focus on improving access to community resources for social needs.[5]

Notable CMS actions for specialty care likely will occur through the Merit-based Incentive Payment System (MIPS), which will enter its sixth year in 2022. CMS has proposed Value Pathways for measures with the goal of reducing provider burden,

Abbreviations used in this paper: ARPA, American Rescue Plan Act; CMMI, Center for Medicare and Medicaid Innovation; CMS, Centers for Medicare and Medicaid Services; Covid-19, coronavirus disease 2019; GI, gastrointestinal; MIPS, Merit-based Incentive Payment System.

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allowing providers to choose measures relevant to their practice, and providing the ability to compare measure performance against similar providers. If finalized, the initial pathways would begin in the 2023 performance year and remain voluntary for the first 2 years. Gastroenterology is not included in the initial pathways, which cover rheumatology, stroke care and prevention, heart disease, chronic disease management, emergency medicine, lower-extremity joint repair, and anesthesia, but it may be included in an upcoming phase.

Beyond MIPS changes, there have not been announcements about new specialty-focused alternative payment models. The Bundled Payments for Care Improvement–Advanced model, which currently includes 4 gastrointestinal (GI) surgical procedures, accepted its second and likely last cohort in January 2020. Part of the reason that new models are not forthcoming for specialized care, in addition to the immediate priorities around advanced primary care and population health, may be the unanswered questions in which specialty-focused payment models are most effective. Although some procedure-based episode reforms have achieved savings and quality improvements, many specialty reform models have had limited savings or even added spending for Medicare.[6] Although new CMMI specialty bundles have not been announced, GI clinicians likely will see bundled payment programs and value-based networks expand in their commercial and Medicare Advantage health plans.

CMS also will prioritize alternative payment models that advance comprehensive care, which may lead to an increased emphasis on encouraging primary care and specialty coordination. GI physicians used by a hospital-based system or in a multispecialty practice may see their organizations participate in more advanced Accountable Care Organizations, another CMS advanced primary care model, or more comprehensive reforms such as direct contracting—either in CMMI's proposed new model or with employers. Those models likely will emphasize effective use of prevention, early treatment, and efficient collaboration with primary care. Specialized GI practices are likely to see their referring primary care practices pay more attention to the total costs and coordination for their patients.

In addition to payment models, complementary benefit reforms are being proposed for longitudinal and preventive care, specifically phasing out coinsurance requirements for colorectal cancer screening tests that become diagnostic tests when additional services are needed. The proposed change would reduce coinsurance beginning in 2022, and reach zero by 2030.

Innovative Care Delivery to Expand Access and Patient-Centered Care: Telehealth and Home Care

Telehealth utilization increased rapidly during the pandemic. Although utilization has fallen from its peak, it remains considerably higher than before the pandemic, a sign that telehealth is here to stay. CMS will continue to cover telehealth services allowed during the pandemic and expand telehealth coverage for mental health care.[7] However, there are cost, quality, and logistical concerns around telehealth coverage. In addition, there is substantial debate about the best approach to turn an abrupt Covid-era shift to a sustainable and effective reform, especially given concerns about the potential for waste, fraud, and abuse.[8] Telehealth also cannot be widely adopted without support for greater broadband access, given disparities in access for less-populous areas. The $1.2 trillion bipartisan Infrastructure Investment and Jobs Act signed by President Biden in November of 2021 includes $65 billion for broadband infrastructure and initiatives to increase affordability and adoption.

The momentum surrounding telehealth fits into a broader movement toward innovative home-care models that incorporate virtual elements, but questions remain about exactly how large the government's investment will be. The proposed reconciliation bill initially included $400 billion to improve home care infrastructure, increase the number of home care workers, and increase the amount of take-home pay many of them receive, but this number is expected to be much lower in the final version. There also are opportunities to continue innovative home-based care delivery innovations from the public health emergency, including GI-focused care models. For instance, before the pandemic, Upstate Homecare and a team of Golisano Children's Hospital gastroenterologists began piloting home infusion therapies for pediatric patients with conditions such as Crohn's disease and ulcerative colitis. During the pandemic, many families requested to participate in the pilot. Advocates see this pilot study as further reason to expand home-based care options for specialty and chronic condition patients, including those with GI diseases.[9]

Centers for Medicare and Medicaid Services: Access, Coverage, and Equity

To complement CMMI's work on value-based payment models, CMS is further prioritizing improving coverage, access, and health equity. In terms of coverage, CMS expanded coverage to an additional 2 million Americans via the health exchanges through a 6-month special enrollment period, although that has not yet resulted in a substantial change in the overall number of uninsured. CMS also revoked the Section 1115 waiver approval for Medicaid work requirements in several states, stating its concern that such waivers are barriers for historically disadvantaged populations.

CMS also hopes to improve infrastructure around health equity to help providers refer patients for assistance with the nonmedical factors that contribute to disparities, such as limited access to transportation, food and housing insecurity, and unsafe home environments. The agency is seeking feedback on what infrastructure support and data collection tools could help assess and improve impact on equity and disparities.

Less Momentum on Drug Reform and Significant Coverage Expansions

Although the Administration's priorities will help make some advancements in payment and delivery reform, other major legislative reforms are less likely. The American Rescue Plan Act and the bipartisan infrastructure bill did not include provisions for significant pricing reforms in Medicare, and unified Democratic support for specific drug price proposals has not yet come together. Drug pricing certainly will receive public attention—including with a new Alzheimer disease drug priced at $56,000 per Medicare patient annually—but the prospects for major legislation using an international reference price for many new drugs appear to be low. However, some changes may come in areas such as payment incentives to use less costly biosimilars and program integrity in the 340B drug pricing program. The Biden Administration earmarked $17 million to create oversight protocols for the 340B drug discount program, with $7 million allocated toward creating a dispute and resolution process.

Conclusions

Overall, the policy priorities of the Biden administration show a continued commitment to value-based care, with investments and regulations that adapt longer-term priorities to address challenges in the care system exposed by Covid-19 while simultaneously leveraging some of the innovations that came from it. These efforts will start in primary care. Although this could mean gastroenterology may see limited targeted reforms, proposed reforms to programs such as MIPS show change could be on the horizon. Gastroenterologists should consider how they can partner with primary care to play a role in comprehensive care reforms and increase their focus on addressing health disparities. Those that do will be best positioned to incorporate new innovations into a better aligned and more collaborative health care system.

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Conflicts of interest
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