September 30, 2020

The Honorable Sarah Davis, Chair
House Committee on Appropriations - Subcommittee on Article II
Submitted via email to Appropriations@house.texas.gov

RE: Interim Charge II

Dear Chair Davis and Subcommittee Members:

On behalf of the Texas Medical Association, Texas Academy of Family Physicians, Texas Pediatric Society, Texas Association of Obstetricians and Gynecologists, American College of Obstetricians and Gynecologists District IX (Texas Chapter), and American College of Physicians, Texas Chapter, thank you for the opportunity to provide input on the House Committee on Appropriations – Subcommittee on Article II's Request for Information regarding:

Interim Charge #2: Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: the Family First Prevention Services Act; the next phase of the 1115 Healthcare Transformation and Quality Improvement Program Waiver; Texas' Targeted Opioid Response Grant; the Centers for Medicare and Medicaid Services proposed Medicaid Fiscal Accountability rule, and the Healthy Texas Women Section 1115 Demonstration Waiver.

Our comments will focus on renewal of the state's Medicaid 1115 Healthcare Transformation Waiver and the Healthy Texas Women 1115 Waiver. Should you have any questions, please contact Helen Kent Davis, associate vice president, Texas Medical Association, at helen.davis@texmed.org or (512) 415-8048; or Michelle Romero, associate director, TMA legislative affairs, at michelle.romero@texmed.org or (512) 743-8665.

Interim Charge 2: 1115 Healthcare Transformation and Quality Improvement Program Waiver

Our organizations have strongly supported Texas' Medicaid 1115 transformation waiver since its inception. We continue to do so. Undoubtedly, thousands of Medicaid enrollees and low-income, uninsured Texans have benefited from it. Among its benefits, the waiver has:

- Improved access to health and dental care services for low-income, uninsured Texans;
- Stabilized financial solvency for safety-net hospitals, particularly rural hospitals;
- Expanded availability of behavioral health care; and
- Allowed Texas to test innovative health care delivery models to determine what models will work or not, such as medical home programs designed to increase use of prenatal care or to better serve children and adolescents with special health care needs.

Barring renewal, in two years the waiver will expire, eliminating vital funding that undergirds Texas' entire health care system as well as the ability to test new health care delivery models. Per the terms of the current waiver, the Delivery System Reform Incentive Payment (DSRIP) program will be phased out first, ending Sept. 30, 2021. Yet, it is DSRIP dollars that provide the means for communities to enhance capacity, especially for low-income, uninsured Texans. Withdrawing funding now will harm the state's ability to care for patients, COVID-19-related or not, particularly given the continued financial strain the pandemic has

caused for DSRIP-participating physicians, hospitals, and behavioral health clinics. **As such, we join with the Texas Hospital Association, Teaching Hospitals of Texas, and other associations urging Texas to pursue a one-year extension of DSRIP funding.**

Just as important, **Texas should seek a one-year extension of the waiver, pushing the expiration to Sept. 30, 2023, to give the state more time to plan Texas' waiver renewal in close collaboration with stakeholders.** In late 2019, the Texas Health and Human Services Commission (HHSC) and waiver stakeholders began those discussions, but they ceased in March when HHSC and waiver stakeholders moved swiftly to respond to COVID-19 – a response that is ongoing. As it stands, physicians, hospitals, community-behavioral health clinics, public health systems, and other vital waiver stakeholders lack the bandwidth to maintain pandemic preparedness while also engaging in the robust dialogue, research, and evaluation needed to reimagine Texas' health care delivery system. Moreover, CMS has clearly articulated its expectation that the state's Medicaid managed care architecture become the framework for any future waiver. However, the transition will not be fast or easy because waiver initiatives do not neatly crosswalk to managed care. Considerably more discussion is needed about how to successfully achieve this goal.

While HHSC has recently resumed stakeholder meetings, it has nonetheless lost valuable time to plan for a health care landscape expected to be realized in two years. Even in the best of times, Texas would have been hard pressed to develop a waiver framework in such an abbreviated timeframe.

The next waiver must be redesigned tip to tail. Despite our support for the existing waiver, it also is fundamentally flawed, having been built on a hospital-centric model of care rather than a community one, cleaving local health care delivery systems into the waiver "haves" and "have nots" and erasing the nascent pre-waiver initiatives designed to address exigent local health care issues. Yet, one thing the pandemic has taught a cross-section of health care leaders is that the ability to rethink ossified health care delivery systems and foster collaboration contributed to survival. Texas must build on this renewed imperative. As such, our organizations strongly advocate establishment of a community-based accountable health organization (AHO) that will foster:

- responsive, accountable, high-quality, equitable and cost-effective care for low-income Texans;
- harness the resources and capacity of the entire spectrum of physician practices (independent, employed, and safety-net practices), hospitals, community clinics, behavioral health organizations, public health departments, and managed care organizations committed to caring for people living in marginalized and low-wealth communities; and
- innovative, community-driven initiatives that connect medical and nonmedical systems to together to synergistically address underlying social determinants of health (SDOH).

Our aim is not to exclude any existing waiver provider from participating in a future model, but to build capacity while also promoting greater transparency and accountability relating to waiver governance, delivery system design, performance measurement, and funding. Under a community-based AHO, waiver dollars would be distributed fairly across the health care delivery system, including to community-based physicians and clinics unaffiliated with hospitals or academic health systems.

The pandemic has revealed deep structural problems with the design and funding of our health care delivery system. All sectors saw steep declines in patient revenue, resulting in layoffs, furloughs or even temporary closures. Yet some are better positioned to weather the changes. Hospitals, for example, have access to supplemental Medicaid funding. Community-based physicians do not. Yet, without help, the upheaval could become an "extinction-level event" as practices close, merge with hospital systems, or sell to private equity firms, resulting in higher costs and less innovation – just the opposite of Texas Medicaid's leading-edge efforts to promote more accountable care. **The deterioration of the states' Medicaid physician network will harm all patients, not just Medicaid beneficiaries.** Moreover, current DSRIP providers cannot possibly make up the lost capacity.

That is why any funding from a new waiver should be invested into pragmatic initiatives that will enhance physician and provider capacity and availability while also accelerating use of value-driven care, including funding to support adoption of data analytic tools; expand use of patient navigators and care coordination,

particularly for high-risk or medically complex patients; and establish mechanisms to share actionable data across medical, social, and behavioral health networks in order to improve management of medical and nonmedical factors

To achieve a genuine community-based approach, Texas will need the active engagement of not only those who provide medical care and social services but also those who obtain it and organize it. Under the current waiver, the state uses Regional Healthcare Partnerships (RHPs) to facilitate dialogue and collaboration among DSRIP providers. RHPs potentially could be restructured, with the goal of promoting community-based governance. Though they use different nomenclature, other states, such as Washington, Oregon, and Colorado, have similar initiatives from which Texas can learn. To guide the AHO, we believe the state should incorporate the following key principles to ensure the entity:

- Is built on a robust primary care foundation;
- Maintains an inclusive network of physicians and providers with an interest in serving the population;
- Actively seeks to improve health care access, reduce health disparities, and engage the community;
- Links medical and nonmedical sectors to better address social drivers of health;
- Promotes accountable, sustainable, and equitable payment strategies that reward improved patient outcomes;
- Promotes collaborative value-based initiatives with Medicaid managed care plans;
- Establishes a robust and meaningful health information exchange for both clinical and social service information;
- Ensures care coordination as a core function; and
- Engages physicians and providers regardless of their degree of practice transformation.

Given the geographic diversity and scale of Texas, we recommend that Texas pilot a community-based AHO model in at least one rural and one urban region.

In addition to supporting a fairer, more accountable waiver, TMA advocates using any new waiver to achieve several other vital goals: **(1) reduce the number of Texans without health insurance; 2) reinvigorate the Medicaid physician network; and (3) implement innovative strategies to address the nonmedical factors that impact health care outcomes and costs.**

Regarding the former, of critical importance to our members is that our patients can obtain timely access to health care services, a goal we know you share. Yet for many Texans, this is becoming increasingly difficult to do. In September, the U.S. Census Bureau published 2019 estimates for the uninsured, finding that Texans who lack health care coverage increased for the fourth year in a row, rising from 16% in 2016 to 18.4% in 2019, for a total of 5.2 million uninsured Texans. Of these, nearly one million Texas children (12.7) lack coverage (one in five uninsured children *in the country* reside in Texas) along with 24.5% of working-age Texans.

Those figures do not include the estimated 1.6 million Texans who lost health insurance when they lost their jobs due to the pandemic. While the job market has bounced back somewhat, and some of the newly uninsured might be able to obtain coverage elsewhere, **Texas can no longer ignore the profound human, social, and economic impact of having more than 20% of our people uninsured.** Health care coverage matters, resulting in healthier constituents and more economically prosperous communities.[i] "It is both mistaken and dangerous to assume that the persistence of a sizable uninsured population in the U.S. harms only those who are uninsured."[ii]

As organizations dedicated to improving the health of all Texans, our members find these numbers especially alarming and troublesome. Decades of research show the lack of health care coverage poses serious health consequences, contributes to higher health care costs, and hurts job growth.

Ultimately, all Texans benefit when their neighbors, colleagues, family, and friends have health care coverage. Insured children are healthier children, missing less school and contributing to their future socioeconomic success. Insured parents miss less work, increasing economic productivity, a win for employers and the state economy. Insured women have healthier pregnancies and maternal and infant health outcomes, reducing Medicaid costs. And more insured Texans contribute to lower health care premiums for everyone. **Moreover,**

estimates show that by extending Medicaid coverage, the state could save $110 million in net general revenue (GR) during the next biennium by offsetting current GR-only healthcare expenditures.[iii]

Using federal Medicaid dollars,[iv] together with other state and federal policy solutions, Texas can and must sharply reduce its number of uninsured. To date, 39 other states, including Indiana, Ohio, and Utah, have navigated paths forward. Texas must develop a plan for Texans too. We recommend that the state develop a meaningful, statewide health care coverage initiative, including pursuing federal dollars to:

- Extend Medicaid coverage to low-income, uninsured working-age adults;
- Establish a state-administered reinsurance program to reduce premiums for people enrolled in marketplace plans;
- Provide 12-month comprehensive coverage for women who lose Medicaid 60 days postpartum; and
- Establish 12-month continuous coverage for children enrolled in Medicaid, the same benefit provided to children enrolled in the Children's Health Insurance Program.

Improving access to health care must be paired with addressing the nonmedical factors that also affect health, commonly known as social determinants of health (SDOH) – the places where people live, work, and play. Texans of color have been disproportionately affected by COVID-19[v] and SDOH have been fuel to the pandemic's disproportionate impact. Black and Latinx populations face a higher risk of infection and death due to inherent inequities in SDOH. These include discrimination; health care access and utilization; occupation; educational, income, and wealth gaps; and housing.

SDOH have been fuel to the pandemic. Susceptibility to chronic disease is closely tied to socioeconomic status, and as unemployment and uninsured rates increase, there is less access to health services and early treatment for preventable disease. Because of SDOH, people of color are more likely to have underlying medical conditions that put individuals at a higher risk of severe COVID-19 illness and death.

Interim Charge: The Healthy Texas Women Section 1115 Demonstration Waiver

In January, the Centers for Medicare & Medicaid Services approved Texas' five-year Healthy Texas Women (HTW) Medicaid 1115 Demonstration Waiver, converting HTW from a state-funded-only program to a federal-state initiative with nine-to-one federal Medicaid matching funds. The infusion of federal dollars will certainly benefit state coffers at a time when they are much needed. Yet, Texas also must ensure that conversion of HTW into a Medicaid program will not inadvertently undermine key programmatic policy objectives, particularly ensuring continuity of care for women transitioning from pregnancy-related Medicaid to HTW.

CMS approved Texas' waiver two months before HHSC and stakeholders shifted focus to COVID-19 preparedness and response, understandably leaving little time for robust stakeholder engagement. HHSC subsequently announced policy changes our organizations believe will contribute to fewer women enrolling in HTW, impacting not only their health but also the projected savings from HTW. We understand Texas' HTW eligibility determination processes and requirements do not align neatly with federal Medicaid requirements, including use of the modified adjusted gross income methodology. But there is still time for the state to reconsider these actions or seek federal approval for a better alternative, as noted below. Gaps in coverage contribute to poorer health outcomes for mothers and babies, increased uncompensated care costs for participating physicians and providers, and potentially higher state costs. Specifically, we recommend the state revisit or explore alternatives to the following decisions:

- Elimination of HTW auto-enrollment.

Beginning in 2016, Texas began automatically enrolling adult women into HTW when they lost pregnancy-related Medicaid 60 days postpartum. The policy helped prevent gaps in coverage, a best practice to promote better postpartum outcomes for women, babies, and families by ensuring new mothers retain access to preventive and basic primary care. Unfortunately, this policy will cease when Texas fully converts HTW to a Medicaid program. In its place, HHSC intends to conduct electronic administrative reviews prior to the mother's anticipated due date to verify if a new mother will be eligible for HTW. In principle, we support electronic verification because it will minimize the need for exhausted new mothers to complete more paperwork in the weeks following their baby's arrival. However, in practice the data sources Texas uses for

administrative renewals have proven unreliable, as evidenced by the number of families who receive requests for additional information to maintain their child's Medicaid coverage. In fact, the Kaiser Family Foundation reported Texas ranks low for successful administrative renewals, renewing less than 25%. Thus, if an electronic database cannot confirm a woman's income, the agency will need to seek verification directly from her. If she fails to return requested documentation before her pregnancy-related Medicaid eligibility ends, she will not be transitioned to HTW, leaving a gap in care. In 2019, more than 80,000 new mothers were automatically enrolled into HTW. If the administrative renewal is accurate only 25% of the time, then 60,000 women could experience a gap in coverage.

Solution: To prevent gaps in coverage, enroll all adult women losing pregnancy-related Medicaid into HTW, but complete income verification post-enrollment or allow women to self-attest.

- Elimination of adjunctive eligibility for women applying for HTW

Since the creation of HTW (and its predecessor program), adjunctive eligibility has been used to expedite enrollment of new women into HTW, allowing women whose families participate in programs like the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, or the Women, Infants, and Children nutrition program to enroll in HTW without once again verifying income. Federal rules allow such policies to minimize duplicative paperwork for families and the states; thus it is unclear why HHSC elected to discontinue this policy.

Solution: Seek CMS approval to reinstate adjunctive eligibility for women applying for HTW.

- Elimination of the simplified HTW application form (Form H1867)

Currently, women applying for HTW complete a one-page application, allowing them to apply quickly. However, HHSC's waiver application noted Texas will not use the simplified application, even though CMS has allowed simplified application forms to be used as part of similar, previous demonstrations, including Texas' previous family planning demonstration.

Solution: Seek CMS approval to continue using the simplified application form.

Enhanced Access to Long-Acing Reversible Contraceptives (LARCs)

Despite Texas' efforts to ensure women enrolled in Medicaid or HTW will have timely access to LARC if they want it, a Gordian knot of administrative, reimbursement and logistical issues have made efforts to increase their availability especially maddening. To address this, House Bill 1, Rider 77, HHSC bill pattern, directed HHSC to "work with CMS to determine if LARC bulk purchasing can be added to the waiver and receive federal matching funds." Like everything else, COVID-19 has delayed this discussion. However, our organizations support HHSC engaging with CMS forthwith to evaluate whether this is a viable option and explore alternatives if not. It remains a high priority for our organizations to ensure that women who choose LARC can obtain it at the time of service – a clinical best practice.

Thank you for your consideration

Sincerely,

Diana L. Fite, MD, President
Texas Medical Association

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[i] The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review, KFF, March 17, 2020

[ii] A Shared Destiny: Community Effects of Uninsurance (2003), National Academies of Sciences, Engineering and Medicine

[iii] State Budget Impact of Providing Health Insurance to Low-Income Adults with 90%, analysis by Randy Fritz, John R. Pitts and John R. Pitts, Jr. for the Episcopal Health Foundation, September 14, 2020

[iv] How Many Uninsured Adults Could Be Reached If All States Expanded Medicaid?, (KFF), June 25, 2020