TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

June 28, 2021

Texas Health and Human Services Commission
Attention: Basundhara Raychaudhuri, Waiver Coordinator
Policy Development Support
Sent via email: TX_Medicaid_Waivers@hhsc.state.tx.us

Dear Basundhara Raychaudhuri:

On behalf of the Texas Medical Association and the undersigned organizations, thank you for the opportunity to comment on the Texas Health and Human Services Commission's (HHSC) proposed extension of the Texas Healthcare Transformation Quality Improvement Waiver (heretofore referred to as the "waiver").

Together, TMA, the Texas Academy of Family Physicians, Texas Chapter of the American College of Physicians Services, Texas Pediatric Society, American College of Obstetricians and Gynecologists – District XI (Texas), and the Texas Association of Obstetricians and Gynecologists represent more than 55,000 physicians and medical students, working together to improve the health of all Texans by increasing the availability of meaningful health care coverage and access; promoting greater delivery system accountability, value and cost-effectiveness; and reducing health disparities. Co-signing with our organizations are the Texas Primary Care Consortium and the Texas Health Institute, entities that share our organizations' goals and vision for modernizing how and where Medicaid and low-income Texans receive health care services.

From its inception, our organizations have supported the waiver, which has benefitted countless low-income Texans as well as the safety-net systems on which they rely for health care. **Today, we write in favor of renewing it.** Yet, we also believe important changes must be made.

As published in the May 28 edition of the *Texas Register*, HHSC seeks federal approval to extend the waiver for another 10 years, requesting approval to (among other changes):

- Preserve authority for Medicaid managed care for most Medicaid populations, including pregnant women, parents, and children as well as adults and children with disabilities.
- Maintain and resize the hospital uncompensated care (UC) pool.
- Establish a new Public Health Provider - Charity Care Program (PHP-CCP) to offset uncompensated care provided by local public health departments and public mental health providers; and
- Support current and new Directed Payment Programs, including the new Texas Incentives for Physicians and Professional Services (TIPPS), to provide a transition from the Delivery System Reform Incentive Payment program, which will end Sept. 30, 2021.

All told, HHSC estimates the waiver will result in more than $11 billion annually for the state's health care delivery system – funding that without which many health care systems would be forced to limit services or close, thus justifying renewal.

At the same, the waiver's basic construct is 10 years old. If Texas gains approval for a decades-long waiver, an aspect of the waiver request for which we outline concerns below, it is imperative that it foster a more inclusive, holistic, and nimble health system that will meet the needs of hardworking Texans, their families, and the physicians and providers who care for them.

Specifically, our organizations support:

- Offsetting uncompensated care for safety net entities to promote a robust health care safety net.
- Amending the waiver to ensure the financial viability of all components of the system, including authorizing and allowing the redirection of funds to physicians and community clinics to improve access to medical care.
- Seeking authority to establish a Texas-style health care coverage initiative to reduce Texas' alarming and growing rate of uninsured among working age adults.
- Promoting an inclusive, holistic, community-driven approach to improve health outcomes and population health.

An effective health care safety net is the bedrock of a high-functioning health care system. **Maintaining the UC pool for hospitals – and establishing a new one for public health departments and mental health care providers – will ensure safety net providers continue to meet the needs of Texas' most vulnerable populations while continuing to serve their larger communities. For these reasons, we support both**.

But more must be done. As noted in the Centers for Medicare & Medicaid Services Jan. 15, 2021 waiver approval letter (since rescinded but the same terms and conditions HHSC's seeks to renew), ***uncompensated care payments do not equate to health care coverage*.**

At least 5.2 million Texans – nearly 20 percent of the population – lack health insurance, most of whom are working age low-income parents and adults who work hard every day, pay taxes, and support their families and communities, but who either do not receive job-based health insurance or cannot afford it. As organizations dedicated to improving the health of all Texans, our members find these numbers especially alarming and troublesome.

Texas can no longer ignore the profound human, social, and economic impact of having more than 20% of our people uninsured. Decades of research show the lack of comprehensive health care coverage poses serious health consequences, contributes to higher health care costs, and hurts job growth. When parents are uninsured, their children are less likely to be covered too, resulting in missed school and poorer academic progress, impacting Texas' next generation of leaders. Texas has the highest rate of uninsured children in the country.

On their own, UC payments to eligible entities will not ensure uninsured patients get the care they need. UC dollars offset the costs of caring for uninsured patients' care within a facility, not any ongoing care afterwards. Moreover, UC dollars do not necessarily benefit those patients for whom hospital-level care is never needed. For all the good they do, hospitals do not provide outpatient cancer treatment, substance abuse treatment, physical rehabilitation following a stroke or traumatic injury. While many health systems manage or own primary care clinics, they do not have the capacity

to serve all those in need, limiting if and where patients can access comprehensive primary care, whether it be for women, who need such services throughout their reproductive life spans to not only improve early detection and treatment of breast and cervical cancers but also to promote healthier pregnancies, or to provide ongoing clinical management of patients with chronic conditions, such heart disease or diabetes. Likewise, giving UC dollars to public health departments and public mental health care providers will offset their rising uncompensated care costs, but not necessarily ensure more people get the comprehensive preventive, primary, and specialty care they need.

Coverage, on the other hand, confers to the individual, allowing patients to choose where and how to get care when they need it. **As such, we respectfully ask that HHSC amend the waiver to request approval for a Texas-style health care coverage initiative for the state's eligible essential workers paired with continued delivery system innovation.** Our organizations stand ready to work with HHSC to design such a program.

Delivery system changes also must be contemplated. The waiver seeks to reauthorize the use of Medicaid managed care organizations (MCOs) – a provision to which we do not object, despite some of the challenges faced by physicians and patients navigating that system. As directed by state lawmakers, Medicaid managed care is the state's Medicaid delivery model. Over the past decade, pioneering MCOs and physician practices have collaborated to design and implement innovative value-based payment and health care delivery models.

Yet, the waiver reflects the delivery system of 10 years ago, not today, when communities seek greater input into on how and where medical care is delivered as well as the flexibility to address health care quality and the social determinants of health that contribute to health outcomes. Systems now must find ways to engage not only those who provide medical care and social services, but also those who obtain it and finance it.

Just prior to the pandemic, our organizations shared their collective vision for a new community-based strategy, an accountable health organization (AHO)[i], to foster greater local accountability, transparency, value, and cross-sector collaboration for medical-social services. The AHO's goal is to improve patient access to care, constrain health care costs, improve health outcomes, and increase health care equity.

An AHO would not deliver care, but instead work with those that do to establish a common vision, purpose, and direction for addressing health care quality, safety, and equity for the community. We envision an AHO governed by a community-based board inclusive of physicians, hospitals, safety-net entities, managed care plans, and public officials tasked with developing a shared vision of health for their community, while ensuring accountability across the medical and social services sectors using value-driven initiatives to improve health outcomes.

Other key AHO tenets include:

- Promoting a robust primary care foundation to help reduce costs and improve access.
- Maintaining an inclusive community-wide network of physicians and providers with an interest in serving the vulnerable populations.
- Actively seeking to improve health care access, reduce health disparities, and engage the community.

- Linking medical and nonmedical sectors to better address social drivers of health.
- Promoting accountable, sustainable, and equitable payment strategies that reward improved patient outcomes

While many safety-net facilities operate free or reduced-price health clinics, these entities cannot meet all the primary and specialty care needs of their uninsured residents. The bottom line is that communities need more say in how and where care is delivered, how best to meet quality improvement goals, and in developing viable local strategies to address nonmedical factors that often undermine good health.

Just as Texas can no longer ignore the human and economic toll of its uninsured residents, so too can the state no longer continue to promote a Medicaid financing system that favors some physicians and providers over others. That is why our organizations also respectfully request that the agency amend the waiver to ensure it protects the financial viability of the *entire* health care safety net, not just hospitals and public providers.

No safety net entity (as defined within the waiver) can possibly meet the preventive, primary, and specialty needs of its local uninsured residents. They rely on community-based physicians and providers to also provide a substantial portion of care to this population. Yet, these practices remain largely excluded from waiver-related funding.

Prior to the pandemic, wait times for preventive and primary care appointments at safety-net facilities often were months long, while patients with chronic or acute illnesses, such as cancer, heart disease, or substance addiction struggled to get specialty care, assuming they could obtain such services at all.

When the pandemic struck, it became even more apparent that publicly funded hospitals, health departments, and mental health providers alone could not care for uninsured and vulnerable populations, making them interdependent on the local network of community physicians and health care professionals and vice versa.

Yet, the waiver's lopsided financing perpetuates division and fragmentation by financially supporting some components of the system and not others. Physicians and other health care professionals who serve the Medicaid and uninsured population will get no relief from their uncompensated care, despite the lack of any enduring Medicaid physician payment update in more than a decade.

Moreover, over the past 15 months, many community practices, particularly those in primary care, have become more financially precarious due to the lingering impact of the pandemic, rising number of uninsured, and low Medicaid payments. This has resulted in some practices limiting the uncompensated care they provide. In turn, patients have no choice but to seek care at already overcrowded safety-net facilities.

We commend HHSC for including community physicians in the Texas Incentives for Physicians and Professional Services (TIPPS) directed payment program. However, few have signed up due to TIPPS' complexity and paltry financial rewards.

The waiver should foster a more equitable funding mechanism to ensure all those who take care of Medicaid and uninsured patients remain viable.

Lastly, we have serious reservations regarding HHSC's request to extend the waiver for 10 years, locking the state into a framework that reflects today's health care delivery environment not one necessarily for tomorrow.

Medicaid 1115 waivers, by their definition, are meant to be demonstrations to test new ways of delivering care, not permanent features of the program, though they can pave the way for federal regulators and/or lawmakers to establish permanent Medicaid changes. Ten years ago, people relied on DVDs to watch movies at home. Today, they stream them on their living-room TVs. Likewise, a decade ago, independent physician practices were the norm, while today market consolidation is transforming the delivery of care – a trend that has resulted in constructive changes, such as the development of entities focused on value-driven, accountable care, as well as more worrisome trends, including increased costs and decreased availability of primary and specialty care services.

Offsetting safety-net systems' uncompensated care costs remains crucial to the financial viability of those providers, but so does ensuring a nimble, adaptable model of care delivery – one made for the future, not the past. We urge HHSC to amend its proposal to request a five-year waiver instead of 10.

We respectfully ask that you amend the proposed waiver extension request to address medicine's concerns.

Thank you again for the opportunity to comment. We look forward to working with you to improve the health of all Texans. Should you have any questions, please contact Helen Kent Davis, associate vice president of governmental affairs, at helen.davis@texmed.org or 512-415-8048.

Sincerely,

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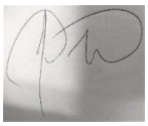

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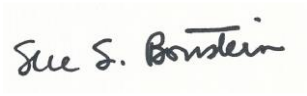

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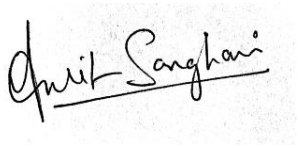

Ankit Sanghavi, BDS, MPH, Executive Director
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[i] Our organizations initially used the term "community-based Accountable Care Organization (ACO)," but have since rebranded the concept as an Accountable Health Organization (AHO) to distinguish it from physician-led and health system-based ACOs, which contract with health plans to organize and deliver care. The goal of an AHO, as noted above, is to organize local medical, social, and community leaders under a common board to collaborate on achieving a common vision and goals for improving the health and health outcomes of low-income and vulnerable people within their communities.