House Appropriations Committee – Subcommittee on Article II
Texas Health and Human Services Commission
March 1, 2021

Written Testimony of Emily Briggs, MD on Behalf of:
Texas Medical Association
Texas Academy of Family Physicians
Texas Pediatric Society
American College of Physicians Services – Texas Chapter
American College of Obstetricians and Gynecologists – District XI (Texas)
Texas Association of Obstetricians and Gynecologists

On behalf of the above-named organizations, which collectively represent more than 55,000 physicians and medical students, thank you for your service and the opportunity to provide recommendations regarding the Texas Health and Human Service Commission's (HHSC's) budget for the 2022-23 biennium.

Throughout the pandemic, HHSC remained very responsive to issues and concerns raised by organized medicine, including establishing and maintaining multiple COVID-19 flexibilities, such as new telemedicine authority, to help physicians adapt to the rapidly changing practice environment in order to ensure access to care for patients. For this, we are most grateful. **We certainly support HHSC's exceptional item requests, which will ensure Texas can continue to provide access to care for its most vulnerable residents. But the need is so much greater. More dollars will be needed to advance and protect the health of all Texans.**

At the Feb. 16 meeting of the House Appropriations Committee, the state comptroller provided much-welcome news: The state's economy not only performed better than expected during the pandemic but also will grow over the next two years. Moreover, federal COVID-19 relief funds will help offset the anticipated budget shortfall, Texas Medicaid will not require a supplemental appropriation for the first time in modern memory, and the Economic Stabilization Fund will end the 2022-23 biennium with a balance of $11.6 billion.

Like you, our organizations breathed a collective sigh of relief at this updated forecast, knowing it will give the committee more flexibility to address Texas' multitude of ongoing and emerging health care challenges. As relieved as we were, we also know that hidden within the rosier-than-expected economic figures are the real-world stories of our patients – your constituents – for whom the news is not as good.

- Nineteen percent of all Texans – more than 5 million people – lack health care coverage.
- One million Texas children – 12.7% – lack coverage, driven by a steady erosion in children's Medicaid and Children's Health Insurance Program (CHIP) enrollment over the past three years.
- 660,000 Texans are eligible for Medicaid but not enrolled, 85% of whom are children.
- Rates of chronic disease, substance use disorders, and mental health needs continue to climb, compounded by the physical, psychological, and emotional harm wrought by COVID-19.

- Too many new mothers still die from preventable maternal health conditions, with nearly one in three deaths occurring following loss of pregnancy-related Medicaid postpartum coverage.
- More Texans now suffer from hunger, housing insecurity, and domestic violence, factors that contribute as much or more to our patients' health outcomes than missed clinical care.

Having a health insurance card does not access make. Yet, it is the key every Texan needs to unlock timely entry into the health care system. People without health insurance – disproportionately women, essential workers, and rural Texans earning low wages – have worse health outcomes and die younger than their insured counterparts. Many have underlying health conditions for which care had been delayed or skipped due to lack of insurance.

Additionally, throughout the pandemic, nonmedical factors that contribute to patients' health, such as housing stability, food security, and freedom from interpersonal violence, also deteriorated, harming long-term health outcomes for patients and communities.

In addition to the physical harm caused by being uninsured, Texans' economic freedom and prosperity also suffer. The uninsured have lower lifetime earnings, contributing to high rates of poverty and financial insecurity. Uninsured children miss more school, harming their future academic and economic success. Promoting economic prosperity for all Texans means ensuring not only a strong job market but also access to meaningful health care coverage across people's life span.

By extending meaningful health care coverage to low-wage working adults, the state will not only help them get and keep jobs[1] but also provide them the freedom to start a small business,[2] the engine of Texas' economy, go back to school, or move or change jobs without worrying whether they'll have health care coverage. Insuring parents also results in more children gaining coverage.

Growing rates of uninsured also imperil the lifeblood of the state's health care system – safety net practices and facilities on which *all* Texans depend, including rural physician practices, rural hospitals, and trauma centers. Prior to the pandemic, many of these entities operated on narrow margins. As the number of uninsured continues to increase, so too does uncompensated care, an unsustainable economic situation.

Texas is now at a crossroad. Thanks to years of careful economic stewardship and planning, the state avoided a pandemic-induced economic tsunami as feared last summer. Instead, it will have resources available to invest. Where will those dollars go? Amidst a deadly global pandemic where health care coverage is more vital than ever, we believe extending health care coverage to more Texans and revitalizing the state's health care infrastructure is the obvious choice.

As Texans painfully learned following the failure of the state's electric grid, it is always costlier to rebuild than to fix a problem before something breaks. **Texas' alarmingly high and growing ranks of uninsured are the health care equivalent of a snowstorm – one that could break the state's health care delivery system.**

This session, we urge you to invest in the health of all Texans.

<u>Recommendations</u>

- **Ensure meaningful, comprehensive health care coverage for Texans, including working uninsured, postpartum women, and children.**
  - Pursue federal funds to extend meaningful health care coverage. According to four recent Texas economic analyses, doing so would provide coverage to nearly 1 million Texans while saving an estimated $75 million to $125 million over the biennium.
  - Increase health care coverage for children by providing 12 months' continuous coverage for children enrolled in Medicaid – one of the single most important steps Texas can take to reduce the number of uninsured children.
  - Increase funding for outreach and enrollment to Texans eligible but not enrolled in Medicaid or CHIP. Several years of declining children's Medicaid and CHIP enrollment correlates with the rise in uninsured Texas children. To reverse this trend, it is vital for Texas to reinstate strong education and outreach for families.

- Eliminate proposed reductions in the number of Texas Medicaid eligibility workers. Maintaining a robust eligibility system will ensure Texans who qualify can timely enroll.

- **Promote better birth outcomes by enhancing women's access to preventive, primary, and behavioral health care throughout their reproductive lifespans.**
  - Build upon Healthy Texas Women Plus to provide women 12 months of comprehensive postpartum coverage.
  - Maintain robust funding to the state's women's health programs, Healthy Texas Women (HTW) and the Family Planning Program (FPP), both of which provide women access to essential preventive health services, including annual well woman exams and screening, and basic treatment for common chronic diseases.
  - Provide funding to allow Texas Medicaid to increase from one to four the number of postpartum depression (PPD) screens for which it will pay a primary care physician, obstetrician-gynecologist or provider to improve early detection and treatment of PPD among new mothers.
  - Protect continuity of care for women transitioning from Medicaid to HTW by directing HHSC to adopt policies and procedures that prevent gaps in care.
  - Increase availability for screening, intervention, and treatment for substance abuse and postpartum treatment.
  - Reduce health inequality by screening, connecting and coordinating care across medical and social domains throughout a woman's lifespan.

  Rationale: According to December 2020 report of the state's panel of maternal health experts, too many women die during pregnancy or in the year following,[3] though 9 in 10 of these deaths were potentially preventable.

  Alarmingly, black women account for 31% of maternal deaths but only 11% of births.[4] For every maternal death, 50 to 100 women suffer a severe illness or complication, which can interfere not only with a new mother's ability to care for her baby but also may influence her child's development**.**

  Without question, many factors contribute to poor maternal health – chronic health conditions, systems of care, poverty, and community. Each must be addressed through collective, complimentary efforts among physicians, hospitals and community stakeholders. But the number one factor Texas as a state can and must address is ensuring that women have access to comprehensive health care coverage across their reproductive lifespans.

  Healthy pregnancies do not begin at conception but in the months and years prior. While many factors contribute to healthy pregnancies, timely access to preventive, primary, and subspecialty care, including behavioral health services, throughout a woman's reproductive lifespan are among the most important. Twenty-five percent of low-income women lack health insurance.

  Before and after pregnancy, the Family Planning Program and Healthy Texas Women fill important gaps in preventive and primary care. HTW Plus, launched in September 2020, builds on HTW, providing postpartum the same benefits available via HTW in addition to one year of specialty care coverage for the three conditions and illnesses most likely to contribute to maternal mortality or morbidity.

  Women living in states with comprehensive health care coverage have better health outcomes, including fewer maternal complications and deaths[5, 6, 7] **Recalibrated, HTW Plus could become the backbone of a such a program for Texas women, thus ensuring access to a full array of benefits across their reproductive lifespans.**

  Comprehensive coverage also is vital to reducing health inequality, the "health differences that are avoidable, unnecessary, and unjust,"[8] which undermine maternal health and increase health care costs.[9] Women of color and low-income women suffer disproportionately from health disparities, including higher chronic disease burden and less timely care. Health care coverage throughout a woman's lifespan greatly diminishes these gaps, resulting in better health care outcomes for new mothers and infants. But health care alone does not improve health. Texas also must address the nonmedical factors, such as food insecurity, unsafe housing, domestic violence, and systemic racism, that make motherhood

unnecessarily risky for too many women. Moreover, according to the state's own data, when women become uninsured after losing pregnancy-related Medicaid 60 days postpartum, they are more likely to suffer severe complications or to die from pregnancy-related complications. The majority of maternal deaths occur from 31 days to one year following delivery, with most being potentially preventable.

Enrollment in HTW and FPP continues to grow, a positive development because these programs often are the only source of care for low-income uninsured women**. We support proposed funding within HB1 for both strategies**. It is vital that funding be provided to reflect the continuing and growing need for women's health services. Not only does access to preventive health care improve women's lives, it also save money. According to HHSC, together HTW and FPP resulted in a net savings of nearly $20 million in 2019 women better time their pregnancies.[1]

Texas also must ensure that new mothers seamlessly transition from Medicaid to HTW by adopting policies and procedures that will prevent gaps in enrollment – gaps that can have lasting and potentially deadly consequences, ranging from unintended pregnancies due to lack of contraceptive access to delayed or skipped treatment for serious postpartum complications.

Best practices to promote continuing of care include maintaining automatic enrollment for new mothers moving from pregnancy-Medicaid to HTW; simplified HTW enrollment form; and preservation of non-redundant eligibility determinations, known as adjunctive eligibility, that allows a mother to qualify for HTW based on her household's participation in other income-based programs, such as Supplemental Nutrition Assistance Program.

Lawmakers have strongly advocated for such best practices over the past several sessions. According to HHSC, Texas cannot continue these policies under the terms of the state's HTW Medicaid 1115 Waiver, and instead must replace them with alternative policies. For example, 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. Yet, 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.

Our reading of federal eligibility guidance and the waiver terms indicate there are better, more constructive steps HHSC could take to maintain the intent of all 3 policies if not the exact same process. We recommend that HB1 include instructions that HHSC purse better policies that promote continuity of care for new mothers.

- **Reinvigorate the Medicaid physician network by rewarding value-driven initiatives that improve health outcomes; promote sustainable, accountable, and cost-effective care; reduce health disparities; address social drivers of health; and strengthen rural, border, and underserved physician networks.**

Rationale: **Physicians value Medicaid,** a program that benefits not only the health and financial security of more than 4 million people but also that of *all* Texans by bringing federal tax dollars back to the state -- monies that underpin the state's health care system and the thousands of jobs associated with it.

Despite Medicaid's importance to our state, too often the program gets labeled as "broken," in part because of a flagging physician network. But what's broke, can be fixed, and lawmakers have it within their power to do so. A trio of legislative reforms enacted in 2019 will help, eliminating some of the red tape and administrative hassles that drive physicians up the wall and out of Medicaid. However, improving access to care must be more than paper deep. It also requires paying competitively.

Unacceptably low Medicaid payments rates – determined by the legislature -- directly correlate to an inadequate physician network. Yet, Texas has not enacted a meaningful, enduring physician rate

[1] Texas Health and Human Services. Women's Health Programs Report Fiscal Year 2019. May 2020.

increase in more than a decade. For example, Medicaid pays $37 for a routine pediatric office exam ($33 for that child's parent). Yet, if the same physician saw the child's grandmother, Medicare would pay $73[10] for the same service, while a commercial health plan would be pay $87[11] regardless of the patient's age. Some lawmakers argue Medicaid managed care organizations (MCOs) must solve the problem. **While it is true that MCOs have discretion to pay physicians more (or less), they cannot squeeze blood from a turnip. The amount they pay is ultimately tied to the fee schedule set by the state.**

COVID-19 has deeply impacted the financial viability of physician practices. 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. Whole communities could see their physician networks wither away, taking jobs with them.**

Lawmakers must find a solution. Using the state's value-based payment framework, Texas can increase physician payments while improving health equity, outcomes, and cost-effectiveness. To pay for this, Texas should consider allocating a portion of the MCO experience rebates (profits above a preset limit) the MCOs already must remit to the state. Likewise, any savings from extending health coverage should be used to improve physician Medicaid payments.

We strongly support Rider 23 within HB1, which will increase Medicaid pediatric payments by 7 percent, benefitting all physicians who serve children ages 0-3. This is an investment in the health of Texas' future leaders. We also urge the committee to support similar targeted increases to improve maternal, rural, and behavioral health.

- **Direct HHSC, in collaboration with physicians, Medicaid managed care organizations, and other stakeholders to establish clear policy and payment guidelines relating to Texas Medicaid's efforts to address social determinants of health as authorized by the Centers for Medicare & Medicaid Services.**

  Rationale: Access to timely, high quality medical care is an important component in the state's efforts to improve the health of all Texans. However, non-medical factors, referred to as social drivers of health (SDoH), contribute to as much as 80% of patients' health. These factors include access to safe places to live, study, and play; nutritious food; and freedom from interpersonal violence, as well as personal decisions, such as smoking and diet. For Texas to make significant strides towards improving Medicaid patients' health outcomes – and constraining costs –it must address all the factors that contribute to healthy patients.

  In Jan. 2021, the Centers for Medicare and Medicaid Services sent state Medicaid directors new guidance regarding opportunities for programs to address SDoH. As a result of the pandemic, finding cost-effective strategies to address SDoH will be even more important than ever as more Texans face eviction, hunger and interpersonal violence.

- **Increase access to evidence-based community and crisis mental health and substance abuse services.** Medicine is thankful for the state's recent prioritization of mental health promotion and services. The continued support for improved quality of and access to mental health services and substance use disorder care for Texans is key for making significant progress. Additionally, the public health emergency of COVID-19 has affected nearly every facet of our lives, resulting in negative impacts to Texan's mental health, and compounded and increased the number of barriers to get help.

  - Fully fund a Medicaid behavioral health Collaborative Care Model, which allows primary care physicians, psychiatrists, behavioral health providers, and case managers to work together to manage and coordinate care. A large body of research demonstrates CCM is both clinically and cost-effective for patients with various mental health conditions. Medicare, commercial health plans, and at least 16

state Medicaid programs reimburse care team members by recognizing specific care coordination billing codes. We strongly support Texas Medicaid doing the same.

- Medicine continues to support safe and supportive school policies and programs. Funding for school districts' school safety and higher education mental health services should be maintained so it can support campus-tailored, comprehensive school programs.
- We support the funding of reforms that will prevent unnecessary institutionalization. Medicine supports timely access to mental health services and state hospital care for those who are institutionalized, including stabilization medication consistent with the patient's regimen.

➢ **Continue investments in Early Childhood Intervention (ECI)**

Restore the $27 million ECI reduction included within Senate Bill 1. This equates to a significant decline in per-child per-month funding and takes us further away from the ideal 2013 levels of funding prior to a host of ECI providers dropping out of the program. Investments in early childhood programs pay long-term dividends for our society and the state budget. We must continue to prioritize them throughout fiscal hardships.

Rationale: ECI is a statewide program for families with children, birth to age 3, with disabilities and/or developmental delays. For more than 30 years, ECI has supported more than 800,000 families to help their children reach their potential through targeted developmental services and parent counseling and training. What makes ECI different from other services is its focus on training parents and other caregivers, such as grandparents or child care facilities, on how best to help a child achieve specific goals and developmental milestones.

The benefits of early intervention services, like Texas' ECI program, are numerous for both child health outcomes and economic advantages to the family and society. A substantial amount of longitudinal research has demonstrated that access to early intervention for children results in marked improvement in verbal abilities, receptive language scores, and overall cognitive abilities, which can translate later in life to better school performance, graduation rates, and social and emotional skills need to succeed in life.

By intervening early, when a baby's cognitive and physical health are still being formed, we can reduce costs in other domains and interventions, such as school-age special education services, and improve a child's functional trajectory for life. Furthermore, early intervention services such as ECI are vital to more high-risk populations of children including those who come from environments of abuse and neglect, those with mental health issues, those from culturally diverse backgrounds, and children living in economically deprived environments.[12]

The Texas Legislature made a $31 million investment in the ECI program during the 2019 legislative session to ensure a robust network of community providers in all areas of the state. Without these providers, children will go without much-needed services during the most crucial time in their life. While this investment is most welcome, it still does not raise the per-child spending to 2013 levels, or $484 per child each month. Furthermore, more investment is needed to ensure all providers have adequate funding for Child Find services, which go into hard-to-reach communities to find families who need services. This is especially important because of a 2018 report[13] that found Black children made up a disproportionate share of decreased enrollment compared with Hispanic or white children.

Since then, following a federal review, the U.S. Department of Education Office of Special Education Programs cited HHSC in a letter[14] for falling short in meeting its federal obligation to ensure access to ECI services for eligible children. The letter specifically identifies lack of funding as a primary cause for eligible children not receiving timely services. To rectify this concern and ensure Texas does not enter prolonged monitoring by our federal partners, the legislature must continue to invest in ECI.

➢ **Improve Medicaid managed care procurement and oversight while also safeguarding patient and physician choice, value-based care and delivery system innovation**

Over the past several months, an escalating debate about the adequacy, effectiveness and transparency of HHSC's Medicaid managed care organization (MCO) procurement process has filled lawmakers' email boxes and Zoom schedules. On one side, a health plan argues for a fundamental overhaul of the system

while on the other, the two health plan associations support continuation of existing policies, with some refinements. For our organizations' part, we brook no opposition to efforts that improve MCO transparency, accountability and effectiveness. Our organizations have worked closely with lawmakers and HHSC over the past decade to devise policies to do just that, including legislation and contractual policies that reward and promote MCOs that achieve better quality, health outcomes and lower costs.

Rider 22 articulates a wholesale change in the MCO procurement process. While there are elements of the rider with which we agree, it also raises concerns about unintended consequences. First and foremost, the rider appears to make cost-effectiveness of utmost importance, without considering other essential goals, such as patient *and* physician/provider satisfaction, delivery system innovation, and performance on health quality measures. The rider also wrongly assumes that poor financial performance is always a sign of poor MCO management versus inaccurate actuarial assumptions. After the implementation of STAR Kids, an MCO model designed to serve medically fragile children and children with disabilities, several plans lost money, mostly attributable to deficient actuarial assumptions regarding the costs to care for children with highly complex medical and long-term care needs.

With 94% of Medicaid patients enrolled in an MCO, MCO performance impacts not just the health of four million Texans and the state's bottom line but also the viability of Medicaid participating physician practices. At lawmakers' direction, Texas Medicaid requires Medicaid MCOs to advance value-based payment (VBP) initiatives that provide incentives for physicians, community clinics, and other providers to improve care while lowering costs. Unlike Medicaid fee-for-service, MCO VBP arrangements allow plans to reward physicians that achieve certain quality and performance, either by enhancing payments, eliminating Medicaid red tape or both. These initiatives are by no means perfect, and do not solve Medicaid physician payment challenges as outlined in our testimony above, but they do provide a path forward to build a better Medicaid program for patients, physicians, and the state.

As written, rider 22 could inadvertently undermine the move towards VBP. For example, the rider's proposed financial penalties, such as changes to the MCO risk corridors, could jeopardize plans' ability to sustain or expand VBP to more physicians. Additionally, the rider's focus on "efficiency" may result in HHSC favoring larger health plans over community-based ones. Yet, it is competition among for-profit and community-based plans that generate the innovation necessary to make Medicaid better.

We look forward to working with you in the coming weeks to refine the rider to ensure Texas Medicaid's MCO procurement process achieves our mutual goals of better MCO oversight and accountability without losing the ability for Texas Medicaid to innovate.

- **Support HHSC's exceptional item to ensure Texans with hepatitis C can receive lifesaving prescription medications at the outset of their diagnosis.**

Rationale: According to the Centers for Disease Control and Prevention, hepatitis C is one of the nation's deadliest infectious diseases, affecting more than 2 million patients nationwide each year. Antiviral medications offer patients a potential cure, but the cost of medications has kept Texas Medicaid from making them broadly available. The National Viral Hepatitis Round Table grades Texas a D+ because it has one of the most restrictive hepatitis C drug prior authorization policies in the country, meaning patients cannot obtain treatment before suffering advanced liver disease. HHSC recently announced it will be extending hepatitis C treatment to additional Medicaid patients, but requires legislative approval to ensure all eligible Medicaid patients can obtain cost-effective hepatitis C medication. Funding is literally a matter of life and death.

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

[2] Medicaid and the Supply of Entrepreneurs: Evidence from the Affordable Care Act, Kyung Min Lee, Oct. 2018.

[3] Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report, Sept. 2020

[4] ibid

[5] High Rates of Perinatal Insurance Churn Persist After The ACA, Jamie Daw, Katy Backes Kozhimannil, and Lindsay K. Admon, *Health Affairs*, Sept. 2019.

[6] Effects Of Medicaid Expansion On Postpartum Coverage And Outpatient Utilization, Sarah H. Gordon, Benjamin D. Sommers, Ira B. Wilson, and, Amal N. Trivedi, *Health Affairs*, Jan. 2020.

[7] Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality, Erica L. Eliason, MPH, *Women's Health Issues*, Feb. 25, 2020.

[8] What Are Health Disparities and Health Equity? We Need to Be Clear, Paula Braveman, MD, MPH.

[9] Disparities in Health and Health Care: Five Key Questions and Answers, KFF, March 4, 2020.

[10] Medicare physician payment rate for the Rest of Texas geographic locality, which encompasses San Antonio, South Texas, and non-metro counties and is the lowest amount paid by Medicare

[11] Texas Medicaid establishes rates for each service billed by physicians. However, Medicaid managed care organizations may contractually establish different payment rates, which are proprietary. TMA estimated the average commercial payment based on analysis from the Medicare Physician Payment Advisory Committee.

[12] Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes. Richard C. Adams, Carl Tapia, The Council on Children With Disabilities. *Pediatrics*. October 2013, 132 (4) e1073-e1088; DOI: 10.1542/peds.2013-2305.

[13] Texans Care for Children. (November 2018). New Data Show Decline in funding for Texas Early Childhood Intervention (ECI). Retrieved from: https://static1.squarespace.com/static/5728d34462cd94b84dc567ed/t/5c0ed746cd8366413d0490f9/1544476498788/2018-ECI-Funding-Report.pdf.

[14] U.S. Department of Education, www2.ed.gov/fund/data/report/idea/partcdmsrpts/dms-tx-c-2020-dmsletter.pdf.