House Select Committee on Health System Reform
Written Testimony of John Carlo, MD, TMA Trustee
Friday, Aug. 5, 2022
Testifying on behalf of:
Texas Medical Association
Texas Academy of Family Physicians
Texas Pediatric Society
Texas Association of Obstetricians and Gynecologists
Texas Chapter, American College of Physicians Services
American College of Obstetricians and Gynecologists, District XI (Texas)

Chair Harless, Vice Chair Rose, and esteemed committee members, thank you for the opportunity to testify. My name is John Carlo, MD, a practicing preventive medicine specialist and Texas Medical Association trustee, testifying on behalf of TMA and the specialty societies listed on my testimony. Together, our organizations represent more than 56,000 physicians and medical students.

Meaningfully reducing health care costs has proven elusive for Texas and the nation, in part because of the complex interplay between multiple, dynamic, and interconnected factors – excessive administrative costs, consolidation of health care markets, fragmentation of the health care delivery system, erosion of primary care, growing rates of health disparities, and rising rates of uninsured.

COVID-19 amplified many of these trends. Yet, it also has created a stronger imperative to address them – *and we must*.

Studies show that higher spending has not resulted in better health care outcomes, though it can destabilize a family's financial security and well-being. **According to the Commonwealth Fund, in 2022 Texas ranked last on measures relating to access and affordability,[1] a black eye on a state with world-renowned physician practices, medical centers, medical schools, and health policy institutes.**

Texas has the fifth highest rate of adults with unpaid medical bills.[2] Prior to the pandemic, nationwide more than one in three adults reported they could not afford to pay their health plan deductible before obtaining health care services. Moreover, 5.4 million Texans – more than the population of Arkansas and New Mexico combined – lack health insurance at all, resulting all too often in delayed or forgone care due to costs.

Yesterday, you heard from numerous, esteemed witnesses on factors contributing to rising costs as well as opportunities to address them. Every day, as a practicing physician, I see the tradeoffs patients make when confronted with health care services they cannot afford, such as skipping medications or health care services. **Sadly, my colleagues and I have seen firsthand the tragic, even deadly, consequence of delayed or forgone care.** Not only can it result in financial harm stemming from missed work or lower productivity, but long-term disability or death.

Thus, Texas physicians strongly support efforts to make health care more affordable, *recognizing that affordability and accessibility are inherently intertwined.* Physicians take an oath to do no harm,

which increasingly means we also must be collaborative and mindful stewards of our patients' health care dollars.

So how do we constrain costs while improving access, quality, and safety? You may have heard the oft-repeated adage distilling "health system reform" to this: Ensure the right care at the right time and right place.

For example, children with routine ear infections should be able to obtain a timely primary care office visit versus obtaining care at an emergency department. Likewise, when a pregnant woman begins labor, she should have ready access to maternity care at a local hospital equipped to deliver babies rather than having to drive hundreds of miles away.

This sounds easy enough, but in practice it is much harder to achieve because of strained safety nets, misaligned payment practices, workforce shortages, outdated delivery models, and antiquated data systems.

At the same time, **over the past two years, the health care system has shown remarkably alacrity in changing for the better, rapidly adjusting to a global pandemic to ensure continued patient care services**. For example, within a few short months of the pandemic's onset, physicians, hospitals, providers, and patients rapidly adapted to use of virtual health care, even though few practices regularly used it prior.

On the other hand, the pandemic also revealed dangerous fissures spider-webbing across our health care system. These cracks, including widening health disparities and withering primary care infrastructure, have been there for years but have been unnoticed or ignored. Yet, like a shattered window that could break any time, they pose a significant threat to the health and financial stability of individuals and communities.

To make meaningful progress on the committee's broad charge, Texas must undertake a manifold, concerted, data-driven strategy. Specifically, we urge the committee to support five broad goals and the strategies within each. My written remarks will fully articulate each recommendation. To best use my time, I'm going to describe each goal and highlight a few strategies within each, but I'm happy to take questions on any strategy on which you'd like me to elaborate.

Specifically, our five goals are these:

1. Enact a comprehensive strategy to reduce Texas' rate of uninsured.
2. Encourage greater use of high-value care.
3. Adopt or promote initiatives to improve use of timely, appropriate place and use of health care services.
4. Improve population health by reducing health disparities and better aligning health care delivery and public health.
5. Minimize costly administrative waste and outdated or inefficient care.

➢ Goal 1 – Enact a comprehensive strategy to reduce Texas' rate of uninsured

Over many legislative sessions, you have heard from organized medicine and diverse health care stakeholders the mantra that Texas must enact a comprehensive plan to reduce its rate of uninsured. As a physician, I know that when I counsel my patients on proper medication adherence or healthier habits, many need to hear the message multiple times before they are ready to make changes. **With your leadership, I hope this is the year Texas hears this message, just as Arizona, Arkansas, Utah, and other conservative states have done.** By carefully examining the evidence, these states ultimately

determined it is in their economic interests to enact such a strategy, though how each state did it has varied.

Texas' rising rates of uninsured has profound human, social, and economic impact on our patients and your constituents. Decades of research show the lack of health care coverage not only poses serious health consequences but also contributes to higher health care costs and curtailed job growth. Insured women have healthier pregnancies and healthier maternal and infant outcomes, reducing Medicaid costs. And more insured Texans contribute to lower health care premiums for everyone.

Coverage is like a key to a house. With it, you can quickly unlock the door, gaining access to important services. While there are other ways in, like through an emergency department "window," they delay entry and are more expensive. All too often, without a key, people remain locked out.

Strategies:

a. Pursue federal dollars to design a health care coverage initiative for Texans by Texans to increase coverage among working-age adults and parents.

When the uninsured do need health care, it's not free. The cost to treat them gets passed along to all of us via higher health insurance premiums and property taxes levied to support local health care safety-net systems. That is why 38 states, including all of Texas' neighbors, have implemented their own coverage initiatives. Studies show doing so will reduce state expenditures, promote economic growth, and improve the health and well-being of Texans.

Moreover, increasing coverage to working-age adults and parents is critical to improving access to care, health care quality, and financial security and well-being of families. When parents are insured, their children are more likely to be too.

For women, comprehensive coverage across the life span is particularly important to their own health as well as that of their families and children. Texas Medicaid covers 54% of all births, beginning with prenatal care through delivery followed by 60 days of postpartum coverage. But before and after pregnancy, an estimated 25% of Texas women lack health insurance. While Texas offers Healthy Texas Women and other programs to provide preventive care, women in need of specialized services to treat chronic physical or mental health issues often cannot get it. However, healthy pregnancies do not begin at conception but in the years and months before. For example, diabetic women can and do have healthy pregnancies, but the optimal time to identify, treat, and manage the disease is well before conception to mitigate the chance of diabetes-related birth defects and complications. Now more than ever, women will need pregnancy-related Medicaid and health insurance hereafter. Texas must do all that it can to ensure women have healthy pregnancies and motherhoods. coverage to working-age parents and adults is one part of that strategy.

b. Extend Medicaid postpartum coverage to a full 12 months.

Among its peer countries, the U.S. has the highest rate of maternal mortality, particularly among Black women. Tragically, these deaths are increasing, though most are preventable. While many factors contribute to these deaths, the lack of postpartum coverage for the full year following delivery is especially critical. Nearly one in three pregnancy-related deaths (31%) occur between 42 days to one year after delivery – after Medicaid coverage ends. Moreover, many women suffer grave postpartum illnesses, which if left untreated have serious, long-term implications. That is why Texas' Maternal Mortality and Morbidity Review Committee has made extending Medicaid postpartum coverage a full year its top recommendation in each of its legislative reports.

In 2021, the Texas House championed a full year of coverage, a policy we strongly supported. We are grateful to the Speaker, Vice Chair Rose, and the many other House members who championed this policy. In the end, the House and Senate compromised on six months – a good start. However, we urge the committee to again pursue 12 months' coverage. Eighteen other states, including Florida, Kansas, and South Carolina, have exercised a new federal option to do so, with many more states in the pipeline.

c. Mitigate potential gaps in health care coverage during the Medicaid continuous eligibility "unwinding" by ensuring an effective, timely and organized process to redetermine eligibility.

In the coming year, the federal public health emergency (PHE) will end, resulting in the unwinding of Medicaid continuous eligibility for more than 1 million Texans. Because of the pandemic, this policy has been in place for more than two years following passage of federal COVID-19 legislation in 2020, which increased Medicaid funding to states in exchange for keeping people covered on Medicaid throughout the PHE.

When it expires, Texas will be required to redetermine the Medicaid eligibility of everyone currently enrolled – a requirement we do not question. However, Texas must implement a thoughtful, staged, and accurate strategy to avoid inadvertently terminating coverage for anyone still eligible for Medicaid or another state or federal program and creating confusion and costs across the health care delivery system. Already, Texans experience difficulty updating their Medicaid information or enrolling in the program – even if eligible – because of many unnecessary hoops and outdated systems.

Without a controlled unwinding, Texas' health care system will be thrown into unnecessary chaos, disrupting care to patients and cash flow to already financially strapped physician practices.

d. Enhance coverage under Texas' Breast and Cervical Cancer Treatment Program

Extend eligibility for the Medicaid Breast and Cervical Cancer Treatment Program to the highest level allowed under federal law, 250% of federal poverty, to provide more women access to comprehensive treatment when diagnosed with either cancer.

e. Conduct a sustained, robust outreach and enrollment campaign to ensure all Texans eligible for Medicaid or the Children's Health Insurance Program (CHIP) are enrolled.

➢ Goal 2: Promote greater use of high-value care

Key to promoting use of high value care is increasing transparency regarding health care costs. This will help consumers, physicians, employers, and payers better assess health care utilization trends and costs and associated opportunities to improve. Texas' new All-Payer Claims Database should be useful in these efforts.

While existing evidence suggests that giving patients pricing information alone has minimal impact on their decision-making, analyses by other states does indicate this data can be useful in efforts to promote high-value care.

While existing evidence suggests that giving patients pricing information alone has minimal impact on their decision-making, such data are important for patients, employers, and physician-led entities to have nonetheless, particularly for entities seeking to promote high-value care.

For example, studies indicate that patients and physicians respond to information regarding unnecessary use of "low-value care," defined as "services that provide little or no benefit to patients, have potential to cause

harm, incur unnecessary cost to patients, or waste limited healthcare resources,"[3] contributing to more than $345 billion annually in wasteful health spending.

While "low-value" services are not easily defined and depend upon each patient's circumstances, more than 70 national medical specialty societies have identified such services through the Choosing Wisely campaign. An example is overuse of antibiotics or diagnostic imaging, both of which can cause more harm than good when not clinically indicated.

When the APCD becomes fully functioning, it has the potential to help the health care community identify and promote high-value, cost-effective services to improve health outcomes and reduce health disparities, among other uses. With insight from the medical community, APCDs in other states, including Colorado and Washington, have conducted assessments of potentially wasteful services to better educate stakeholders about the costs and potential harmful impact. **Texas' APCD should be encouraged to conduct the same assessment as one of its initial publications.**

We also support establishing a state-led collaborative to allow a coalition of stakeholders – physicians, consumer advocates, providers, and payers – to identify and recommend evidence-based strategies to improve care delivery within the public and private spheres. Texas has similar initiatives already in place, including the Texas Collaborative for Healthy Mothers and Babies, which has been at the forefront of improving maternal and infant care. However, no similar structure is in place to identify opportunities to improve health outcomes for other populations. In 2011, lawmakers in Washington state established such a venture. Over the past decade, it has developed recommendations on better managing everything from pediatric asthma care to opioid use disorders to prostate cancer.

Strategies:

a. Redouble efforts to increase availability of primary and preventive primary care.

Abundant research shows that health systems built on robust primary care use have lower costs and better quality. **For example, primary care physicians play a vital role in providing mental health care, serving as the entry point to initial treatment by many patients, particularly those reluctant to seek care elsewhere because of the potential stigma.** Studies show that integrated systems of primary and behavioral health care improve patient outcomes and curtail use of more expensive services.

Yet, instead of elevating this asset as part of cost-containment strategies, primary care withers. **In 2019, Harvard researchers reported that nationwide fewer patients have primary care than ever before, with serious implications for the entire health care system.** As noted by one of the researchers, "primary care is the thread that runs through the fabric of all health care and this study demonstrates we are potentially slowing unweaving that fabric." Since the report was published, the primary care fabric has become even more threadbare. Staffing shortages, payment stagnation, and burnout have contributed to primary care practices consolidating with larger systems or closing.

Texas must reinvigorate primary care to help contain costs:

- Adopt new payment strategies within state-funded programs, including the Employees Retirement System of Texas (ERS), to advance the work in the 21st century.
- Reinvest in the state's proven primary care loan repayment program.
- Reduce uncompensated care by increasing rates of health care coverage.

b. Promote value-based health care.

"Value-based health care" is a system in which physicians and providers, including hospitals, get paid based on whether patients achieve certain predetermined health outcomes.[4] Examples are ensuring

women obtain timely, routine prenatal care; children receive age-appropriate preventive health services, including vaccines; and patients with chronic diseases, such as diabetes, avoid unnecessary emergency department visits or inpatient hospitalizations. All physicians want their patients to get the right care at the right time and at the right place – which are the pillars of value-based care. Yet, payment and other policies do not always align to support these efforts. Greater use of alternative payment models (APMs) such as prospective payment models or payments for episodes of care, could change this.

c. Increase transparency and accountability among alternative benefit plans.

As defined by the Texas Department of Insurance, alternative benefit plans include short-term plans, limited duration plans, and association plans, among others, though notably these do not include direct primary care models – a model TMA supports. Any health plan benefit design ultimately requires tradeoffs – decisions well-informed patients should be able to evaluate for themselves. At the same time, in the 13 years since enactment of the Affordable Care Act, physicians and patients have come to expect at least minimum guardrails.

To ensure the right balance between affordability and coverage, TMA recommends greater transparency and accountability among alternative benefit plans (ABPs), that are not subject to regular state and federal regulations including:

- Ensuring these plans adhere to state-mandated consumer and provider protections, including network adequacy standards, prompt payment, mental health parity, independent review of utilization denials, and gold-carding requirements;
- Supporting robust, easy-to-understand written disclosure requirements for all issuers of ABPs, regarding exemptions from or limitations on patient, physician, and provider protections, including exclusion of coverage for preexisting conditions;
- Requiring ABPs to clearly identify themselves on the patient identification card and to provide a link to the plan's website describing what standards govern the plan;
- Promoting development of tiered health insurance products that offer sliding scale deductibles and cost sharing based on an enrollee's ability to pay;
- Requiring ABPs to provide consumers a dispute resolution resource and notify them where to file complaints; and
- Requiring ABPs to report data to the state's all-payer claims database.

d. Ensure timely access to mental health community and crisis services.

Over the past decade, emergency department utilization for mental health conditions, especially substance use conditions, significantly increased.[5] Nationally, Medicaid is the largest payer for behavioral health, so redirecting patients to more cost-effective places of care can reduce costs.

As previously noted, patients suffering mental health disorders often seek treatment from their primary care physician. Given the shortage of both adult and child psychiatrists as well as mental health professionals, the primary physician's role cannot be overstated as part of the team strategy to ensure early intervention, treatment, and management of mental illness.

Yet, low Medicaid payments and administrative hassles mean more primary care physicians are forced to limit or halt Medicaid participation. Innovative Medicaid managed care value-based payment arrangements help, rewarding primary care physicians for improving health outcomes. However, these

payment arrangements remain based on a Medicaid fee-for-service physician fee schedule largely unchanged for more than a decade, falling farther and farther behind compared with other payers.

To promote greater mental health/primary care collaboration, Texas must boost payments for mental health services provided within primary care settings. Texas also must expand its use of community health workers and peer support specialists.

➢ Goal 3: Promote initiatives to improve health care timeliness and appropriate place of service

Strategies:

a. Promote greater use of community paramedicine.

People in need of timely health care services, particularly the uninsured and/or patients with unmet health care needs, frequently call 911 when they do not have a usual source of care. In 2021, 29% of Texans reported that they did not have a usual source of care or relied on emergency department care.[6]

These calls may result in the dispatch of an ambulance followed by transport to a nearby emergency department. Yet not all callers truly need emergency care. Instead, they need treatment for a low-acuity condition along with a referral to a community clinic or practice. In some cases, patients need community services, such as referral to Meals on Wheels.

To better utilize emergency medical services (EMS), we support expanding community paramedicine**,** a program wherein services provided by paramedics and emergency medical technicians, under the auspices of a physician medical director, are integrated into the local health care system, allowing them to treat mild illnesses without transporting a patient to the hospital. The model works in both urban and rural areas, with special benefits in rural communities where nonemergent use of 911 strains limited resources. By implementing a community paramedicine model, communities can reduce nonurgent 911 requests, decrease downtime between calls, and connect patients to primary care services.[7]

In Austin, an analysis found that by sending an EMS physician or paramedic practitioner to the caller, or providing a telehealth consult, per-visit costs dropped from $1,250 per hour to $290 per hour. Nationally and in Texas, many other communities are experimenting with the model. However, statutory and payment changes will be needed to make it work, including adding "EMS paramedic physicians" and "EMS paramedic practitioners" to the code in addition to allowing Medicaid payment for the services.

b. Improve access to cost-effective, community-based care by strengthening the Medicaid physician network.

Medicaid patients are people we all know or encounter every day, including hard-working, low-income parents; people with disabilities; and seniors. Medicaid is a program organized medicine strongly supports. As part of the larger health care system, it is subject to the same factors that contribute to rising costs. However, state analyses show that the program, on average, contains costs better than commercial health plans and Medicare, despite being one of the largest payers for people with disabilities, behavioral health, and medically complex children and adults. Texas Medicaid's efficiency is in part due to the program's early adoption of innovative value-based initiatives as well as promotion of primary care medical homes and preventive health care.

However, Medicaid functions in unique ways that contribute to unnecessary system costs – and cost shifting. **Woefully low Medicaid payments rates – determined by the legislature – directly correlate**

with an inadequate physician network. Yet Texas has not enacted a meaningful, enduring physician rate increase in more than a decade. For example, Medicaid pays $37 for a routine pediatric office exam. If the same physician saw the child's grandmother, however, Medicare would pay $73[8] for the same service, while a commercial health plan would pay $87[9] regardless of the patient's age. Some argue Medicaid managed care organizations (MCOs) must solve the problem. **While it is true MCOs have discretion to pay physicians more (or less), the amount they pay is ultimately tied to the fee schedule set by the state.**

Physician practice costs, like that for other small businesses, are not static. To keep the lights on, many practices have reluctantly limited how many Medicaid patients they accept, despite broad physician support for Medicaid as a program. **Physicians do not want to limit their ability to see Medicaid patients, but some have felt forced to because Medicaid typically does not cover the cost of care.**

Texas' Medicaid 1115 Transformation Waiver paves the way to direct higher payments rates to hospitals, health systems, public mental health care providers, and others, contingent on meeting certain performance measures. However, to benefit from these resources, eligible entities must have a source of local tax revenue –funding community-based physicians decidedly lack. **As a result, physicians require lawmakers to provide the needed matching dollars**

We support targeting rate increases within Medicaid's value-based payment framework that will align with our mutual interest in improving maternal, child, and behavioral health, while addressing access to care, health disparities, outcomes, and cost effectiveness. Targeted rate increases also should include adjustments in needed specialty-care services.

Additionally, we urge the ERS, the Teacher Retirement System of Texas (TRS), and Texas Medicaid to establish a prospective payment system to sustain primary care physicians who voluntarily agree to such payment arrangements.

- **Goal 4 – Improve population health by reducing health disparities and better aligning health care delivery and public health.**

A startling new actuarial analysis by Deloitte Insights found that rising levels of health disparities contribute to billions in higher annual health care costs, noting that nationally, "health inequities account for approximately $320 billion in annual health care spending … [a] figure that could grow to $1 trillion or more by 2040. …The projected rise in health care spending could cost the average American at least $3,000 annually, up from today's cost of $1,000 per year.[10]

Likewise, in 2020, a Texas-specific analysis[11] found that health disparities resulted in $2.7 billion in excess medical care spending and $5 billion in annual lost productivity, noting that if these disparities persist, by 2030 they will cost Texas $3.4 billion in excess medical spending.

Addressing health disparities will require systemic changes to the health care system in concert with the broader community. Enhancing health care coverage is key to doing so, paired with promoting access to more timely medical interventions, including enhancing primary care availability and access.

However, Texas also must address nonmedical factors, such as where people live, work, and play, all of which have a bigger impact on their health than medical interventions. Research indicates that nonmedical factors contribute as much as 80% to a person's health outcomes compared with 20% for medical services.

In one recent study, researchers found that by connecting patients with low incomes to community services, health care costs could be reduced by as much as 10%.[12] Additionally, a study commissioned by Texas Medicaid found that factors such as physical infrastructure (e.g., safe housing) and economic

environment (e.g., educational attainment) have an influence on Medicaid and CHIP enrollees' health outcomes, particularly among children, adolescents, and pregnant women.

Federal guidance allows states to implement strategies to address these factors. One way is by allowing MCOs to provide services "in lieu of" another, so long as the substituted service is cost-effective and voluntary. A potential option would be to establish a "food as medicine" initiative, wherein a patient receives a prescription for healthy food or medically tailored meals. For example, this might mean providing healthy, prepared meals for a diabetic pregnant woman at risk for preterm birth or giving a hypertensive patient a prescription for healthy foods, provided at a local food bank that collaborates with the MCO and the physician. In both examples, the intervention is designed to mitigate the need for costlier health care services later.

Our organizations support legislation directing the Texas Health and Human Services Commission to enact a cohesive strategy to address nonmedical drivers of health.

➢ Goal 5 – Eliminate costly administrative waste and outdated or inefficient care

Strategies:

a. Eliminate red tape.

In 2021, lawmakers enacted Texas' model gold-card legislation, specifying that physicians participating in state-regulated health plans, they can earn a continuous exemption from prior authorization (PA) by earning approvals on at least 90% of PA requests for a particular medication or service. This allows patients to more quickly obtain the treatment needed while reducing administrative burden. While we still anxiously await the rules governing the new process, we believe Texas also should evaluate targeted services where PA can be eliminated altogether. In other states, payers, physicians, and consumer advocacy groups are working together to identify what PAs can be eliminated or minimized, while still also ensuring patient safety, such as screening to avoid inadvertent drug interactions.

Gold carding rewards physicians who demonstrate appropriate utilization of services, but to further reduce wasteful administrative practices, Texas should evaluate what services need PA at all.

Moreover, despite its potential to eventually simplify Medicaid provider enrollment, the roll out of Texas' new Provider Enrollment Management System (PEMS) has gone off the rails, delaying timely enrollment of thousands of physicians and other clinicians and creating mountains of backlogged, unpaid claims. Texas Medicaid implemented PEMS in December 2021. We supported modernizing the system, though significant problems quickly emerged. We thank HHSC for collaborating with us to expedite resolution. Progress has been made. Yet, nine months into the implementation, major problems remain. Medicaid must move much, much faster to resolve them, including accelerating integration of provider Medicaid enrollment and Medicaid MCO credentialing as intended by lawmakers.

We recommend:

- Requiring the Texas Department of Insurance to perform audits of health plan compliance with statutory PA timelines for approvals and denials as well as gold-card rule compliance;
- Evaluating if state-regulated plans should be required to pay for the administrative costs associated with prior authorizations, thus incentivizing plans to apply PA requirements more sensibly;[13] and
- Establishing an expert panel to review prior authorization requirements within ERS and TRS to eliminate unnecessary PAs, particularly for chronic conditions, such as diabetes and heart disease.

- Provide resources to accelerate much-needed upgrades to the Medicaid Provider Enrollment Management System

b. Promote interoperable data systems.

Texas must redouble its efforts to promote accurate, secure, affordable, interoperable, and bidirectional health information exchange among physicians, pharmacies, hospitals, and health plans.

Twenty-first century patients expect 21st-century coordination of care among physicians, pharmacists, laboratories, and other providers to ensure holistic, whole-person care. Yet Texas' health care data environment remains stubbornly antiquated, with many electronic health records still unable to easily talk to each other without physician practices paying exorbitant fees to connect them, if then. Over the coming months, we will have more specific recommendations.

TMA's mission is to improve the health of all Texans. We look forward to working with the committee to constructively constrain health care costs, while improving access, quality, and safety.

Thank you again for the opportunity to testify.

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