Thank you for the opportunity to comment on the momentous health and human service issues under contemplation today. Our organizations, which collectively represent more than 49,000 physicians and medical students, share your commitment to finding pragmatic, cost-effective ways to strengthen families by enhancing health care coverage for low-income Texans, preventing child abuse and neglect, improving women’s timely access to preventive and primary care services, and implementing sensible measures to moderate Medicaid costs.

As you develop legislative proposals for the 85th legislative session on these issues, we offer the following recommendations for your consideration.

➢ **Enact Creative Solutions to Increase Health Care Coverage Among Low-Income Texans**

Medicaid and the Children’s Health Insurance Program (CHIP) cover more than 4 million low-income Texans (pregnant women and children; patients with disabilities; or seniors who rely on Medicaid for long-term care services, including nursing homes). Without Medicaid, the majority of these patients would be uninsured, forcing them to go without cost-effective preventive and primary care, and instead seeking services from already-strained county-based programs, and/or relying upon taxpayer-supported or private emergency departments. The program also is the linchpin in Texas’ efforts to improve birth outcomes and child health, mental health and substance abuse treatment, cancer prevention and treatment, and chronic disease management. Like Medicare and the private health care system, Medicaid is not perfect, suffering from byzantine physician enrollment requirements, excessive red tape, and too-low physician payments. Nevertheless, without it, Texas would be in worse shape. Texas physicians believe that with a lot of elbow grease, inspiration, and determination, the problems facing Medicaid are ones we can fix.

Texas continues to be the “Uninsured Capital of the United States.” More than 5 million Texans — including 784,000 children — lack health insurance. Texas’ uninsurance rates are 1.5 to two times the national average. Among adults, the majority of the uninsured work, but either they cannot afford employer-sponsored insurance, or it isn’t available. Purchasing private health insurance is prohibitively expensive for low-income families. But insuring more low-income Texans does not have to mean expanding traditional Medicaid. A half-dozen conservative states — including Indiana and...
Michigan — have implemented innovative programs to privately insure more people mostly paid for with federal dollars.

Health insurance matters — to patients and their families, to their communities, to taxpayers, and to the economy. For patients, insurance coverage can mean better health, and faster and more affordable and appropriate care. Better coverage also will be essential to further improving Texans’ timely access to behavioral health interventions and reducing Texas’ distressingly high rate of maternal mortality and morbidity, which, in part, is attributable to high-risk pregnant women losing comprehensive Medicaid coverage 60 days postpartum. Expanded coverage can mean savings for state and local taxpayers in Texas. And creating a healthier workforce can help Texas attract the kinds of jobs that will grow our economy into the future.

We urge the legislature to use federal money to develop a plan, tailored to Texas’ unique circumstances, to cover more than 1 million uninsured individuals. Instead of expanding traditional Medicaid, this plan would provide low-wage, working Texans with private insurance that includes copays and personal responsibility.

Further, TMA supports Texas’ efforts to extend the 1115 Medicaid Waiver. Even with broader health care coverage, the safety net system’s ability to care for vulnerable Texans will be seriously imperiled if hospitals lose supplemental federal funding for uncompensated care. Moreover, the Delivery System Reform Incentive Payments funding designed to test new ways to deliver and pay for care is starting to show genuine improvements in health outcomes. The waiver renewal must ensure greater community-based physician involvement in waiver planning and evaluation.

Rebuild the Medicaid Physician Network by Reducing Medicaid Managed Care Red Tape and Paying Competitive Medicaid and CHIP Rates

Medicaid managed care covers nearly 90 percent of Medicaid enrollees. The conversion from Medicaid fee-for-service to managed care concomitantly has increased Medicaid’s complexity, amplifying the bureaucratic hassles and onerous paperwork that interfere with Texas physicians’ ability to care for their patients. However, as a result of legislative and regulatory initiatives undertaken over the past 18 months, Texas Medicaid has set about to reduce Medicaid managed care red tape, including streamlining Medicaid enrollment and credentialing, reducing excessive prior authorization requirements, and seamlessly transitioning women losing pregnancy-related Medicaid into the Healthy Texas Women program, thus eliminating gaps in coverage.

In TMA’s 2016 Physician Survey, 41 percent of respondents said they do not treat Medicaid managed care patients because of the administrative burden, and 54 percent said they would be likely to accept more Medicaid managed care patients if red tape is reduced. Yet even becoming a “Medicaid provider” is a time-consuming hassle for Texas physicians, often requiring six months or more to obtain a state Medicaid number, then earn credentials from one or more Medicaid HMOs in the state.

We recommend directing the Health and Human Services Commission (HHSC) to continue its efforts to streamline Medicaid managed care processes and eliminate unnecessary administrative hassles that keep good doctors out of the program or force them to limit the number of Medicaid patients they can see. New reforms should include improving Medicaid coordination of benefits with other payers, modernizing the Medicaid Vendor Drug Program, and axing unnecessary prior authorizations.

As organized medicine has long cautioned, however, a Medicaid card does not equal access to health care. Extremely poor payment rates and extraordinarily high bureaucratic burdens lead most Texas
physicians either to refuse to accept all new Medicaid patients or to limit the number they can see. Historically, Medicaid and CHIP have been the lowest-paying health insurers in the state, paying far less than what it costs physicians to provide the services to covered patients. In the past 20 years, Medicaid physician payments have mostly stagnated or declined, save rate increases enacted in 2007 for children’s preventive and office-based services. The physician participation rate consequently has plummeted.

A natural “experiment” documents the direct correlation between physician participation and Medicaid payment rates. In 2012, 21 percent of primary care physicians told TMA they accept all new Medicaid patients. In 2014, that figure jumped to 30 percent, an increase directly attributable to the temporary, two-year primary care physician rate increase paid for with federal funds. The increase brought Medicaid payment rates for certain primary care services equal to what Medicare pays. After that increase expired, the share of primary care physicians who accept all new Texas Medicaid patients fell to 26 percent, according to preliminary data from TMA’s 2016 Physician Survey.

We urge the legislature to exempt physician Medicaid payments from proposed 4 percent budgetary cuts for the 2018-19 biennium. Instead, Texas should set physicians’ Medicaid rates equal to Medicare for all services and all specialties and restore full Medicaid cost-sharing for patients dually eligible for Medicaid and Medicare. Expanding covered patients’ access to physician care would keep them healthier (and in school and at work).

- Boost Preventive and Public Health Initiatives to Blunt Medicaid Costs

Medicaid per-patient costs are relatively flat, though there is no doubt Medicaid costs are rising. In large part, higher costs are driven by rising enrollment. But Texas Medicaid, like the larger health care system, isn’t immune from forces driving health care costs ever upwards: rising pharmaceutical costs; an older, sicker, fatter population; stagnant tobacco reduction efforts; untreated behavioral health disorders, including drug abuse; and fragmented, uncoordinated care. Texas, as noted above, also leads the nation in the number of uninsured, who often delay needed care for chronic illnesses, resulting in higher health care costs and uncompensated care, which ultimately get passed along to other payers.

Thankfully, Medicaid delivery system and payment reforms are blossoming, with many promising collaborations among Medicaid managed care plans and physicians aimed at improving care coordination, early intervention and management of chronic diseases, and better birth outcomes. For example, Texas Children’s Medicaid HMO partnered with an interdisciplinary physician and provider team to develop a pregnancy medical home. Early data indicate the initiative has resulted in earlier entry into prenatal care and reduction in premature and low-birth weight babies. United Medicaid HMO is partnering with physicians and community clinics to implement patient-centered medical homes, rewarding practices for improving preventive and primary care and redesigning practices to encourage same-day and after-hours care with the patient’s primary care physician instead of the emergency department. These examples should be the rule, not the exception. **HHSC must boost its contractual expectations that managed care organizations (MCOs) promote and adopt creative, physician-led, value-based payment models.**

Our members want to be partners in Texas’ efforts at Medicaid cost-containment. Given Texas’ forthcoming budget challenges, it will be even more critical for lawmakers, physicians, providers, and patients to identify constructive solutions to mitigate health care costs in publicly funded programs. But it must be stated that physicians, as a group, have paid their fair share over the last decade. In 2010-11, physician Medicaid payments were reduced by 2 percent across the board followed by a 20-percent payment reduction for services provided to dual-eligible patients — those poor enough to qualify for Medicaid and Medicare. For the past two decades, Medicaid payments have failed to keep pace with inflation. Any further reductions will be absolutely detrimental to MCO physician networks.
Instead of payment cuts, we urge the legislature to focus on prevention and early intervention as the best means to constrain costs:

- **Promote better birth outcomes by enhancing women’s access to preventive, primary, and behavioral health care.**
  
  o Enhance women’s health services to provide comprehensive preconception and interconception care, including specialty treatment for chronic physical and mental health conditions, with particular emphasis on women at high risk for delivering a low-birth weight or premature baby. As noted in the August 2016 Maternal Mortality and Morbidity Task Force Report, Texas’ rate of maternal mortality and severe illness spiked dramatically over the past few years, though it is not fully understood why. However, the authors of the report noted that 60 percent of deaths occurred six weeks after delivery, with cardiac disease and substance abuse disorders being leading causes. Women lose Medicaid 60 days postpartum, meaning those with ongoing medical needs often cannot get it.
  
  o Regularly review and adjust payments for long-acting reversible contraceptives purchased directly by physicians or clinics to ensure women can obtain the devices during an office visit rather than returning later when the device is ordered from a specialty pharmacy. This will help reduce Texas’ high rate of unintended pregnancies, many of which Medicaid pays for.
  
  o Increase outreach to inform women about the new women’s health programs and the importance of preventive health care throughout their lifespan.
  
  o Increase screening for postpartum depression by paying pediatricians for conducting maternal mental health screenings during Medicaid well-baby/well-child exams.

- **Increase access to evidence-based community and crisis mental health and substance abuse services.**
  
  o Enhance funding for medication-assisted treatment for patients with substance abuse disorders, including opioid addiction, to reduce rates of recidivism.
  
  o Ensure funding for naloxone to help prevent overdoses for patients with opioid addictions.
  
  o Expand availability of supportive services such as housing assistance and peer specialists to avert high-risk patients from repeat incarcerations or frequent visitation to hospital emergency departments.
  
  o Expand the neonatal abstinence syndrome initiatives to additional counties with high incidence of NAS, including East Texas.

- **Reduce disease burden and concomitant costs** by investing in evidence-based strategies to improve health, including increasing Texas’ adult and child vaccination rates, decreasing tobacco usage, and reducing potentially preventable hospitalizations.
  
  o Increase funding to deter usage of tobacco and e-cigarettes, particularly among teens and young adults, which is on the rise and results in future taxpayer costs.
  
  o Initiate an ongoing, effective, robust statewide media campaign on the importance of vaccinations, with targeted campaigns towards:
    
    - Boosting the number of adolescents receiving the HPV vaccine,
    - Increasing vaccine rates among workers in child care settings and long-term care facilities, and
    - Increasing the number of pregnant women receiving flu and Tdap vaccines.
  
  o Expand the Department of State Health Services’ potentially preventable hospitalization initiatives to 50 additional counties.
Intensify State Initiatives to Provide Women’s Preventive and Primary Care

We applaud HHSC for its partnership with physicians and women’s health clinics to transition women seamlessly from three preventive health programs to two. Not surprisingly, hiccups occurred. Yet all in all, we are pleased with the process, though more work remains. An estimated 1.8 million low-income women go without preventive health services such as access to effective contraceptives and cancer screenings. More distressingly, two independent reports\(^1\) found Texas’ rate of maternal mortality more than doubling over the past two years, with African-American women at the greatest risk of death. Indeed, black women account for 11.4 percent of births but 28.8 percent of maternal deaths.

Texas cannot pin the higher mortality rates to a single cause. Experts remain baffled by why Texas’ maternal morbidity and mortality far exceeds that of other states. But there are useful, evidence-informed steps Texas can take in the next biennium to improve the lives of mothers and babies. Specifically, we urge the legislature to support academic research at a Texas public health university into genetic, medical, and/or socioeconomic factors contributing to severe maternal illness or death. Additionally, we strongly support recommendations submitted by the Texas Women’s Healthcare Coalition, of which each of our organizations is a member, including:

- Providing comprehensive health care services to women of reproductive age;
- Enhancing outreach initiatives to enroll more women and health care providers into the Healthy Texas Women program;
- Increasing uptake of long-acting reversible contraceptives, the most effective form of contraceptive, by educating women, men, and family planning providers about their safety and efficacy; and
- Reforming Texas’ Medicaid and CHIP eligibility systems to allow teenagers to enroll in both CHIP and the Healthy Texas Women program to ensure timely access to contraceptive services with parental consent.

Ensure Children in Child Protective Services Receive Timely Access to Medical Services

We strongly concur with the support from the governor and Senate and House leadership for continued funding and additional investment in Department of Family and Protective Services (DFPS) programs. In light of recent concern about child safety in Texas, the state’s foster care redesign initiative and the national shift toward prevention and early intervention services, we believe there is no better time to invest heavily in the system that serves the state’s most vulnerable children. As physicians, we give strong support to the recently released exceptional items from the department that would enhance child and family services and the DFPS workforce. However, we should not lose sight of the health care needs of children in foster care. On average, youth in foster care have higher instances of physical, developmental, and behavioral health conditions compared with any other group of children. One-third of children in care have a chronic medical condition, and up to 80 percent of children enter care with a significant mental health need.

In an effort to continually improve the provision of health and mental health care for children in foster care, we recommend that children receive an initial health screening within 72 hours of entering care as opposed to the current 30-day requirement, aligning state practices with the American Academy of Pediatrics national standards. Additionally, we recommend that DFPS notify a child’s primary care physician about a change in foster care placement to ensure continuity of health care and readiness of the new placement to meet a child’s health care needs. Lastly, we recommend that DFPS ensure a child’s primary care physician has access to the child’s abuse and neglect history. We strongly believe these recommendations would greatly enhance the overall system of care for these children and mitigate the long-term health and mental health effects of adverse childhood experiences.

\(^1\) Recent Increases In The U.S. Maternal Mortality Rate, *Obstetrics & Gynecology*, September 2016; Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, July 2016.