TO: House Appropriations Committee, Article II Subcommittee

The Honorable Four Price, Chair
The Honorable Dawnna Dukes
The Honorable Cindy Burkett
The Honorable Sarah Davis

The Honorable Oscar Longoria
The Honorable J.D. Sheffield, DO
The Honorable Armando Walle

TO: Texas Medicaid Association
Texas Pediatric Society
Texas Academy of Family Physicians
Texas Association of Obstetricians and Gynecologists
American Congress of Obstetricians and Gynecologists
Federation of Texas Psychiatry
Texas Ophthalmological Association
American College of Physician Services-Texas Chapter

DATE: April 7, 2016

On behalf of the above-named organizations, thank you for the opportunity to submit comments on the subcommittee’s interim charge 12, which directs the subcommittee to examine Medicaid’s historical growth, to review legislative or policy initiatives to reduce costs, or to improve the quality of health care within the program.

Since Medicaid’s inception in Texas, physicians have been active partners in the state’s efforts to ensure high-quality, cost-effective care to low-income Texans, who also happen to be our friends, neighbors, and family. Organized medicine has collaborated with the state from everything to improving access to prenatal and postpartum care to reforming the Medicaid delivery system to strengthening efforts to prevent and effectively treat chronic diseases, such as diabetes and heart disease. We also have worked cooperatively with Texas Medicaid to identify and implement responsible, evidence-informed approaches to ensuring responsible utilization of Medicaid services, including prenatal ultrasounds, antipsychotic prescription drugs for children, and high-cost diagnostic imaging services, such as CT scans and MRIs.

We take seriously our role as stewards of the program, recognizing that Medicaid must spend its limited tax-payer dollars judiciously. We want to work with you in the coming months to identify potential new options to constrain cost-growth while ensuring our patients’ ability to access needed care is not jeopardized, a goal we know you share.

An example of where we believe Medicaid must continue its efforts to improve health outcomes while spending less in the long run would be to invest more in postpartum/interconception care, particularly for women with a prior history of preterm birth or low-birth-weight babies. According to Texas’ most recent
data, 10.3 percent of babies are born prematurely, compared with 9.6 nationally. Texas is making progress. Just a few years ago, Texas’ prematurity rate topped 13 percent. But Texas can do better. In pockets of Texas, including Houston, El Paso, and San Antonio, the preterm birth rate is much higher. According to the Texas Health and Human Services Commission, Texas Medicaid spends on average 18 times more on babies requiring neonatal intensive care services compared with babies born healthy. Many factors contribute to preterm birth, but critically important to reducing rates of prematurity is the prevention and treatment of chronic conditions before, during, and between pregnancies. Lifestyle interventions also matter, including tobacco cessation and maintaining a healthy weight.

Women lose Medicaid 60 days postpartum, leaving them without coverage unless they are fortunate enough to live in a community with generous indigent care benefits. Without coverage, women may skip needed treatment. Thankfully, beginning in July 2016, the new Healthy Texas Women’s program will provide treatment for a very narrow set of illnesses, including hypertension, a change we have long championed. But if Texas wants to meaningfully reduce preterm births, it will need to invest in coverage that promotes healthy behaviors and provides interventions for all health conditions that may potentially contribute to poor birth outcomes.

We also strongly support efforts to reduce costs by averting the occurrence of preventable diseases such as heart disease, cancer, and diabetes through proactive policies to reduce Texas’ rate of obesity and tobacco usage. Tobacco use and obesity are the leading causes of death in Texas. They also are leading cost drivers. According to a 2014 report by researchers at the Centers for Disease Control and Prevention, 15.2 percent of Medicaid spending is attributable to tobacco use, which contributes to everything from heart disease to skin and eye disorders to cancer. Similarly, obesity hikes costs. The 2014 report, The State of Obesity, by the Robert Wood Johnson Foundation and Trust for America’s Health noted that overweight or obese patients had substantially higher emergency department visits and greater usage of prescription drugs to manage chronic conditions. Thirty-two percent of Texans are obese. Our ideas for tackling the tobacco use and obesity are contained in the attached recommendations, submitted on April 6, 2016, to the House Public Health Committee.

Achieving the cost-savings we mutually envision will require more than just innovative and clinically sound health care policies. It also will require bold action by the legislature to rebuild the Medicaid physician network, which has steadily eroded over the 16 years largely for one reason: unreasonably low payment rates. Medicaid physician payments average 73 percent of Medicare and 50 percent of commercial payments.

As we have frequently reminded this body, in 2000 67 percent of Texas physicians accepted all new Medicaid patients. By 2014, that number had plummeted to 37 percent. Despite the exodus, our members tell us they strongly support the program. Indeed, our organizations continue to support legislative efforts to cover more Texans via a Medicaid innovation waiver to provide more coverage while also testing use of mechanisms such as cost-sharing to encourage appropriate utilization of services. Providing health care coverage to more Texans not only will benefit the health and well-being of our patients but also will yield savings to Texas. A recent study by the Robert Wood Johnson Foundation found the 31 states that have already availed themselves of these federal dollars saw Medicaid savings and increased revenues — as well as large drops in hospital uncompensated care — which could then be used to reduce local property taxes.

While we support pursuing a Medicaid coverage waiver, an insurance card does not coverage make. To meet the needs of all the Texans who benefit from Medicaid now or in the future, Texas must expand the number of physicians and providers who participate. The good news is that we know paying more does increase the number of physicians accepting Medicaid. The TMA 2014 physician survey found 5 percent more primary care physicians accepted all new Medicaid patients than did in 2012, a jump attributable to the two-year, federally funded Medicaid initiative increasing certain primary care physician payments to Medicare parity. Plainly, increasing Medicaid payments has a measurable, positive impact on physician participation.
As owners of small businesses, facing ever more costly and demanding federal and state regulatory burdens, many physicians just cannot afford to stay in a program that pays less than half their costs. **Legislatively driven efforts to reduce Medicaid red tape and improve network adequacy will definitely** help. Administrative overhead is not only frustrating for physician practices but also costly. Lessening that burden will make it easier to recruit and retain new physicians. But it is simply not enough.

The legislature sets Medicaid rates. But 87 percent of Medicaid patients are enrolled in a managed care organization (MCO). So MCOs should be part of the solution. During contracting, plans frequently tell physicians they only pay according to the Medicaid fee-for-service fee schedule. Yet plans have the discretion to pay more. While some indeed do, at least for certain services or hard-to-find specialties, the Medicaid fee-for-service rate is what most pay. Plans could be paying more. An analysis of Medicaid MCO finances found that in 2014, the plans’ collective retained earnings reached a whopping $683 million dollars. These dollars could be harnessed to improve network adequacy.

Further, we agree that Medicaid needs a facelift. We want to work with you to continue to identify commonsense changes that will benefit patients and the physician and provider network while also improving patient outcomes and lowering costs.

During the 2015 legislative session, you led the charge to establish higher Medicaid payments. For your leadership, we are extraordinarily grateful. **We are calling upon you again to champion competitive Medicaid payments to ensure our most vulnerable Texans have access to services they need to stay healthy and productive.**
## History of Medicaid Physician Rate Increases

In 1992, Texas Medicaid created the current physician Medicaid payment methodology, modeled on the same formula used by Medicare but without any geographic modifiers. At that time, Medicaid also adopted a process to designate certain services with “access-based fees (ABF)” to account for the fact Medicare covers mostly seniors. Without the adjustment, pediatric and obstetric-related services, not accounted for in Medicare rates, would have been undervalued. Today, few codes are still considered “access based,” though the Medicaid medical director retains some jurisdiction to slightly increase fees if an access issue can be demonstrated.

Medicare physician payments, while imperfect, are annually adjusted. Texas Medicaid physician payments, on the other hand, are not, even though the Medicare Payment Advisory Commission estimates physician practice costs grow an average of three percent annually as a result of changes in practice expenses, such as salaries, rent, and other overhead costs.

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid Physician Payments</th>
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<tbody>
<tr>
<td>1993</td>
<td>Medicaid physician payment rates frozen.</td>
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<tr>
<td>1993-1999</td>
<td>No payment increases. Meanwhile, Consumer Price Index increased more than 27 percent.</td>
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<td>1999</td>
<td>Two percent across the board physician payment increase.</td>
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<td>2001</td>
<td>$50 million increase targeted to improve preventive care for children as well as “high volume” primary and specialty physician practices.</td>
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<td>• Phase I - Increase payment for Texas Health Step (well-baby/well-child) visits by $21 from $49 to $70</td>
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<td></td>
<td>• Phase II – 1) Eight percent increase in office-code 99213 from $27.28 to $29.52; 2) Allocate 1.9 percent increase in payments to “high volume” PCPs; 3) Increase payments to high-volume specialists by 6.1 percent increase</td>
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<tr>
<td>2003</td>
<td>2.5 percent reduction in physician Medicaid payment rates</td>
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<td>2007</td>
<td>Frew consent decree results in 25 percent increase in dollars available for pediatric physician services. Higher payments targeted to select codes and specialties, leaving out key services</td>
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<td>2010</td>
<td>One percent across the board payment reduction</td>
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<tr>
<td>2011</td>
<td>One percent across the board payment reduction</td>
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<td>2012</td>
<td>Elimination of Medicaid payments for “dual eligible” patients’ Medicare deductible and copayments. Dual-eligible patients are low-income seniors and people with disabilities who qualify for both Medicare and Medicaid. The policy change resulted in a twenty percent payment reduction for those physician practices who care for this population. (In 2013, the legislature restored the Medicaid’s payment of dual-eligible patients’ Medicare deductible but kept in place the elimination of copayments.)</td>
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<td>2013-14</td>
<td>Temporary “Medicaid to Medicare” primary care physician parity payments, funded by the federal government. The two-year payment adjustments applied to a limited set of codes, not all physician services. The higher payments ended on Dec. 31, 2014.</td>
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