TEACHING HOSPITALS of TEXAS

September 25, 2020

House Committee on Human Services
Texas Capitol - E2.125
Austin, TX 78701

RE: Interim Charge 2.2 - Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: The next phase of the 1115 Healthcare Transformation and Quality Improvement Program Waiver

Chair Frank and Members of the Committee,

Thank you for the opportunity to provide information on Interim Charge 2.2. The Teaching Hospitals of Texas members include large public urban teaching hospitals and several affiliated non-profit health systems. Eleven of the 20 regional health partnership (RHP) waiver anchors are THOT members. Our members also provide the majority of the funding needed to access federal transformation funds under the Delivery System Reform Incentive Payment (DSRIP) program.

We understand that the Committee is evaluating the next phase of the 1115 waiver and its effect on the state budget. In light of COVID-19's unparalleled, disruptive and ongoing impact on Texas' health care delivery system the Teaching Hospitals of Texas along with other stakeholders have urged Texas to seek a one-year extension of the current Delivery System Reform Incentive Payment Program (DSRIP) program under the state's Medicaid 1115 Transformation Waiver. With just one year left in the current Waiver, DSRIP funding of $2.49 billion is set to zero out just 12 months from now (FY 2022; September 30, 2021) with just over 13 weeks left to finalize Texas' proposal for transition projects and financing. A one-year extension of DSRIP will not be a cost to General Revenue and we believe the extension will ensure critical public health, behavioral health and uninsured care services that will either be lost or require additional General Revenue. With a five percent reduction to the overall state budget and the potential reduction to the next biennium's budget, any loss in DSRIP funding to providers will likely have detrimental impact on to Texas' health care safety-net.

An extension will allow Texas DSRIP-participating providers to recover and stabilize from the pandemic's economic toll, complete the current DSRIP programs that were unexpectedly disrupted as a result of COVID-19, and have the time necessary to assess alterations in the health care landscape before setting about to transform DSRIP programs and plan for necessary health system reforms for Waiver III.

Early in the pandemic, Texas quickly activated its resources to prepare for the pandemic. Even so, the pandemic continues to take a heavy toll and is still unfolding with no clear end in sight. It is taking lives, jeopardizing the health of essential health care workers, and undermining the stability of the health care safety net. It has slowed commerce, increased unemployment, and altered our way of living. Yet to date, DSRIP providers and HHSC also have continued to meet the required 1115 Waiver DSRIP transition metrics and planning timelines.

With characteristic grit, Texas continues its work to support our critical health system infrastructure, meet the critical health and social safety needs of its citizens, and navigate the pandemic's shifting sands. Yet, despite the state's overall resilience, COVID-19 has starkly revealed long-time weaknesses in the state's health care safety net and

undermined the health care delivery system's capacity to manage the significant changes required for a successful DSRIP transition.

That transition will shift $2.49 billion in provider-driven health care funding; end current DSRIP support for uninsured Texans; and require planning, development, financing and staffing for new programs and data reporting even as our healthcare providers are navigating extraordinary challenges to manage the continuing pandemic. Since March, patient care delivery, healthcare facility infrastructure, health care finances, supply chain management, health care staffing, patient volumes and utilization trends, workflows, and clinical operations have all changed in response to the pandemic. Our providers are nimble, dedicated, professional, and responsive. Yet, successfully implementing a $2.49 billion program change in 12 months while also remaining focused on sustaining care through a still-evolving pandemic would be like asking them to build a new bridge while the one they are on crumbles.

We therefore have requested that Texas seek CMS flexibility to keep $2.49 billion available in DSRIP funding in DY 11 through an extension of its DSRIP program. Doing so will allow HHSC and its waiver participants to:

- Assess and stabilize healthcare systems before adding another system change and associated system shock and transition.
- Help make up for the progress lost this year due to COVID-19 and offer providers two full years to achieve their current DSRIP goals.
- Maintain critical access for the 40% of uninsured individuals served through DSRIP funds who will lose those services when the DSRIP funding ends.
- Provide health care stakeholders time to better evaluate the impact of COVID-19 on the state's health care delivery system so that they can better identify the future improvements that can be operationally and financially integrated into Texas' delivery system during and after COVID-19.
- Align Texas' post Waiver-II delivery system planning with the end of DSRIP, allowing for
    - uninterrupted continuation of programs serving uninsured Texans, which will be particularly essential as the number of uninsured increases to due rising unemployment; and
    - comprehensive delivery system improvements that align waiver budget neutrality, financing, and programmatic planning post Waiver II with the DSRIP transition.

Below we share provider perspectives collected through mid-June. Since that time, the challenges summarized here have been exacerbated by COVID-19 case growth, and our ability to successfully transition DSRIP and to implement new programs and financing within 12 months has been further diminished.

Rapid Change, Challenges, and Innovation in the Current Delivery System

Health care is COVID-19's ground zero, causing disruption and unexpected restructuring throughout the delivery system. Limiting harm, ensuring safety, and creating clinical capacity have required restructuring physical access, increasing Intensive Care Unit (ICU) and isolation space and duplicating processes to keep patients and staff safe and preserve Personal Protective Equipment (PPE). For example early in the pandemic, Parkland Hospital staff took just five days to convert their entire Post-Anesthesia Care Unit (PACU) and half of the operative suites into a 116-bed negative-air pressure unit dedicated to COVID-19. Similarly, and due in large part to DSRIP initiatives that expanded technology infrastructure and platforms for telemedicine and other technology enhancements, Community Mental Health Centers across the state were able to adapt to video-audio only service within a few days to ensure sustained access to outpatient mental health treatment.

At the same time, non-emergent, in person visits plummeted, threatening the viability of many providers. Among primary and specialty care physicians, 63% reported losing 50 % or more of their revenue because of the pandemic, with little cash on hand to weather the hemorrhage. As a result, many practices have reduced salaries, furloughed, or laid off staff, discontinued certain services, or closed their doors, some permanently.

Many facilities critical to access are also struggling. Two rural clinics in Electra closed when 12 of 16 staff in one clinic contracted COVID-19 after an undiagnosed asymptomatic COVID-19-positive patient came in for unrelated care. Both clinics were closed for two months and have only recently and slowly been re-opening. Clinics remaining open have experienced steep reductions in preventive, primary and chronic care management services, some by as much as 75% to 90% of their typical in-person visits. A recent poll[1] showed that nearly half of Americans or one of their family members deferred healthcare due to worries about COVID-19. While most of these are expected to come back, the timing and nature of their return is uncertain, making planning, metrics and financial risk challenging. In those two rural clinics that closed, patients are still hesitant to return for care – even needed care.

Because of clinic closures and patient concerns about seeking primary and specialty services during initial months of the pandemic, our members worry that "the lack of access and/or fear of seeking primary care services is negatively impacting the health status of those with chronic conditions.[2]" Some hospitals' emergency departments report seeing a higher volume of patients with chronic disease and worse health status.

As the COVID-19 survival population increases, providers anticipate seeing more patients with special care needs and chronic disease (El Paso projects that their patient population with heart disease, for example, may double). At the same time, medication compliance is emerging as a growing challenge. Patients are afraid or unable to travel to a pharmacy; they report affordability issues due to job losses and fiscal constraints; and not all providers have in-house pharmacies with mailing capacity or the ability to provide discounted medications.

Providers are also seeing an increase of COVID-19-survivors in indigent care clinics – some of whom have been redirected from other hospitals after discharge and presenting as new patients with significant comorbidities and health challenges. And with the number of uninsured Texans on the rise due to increasing rates of unemployment, all providers are concerned that more patients will face unmet health care needs. Safety net providers also are concerned that revenue losses in the larger healthcare system will force providers to prioritize paying patients, leaving uninsured Texans with fewer options, and exacerbating pressures on their capacity to provide care. The simultaneous drop in revenues and the increasing need for charity care would strain safety net clinics' and facilities' ability to meet community needs, particularly with the impending loss of DSRIP funding.

Crisis Spurred Rapid Adoption of Innovative Alternate Access Models. In response to the crisis, priorities for providing care eclipsed reimbursement restraints leading to innovations in access: creating new centralized drive through blood testing for patients on anticoagulants; giving pulse/oxygen monitors to COVID-19 positive patients in the emergency department for remote at home symptom reporting to care managers; giving blood pressure monitors

[1] https://www.kff.org/report-section/kff-health-tracking-poll-may-2020-health-and-economic-impacts/

[2] e.g., Quotes included in this document are from provider surveys and interviews and used without specific citations to share direct provider perspectives.

to high risk pregnant women for phone reporting in lieu of weekly clinic visits; and using remote glucose monitors and having patients call in results rather than come in face to face. Much of the innovation enabled by DSRIP - including that related to telemedicine/telehealth, patient care navigation, chronic care management, better integration of physical, behavioral and public health, and coordination with community stakeholders – positioned Texas to be able to respond to the crisis better than they would have been able to absent DSRIP. And even as providers quickly shift to telehealth and telemedicine, in many cases neither workflow changes nor IT systems have caught up. Standards, protocols, development and integration into data systems and practices need to be established and stabilized.

Uncertainty and Planning Challenges

The unpredictable trends and timelines for COVID-19 cases, reductions in workforce due to economic fallout from the pandemic, and the unintended costs to retool care delivery systems while also maintaining surge capacity means providers throughout the state do not have the stability or capacity to plan and implement significant new programs. It also is too soon to predict what new post-COVID-19 patient behavior and health systems will look like. Providers have lost significant levels of critical revenue at the same time many have made unbudgeted investments in COVID-19 preparations, protections, testing and critical care. While budgeting involves predicting future trends and developing reasonable and rational assumptions, the level of unknowns in the coming year for some providers makes it "impossible to budget at this point." Unknowns such as COVID-19, the DSRIP transition, patient responses, and system changes exacerbate budget variability. Add to these other unknowns, like state budget decisions, pressure on property taxes and current law DSH cuts. "This is unsettling as we move into our next budget year. As we begin budgeting, we are uncertain about which programs we need to start scaling back to maintain solvency once they are discontinued."

At a time when the delivery system faces severe financial instability, it will be enormously risky to have so much funding at risk for services and outcomes that are unknown, beyond providers' control and cannot be planned for. In today's world, the new "normal" continues to unfurl, making it difficult to predict what the new normal will look like. **Texas will need a least a year to better understand the implications of the virus' impact on patients and health care delivery systems before it can have an informed strategy for the future.**

Uninsured

If DSRIP terminates as planned in 12 months, there is no proposed replacement program to continue some level of care for the 40% of those served through DSRIP who were uninsured.[3] Loss of DSRIP funding will result in less access, increased reliance on more costly places of service, such as the ED, in lieu of DSRIP's more cost effective programs, and increased pressure on public providers and indigent access programs at the same time local and county revenues are strained by COVID-19. As noted above, the financial fall out of COVID-19 combined with increasing uncompensated care will strain the ability of the safety to meet community needs. Ultimately, without DSRIP funding or equivalent alternative funding, access to care for Texans without insurance will be reduced. This loss of programs will be exacerbated by a growth in the number of uninsured Texans since COVID-19 job losses and related losses of health insurance are predicted to hit Texas with an additional 1 million uninsured Texans.[4] Adding to the challenges, increases in unemployment rates and other pandemic pressures on individuals and families are expected to create surge demand on behavioral health providers currently relying on DSRIP funds to increase access to mental health and

[3] HHSC reported that the patient mix of those accessing DSRIP services from DY 3 – DY 6 was: 25% Medicaid; 35% other and 40% low income / uninsured.

[4] https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage. Up to an additional 1.16 million Texans could be without insurance this year

substance use disorder treatment.[5] If alternate plans are not well in place, this surge, with commensurate loss of public mental health capacity, could be devastating to individuals and communities across Texas.
Innovative DSRIP initiatives include funding for homeless shelter programs, palliative care and hospice programs, home health visits and Nurse Family Partnership programs[6]. While we acknowledge that the current waiver required Texas to identify how it would sustain worthwhile projects going forward, the ability to do so successfully has been greatly diminished by the ongoing pandemic. The most likely source of dollars to continue effective DSRIP work — state and/or local revenues —has dropped precipitously over the past several months. While the state's economy has shown signs of a rebound, many jobs have been permanently lost. Unemployment is forecast to be at 10 percent or higher for the next several years followed by a concomitant increase in need for health and social services. Unexpectedly, Texas will not have the means to replace DSRIP funding.

Texans Want to Finish Their Investments and DSRIP Work – Not Leave It Hanging

DSRIP providers of all stripes said they do not want the COVID-19 disruption to result in them losing years-long momentum and community health improvements. An extension will help them stabilize and recover from COVID-19, help make up for the progress lost this year and give them two full years to complete current DSRIP initiatives and move to broader system transformation.

Going Forward: Coverage Options

Beyond the DSRIP extension, THOT has proposed a community-based coverage option for the next phase of the waiver. Using available budget neutrality, local communities could choose to provide the non-federal share of funding to support an integrated, local system of care for Texans without insurance. Structured like a provider accountable care organization, these programs could pilot value-based integrated coverage programs that partner with community based organizations and other to address social factors of health, and improve health equity and access to care based on community priorities and care needs.

Thank you for your consideration of these comments. Please let me know if you have any questions or we can be of assistance to the Committee.

Maureen Milligan,
President & CEO
Teaching Hospitals of Texas

[5] Brown, E., & Wehby, G. L. (2019). Economic conditions and drug and opioid overdose deaths. Medical Care Research and Review, 76(4), 462–477. https://doi.org/10.1177/1077558717722592
Compton, W. M., Gfroerer, J., Conway, K. P., & Finger, M. S. (2014, June 14). Unemployment and substance outcomes in the United States 2002–2010.Drug and Alcohol Dependence,142, 350–353.

[6] NFP programs have been shown to reduce future Medicaid and SNAP use, increase academic performance and family incomes. https://www.nursefamilypartnership.org/about/proven-results/18-year-follow-up-study/

TEACHING HOSPITALS of TEXAS

September 25, 2020

House Committee on Human Services
Texas Capitol - E2.125
Austin, TX 78701

RE: Interim Charge 2.4 - Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: the Centers for Medicare and Medicaid Services proposed Medicaid Fiscal Accountability Rule.

Chair Frank and Members of the Committee,

Thank you for the opportunity to provide information on Interim Charge 2.4. The Teaching Hospitals of Texas members include large public urban teaching hospitals and several affiliated non-profit health systems sharing three core commitments. They provide quality care to all, in particular vulnerable Texans; are prepared for and provide trauma and disaster services and care; and support Texas' healthcare workforce and graduate medical education as well as clinical and delivery system research and transformation.

On Monday, September 14, 2020, CMS announced they would be withdrawing the Medicaid Fiscal Accountability Rule (MFAR). While CMS has announced the rule withdrawal there is the potential for the federal agency to republish the rule and move forward with the regulation in the future. This rule would adversely impact Texas' Medicaid Program by reducing program clarity and oversight transparency, reducing access and causing instability in the health care safety net by restricting local funding in the Medicaid program, narrowing provider definitions, placing new requirements and reviews related to state plan amendments and waiver-based supplemental payments, and interjecting new discretionary authority for CMS that is unclear and subjective. It has the potential to put $11 Billion in Medicaid hospital financing at risk.

In the rule summary, CMS notes the purpose of the proposed rule is to "*promote transparency*" and "*strengthen the overall fiscal integrity of the Medicaid Program*." CMS identifies the need for more information to assist in improving transparency and in assuring consistency with efficiency, economy

and quality of care in the program: "this proposed rule would promote transparency by establishing new reporting requirements for states to provide CMS with certain information on supplemental payments to Medicaid providers." THOT is fully supportive of improving transparency in the Medicaid program and as a vehicle to ensure the fiscal integrity of the program. We agree with CMS on the need for financial reporting at a level sufficient to meet the Medicaid program's fiscal integrity requirements. Texas supplemental payment programs require reporting to HHSC. HHSC consistently collects and reports hospitals, and other eligible provider, Medicaid and uninsured eligible costs and payments through the DSH/ UC application. In addition, HHSC has also set up a portal to capture data regarding local provider participation funds (LPPF).

While CMS proports to be promoting transparency, the rule actually reduces program transparency by interjecting new discretionary authority for CMS that is unclear and subjective; and usurps state authority.

When evaluating what state and local funding is allowed, MFAR adds a very broad definition of "net effect," enabling CMS to subjectively look at the "totality of the circumstances" in its decisions. CMS' broad and subjective purview, lacking specific criteria for enforcement, will further destabilize Medicaid financing and policy since states, local governments and providers will have no certainty regarding program financing.

MFAR also limits the use of current state matching funds by dictating which public funds state and local governments can use to match federal Medicaid funding. The rule also penalizes government providers and state health systems that have reduced their reliance on tax revenues, and chills limits public-private partnerships. If MFAR were to move forward again, Texas communities would need to either cut services or increase taxes to offset these new limits. Reduced funding to safety net providers caring for the uninsured and fortifying Texas' disaster planning and public health response[i] would put the health of Texas and its economic engine at risk.

Hospital districts in Texas have a state constitutional obligation to provide care to individuals who are indigent, and as such have partnered with the state to finance vital supplemental payments to ensure stability in the safety net.

Texas has worked over the years with CMS to implement methods of finance that are uniquely tailored to the needs of our state.

THOT believes this partnership has worked well and should not be disrupted by new restrictions and subjective decision making proposed by CMS in MFAR.

Additionally, MFAR gives CMS the authority to determine which state and local entities are defined as government units for purposes of Medicaid financing, creating a new, narrow definition for them and proposes a definition of "public funds" at odds with the Texas Constitution[ii]. The rule also provides CMS wide discretion on determining provider types. This provision interferes with how states allocate dollars across provider types, making it difficult for states to determine with confidence whether their payment and financing approaches meet federal requirements.

MFAR increases uncertainty with new requirements and more reviews of state plan amendments. MFAR limits federal approvals (state plan amendments (SPA)) for supplemental payments to three years and requires new criteria to be included in plans, causing administrative burdens for states even when programs are unchanged.

Texas Medicaid covers a diverse population of more than 4 million Texans, including children, nursing home residents, and individuals with disabilities.

Texas Medicaid supplemental payments are crucial as Medicaid base payments on average cover only 69% of hospital costs (and according to the most recently published state public data, just over 50% of hospital costs for large urban public hospitals).

In addition to Medicaid, Texas Hospitals provide billions in uncompensated care to uninsured Texans the costs of which these supplemental payments also help defray.

These proposed changes will cause delays and instability in the financing system with potential backlogs or changes in CMS administration delaying critical payments to hospitals and providers. CMS seeks broad discretion on SPA approval and provides little direction on meeting economy, efficiency, quality of care and access requirements.

Significantly, CMS provided no estimated fiscal impact for the proposed rule, simply claiming the impact is unknown and that it does not "have sufficient data to predict or quantify the impact of the proposed provisions," except for a $222 million reduction related to new limits on supplemental payments to professionals.

To reiterate, the uncertainty related to how CMS will apply its proposed vague but expansive authority to disallow programs and Medicaid funding could put at risk a significant share of $11 billion in funding that today helps offset otherwise catastrophic Medicaid and uninsured losses.

Resulting reductions in Medicaid funding will leave states and local governments with limited options to identify new revenue (e.g., increases in local property taxes); or service reductions (e.g., cuts in cost- effective Medicaid optional services or reductions in care for those who lack health insurance).

In addition, many of the proposed provisions in the rule would have taken effect immediately, leaving Texas with insufficient time to make policy and budgetary adjustments to mitigate the loss of non-federal share and federal funding.

THOT is appreciative of CMS' decision to withdraw and the work of Texas' leaders in communicating the serious unintended consequences to Texas of the proposed rule.

Thank you for your consideration of these comments. Please let me know if you have any questions or we can be of assistance to the Committee.

Maureen Milligan
President and CEO
Teaching Hospitals of Texas

[i] THOT's Safety Net providers are prepared for disasters and public health such as the Wuhan coronavirus.
[ii] Section 3 Article 52 of the Texas Constitution.

TEACHING HOSPITALS of TEXAS

September 25, 2020

House Committee on Human Services
Texas Capitol - E2.125
Austin, TX 78701

RE: Interim Charge 2.5 - Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: The Healthy Texas Women Section 1115 Demonstration Waiver.

Chair Frank and Members of the Committee,

Thank you for the opportunity to provide information on Interim Charge 2.5. The Teaching Hospitals of Texas members include large public urban teaching hospitals and several affiliated non-profit health systems sharing three core commitments. They provide quality care to all, in particular vulnerable Texans; prepare for and provide trauma and disaster services and care; and support Texas' health care workforce and graduate medical education as well as clinical and delivery system research and transformation. Our members also provide a significant amount of care to Texas Women.

Texas has invested substantially to create a strong women's health infrastructure, with the Family Planning Program (FPP) and Healthy Texas Women (HTW) working together to ensure that women throughout the state have access to care. HTW and FPP programs provide eligible women access to women's health and family planning services at no or low cost. These programs increase access to services that avert unintended pregnancies and positively impact the outcome of future pregnancies. Both of these programs have seen a steady increase of clients enrolled and served since their launch in the summer of 2016. For example, in fiscal year 2019 HTW saw a 16.2 percent increase in client enrollment from the previous year. HHSC in its most recent Texas Women's Health Programs Report estimated a $13 million net savings due to births averted by HTW and $6.6 million net savings due to births averted by FPP. These programs are cost effective and work to provide access and improve the health of the clients they serve.

1210 San Antonio St, SUITE 204. AUSTIN, TEXAS 78701. PHONE: 512-476-1497

In January 2020, HHSC received approval from US Centers for Medicare and Medicaid Services (CMS) for a five-year 1115 Healthy Texas Women demonstration project. Approval of this waiver will allow the state to draw down federal funding to support the current programs efforts which were all general revenue funded. HHSC held a briefing to inform stakeholders that as it transitions the current program, three critical enrollment policies will be eliminated or changed:

- Auto-enrollment will be replaced with the HHSC's current administrative renewal process.
- Adjunctive eligibility for women applying for HTW that are already enrolled in WIC, have a child in Medicaid, or in a household that receives SNAP or TANF will be eliminated
- Simplified HTW application will be discontinued, and women will be required to complete the Texas Health Coverage Application.

The policies above were implemented to streamline the enrollment process for women into HTW and have been effective in ensuring that eligible women are able to enroll and access services in a timely manner. Removal of these policies could create barriers and disrupt the efficiency of the current program and may result in fewer women being served, increasing unintended pregnancies -- thereby increasing Medicaid costs to the state. While we understand that some of these changes may be federally required, we would ask that where the State has flexibility that they work with stakeholders to simplify the enrollment process for HTW clients.

HTW Plus

We also appreciate that the State has made additional investments to develop an enhanced, cost-effective post-partum care service package for women enrolled in HTW. This additional 12 months of coverage will provide access to a limited array of critical services postpartum, helping to ensure the state has healthy mothers and babies. We understand that the program has launched as of September 1st, 2020. As the state builds out the program, we would encourage that a strong provider network be in place to provide the additional benefits such as cardiology, psychotherapy, and other mental health professionals.

12 months Medicaid postpartum coverage for mothers

We applaud the Legislature's work to address maternal death and pregnancy related complications by creating the Maternal Mortality and Morbidity Review Committee and making substantial investments in Women's Health programs. The Maternal Mortality and Morbidity Review Committee (MMMRC) found that the majority of maternal deaths occurred more than 60-days postpartum and that many of them were preventable.[i] We know one of the best strategies to reverse these trends is to ensure women have access to health care before, during, and after pregnancy.[ii] One of the Committee's recommendations was to "increase access to services during the year after pregnancy and throughout the interconception period to improve the health of women, facilitate continuity of care and enable effective care transitions and promote safe birth spacing." Programs like HTW Plus provide coverage for many of the top causes of maternal mortality and morbidity, which is encouraging, however it does not provide the same level of coverage that a client receives

on Pregnant Women's Medicaid. We recommend extending the 60 days Medicaid postpartum coverage to 12 months coverage to better address and treat postpartum conditions.

Thank you for your consideration of these comments. Please let me know if you have any questions or we can be of assistance to the Committee.

Maureen Milligan
President and CEO
Teaching Hospitals of Texas
[redacted]

[i] Texas Department of State Health Services. "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report." September 2018.
[ii] Ibid