Summary provided by TELICON

H. SELECT COMMITTEE ON HEALTH CARE REFORM – DAY TWO

AUSTIN (8/5/22, E2.010, 9:09 AM)

The House Select Committee on Healthcare Reform met today under the direction of Chair Sam Harless.

(9:09) Chair Harless called the hearing to order. Roll called. Chair Harless made opening comments and reviewed protocols for providing oral and written testimony.

Ensuring Prescripiton Access (9:11) Dr. Darren Okuda, Professor of Neurology - UT Southwestern, testified. Dr. Okuda said he primarily treated patients with MS and provided information on the disease.noting it was not uncommon for treatments to be $10 thousand a year or patients to be treated for 20-30 years which were vital to reducing clinical relapses, new inflammatory areas in the brain or premature neurological disability. Dr. Okuda provided information on his study for un- used and under-used MS therapies.noting that when he collected these medications from those voluntarily relinquishing them had a retail of nearly $6 million in 11 months and the extension of one month brought in another $1.1 million worth of medications. Dr. Okuda said the primary reason a person had not been using a medication was because they were forced by a third party payer to switch to a similar medication, were switching to a new therapy, did not like the treatment or did not like the frequency the medication was taken. Dr. Okuda said patients often received 3 month prescriptions for $119 thousand and had the first refill after 7 days and another after 1 month-each being 3 months worth. Dr. Okuda said they were finding that unused medications were being sold online, donated to members of their support groups or flushed down the toilet.including medications in syringes. Dr. Okuda said he had one patient submit 1 year's worth of one medication which was sold for $103 thousand and had no value once sold. Dr. Okuda recommended that they create a certification for resale, provide reimbursement for unused medications and/or create a legal sharing program-noting that even with blister packs many times they did not know how they had been stored.

Chair Harless asked how he used the medications when they were returned to him. Dr. Okuda said they were currently just storing them as they did not know how they were stored, they had a room that took 8 hours to stack medication in, they'd had to scale back what they'd stored due to lack of storage space and he'd collected $25 million worth of treatments since 2018. Dr. Okuda said, while many practitioners were aware of the issue, his team was the first to quantify the scope of the problem for MS. Dr. Okuda said his goal was to find a way to make the medications more affordable whether they were reused or not. a problem he'd been hearing about since well before he made the decision to go into medicine. Chair Harless asked if the medications all had expiration dates. Dr. Okuda said they did and provided information on the data collected including lot number, insurer, prescriber, expiration date and clinical justification for the prescription. Dr. Okuda said they also found significant disparities for BIPOC patients who had found that the medications

did not work for them or did not fit into their schedules. Dr. Okuda said patients would like to see their unused medications go to use for other patients, but, after sale, they did not have any use.

(9:25) Rep. Klick asked if they were speaking to injections or oral medications. Dr. Okuda said they used oral medications, capsules, subcutaneous injections and intramuscular injections-essentially all methods of delivery except infusions. Rep. Klick said the state had a fledgling medication sharing program which may be able to be expanded. Dr. Okuda said many pharmaceutical companies were risk averse to the medications being shared, but he was concerned about the padding in the system which created the waste as much as he was about the reuse.ideally each medication would be distributed in 1 month allotments to avoid the waste. Rep. Klick said when her mother passed, they found several boxes of medications which had never even been opened and she understood there were other chronic diseases which fell into the same category. Rep. Klick recommended Dr. Okuda meet with her to expand the state's pharmaceutical donation program.

Rep. Bonnen said they.d defined the problem and now needed the solutions.on the front end, a smaller initial quantity may be advisable but there were only limited methods for the state to act; on the back end, they could find another use for the medications, but he was unsure how applicable the reuse was. Dr. Okuda said manufacturers should provide a reimbursement program for changes in medications for products which were unused. Rep. Bonnen asked if that may reduce the amount prescribed at once. Dr. Okuda said it may-noting it would not be the manufacturer providing reimbursement, but the specialty pharmacies. Dr. Okuda said they had 9 therapies which were considered specialty and were on average about $109 thousand a year with the spread being about $1 thousand. Dr. Okuda said the PBM would eat the cost as the employers were currently paying for the additional cost. Dr. Okuda said, while reimbursement or exchange should theoretically fix the front end, he was unsure it would.which was why he'd provided the more altruistic though also more provocative donation program. Dr. Okuda said many patients were uncomfortable with the unused medications being stored in their homes. Dr. Okuda said they were unable to compensate patients for the study participation and many were providing the medications for altruistic purposes as they did not know they could not be redistributed.

Rep. Harrison noted the issue was a problem across the country and asked how his conversations with specialty pharmacies had gone, had he had any. Dr. Okuda said he'd had conversations with them, manufacturers, PBMs and other stakeholders-he found many had their own levels of comfort with his proposed options and each had specific liability concerns regarding each proposed solutions. Dr. Okuda said, if he were the PBM, he'd be concerned about disease progression for patients with unused medications. Dr. Okuda said some may have concerns that cancers treated with the same medications may be adversely affected by limitations on the prescribing of those medications. Dr. Okuda said he did have clinical outcome advancements for each medication to provide to PBMs to demonstrate how their bottom line was affected should they not do something about the issue. Rep. Harrison said he was interested in seeing that data when it was available.

Rep. Walle asked what the breakdown was on payor for the patients.insured, insured by Medicaid/Medicare or uninsured. Dr. Okuda said their patients went to the Parkland Hospital System with 80% privately insured and 20% publicly insured. Rep. Walle asked if there was a difference in prescribing patterns between the two populations. Dr. Okuda said on the public side, there may be cost control mechanism that prevailed; on the private side, they may favor experimental drugs because the trial would have additional insurance.

(9:40) Rep. Walle and Dr. Okuda discussed formularies, access, and deficiencies in the system.

Chair Harless asked if there was anything limiting him to writing a one month prescription for a new medication. Dr. Okuda said they were generally required to prescribe for 6 months or 12 months due to pre-authorization requirements. Dr. Okuda said he felt that it was not an issue to be required to prescribe in that manner, but there should be a method to "turn-off" the prescription when the recommendation was that the prescription be changed. Dr. Okuda said, because

specialty pharmacies were primarily used and they did not have methods for receiving returned medications, there was often accumulation. Dr. Okuda said for reverse distributions, the medications may be resold at a lower price for a different disease or partially reimbursed, but the patients were not reimbursed.

Texas Medicaid Access (9:47) Stephanie Stephens, State Medicaid/CHIP Director - HHSC, testified. Ms. Stephens noted that they had 5.5 million Texans on Medicaid due to the disenrollment prohibition during the PHE. Ms. Stephens provided criteria for qualifying for and receiving Medicaid and/or CHIP as well as information on the managed care and fee-for-service models. Ms. Stephens provided information on the evolution of managed care in the state and the quality of care monitoring for managed care.

Trey Wood, CFO - HHSC, testified. Mr. Wood provided information on the funding which flowed through the agency and said 2.1% of the funding was related to facility based payments, and 3.8% was used for administration. Mr. Wood provided information on the 6.2% expanded FMAP which amounted to an additional $5.7 million in Medicaid and $137 million in CHIP additional payments. Mr. Wood provided information on the tipping point where cost exceeded monthly benefits which they had projected been reached in May 2022 and had instituted eligibility actions.noting that there was a 9 month off-ramp being initiated after the PHE concluded to disenroll or transfer enrollment with the 30 day period for full disenrollment projected to be in November and December 2022. Mr. Wood provided information on the costs associated with the program for transition of children currently on Medicaid going to CHIP.

(10:05) Mr. Wood provided information on caseload starting from 1990 and the current rise in caseload associated with the PHE as well as the cost per month for Texans currently eligible for full benefits outside the PHE. Mr. Wood said they had seen cost growth trends for private insurance leading up to the PHE and were seeing that, while children were the largest portion of Medicaid patients, they were much lower cost than the small number of seniors covered by the program. Mr. Wood said total supplemental costs projected for the program were $3.7 billion. Mr. Wood provided information on the 1115 waiver program as well as the litigation related to the rescinding of the extension of the waiver.

Michelle Alletto, Chief Program & Services Officer - HHSC, testified as a resource witness.

Rep. Rose asked about the implementation for House Bill 133 (87-R). Ms. Stephens said they'd submitted an 1115 waiver amendment and had been told by CMS that it was not currently approvable-noting it was not disapproved, but pending. Ms. Stephens said the amendment did not comply with federal postpartum coverage requirements which only granted coverage for 60 days after birth. Rep. Rose asked if they were technically in limbo and, if so, how that would affect her plans to refile the bill with the full 12 months initially intended in the bill. Ms. Stephens said it was technically in limbo and they were trying to get the communication in writing to inform her bill given that verbal notification was subject to more change than written. Ms. Stephens said because there had been no actual action, there was nothing to appeal which was one of the reasons they were requesting formal response.

Rep. Walle asked what the estimate was for the cost of House Bill 133 (87-R). Ms. Stephens said she'd have to refer him to the fiscal note. Rep. Walle asked if they were collecting data on postpartum Medicaid patients who were maintained due to the PHE and if women on Medicaid within the 60 day postpartum period when the PHE ended if they would be disenrolled early. Ms. Stephens said still eligible women would remain on Medicaid for the allowable period. Ms. Alletto said the federal government tended to renew the PHE for 3 months periods and generally provided notice of whether they planned to extend the PHE about 3 months prior to expiration. Rep. Walle asked if they'd received notification. Ms. Alletto said they would be doing so by August 13 and they'd expect an extension if they did not receive a notification. Rep. Walle and Ms. Alletto discussed the data being collected related to disenrollment after the PHE concluded-noting they suspected about 1.4 million people would be subject to redetermination that would likely be ineligible due to aging out of their current program and not being eligible for another program. Ms. Alletto said they were required to redetermine all current Medicaid patients within 12 months of the end of the PHE, but the 2.7 million were in need of

redetermination with 1.4 million of those being most likely to be ineligible for Medicaid outside the PHE, most of the remaining being eligible for another Medicaid program and a small portion who would likely continue to be covered by their current program.

(10:23) Rep. Walle asked how people would become eligible for Medicaid during the PHE. Ms. Alletto said the eligibility requirements for enrollment had not changed, but they were not allowed to disenroll people.

Rep. Bonnen and Ms. Alletto discussed the possible requirement for the state to pay for the full cost of House Bill 133 themselves. Ms. Alletto noted that the PHE had made the matter moot, but were working to address the issue before the end of the PHE.

Rep. Rose asked if they were collecting data on those remaining on Medicaid during the PHE due to postpartum status. Ms. Alletto said they were, but utilization patterns were different outside the PHE.noting that often those enrolled utilized care at lower rates outside the PHE. Rep. Rose asked why it took so long for her office to receive the data. Ms. Stephens said it appeared to be an oversight as they thought they'd sent it.

Rep. Walle asked if the COVID relief bills provided an incentive to expend the e-FMAP for 12 months. Ms. Stephens said there was funding for a 12 month extension. Rep. Walle asked if they'd adopted that. Ms. Stephens said they'd need a state plan amendment. Rep. Walle asked if they were currently in litigation for the extension of the 1115 waiver because they had not adopted a 12 month extension. Ms. Stephens said they'd have to get back to the committee.

Rep. Frank said his understanding was that one of the issues was that " postpartum" implied a desired outcome for the pregnancy. Ms. Stephens said federal statute did not stipulate coverage based on how a pregnancy ended.

Rep. Bucy asked if they returned to the 12 month plan that the House had initially passed before it was sent to the Senate "to be messed with" if it was likely to receive approval based on precedent set in other states. Ms. Stephens said they'd need to apply for a different state plan amendment.she didn't know given the pregnancy outcome language. Rep. Bucy and Ms. Stephens discussed the QAP measures which would be available for Medicaid enrollees under the PHE-noting that she would still caution that there was a lag in data and utilization trends in the PHE differed from historical data. Rep. Bucy asked if they had an idea of how many Texans were eligible for Medicaid but not enrolled Ms. Alletto said pre-PHE data indicated there was about 550 thousand. Rep. Bucy asked if they had a breakdown by age. Ms. Alletto said they.d have to go back and look at the data collected. Rep. Bucy asked if they could reach-out to those who were eligible but not enrolled. Mr. Wood said it was high level data.they did not have identified data. Rep. Bucy said he.d like HHSC to develop recommendations for how to do so.especially for eligible minors.

(10:38) Rep. Bucy said his office got a lot of calls about the 2-1-1 system and he also wanted to know what the chair of the IT caucus had to say about it. Ms. Alletto said they had an average wait time of 30 minutes currently and they were looking at technology that could be leveraged to reduce those times as well as addressing workforce challenges for both their office and their vendor. Rep. Bucy asked if they could expect an exceptional item in their LAR to provide funding for those improvements. Ms. Alletto said they expected to do so, but they wanted to collate PHE data that could inform that argument. Rep. Bucy asked if they needed to talk to 5.5 million people in 12 months. Ms. Alletto said they would at the end of the PHE. Rep. Bucy asked how they would do so. Ms. Alletto said they'd leverage electronic contact through TWC and SNAP first before determining who they needed to seek out physically-noting that they would provide physical packets to those they had physical addresses for who could not be contacted electronically as it was the most commonly utilized method with 211 being second. Ms. Alletto provided information on how they stationed eligibility workers at certain locations to help unenrolled youth get enrolled as well as to inform families about the coming re- evaluation of eligibility. Rep. Bucy asked how they let them know when paperwork was available. Ms. Alletto said if they had a cell phone number, they may use that to followup and noted that there were some that were unclear on what the message was for

or the message was classified as spam which they did need ot re-enroll. Rep. Bucy and Ms. Alletto discussed TANF and SNAP backlogs.

Chair Harless asked of "archaic technology was an issue" Ms. Alletto said human resources were a larger problem.

Rep. Harrison asked who Ms. Stephens had talked to at CMS. Ms. Stephens said she'd spoken with Judith Cash. Rep. Harrison asked if they'd talked to the director. Ms. Stephens said they'd sent a request with a CC for Ms. Cash. Rep. Harrison asked what program extension of postpartum coverage was. Ms. Stephens said it was usually under SPAs. Rep. Harrison asked if they had considered submitting a 1115 waiver amendment rather than a SPA. Ms. Stephens said they typically did so if a SPA was not approved-particularly with the litigation involving the waiver still being active. Rep. Harrison discussed "program integrity" and asked if they.d considered re-reviews to be based on available information. Ms. Stephens said parents had monthly income checks from months 3 to 8 for CHIP eligibility and could use that information for review. Rep. Harrison asserted 1 in 4 Medicaid/CHIP patients in the US were not eligible for their programs which impacted the available funding for eligible enrollees.

(10:54) Rep. Walle asked if there was an estimate for how much it would cost for the state to cover what was not currently covered under maternal Medicaid program for the delta in the 12 months postpartum coverage. Mr. Wood said they did have a fiscal note and they could estimate how many would not be covered and for how long-noting it would require GR spend unless a new revenue stream was identified.

Rep. Bonnen had Ms. Stephens reiterate the result of her phone conversation with CMS. Rep. Bonnen asked if the implication that they would not approve extension for specific outcomes should they not include abortion as an outcome. Ms. Stephens said they had not said so or implied that. Rep. Bonnen asked if including abortion as an outcome was barred by state law. Mr. Wood confirmed. Rep. Bonnen and Mr. Wood discussed the UC program.

Rep. Rose asked if public perception that people were on Medicaid were not eligible was incorrect. Ms. Alletto said the majority of people on the program were women and children. Ms. Stephens qualified the statement as pregnant women and children.noting they only had 60 days of postpartum coverage outside the PHE currently. Rep. Rose asked if it was correct that the program covered pregnant women, children and disabled people. Ms. Stephens said it also covered parents under certain incomes and additional coverage for certain eligible seniors.

Rep. Harrison asked that certain data be submitted to his office.

(11:09) Alec Mendoza, Senior Health Policy Advisor - Texans Care for Children, testified. Mr. Mendoza said state leaders had the opportunity to slash the number of uninsured children by expanding eligibility before the end of the PHE. Mr. Mendoza said the state had the highest rate of uninsured children in the country at 12.7% compared to a national average of 5.5%. Mr. Mendoza said children who had access to care had better life outcomes and that care was " out of reach for many Texas kids." Mr. Mendoza said there were a high number of children eligible for Medicaid/CHIP-noting 84.5% of children eligible for the programs were enrolled in Texas. Mr. Mendoza said without careful management of the end of the PHE, they would face a crisis-noting their outcomes had improved under the eFMAP. Mr. Mendoza said the state had 12 months for re-eligibility determination, but Texas had indicated the intent to complete the process in 5-8 months which may result in confusion for some families given already scheduled care. Mr. Mendoza reviewed barriers parents often encountered when attempting to enroll or renew their child's status such as forgetting a password-providing common examples for how redesignation of passwords were commonly available for social media compared to the HHSC requirement to redesignate it either over 2-1-1 (which had limited hours. providing information just for navigating the phone tree to re-set a password) or in-person at a benefits office (many of which had closed during the pandemic and had yet to reopen). Mr. Mendoza said it was understood the wait- times were unintentional and legislative office staff would likely once again be necessary to supplement HHSC and the vendor in answering 2-1-1 calls at the end of the PHE

as they had at the beginning. Mr. Mendoza recommended institution of measures like Express Lane Eligibility (allowing for data to be submitted once for children who are eligible for more than one program-like being dual eligible for SNAP and Medicaid; as well as screening all applicants for one program for automatic enrollment into others for which they were eligible which would reduce administrative costs to the state), automatic enrollment of babies whose mothers had been on maternal Medicaid during their pregnancies including issuance of Medicaid numbers for infants prior to birth (noting they were eligible, but there was not a set process to handle discharge from one program to another given the gap between eligible infants and enrolled infants), and leveraging SHARS To provide Medicaid reimbursement to schools for on campus medical and mental health services.using Uvalde as an example of a potential site it could be used for and MO as a state which had adopted the expanded SHARS option after it was passed in 2014.

(11:29) Mr. Mendoza provided additional recommendations for removing barriers to enrollment.

Anne Dunkelberg, Associate Director - Every Texan, testified. Ms. Dunkelberg said they had the largest population of adults with children or with adult children-providing information on how parental enrollment into programs they were newly eligible for after losing eligibility for another program was conducted in other states. Ms. Dunkelberg said she'd provided the links to studies upholding her conclusions in her packet which many of the members were familiar with and noted that those eligible for care under Medicaid expansion were not eligible for subsidies in the healthcare marketplace-noting ARPA included a 1 time hold harmless payment. Ms. Dunkelberg said 60% of adults eligible for Medicaid under ACA Medicaid expansion were working adults and the remaining were not required to show income under various programs. Ms. Dunkelberg said those without coverage which would be eligible under expansion were BIPOC Texans.

(11:42) Stacey Pogue, Senior Policy Analyst - Every Texan, testified. Ms. Pogue provided information on barriers to enrollment for Medicaid and SNAP due to lack of properly leveraged technology-noting that SNAP did not have the extension Medicaid did therefore the barriers common between the two were still affecting those trying to enroll in or renew SNAP benefits-noting that staffing challenges would be exacerbated by the end of the PHE given the scope of work and staffing vacancies-noting they had projections for significant gaps in coverage for those eligible for continued enrollment due to lack of staff. Ms. Pogue recommended that in addition to expanding recruitment and retention efforts, they could put in place data driven renewal options to provide more automation for the process rather than the labor intensive process of mail renewals.noting that TWC income data was the most promising given that the data was already collected rather than requiring paycheck stubs to be physically submitted. Ms. Pogue said 1 in 4 eligible youth had a non- citizen parent and they should consider how to assist mixed residential status families. Ms. Pogue recommended an alternative line for technical hurdles to 2 -1-1 and further increases in utilization of healthcare.gov.

Rep. Frank said he felt insurance wasn't the best proxy for access to care as it had been in the past-citing FQHC utilization as an example that accounted for care to uninsured persons and lack of Medicaid network facilities within a reasonable distance of their enrollees. Ms. Dunkelberg provided a family member who had recently been able to deal with a medical emergency due to caps on out of pocket costs under the ACA and said the number of people estimated not to receive care at an FQHC due to distance or lack of knowledge was about the same amount as those who were not insured due to barriers and their intent was to get coverage for as many people as possible. Ms. Dunkelberg noted that FQHCs did not cover certain chronic conditions that older people had. Ms. Dunkelberg said the 1 in 4 children who had a non-citizen parent were a mix of those who were legal residents and those who were undocumented, but even legal residents had pulled eligible children out of the program due to rhetoric from the previous administration. Ms. Dunkelberg said they.d started a campaign to reach out to non-citizen parents to reassure them when choosing to enroll their citizen and green card holding children.

(11:57) Rep. Oliverson said he felt that with 91.9% of eligible children in the US being enrolled in Medicaid and 84.7% of eligible Texas children being enrolled, Mr. Mendoza was "a hard grader". Mr. Mendoza noted that the drop accounted for a significant number of children in a state with the population of Texas. Rep. Oliverson said he also agreed that

technological challenges could be addressed, but he wasn't sure he would support automatic enrollment as parents with private insurance didn't seen their children automatically enrolled in their private plans. Rep. Oliverson said some people did not want Medicaid due to it possibly limiting their eligibility for FQHC services. Mr. Mendoza said he.d provided information on states which had such programs and the limitation of hours was harming working Texans. Rep. Oliverson said he didn't believe enrollment should be "a pound of flesh and a pint of blood", but he felt automatic enrollment was thinking too little of Texans. Rep. Oliverson said he did believe there should be a better option than waiting on the phone or going into an office in person, but they shouldn't insult Texans as to their ability to fill out a form online. Rep. Oliverson asked if they should see the state as a failure for anything other than 100% enrollment. Ms. Dunkelberg said the national average would be 100% if they did that, but they should consider trying to come up to that average-noting that Texas. lower participation was likely heavily weighted by children of non-citizen parents. Ms. Dunkelberg said she'd recommended addressing the discharge paperwork because that was the most common method used for parents with private insurance to enroll their infants on their plan. Rep. Oliverson said he agreed with the latter and appreciated the information regarding children of non- citizen parents and would appreciate recommendations on how to counter that. Rep. Oliverson said he'd also like to know how many simply did not want to be enrolled in Medicaid. Ms. Dunkelberg said there also was the issue of drop in utilization following Uri to sort out and she was a invested in coverage for children whose parents didn't enroll due to technological barriers as those whose parents did not do so out of pride as those who did not do so because of residency status. Ms. Dunkelberg said if parents had to navigate barriers like an hour phone wait during working hours, they needed to address that both by staffing up and expanding options for enrollment. Rep. Oliverson said he was also interested in under-enrollment in SNAP as he was not seeing it used on foods which could improve health outcomes as often as they'd like-noting it could be a change in benefits, addressing food deserts and making healthy foods covered at a higher rate. Ms. Pogue said the issue was often that benefits were too low to cover food for a month when fresh produce was preferred, but more expensive. Rep. Oliverson asked if it was reasonable that it was cheaper to provide healthy food than to provide diabetes care-noting that when it came to the budgetary impact, it would benefit the state. Ms. Pogue said that as well as addressing food deserts were two things which could significantly improve outcomes. Rep. Oliverson asked her to meet with his office on the issue and asked what their opinion was on having a state based exchange under a 1332 waiver. Ms. Pogue said off-the-shelf technology which could be used for such an exchange was much better, but they would still need more staff-noting that healthcare.gov also functioned much better than it had in the past. Ms. Pogue said the precursor should be whether they were willing to commit the resources necessary to having such an exchange rather than whether it would save the state money.

(12:13) Rep. Rose noted that the majority of people on SNAP lived in food deserts which meant they often resorted to purchasing food from places like the Dollar Store which only had processed food.

Rep. Lujan said he didn't believe that there should be so many hoops to resetting a password and applying online so they needed to do a better job at leveraging technology-noting he was not sure how much needed legislative action.

Rep. Bucy said he felt that they needed to do what they could to ensure eligible but uninsured children had access to care despite failures of parents or other stakeholders. Rep. Bucy said he understood the concern for automatic enrollment, but screening for eligibility when applying for one program- especially through the universal form.would be beneficial when it came to notifying for eligibility and streamlining enrollment for those opted in. Rep. Bucy asked what other non-automatic enrollment options would work. Mr. Mendoza said providing information on eligibility for parents when enrolling their children for school would be a good idea. Rep. Bucy asked if they could address how lack of Medicaid expansion had affected both the eligible but not covered as well as to other residents regarding costs to taxpayers. Ms. Dunkelberg said it would allow for the coverage of many of the parents of Medicaid eligible children who were not otherwise eligible.noting that Kaiser Family Foundation had collated a lot of the research demonstrating financial benefit to the state for doing so. Ms. Dunkelberg said many of the working poor constitution "the backbone" of service related industries and would benefit those industries. Ms. Dunkelberg said lack of coverage could create mental healthcare conditions for both parents worried about the health of their children and strain on families from lack of coverage for

parents with chronic conditions-noting it was also a barrier to social mobility and they were treating different income levels differently as those who were slightly better off than the expanded Medicaid population were able to access subsidized plans on the healthcare marketplace and those who would be under expanded Medicaid could not. Ms. Dunkelberg noted that women making $4 thousand or more a year were not eligible for Medicaid outside the 60 day postpartum period. Rep. Bucy asked what that meant to those women. Ms. Dunkelberg said it depended on where they lived-noting the number of FQHCs in urban areas compared to rural areas. Ms. Dunkelberg said lack of access to certain services would increase the costs of those services and prevent savings for other things like college for their children. Rep. Bucy and Ms. Dunkelberg discussed the lack of care options in rural areas resulting in higher ER utilization at rural hospitals-Ms. Dunkelberg noted that the rural hospitals in states with Medicaid expansion were more financially stable than their counterparts in states which had not adopted that expansion. Ms. Dunkelberg said directed payment programs did not help families with upward mobility as they were mostly for emergent care and did not preclude out-of- pocket costs and medical debt.

(12:30) Ms. Dunkelberg discussed the monthly wage data requirements the state had which were not required by federal law-noting an administrative renewal using the previous two quarters of wage data may help.

Rep. Harrison said his data indicated there were significant increases in state costs for Medicaid expansion which would require higher taxes to cover.

Improvement of Access and Quality of Care (12:32) Dr. Fred Cerise, CEO - Parkland Health, testified. Dr. Cerise provided background information on the system.noting that they had the largest ER department in the country and provided teaching hospital services for GME and nursing students. Dr. Service said they provided 1.2 million out-patient treatments a year which were primarily scheduled preventative care and received significant financial support from Dallas Co. to cover their 45% of uninsured patients and 30% on Medicaid-noting the patient mix was treated not based on payer willingness to reimburse, but on quality of care. Dr. Cerise said they were not driven to increase overutilization of care, but to provide the best quality of care to prevent readmission or development of chronic conditions. Dr. Cerise provided information on their substance abuse program which was partially funded through the DA's office as a jail diversion program and putting a clinician with DPD to allow for enrollment into preventative care programs and prevent hospital admission. Dr. Cerise said they were putting tele-health hubs in other centers like food banks and community resource centers to reach people who may not need in-patient care for any other reason due to lack of adequate internet and/or cellphone service. Dr. Cerise provided recommendations for how the state could improve their ability to provide care or prevent the need for care.thanking the legislature for funding of DSH and recommending approval of use for Medicaid funds for psychiatric care which was currently prohibited by the Medicaid cost-control rider.

Chair Harless asked if the nursing shortage trends were reversing. Dr. Cerise said they were still spending $6-8 million a month on contract labor to address the shortage and which he could report otherwise.

Rep. Rose thanked Dr. Cerise for this testimony, service to the community and responsiveness to her office.

Access to Coverage (12:46) Rachel Bowden, Director of Regulatory Initiatives - TDI, testified. Ms. Bowden provided information on 1332 waivers, performance in other states and options for Texas to use one. Ms. Bowden said the passthrough would provide 1- 3% in premium reductions and provide a 25-30% passthrough for about 120 thousand Texans.noting that ARPA had extended that number further after their analysis was conducted.

(1:00) Ms. Bowden provided information on the CO option which included specific premium reduction targets for certain plans required of all participating insurers on the state administered marketplace-noting that WA had a pending program which was similar and NV had passed a more limited program. Ms. Bowden said the CO model was intended to reduce costs to the state and to premiums which would allow them to subsidize more state plans. Ms. Bowden provided

additional information of models adopted outside 1332 waivers in addition to the 21 states which had state based marketplaces in part or in full.

Blake Hudson, Director of Public Affairs - TAHP, testified. Mr. Hudson said Ms. Dudensing was not available due to COVID infection and emphasized the importance of having access to coverage-noting it made people significantly less likely to forego care and continuity of care prevented gaps during critical periods. Mr. Hudson provided data on improved outcomes for those on eFMAP.noting that when care was more affordable, people demonstrated the desire to have coverage by signing up for it. Mr. Hudson said they were consistently adding additional plans and/or reducing the number of counties with only one plan available by expanding existing plans available to those areas year over year. Mr. Hudson provided information on cost control incentives under managed care. Mr. Hudson noted the availability of case assistance fellowships at MCOs and recommended allowing that to be continued, carving in the 5% of medications not covered by the program, and providing options for MCOs to help clients access health improvement options like better dietary options.

(1:18) Mr. Hudson recommended reform to contract staffing-noting the majority of staffing organizations had indicated they did not consider ability for a facility to pay when setting prices. Mr. Hudson discussed consumer choice incentives as an option which had been eroded over time and recommended bringing it back in full within federal requirements. Mr. Hudson provided information on their efforts to curb favoritism and requested that new mandates come after a significant break with full evaluation for costs to employers.

Rep. Frank said he was impressed by the testimony, but that they often involved fixing other portions of the industry. Rep. Frank asked what TAHP's opinion was on facility fee reduction and if he was hearing correctly that they were saying they could not negotiate down facility fees. Mr. Hudson provided information on why they were having difficulty on the issue.

Rep. Oliverson said he felt that their decision not to negotiated when they did not have at least 100 thousand members was a problem of their own creation -noting that they had one of the same problems with a member that had that leverage. Rep. Oliverson said they needed to unwind the entire thing and requested that TAHP members look at how they drove consolidation by consolidating within their own industry. Mr. Hudson noted that there were certain services which were not shoppable like anesthesiology which had seen significant consolidation-noting that there was a private equity owned provider which controlled over a thousand providers in North Texas and would charge significant amounts of out of network patients. Mr. Hudson asserted that transparency measures would allow the market to work out the issues. Rep. Oliverson said he was concerned that one of the most profitable industries was asserting they had little leverage. Mr. Hudson said DME was a larger share of the market. Rep. Oliverson said from a net profit standpoint they were. Mr. Hudson said there was not enough information on the liquidity of private equity companies to agree with that.

(1:36) Rep. Harrison asked if there were more or less options prior to the ACA. Mr. Hudson said there were more. Rep. Harrison asked if available premiums were on average higher or lower. Mr. Hudson said they were higher. Rep. Harrison asserted the ACA had only created problems and discussed proposals under the Trump Administration which were intended to address the issue with the value plan rule. Mr. Hudson said they were seeing some more of those coming online-noting they'd existed, but had to be renewed every 3 months.

Overview of the Employer Based Market (1:36) Glenn Hamer, President/CEO - TAB, testified. Mr. Hamer said employers over 50 employees took on the liability of the coverage and they had concerns about ERISA options-suggested more options be provided for small employers as the number of such employers providing healthcare to their employees had decreased by 16 points over the past decade with 70% citing costs as the leading factor. Mr. Hamer lauded the efforts to expand options and noted hurdles they'd faced in doing so over the past 2 decades. Mr. Hamer said Rutledge v. PCMA opened the door to allow for new mandates to be applied to ERISA health plans by states and recommended against doing so as it would increase burdens for companies-especially those covering employees in multiple states. Mr. Hamer said

they supported the efforts to extend postpartum Medicaid to 12 months and recommended protecting IP for medical technology manufacturers. Mr. Hamer recommended passing programs to improve the adoption of lifestyle changes which improved overall outcomes.

Annie Spilman, State Director - NFIB, testified. Ms. Spilman said polling of their members indicated that costs for providing healthcare to employees was the highest concern for employers.higher than inflation and supply chain issues.which were driven by the uncertainty of future costs. Ms. Spilman said 34% of members placed inflation as a current concern which was the highest it' d ever been polled in their existence with 69% of members increasing prices which upset their customers. Ms. Spilman said 60% of members indicated economic uncertainty was driving their decisions which decreased the likelihood they would expand their businesses as well as salaries and benefits. Ms. Spilman discussed the concern of labor shortages to their members. Ms. Spilman said they'd partnered with TAB for several sessions to oppose health insurance mandates and, of the 60 filed, only one had passed because it increased policies for employers by 1-5% which could cost employers millions. noting Texas was 3rd in the number of employer mandates for insurance coverage. Ms. Spilman provided information on .uncomfortable conversations. employees were having to have with their employers when the became eligible for Medicare and concerns about the program covering their chronic conditions.

(1:55) Rachel Means, CEO - Employee Benefits Consulting, testified. Ms. Means provided information on her company and some examples for how she assisted companies in identifying savings for companies which had allowed them to increase their wages to a living wage from the minimum wage and a food scientist was concerned about her family history of cancer at 32 and were able to adjust her health plan to allow for a preventative mastectomy for $26 thousand without a patient deductible. Ms. Means provided an example of building a health plan for a specific business which could not afford any options available without assistance. Ms. Means said they could only continue to do their work without additional mandates.

Rep. Oliverson said he believed the exchanged she.d referenced was with Rep. Bonnen and said he agreed that there was a lot of cost in back-office administration which was fueling consolidation-noting that his colleagues had indicated that their primary goal in joining a hospital system was so they did not have to deal with the administration, they wanted to practice. Rep Oliverson said he was appreciative of companies like Ms. Means' because it got past prior authorization with direct service options and it created both higher value for patients, but also savings for their employers. Ms. Means noted that the methods they were using were not new either. Ms. Means asked why they needed prior authorization for routine colonoscopies because it was not really something people wanted to do, but was routine care. Rep. Oliverson said it was coverage they required because it was necessary screening and it was the mandate which had passed the previous session.

(2:10) Rep. Frank noted that there were companies similar to that of Ms. Means and they worked on a fixed fee which allowed for alignment of incentives. Rep. Frank said the lawmakers had the system they'd created, but they should find a way to incent employers to look at the benefits costs as the money of their employees instead of looking to overall company savings with those benefits.

Dr. John Carlo, CEO - Prism Health North Texas/Board of Trustees Member - TMA, testified. Dr. Carlo provided information on his business. Dr. Carlo said they needed to control healthcare costs-which he was speaking to as both an employer who provided his employees healthcare and a healthcare provider. Dr. Carlo said despite paying the most in the world, they had worse outcomes than all other 12 developed nations and had the least access to care in the country in the state despite several world class medical institutions. Dr. Carlo recommended accepting Medicaid expansion. Dr. Carlo said increased taxes for healthcare did not necessarily preclude a good economy-it could relieve some costs for small businesses and allow them to continue to support the state economy. Dr. Carlo said they were concerned with the lack of extension of postpartum Medicaid to 12 months and the fiscal cliff of the end of eFMAP. Dr. Carlo recommended utilization of outcomes based funding for certain kinds of preventative and low-value care with high value services. Dr.

Carlo said Texas ' system placed volume over value and provided patient examples. Dr. Carlo said primary preventive care was one of the lowest-cost, highest-value service in the system and noted the expansion of people utilizing that care during the eFMAP but had also led to provider burnout. Dr. Carlo said, "ER care is not real care," noting that it provided a much lower value care option for higher cost. Dr. Carlo recommended they revisit Medicaid rates which had not increased since 2007. Dr. Carlo said not having access to crisis behavioral health services could spin out of control in the wake of the pandemic if not properly managed like the opioid crisis had. Dr. Carlo said disparities in access to care created an additional $93 billion in care costs nationally per year, and cost Texas about $2.7 billion in extra spend with $5 billion in lost productivity.

(2:26) Dr. Carlo said elimination of unnecessary waste had contributed to generational lack of access and they would be assisting TDI in expansion of the gold card program. Dr. Carlo said providers under the Medicaid program required navigation of a significant credentialing process-noting that he.d take on the finances if he could get more of his providers credentialed, adding that they were seeing 3 times the bureaucratic burden to providers for 1/3rd the pay.

Chair Harless asked if Dr. Carlo was a primary care physician. Dr. Carlo said he was a public health physician who ran a primary care system of clinics.

Chase Bearden, Deputy ED - Coalition of Texans with Disabilities, testified. Mr. Bearden said he was relieved to be invited to the table as a patient advocate and said they'd been running into a problem in Medicaid which was turning into a crisis for those receiving at-home services from a community care attendant. Mr. Bearden said these attendants were often doing the most for their patients while also being the lowest paid with entry salaries of $8. 11/hr. Mr. Bearden shared a testimony from Sally who had severe CP and had received a degree in journalism from UT prior to the ACA with peers carrying her up the stairs to attend classes. Mr. Bearden said she now typed either with her nose or a roller ball. Mr. Bearden said the member was often assisted by her partner who also had CP by leveraging their abilities the others did not which had saved the state significantly. Mr. Bearden said after receiving a diagnosis of cancer, they'd tried to do everything they could. Mr. Bearden said Sally's attendant, Sandy, had continued to provide care throughout the pandemic and there had been a decline in those willing and able to do so. Mr. Bearden said Sandy had been asked to say overnight while Sally's partner, Juan, was visiting his wife out of state, but Sandy passed away unexpectedly the first day of the trip and Sally's health had spiraled during the 8 weeks following that due to not being able to find a replacement for Sandy and had to be admitted to the hospital due to lack of access to basic care like food and water. Mr. Bearden said after Sally left the hospital, they could not find an agency to take the case with her provider reaching out to 42 agencies and she had to be admitted to a nursing home under respite where her health continued to deteriorate and a feeding tube had to be placed which would require in-patient rehab with skilled nursing even if they did find a new attendant. Mr. Bearden said they didn't even know if they could continue to hold Sally's position open. Mr. Bearden said premiums for private insurance went up as healthcare costs went up, but Medicaid remained constant which had meant the salary increase had become significant over time. Mr. Bearden provided information on the cost for competitive pricing-noting that it came with no sick leave, holidays or state provided healthcare for the attendants which provided the state with a lower cost. Mr. Bearden said there were significant waitlists for services and noted the previous day HHSC testimony had included persons receiving SSI disability checks as receiving services. Mr. Bearden said they needed to clear the waitlists-noting they'd cleared a backlog with the 1115 waiver before and could do so again. Mr. Bearden said they were not noticing the long term costs for lack of care because they were constructing 2 year budgets and needed to do so. Mr. Bearden discussed the costs of pharmaceuticals-noting his experience of going from an elite athlete to a person who had broken his neck and become disabled. Mr. Bearden said many of their members found once they had stabilized on a medication they would find themselves switched for non-medical reasons and only find out at the pharmacy. Mr. Bearden said he didn't care who needed to change what, "At the end of the day, it's the patient that gets beat up," so they needed to bring all the stakeholders to the table to sort out issues they'd had with House Bill 1646 "instead of waiting and muddying the water once it has a hearing." Mr. Bearden recommended institution of co-pay accumulators. Mr. Bearden said his wife had been stabilized on a medication which allowed her to address other issues and decrease visits; but they

had lost their pharmaceutical coverage upon renewal which had upset the progress she'd made. Mr. Bearden recommended adoption of the Express enrollment option Mr. Mendoza had recommended and training for child center employees on where to send parents when they noticed a developmental delay in addition to the training they received on detection of developmental delays because a significant number of those children would not need special education services if they received ECI.

(2:48) Mr. Bearden discussed other bipartisan legislation to address ECI which had failed to pass in the past, but should.

Jana Eubank, Texas Association of Community Health Centers, testified. Ms. Eubank said they represented FQHCs which provided affordable and accessible primary care to low-income Texans.nationally providing care to 1 in 3 Americans in poverty and 1 in 5 rural patients. Ms. Eubank said they provided care to 1.6 million Texans at 660 sites in 137 counties-though there were a lot of service areas they had not been able to be established in yet which needed them. Ms. Eubank said FQHCs provided care to whole families and served the most vulnerable with 66% of their patients living at or below the FPL. Ms. Eubank said 600 thousand of their patients were children and the remaining million were primarily women of child bearing age, those with chronic conditions and those with disabilities. Ms. Eubank said the provided school based services at over 90 campuses. Ms. Eubank provided information on their funding model. Ms. Eubank said they also assisted in enrolling families into programs they were eligible for and worked as a care team rather than in silos. Ms. Eubank provided information on barriers to opening new FQHCs and reviewed their ability to draw down additional federal funds for collaborative care models which included mental health services for a $10 million investment from the state under the incubator program. Ms. Eubank said only 20% of health issues were related to quality of care and the other 80% required screening they did for non-medical support needs like access to healthy foods and transportation to attend appointments.

(3:08) Ms. Eubank said coverage access was key to improving outcomes for their patients so they supported passage of the full 12 months of postpartum medicaid and maintaining enrollment for all eligible Texans once the eFMAP expired. Ms. Eubank recommended they expand the incubator program as well as their ability to provide care through school based clinics. Ms. Eubank said they supported expanded access to mental healthcare and alternative payment models like direct payment. Ms. Eubank recommended leveraging student loan repayment programs for all types of providers.not only for doctors and nurses.

Chair Harless said he was a fan of the enrollment and eligibility assistance services provided by FQHCs.

Rep. Walle asked how they could assist in helping FQHCs scale their operations outside the incubator program as that was a one time payment. Ms. Eubank said they estimated $200 million to cover both scaling of existing clinics and establishing new clinics in communities which had requested them. Ms. Eubank noted that their federal grant was only 23% of their services with 45% of patients receiving UC care so they needed more assistance and noted that the incubator program did allow them to draw down additional funding from federal sources. Rep. Walle asked how many more patients would be covered for the $200 million. Ms. Eubank said she.d have to get back to them for specific estimates and noted that all FQHCs were required to provide a full array of services or contract for services they could not cover.noting the $200 million would allow some facilities to qualify as FQHCs by being able to contract for services they couldn't currently provide. Rep. Walle said he was interested in better understanding how to address barriers to establishing FQHCs in rural communities and any snags they were having with MCOs. Ms. Eubank said their preference was to be able to provide care under all MCO plans and needed to address delays in credentialing for their new employees. Rep. Walle expressed support for expansion of the incubator program.

Rep. Frank said he appreciated the services provided through FQHCs as they addressed lifestyle contributors to health outcomes and it treated the whole person while also giving the patients a sense of buy-in and control. Rep. Frank thanked Mr. Bearden and asked for additional information about the medication switching.noting he.d been trying to work with Rep. Lambert and that they were worried about eliminating the ability for costs of medication to go up more than 5% in a

new formulary. Rep. Frank said he felt they had the plan they needed to address attendant care, but needed more commitment.

Rep. Rose recommended Rep. Frank take that leadership. Rep. Rose said she'd been on the House Human Services Committee since her first session and was annoyed that they could not make any progress on the issue of attendant pay, thanking Mr. Bearden for his input. Rep. Rose asked Dr. Carlo to set up a meeting with her office.

Rep. Frank said two sessions prior they.d conducted a study on the Medicaid waitlists for special needs Texas and were now asking for up-front data to address it as they were concerned that special interest groups often tried to use other groups to position themselve better. Mr. Bearden said, "We'll stand in the breach for you."

Rep. Bucy asked Dr. Carlo to meet with his office after the hearing.

Rep. Rose asked if they could use some of the $600 million in certain savings. Chair Harless said they should use their time to hear the next panel.

Innovations in Care Delivery Models (3:28) Dr. Sumit Perakathu, Harlingen family care physician, testified. Dr. Perakathu provided information on the direct primary care model used by Frontier Care-her current system.when compared to a traditional fee-for- service model. Dr. Perakathu provided two patient examples who had improved care under direct primary care.one a diabetes patient who had been her patient when she was a private practitioner, and a TBI patient from a severe motorcycle accident.

Dr. Roger Moczygemba, Founder - DirectMed Clinic/Founder - San Antonio Chapter - Free Market Medical Association, testified. Dr. Moczygemba joked, "It's pronounced exactly as it sounds." Dr. Moczygemba noted that tele-health had been originally constructed to provide care in a direct primary care model and discussed how he'd addressed common barriers to access of care for his patients.

(3:49) Dr. Cristin Dickerson, Founder - Green Imaging, testified. Dr. Dickerson said her son had Angelman's Syndrome and they lived half a mile from Texas Medical Center, but chose to use Spring Branch Medical Clinic due to the better care provided under the direct primary care model. Dr. Dickerson said she was an imagining specialist at Green Imaging which primarily provided imaging services for FQHCs and direct primary care providers. Dr. Dickerson provided information on their coverage model which had expanded to several states and their data had been validated by the Value Institute.

Dr. Lena Sholar, independent practice owner/general and plastic surgeon/Texas 400/Texas Physicians for Patients PAC, testified. Dr. Sholar discussed the physician shortage in the state and provided options for addressing that- particularly in rural areas.

(4:22) Rep. Frank said it did scare him to put medical residents in rural areas they were not familiar with without direct supervision and that he felt the direct primary care model was a better option given that their current Medicaid model paid for procedures rather than care. Dr. Sholar said they would have direct supervision by the PCP they were placed with and dovetail well with the DPC model.

Chair Harless asked if they'd be providing care in the same county as their supervisor. Dr. Sholar said they would.though they may be able to provide care within a 50 mile radius of their clinic which had worked well in other states. Dr. Sholar said it would double the available care in places like Big Bend and they could "drop" the medical residents into the areas-noting that they were currently using medical assistants and nurse practitioners which she asserted had less training.

(4:27) Chair Harless adjourned.