



June 23, 2020

Ms. Stephanie Stephens
Deputy Executive Commissioner, Medicaid & CHIP Services
Texas Health and Human Services Commission
Sent via email: stephanie.stephens01@hhsc.state.tx.us

Dear Ms. Stephens:

In light of COVID-19's unparalleled, disruptive impact on Texas' health care delivery system, the undersigned organizations, representing hospitals, physicians, and behavioral health care providers, urge the Texas Health and Human Service Commission (HHSC) to seek a one-year extension of its current Delivery System Reform Incentive Payment Program (DSRIP) program as authorized under the state's Medicaid 1115 Transformation Waiver. The 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.

Texas quickly prepared and activated its resources to mitigate a worst-case COVID-19 scenario. Even so, the pandemic took a heavy toll and is still unfolding with no end in sight. It has taken lives, jeopardized the health of essential health care workers, undermined the stability of the health care safety net, stalled commerce and employment, and altered our way of living. Throughout the last three months, DSRIP providers and HHSC have also continued to meet the required 1115 Waiver DSRIP transition metrics and planning timelines.

With characteristic grit, Texas now is working to safely open up its economy, ensure and 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. Over the past three months, 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 less than 15 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 request that Texas seek CMS flexibility to keep \$2.49 billion available in DSRIP funding in DY 11¹ 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 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 due to rising unemployment; and
 - comprehensive delivery system improvements that align waiver budget neutrality, financing and programmatic planning post Waiver II with the DSRIP transition.

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 at 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 percent or more of their revenue² 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. While community-based physician practices do not directly participate in current DSRIP initiatives, they are nonetheless vital to the state's safety net and to a transitioned system of care in Texas. They also are a key stakeholder in the design and implementation

¹ DY 11 starts October 1, 2021. DY 10 DSRIP funding is \$2.49 billion. Rather than being required to transition these funds to new programs for DY 11 starting October 1, 2021, Texas requests continuation of that funding in DSRIP for an additional year. Since these funds will not be transitioned for DY 11, Texas' request is budget neutral.

² Texas Medical Association Practice Viability Survey, May 2020

of a reimagined, sustainable delivery system envisioned under any future waiver. Like DSRIP-providers, they will need time to recover and evaluate future delivery system models

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. A nurse working in both clinics unknowingly transmitted the virus to the other clinic, which forced it to close. Both clinics were closed for two months and are only now slowly 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. In El Paso, in-person clinic visits dropped 67% from 12,000/ month to 4,100/month in April. Year over year diabetes management visits (from January to April 2020 compared to 2019) are down by 900 (14%); heart disease management visits are down 1760 visits (11%); and adult prevention and screening is down by 9500 (33%). These are significant drops given that only two months of COVID-19 data are included in this four-month period. A recent poll³ 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.”⁴ Some hospitals emergency departments report seeing a higher volume of patients with chronic disease and worse health status.

Clinical Challenges. The clinical implications of COVID-19 and of reduced primary and chronic care visits during the pandemic concern providers. They worry that conditions will worsen or not be diagnosed and that the comorbidities of COVID-19, including heart and respiratory complications, will exacerbate the health of the communities they serve. El Paso Hospital District, for example, reports changes in their patient populations with increased morbidity and quicker declines in patient health due to COVID-19 exacerbating chronic conditions including diabetes, respiratory and heart diseases. This has led to more hospitalizations and raised concerns about increased readmissions.

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

³ <https://www.kff.org/report-section/kff-health-tracking-poll-may-2020-health-and-economic-impacts/>

⁴ e.g., Quotes included in this document are from provider surveys and interviews and used without specific citations to share direct provider perspectives.

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 healthcare system will force providers to prioritize paying patients, leaving uninsured Texans with fewer options, and exacerbating their capacity pressures. Yet, the simultaneous drop in revenues and the increasing need for charity care will strain safety net clinics' and facilities' ability to meet community needs, particularly with the impending loss of DSRIP funding.

Pre-COVID-19 Patient Flow and Efficiency Assumptions May No Longer be Valid. Houston's health department had an intensive *Save a Smile* dental sealant program for second graders, using a high volume, efficient patient throughput able to serve 300 to 500 children in one day. Social distancing and the high burn-rate of Personal Protective Equipment has required the program to be re-structured into smaller groups of patients at different sites and times. The new approach is less efficient and more costly. Mobile community outreach, screening and treatment programs also have been halted as have on-site health care programs provided in schools, nursing, and retirement communities.

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 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 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. Harris Health responded to patient medication needs by increasing home delivered prescriptions by 1,042% in one month: from 12,000 or 8% of total volume in March 2020, up to 125,000 or 77% of April's total prescriptions. Harris Health also provided curbside food pickup in its Food Farmacy for food insecure diabetes patients and provided iPads to patients in isolation units to connect with their families.⁵

Additionally, providers quickly deployed telemedicine/health services. At University Medical Center El Paso, telehealth visits increased to nearly 5,000 per month comprising over 40% of its monthly budgeted clinic visits. Harris Health increased its telemedicine from 0 visits in February to over 39,000 in April, using video visits through its patient internet portal, video chat visits, telephonic visits and written e-visits through a secure app. Telehealth has made remote access an option for many patients across Texas, though challenges remain ensuring low income Texans who may not have smart devices or internet access can use the technology. All these innovations have helped to make patient care timelier and more accessible; and many of them built off existing DSRIP programs or approaches.

Still, Care Challenges Remain. Well-woman exams, diabetic foot exams, Body Mass Index screenings, cancer screenings, dental services, STD testing, vaccines, and surgical services cannot be performed via telehealth. On the behavioral health front, psychiatric crisis response services that require in-person interactions, such as crisis respite, crisis stabilization and extended observations units, are operating at substantially lower capacity in an effort to avoid spread of the virus, increasing pressures on other

⁵ "Thank you Harris Health for taking such amazing care of our granny as she fights this virus," a patient's family member writes. "Your amazing nurse (used FaceTime) with our family, allowing us a small moment to see her and let her feel our love. That phone call made a huge difference for all of us and gave us peace being able to see her."

systems. Additionally, discharge planning from hospitals has been hampered by reduced capacity of homeless shelters, especially in large urban areas.

And even as providers quickly shift to telehealth and telemedicine, in many cases neither workflow changes nor IT systems have caught up. Effective clinic processes rely on pre-visit planning and at appointment use of medical assistants and case managers to gather baseline medical information including documenting vitals and patient assessments (e.g., pain assessments and assessments for depression, tobacco use, sexual activity) for physicians. Pre-COVID-19, workflow relied on medical assistants and care managers to organize follow up services and post-appointment care coordination.

But those processes have not been consistently or completely redesigned for telehealth and telemedicine as it is being used today. Standards, protocols, development and integration into data systems and practices need to be established and stabilized. In all settings, IT staff are being pulled away from core tasks and spending “an enormous amount of time” to stand up telehealth: creating web pages; learning and implementing new billing codes; developing billing procedures; coordinating and integrating clinical information; understanding new video programs, privacy and new waiver requirements; and training staff. At the same time, providers are also uncertain about whether the regulatory relief that made some of their services and innovations possible will remain in place, making planning for and implementing a DSRIP transition and possible directed payment programs more challenging. Will telehealth flexibilities and reimbursements be in place, contracted or expanded? Will patients, providers, and reimbursement systems shift back to in-person care or maintain telehealth? Which services will transition and when will patients return for in-person care?

“It has been overwhelming” even for larger systems, and questions remain. One provider described the impact on staff this way: “For providers, it has been difficult to do comprehensive exams because they are overbooked. For example, they are booked every 15 minutes for phone visits, in-person visits and car visits (parking lot). A provider may move from the phone, change into PPE for the parking lot and then back inside for a face to face. Talking to patients through a car window about preventive care is not appropriate or convenient for anyone. They are literally running from one location to another.”

In one rural hospital, the Director of Nursing also managed DSRIP, but was unable to submit reporting on time because she needed to work the floor for two weeks at the height of the pandemic. Staff are finding it difficult to stay afloat and juggle responsibilities in a new world. Just trying to keep up with current DSRIP programs in the face of COVID-19 is not always possible and in most provider settings, DSRIP staff have another full-time job that they need to focus on.

It is not surprising then that due to the pandemic, healthcare staff face more stress and new kinds of stressors. One hospital reported a loss of “highly competent” key nursing staff and respiratory staff from its emergency department and ICU who left for a unique level of experience and significantly higher pay in places like New York. Those losses compound staffing challenges from exposure to or COVID-19 positive status and taxes remaining staff. Clinical staff from other clinical or specialty areas or PRN staff are hired and are being pulled into emergency and inpatient settings with unfamiliar environments and processes, resulting in longer through-put times including times for admissions, discharge planning and discharges. Some providers are offering testing or serving as reference labs for testing and setting up new processes, training and reporting systems for that work; and providers have been called in to test Texas Department of Criminal Justice staff and others, using health coaches and support staff to help out. “We are spending many additional hours working on non-patient related care services while preparing for patient related care. Staff morale has been a challenge.”

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.

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 15 months, there is no proposed replacement program to continue some level of care for the 40% of those served through DSRIP who were uninsured.⁶ 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.⁷ 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 substance use disorder treatment.⁸ 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 programs⁹. 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 is showing signs of a rebound, many jobs have been permanently lost. Unemployment is forecast to be at 10 percent or higher for the

⁶ 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.

⁷ <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.

⁸ 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.

⁹NFP 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/>

next several years followed by a concomitant increase in need for health and social services. Texas will not have the means to replace DSRIP funding,

Budgeting, Financial Impacts and Fiscal Uncertainty

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. Just surviving is a common theme among providers. One anchor said that many of the providers in its region, “especially now, may be in a serious financial situation as soon as this year.” At the federal level hundreds of billions of dollars are allocated for providers, with all but the latest allocations disproportionately targeting providers with higher net patient revenues and a significant Medicare patient mix, leaving other providers serving a higher share of uninsured and Medicaid patients receiving as much as 50% less than other providers in federal recovery funding.¹⁰ The most recent allocations for high Medicaid, CHIP and uninsured providers missed by earlier payments, and for safety net providers with high uncompensated care volumes, missed many safety net providers based on the three criteria needing to be met in a single one data year.

These dollars have helped, but more are needed.¹¹ Some providers, including physicians, dentists, and FQHCs, have closed, at least temporarily. Others have laid off¹² or furloughed staff.¹³ For many rural hospitals, additional federal funding will only sustain their facilities through August 2020. DSRIP funding directly supports programs including those for the uninsured that would need to be curtailed. “If DSRIP goes away and providers aren’t able to replace that funding it could mean a substantial loss that will likely result in reduction to services.”

Budgeting for the future with COVID-19 and with unknown DSRIP transition financing, as one provider put it, will “be a mess.” While budgeting involves predicting future trends and developing reasonable and rational assumptions, the level of unknowns in the coming year 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, DSH cuts or CMS’ action on MFAR. Under a DSRIP transition, current DSRIP providers also are unlikely, even in a best-case scenario, to receive their historical funding. “This is unsettling as we move into our next budget year. We will need to begin cutting back NOW if we are to survive 2 years from now without a definitive budget. As we begin budgeting next month, we are uncertain about which programs we need to start scaling back to maintain solvency once they are discontinued.” Amidst this historic financial instability, maintaining DSRIP funding of \$2.49 billion for another year will support a critical measure of stability.

¹⁰ <https://www.kff.org/coronavirus-policy-watch/a-look-at-the-100-billion-for-hospitals-in-the-cares-act/>

<https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html?referringSource=articleShare>

¹¹ <https://www.kff.org/coronavirus-policy-watch/a-look-at-the-100-billion-for-hospitals-in-the-cares-act/>

<https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html?referringSource=articleShare>

¹² <https://www.npr.org/2020/05/08/852435761/as-hospitals-lose-revenue-thousands-of-health-care-workers-face-furloughs-layoff>

¹³ E.g., in Texas Baylor Scott and White is furloughing 1200 patients. https://www.beckershospitalreview.com/finance/baylor-scott-white-to-lay-off-1-200-workers-furlough-others.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_source=BHRE&utm_medium=email&oly_enc_id=8331H77169014M

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

Finally, across the board providers said they do not want the COVID-19 disruption to result in them losing the 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.

Waiver Deadlines

Our organizations also request a meeting as quickly as possible to discuss HHSC’s strategy and timeframe for soliciting stakeholder input into key waiver milestones, including whether Texas should pursue extension of any waiver deadlines. In short order, the COVID-19 has wreaked mayhem across the health care landscape while also requiring providers to keep up their guard as the pandemic evolves. As such, our respective members are stretched very thin. Yet, their experience dealing with COVID-19 also will provide important insight about revisions Texas should consider as it updates its Value-Based Roadmap, Quality Strategy, and DSRIP sustainability options. We want to ensure there is sufficient time to provide HHSC our shared insight before any updates are shared with CMS.

Sincerely,



Maureen Milligan
President/CEO
Teaching Hospitals of Texas



Ted Shaw
President/CEO
Texas Hospital Association



Danette Castle
CEO
Texas Council of Community Health Centers



John Henderson
CEO/ President
Texas Organization of Rural &
Community Hospitals



Diana L. Fite, President
Texas Medical Association