CODE RED

The Critical Condition of Health in Texas

2015

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EXECUTIVE SUMMARY

Since its inception, the Code Red Task Force on Access to Health Care in Texas (Task Force) has studied the issues, deliberated, and provided recommendations on improving the health of Texas residents.

To improve the health of all Texas residents, the Code Red Task Force recommends the use of available federal funds to allow more low-income, working Texans to obtain health insurance.

A significant amount of federal funds are currently used by Texas hospitals, Federally Qualified Health Centers (FQHCs) and other health care providers to supplement the low reimbursement rates for the care of Medicaid patients, and to offset the costs of care for the uninsured. Under the Patient Protection and Affordable Care Act (ACA), these payments will be significantly reduced in order to pay for the expansion of health insurance coverage across the country. Such reductions strike especially deep for Texas health care providers due to the rapid increase in population, the high rate of uninsured in our state and the related high cost and increasing amount of uncompensated care.

The high cost of uncompensated care affects all Texans:

- Property taxpayers support county indigent health care programs and hospital districts.
- Employers and individuals pay higher health insurance premiums due to cost shifting.
- Small business owners are unable to afford the continuing increased cost of health insurance.
- More uninsured and underinsured people seek access to care in a fragmented health care system or delay seeking care due to costs.
- Uninsured Texans unable to access early diagnosis and treatment for advanced diseases increase costs for all who pay for or provide care in the state.
- Federal Disproportionate Share Hospital (DSH) monies, which compensate hospitals for uncompensated care of the uninsured and underinsured are scheduled to phase out over several years with a loss of $1 billion per year to Texas hospitals.
- Unless the five-year federal health care trust fund is restored in 2015, there will be a 70% cut in support of FQHCs in Texas with a loss of $133 million per year.
- Failure to renew the Medicaid 1115 Waiver could result in a loss of up to $17 billion over five years, beginning in 2016.

Texas has chosen not to implement Medicaid insurance expansion made possible through the ACA. Failure to expand Medicaid health care coverage has already cost Texas $3.6 billion and will deprive the state of approximately $66 billion in direct federal payments over ten years, as well as an estimated $35-40 billion more in secondary benefits, such as jobs and better health for those who might gain health insurance coverage. In the meantime, approximately $32 billion in federal taxes, paid by Texans, will be

used to support Medicaid insurance expansion in other states over the next ten years. Failure of the state to expand Medicaid insurance coverage perpetuates uninsured status for more than one million Texans which expands a large coverage gap that excludes them from affordable health insurance.

In addition, the Texas Health Care Transformation and Quality Improvement Program, the current Medicaid 1115 Waiver approved in December 2011, has resulted in providers and local communities developing innovative programs that will improve coordinated access to care for those currently enrolled in Medicaid, as well as for many uninsured Texans. Innovation is sparked and rewarded by value-based incentive payments earned by health care providers after achieving process milestones and outcome metrics. However, the programs' financial sustainability is in jeopardy when the Waiver ends in September 2016. The Waiver should be extended or renewed.

WHAT ARE THE OPTIONS?

- *Continue the current situation.* The cost of uncompensated care will continue to escalate and burden Texas taxpayers and the Texas economy. *This will leave over one million Texans in a coverage gap without Medicaid insurance.* Texans with incomes below 100 percent of the Federal Poverty Level are ineligible for subsidies for purchasing insurance through the marketplace. These Texans rely on expensive emergency room care, have limited access to primary and preventive care and are less likely to receive early diagnosis and intervention, leading to poorer health overall and resulting in more costly care.

TexasRx

- *Create a health plan such as the Texas Prescription (TxRx)* which would include insurance premium subsidies and appropriate participant premium contributions, encourage healthy behaviors and discourage inappropriate utilization such as unnecessary emergency room visits.

- *Pursue extension or renewal of the Texas Health Care Transformation and Quality Improvement Program/Medicaid 1115 Waiver, while exploring ways to maximize recovery of additional federal funds to provide more health care coverage for low income Texans.*

RECOMMENDATIONS IN BRIEF

- Obtain a greater share of federal tax funding, much of which is paid by Texans and Texas businesses, to expand health insurance coverage so more Texans have access to primary care and health, wellness and prevention programs.
- Create an appropriate state health plan, such as Texas Prescription **TxRx (APPENDIX A)**
- Extend/renew the current Medicaid 1115 Waiver.
- Develop robust local and regional health care delivery systems with increasing emphasis on wellness and prevention programs.
- Continue to expand behavioral health care and integrate with primary care.
- Expand the health care workforce in response to community need.
- Support continued federal funding of FQHCs.

POTENTIAL **10 YEAR** LOSSES TO TEXAS

- Loss by hospitals for indigent health care $55-60 billion
- Loss of federal funding for Disproportionate Share Hospitals $10.2 billion.
- Loss of federal support for FQHCs $1.3 billion

POTENTIAL **10 YEAR** GAINS TO TEXAS

- Gain federal funding for Texas Prescription (TxRx) of $66 billion
- Indirect funding effects $35-40 billion

TexasRx

Texas will realize its full economic vitality and quality of life only when every Texan has access to appropriate health care and preventive services. Improving access to care in Texas will require the collaboration of all Texans – state and local government leaders, employers, health care providers, educators, communities, families and individuals. Every Texan has a stake and a responsibility to pursue good health and to assure the financial well-being of our families and our state.

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THE CRITICAL CONDITION OF HEALTH IN TEXAS

2015

The Code Red Task Force on Access to Health care in Texas (Task Force) is a nonpartisan group that includes representatives from large and small employers in Texas, health care providers, hospitals, medical schools, non-governmental organizations, insurers, health policy experts, as well as community and business leaders. The Task Force issued its first report, Code Red: The Critical Condition of Health in Texas in April 2006, and published an update in 2008. In 2010-2011, the Task Force sponsored four well-attended workshops on improving health care delivery systems. The Task Force's Code Red Report 2012 provided information to support the successful implementation of the Texas Health care Transformational and Quality Improvement Program, the Medicaid 1115 Waiver.

IN 2014, THE TASK FORCE RECONVENED TO EXAMINE:

- The renewal or expansion of the Texas Medicaid 1115 Waiver
- The expansion of health insurance coverage in Texas
- The expansion and increased effectiveness of the health care workforce in Texas
- Improving health care delivery systems in Texas
- The potential impact of the above on improved access to quality health care and on controlling and reducing health care costs.

FOR A COMPLETE DESCRIPTION OF THE BACKGROUND AND SOURCES OF THE CODE RED REPORT AND 2015 RECOMMENDATIONS, SEE CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS AT *WWW.CODEREDTEXAS.ORG*

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OBSERVATIONS

The Task Force **(SEE MEMBERSHIP IN APPENDIX B)** met in Houston, Dallas, San Antonio and Harlingen, Texas, and received diverse and extensive expert testimony. It heard from 30 witnesses and reviewed a broad array of data and literature. Individuals who testified before the Task Force are listed in **APPENDIX C**.

After due deliberation, the Task Force observed:

Since the fall of 2005, when the Task Force was initially formed, both health care and Texas have changed tremendously.

- Texas is among the fastest growing states in the nation; our population grew approximately 16% from 2005 to 2014 and added an estimated 1.3 million people from April 1, 2010 to July 1, 2013.
- According to the Federal Reserve Bank of Dallas: "State employment has risen at the second fastest rate in the nation since the recessions ended in mid-2009, moving past prerecession job totals in 2011 and attracting people from outside the state in search of employment."
- Texas real (inflation-adjusted) GDP has grown approximately 31% from 2005 to 2013, despite the flat-growth period of 2007 to 2009.
- The Patient Protection and the ACA includes provisions designed to make health insurance more attainable and affordable.
- Texans will pay $36.2 billion dollars in federal taxes which will support Medicaid expansion in other states over the next ten years.

However, some things unfortunately remain unchanged:

- Texas has the highest rate of uninsured in the United States at 24%.
- Six million Texans have no health insurance coverage and thus have limited access to primary and preventive care
- At least 20% of Texans report not seeing a doctor in the past 12 months due to cost.
- Approximately 17% of all Texans and 26% of Texas children (ages 0-17) live in poverty which adversely affects their health and educational attainment.
- Texas hospital district and county taxpayers continue to bear a high economic burden for uncompensated care incurred by hospitals.
- Texas has a significant shortage of health care professionals – particularly primary care professionals who could improve the efficiency and effectiveness of health care delivery to all Texans.

- Adequate access to mental health services and dental care remains a major problem for Texas.
- Providing efficient, effective health care to all Texans will require efforts such as prevention, wellness and disease management programs, the use of electronic health records and the innovative redesign of health care delivery models.
- Texas currently needs at least 514 primary care, 349 dental and 193 more mental health practitioners to relieve the state's current Health Professional Shortage Area (HPSA) designations **without** factoring in future population growth and aging.
- The state did not expand Medicaid eligibility for uninsured adults despite the availability of billions of federal dollars for this purpose, and the expressed support of local governments, the business community and many individual Texans.
- **Texas has a supply and demand problem** in which the demand for health care services is increasing substantially, while the supply of health care providers and financial resources to pay for health care services is increasing much more slowly.

> "Non-integrated care is more expensive in the short term and the long term"
>
> -J. James Rohack, MD

CRITICAL OPPORTUNITIES EXIST TO ADDRESS THESE CHALLENGES

- Expansion of insurance coverage could bring over $66 billion federal dollars to Texas over ten years, with another $35-40 billion dollars of additional secondary benefits.
- These federal funds are essential to replace federal monies ($21.8 billion) which will be lost to safety net hospitals and FQHCs over the next ten years beginning October 1, 2015.
- FQHCs in Texas saw over 1.1 million patients in 2013, 51% of whom were uninsured and 25% of whom were receiving Medicaid coverage.
- The Patient Protection and the ACA includes provisions designed to make health insurance more attainable and affordable.

TEXAS MEDICAID 1115 WAIVER

Consistent with the recommendations of the 2006 Code Red Report, Texas obtained a Medicaid 1115 Waiver in December 2011, providing federal funding of up to $17 billion over five years. The Medicaid 1115 Waiver includes funding for Uncompensated Care (UC) and Delivery System Reform Incentive Program (DSRIP) projects. Almost 1500 of such projects have been initiated in Texas, but are not

sufficiently implemented to complete a thorough evaluation of their success. The Medicaid 1115 Waiver ends in 2016 and must be renewed or extended beyond that date if the program is to be continued and Texas is to reap the full benefits of the most innovative and effective projects.

THE AFFORDABLE CARE ACT AND THE COVERAGE GAP

The ACA created a health insurance Marketplace to allow individuals without employer-sponsored health insurance to purchase their own health insurance policies from private, non-governmental insurance companies. To make premium payments affordable, the Marketplace offers financial assistance in the form of sliding scale tax credits for legal residents with incomes between 100% and 400% of the federal poverty level. In Texas, 1.75 million people are now eligible for these tax credits.

The ACA also expanded Medicaid eligibility for adult citizens and certain legal residents with incomes at or below 138% of the federal poverty level. The federal government pays 100% of the cost of the expansion through 2017. After 2017, the federal government's share will gradually reduce until 2020 and after that the federal government will pay not less than 90% of the cost with states paying no more than the remaining 10%. After the US Supreme Court ruling in June 2012 which eliminated Medicaid expansion as a mandatory feature of the ACA, several states, including Texas, have opted not to expand Medicaid to cover more low-income adults. This decision has created a Coverage Gap where there is no financial assistance for those individuals who earn too much to qualify for the current Medicaid program, but not enough to qualify for Marketplace tax credits.

Approximately four million poor uninsured adults fall into the Coverage Gap in the 23 states that have not expanded Medicaid eligibility as of October 2014. This number specifically excludes those who are not eligible for government assistance: legal immigrants who have been in the country for five years or less and immigrants who are undocumented.

ONE MILLION TEXANS FALL INTO THE COVERAGE GAP.

In Texas, current Medicaid eligibility for legal resident adults who are not disabled, elderly or pregnant is limited to parents of dependent children with annual family income of less than 17% of the federal poverty level. Working adult Texans who earn less than 100% of the poverty level cannot take advantage of the Marketplace tax credits to enroll in health insurance.

- **In families of four, these Texans are adults whose household income is between $4,501 and $23,550 per year.**
- **These Texans are single working adults with annual income below $11,490.**
- **Working 30 hours per week at minimum wage provides an annual income of $11,310.**

MEDICAID COVERAGE EXPANSION

Texas has chosen to not implement Medicaid insurance expansion made possible by the (ACA). Failure to expand Medicaid coverage deprives the state of approximately $66 billion in direct federal payments over 10 years and an estimated $35-40 billion more in secondary benefits, such as jobs and better health for those who could gain and benefit from health insurance coverage.

The ACA sharply reduces Disproportionate Share Hospital (DSH) payments to hospitals as well as sources of funding for community health centers. The ACA funding reductions to hospitals and FQHCs were designed as offsets to the cost of expanding Medicaid to cover more people. In the absence of coverage expansion, those hospitals and community health centers providing the greatest amount of health care to the uninsured population will experience the most significant reductions and the largest and increasing losses of revenue.

Several states have developed and negotiated with the Centers for Medicare & Medicaid Services (CMS) for Waivers to implement more affordable access to health insurance by using federal Medicaid funds as premium assistance to purchase non-governmental Marketplace health insurance coverage for eligible adults. These waiver plans contain elements of personal responsibility of the insured through cost-sharing elements such as co-pays at the point of health care service, mandatory monthly contributions to health savings accounts, and penalties for non-emergent use of emergency room facilities.

> "Access to a usual source of care over time is important to improving health."
>
> -Elena Marin, MD

CODE RED 2015 RECOMMENDATIONS IN BRIEF

Based upon its review of expert testimony, relevant information and due deliberation, the Code Red Task Force makes the following recommendations:

- **Expand health insurance coverage through a negotiated alternative to Medicaid expansion under the ACA, designed to meet Texas' unique needs by benefitting from Texas' share of**

available federal Medicaid funds so more low-income, working Texans have access to health care and realize better health status.

- **Develop effective, efficient health care delivery systems throughout Texas.**
  - ▸ **Extend/renew the current Medicaid 1115 Waiver.**
  - ▸ **Expand behavioral health care and integrate it with primary health care.**
  - ▸ **Expand the health care workforce in response to community need.**
  - ▸ **Support continued federal funding of FQHCs.**

The Task Force strongly recommends expanding health insurance coverage as a means of supporting a thriving Texas economy with a healthier, more productive workforce. While the federal health insurance exchange provides access to subsidies making premiums affordable for many small businesses and families, the ACA assumed states would expand Medicaid eligibility to cover residents with incomes below 100% of the poverty level, and therefore avoid a coverage gap for this group. The decision to not expand Medicaid in Texas left a coverage gap for nearly one million Texans who are not otherwise eligible for Medicaid, and most of whom are working poor with no employee health insurance benefits, effectively denying them access to primary and preventive care and leaving hospitals and other safety net providers, such as FQHCs, subject to the financial burden of uncompensated care. Therefore, the Task Force recommends a uniquely Texas alternative to expand health insurance coverage instead of Medicaid expansion under the ACA. The proposed alternative has two levels of coverage known as **Texas Prescription (TxRx)** and **Texas Prescription Plus (TxRxPlus). (APPENDIX A)**

> "We write not to complain about the fiscal burden or duty, but to urge your committee to use this interim to find a Texas way forward to find and increase access to health care coverage for low wage working Texans."
>
> –County judges from the six most populated counties in an August 13, 2014 letter to the Texas Senate Health and Human Services Committee

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Recommendations—2015

For the Successful Implementation of the Section 1115 Demonstration

Recommendation 1: The Task Force recommends that Texas negotiate with CMS to implement the Texas Prescription (TxRx) Plan that would use federal funds to provide premium assistance to Texans in the Coverage Gap so that they can obtain private, nongovernmental health insurance in the Marketplace. This plan may have the following elements:

- Enrollees participate in sliding scale cost sharing based on income. Such premiums should never prevent very low income people from obtaining coverage.
- Access to commercial health insurance with Medicaid premium assistance.
- Incentives for healthy behaviors and disease prevention activities.
- Health Savings Accounts to which enrollees and Medicaid contribute and from which care is purchased. Carryover of monies from year to year would be allowed for enrollees who participate in wellness or preventive activities.
- Access to the Federal Basic Health Plan for those with incomes between 133% and 200% of the Federal Poverty Level.
- Wellness and health maintenance programs.
- Women's access to both primary care and family planning services.
- Modification of the Texas Health Insurance Premium Payment (HIPP) program to increase eligibility wherein premiums could be paid for Medicaid eligible individuals in a family in which another family member has health insurance coverage.
- CMS has been unalterably opposed to block grants for Medicaid. Should CMS be receptive to a block grant for funding Medicaid, it must ensure that the size of the grant will increase with health care inflation, population growth and other relevant variables.

The plans recommended may have two levels of benefits, **TxRx** and **TxRx Plus**, based on participant payment of premium contributions and/or health behaviors.

The Task Force considered a number of plans, adopted or proposed by other states as an alternative to Medicaid expansion as originally contemplated under the ACA.

Among several states using a Medicaid Waiver to expand health insurance coverage, Arkansas provides a very interesting example. Arkansas received approval from CMS in September 2013 for a waiver to expand health insurance coverage by using federal Medicaid funds as premium assistance to purchase coverage in the Marketplace for newly eligible adults with incomes up to 138% of the poverty level. Implemented in January 2014, Arkansas, using federal funds, pays monthly premiums directly to qualified health plans. Those enrollees with incomes between 100% and 138% FPL have cost-sharing requirements which are limited to 5% of annual income. Over a six month period, Arkansas successfully reduced its uninsured rate from 22% to 12%.

Arkansas proposed a Waiver amendment in September 2014 that, if approved, would add cost-sharing for enrollees with income between 50% and 100% FPL, and establish health savings accounts for non-disabled enrollees. As proposed, monthly contributions would be $5 for those with income from 50-100% of the FPL, $10 for those from 100-115% of the FPL, $17.50 for those between 115-129% of the FPL and $25 for those with incomes over 129% of the FPL. A third party administrator would use funds from the health savings accounts to pay cost-sharing to providers.
Variations on the Arkansas or other state plans as part of TxRx and TxRx Plus are outlined in **APPENDIX A**.

Recommendation 2. The Task Force recommends that the Texas Health and Human Services Commission propose a three to five year extension/renewal of the Texas Health care Transformation and Quality Improvement Program, commonly called the Medicaid 1115 Waiver.
Key features of the proposal should:

- Continue funding for Uncompensated Care (UC).
- Identify the most successful Delivery System Reform Incentive Program (DSRIP) projects to scale up these projects for more patients in more communities.
- Develop the mechanisms for the expansion and adoption of successful projects in interested communities across Texas.
- Facilitate opportunities to consolidate similar or related projects to enhance effectiveness and efficiency of interventions across the continuum of care.
- Encourage further collaborations among health care providers to create integrated systems of care.
- Develop statewide initiatives for specialty medical care through the expanded use and appropriate payment for telemedicine consultations.
- Continue to promote consistent, comprehensive data collection and evaluation of the DSRIP projects' value in terms of both health outcomes and cost containment - specifically project impact on potentially preventable emergency department utilization and hospital admissions and readmissions.
- Increase the long-term impact and sustainability of effective DSRIP projects by urging Medicaid managed care organizations to develop value-based reimbursement models.

Texas health care providers and HHSC have negotiated and re-negotiated DSRIP metrics, milestones, quantifiable patient impact, and funding protocols for the first three years of the Medicaid 1115 Waiver, essentially building the airplane as it moves down the runway. Approximately 1,500 DSRIP projects have been designed to improve the health care experience, improve the health of populations and reduce per capita costs of health care. Performing health care providers can earn incentive payments only after documented achievement of milestones and metrics. Innovative DSRIP projects are designed to expand access to primary care and behavioral health care often in an integrated setting, and expand the deployment of health homes, nurse-led clinics, telemedicine, and community health workers and care navigators. Of special note are efforts to provide behavioral health resources to reduce stress on emergency rooms and jails. Transforming health care takes time and careful evaluation to discern the most effective and efficient projects. The Medicaid 1115 Waiver/Extension would give Texas the necessary time to fully capitalize on the prodigious efforts to date.

Recommendation 3. The Task Force recommends the continued development of proven health care delivery systems with an emphasis on preventive and primary care and incorporating population health approaches to improve the health of all Texans.

- **Health care providers and payers, including Texas Medicaid and health plans participating in Medicaid Managed Care, should collaborate to develop value-based payment models to support outcome-focused, team health care delivery as an alternative to the prevalent fee-for-service, physician-focused model. These can include bundled services, gain sharing, increased capitation and paying for performance.**

Society benefits most from the promotion, maintenance, and attainment of health for individuals and for the population. Healthy people drive a healthy economy. In a state as big and diverse as Texas, health status and access to health care vary widely. Due to increasing health care costs that have created a burden for our entire society - individuals, employers, and governments - health care must become more effective and efficient.

Population health recognizes health outcomes within a population and the related impact of various factors on health including the social and physical environments, education, behavior, and genetics, as well as medical care itself. Population health management aims to align the focus of care to health-risk status and to align the delivery of care to health impact. The spectrum ranges from intensive care coordination for those with serious chronic conditions to personal health management, including prevention and wellness for those not yet manifesting chronic conditions that might be kept at lower levels of health risk.

Health (medical) homes are an emerging form of health care delivery and include payment models that incorporate population health management to improve health outcomes and control costs. Key features of health homes include a "health team" of clinical care providers using population health management techniques with 24/7 care coordination focused on keeping people healthy and functioning well. Innovative payment models that support this continuum of care can include monthly management fees, incentive payments for quality care and improved health outcomes, and shared savings, realized through reductions in preventable emergency room visits and hospital stays. Health homes should also include behavioral health programs and services. The demonstration programs currently being funded under the Medicaid Waiver include a number of health home projects with innovative modifications to evaluate a variety of these concepts in different provider settings.

Recommendation 4. The Task Force recommends continuation of state support for behavioral health initiatives undertaken during the 83rd Legislative Session in 2013.

The Task Force recommends that public and private entities:

- Integrate the full continuum of behavioral health services into the overall health care system in order to provide the right care in the right place at the right time. This will include behavioral/primary care teams in health homes, emergency care teams, inpatient services, and community rehabilitation services. Community health workers will be trained in behavioral and physical health subject matter and the relationship/integration of the two.
- Increase the availability of tele-psychiatry in emergency departments, health homes, and school settings.
- Collaborate with the Veterans Health Administration to increase resources and services for veterans with behavioral health issues.
- Expand proven behavioral health crisis intervention programs to reduce inappropriate and ineffective involvement of persons in crisis with the criminal justice system.

Approximately 20% of the Texas population experiences occasional behavioral health problems and 4% of the population suffers from serious mental illness. Among these are approximately 300,000 children with a serious behavioral health problem, including a significant number of adolescents with depression. Three quarters of Texas counties are designated as mental health professional shortage areas with a significant lack of both adult and child psychiatrists. Texas ranks 49th among the states in per capita spending on mental health services even though the Texas Legislature provided over $300 million for the 2014-2015 biennium to improve mental health services. A significant shortage of state-funded hospital beds for patients with serious mental health issues creates enormous pressures on public hospital emergency rooms and the criminal justice system. Emergency rooms must often "board" patients for extended periods due to the lack of psychiatric beds. In addition, behavioral health issues are among the most frequent reasons for hospital readmissions. The criminal justice system incarcerates a substantial number of prisoners who suffer principally from a mental health condition negatively impacting their behavior. Promising approaches for improved behavioral health care, such as crisis stabilization teams and tele-psychiatry, are underway as DSRIP projects.

Recommendation 5. The Task Force recommends continued efforts to expand a culturally competent health care workforce. This includes community health workers (otherwise known as promotores), health care navigators, pharmacists, dentists, social workers, physicians, nurses at multiple levels, dental hygienists, public health specialists, behavioral health specialists, occupational and physical therapists and other health professionals.

- Continue efforts to expand the physician workforce by increasing the number of and financial support or subsidies for graduate medical education positions in Texas with emphasis on residencies in primary care, psychiatry, general surgery, and pediatric sub-specialties. Residency positions should exceed the number of Texas medical school graduates by 10% as recommended by the Texas Coordinating Board on Higher Education.

- Improve the diversity and deployment of the health workforce by providing educational stipends and loan repayment programs to health professionals (physicians, nurses, dentists, clinical psychologists, physician assistants, etc.) who come from diverse, underrepresented backgrounds and/or who will serve Medicaid patients, practice in underserved areas, and deliver primary care or high-need specialty health care areas including behavioral health.
- Enrich the learning experience for all health professionals by expanding inter-professional education. Add curricular modules on patient-centered, team-based care, data analytics, population management, health care quality improvement, effective health care delivery systems, and the concept of health care value as a function of patient-centered outcomes and controlled costs.
- Increase support for nursing education with special emphasis on opportunities to obtain baccalaureate degrees, to prepare advanced practice registered nurses for primary care delivery, and to obtain doctorate degrees in nursing to expand the nursing faculty workforce.
- Expand programs to train community health workers, promotores, health care navigators and health educators and develop pathways for additional competencies and career advancement.
- Grant health professionals practice authority commensurate with the fullest extent of their education and demonstrated competencies.

Texas has shortages of essentially all health care providers with the exception of licensed vocational nurses. The physician workforce ranks 43rd in the country for patient care physicians at 205 per 100,000 population versus 263 per 100,000 nationally. There are particular shortages of primary care physicians in Texas. Our state has only 79 primary care physicians per 100,000 versus a national average of 100 per 100,000. The distribution of physicians in Texas is very uneven with striking shortages in communities in South Texas, East Texas, West Texas, and in all rural areas across the entire state. Without proportional increases in residency programs and opportunities for fellowship and other post-graduate training, graduates of Texas medical schools will continue to leave Texas only to practice their skills achieved at Texas' taxpayer expense elsewhere and never to return. Although the education of nurses has expanded significantly, there are still major shortages of baccalaureate prepared nurses, advanced practice registered nurses, and nursing faculty. Other health professionals, including dentists, physicians' assistants, occupational therapists, and mental health providers are in short supply. Rapid population growth in Texas compounded by the aging of the Texas baby boomer generation will continue to exacerbate provider shortages. In addition, the Texas health workforce should mirror the demographics of the population.

Local efforts, including several DSRIP projects, are expanding and integrating the role of community health workers and promotores. These trained and certified workers empower their neighbors to manage and maintain their own health, improving the value of health care.

Conclusion

The health and economic vitality of Texas depends critically upon the health of its people. Healthy children are academically more successful in school, develop lifelong healthy habits and are healthy as adults. On the other hand, unhealthy individuals with preventable chronic conditions and unhealthy habits adversely impact the Texas economy through county or hospital district taxes, higher insurance premiums, institutional cross subsidies and early disability. Unhealthy adults are less productive workers. Unhealthy Texans often lack access to health insurance. The average insured family of four in Texas pays at least $1800 more each year to subsidize care provided to the uninsured. The per capita and family income levels of Hispanics and African Americans in Texas are generally lower and consequently, they are more likely to be uninsured or underinsured, which results in poorer access to health care and poorer health status.

Access to federal dollars through the current Medicaid 1115 Waiver has been shown to support programs and efforts that improve both access to and the quality of health care, though the final data and evaluation of outcomes is not yet available. Extension or renewal of the Waiver will allow further measurement of its impact and the scaling up of its successes.

Economists estimate that access to federal funds to expand Medicaid and private health insurance coverage for Texas residents would benefit the state by almost $100 billion over the next 10 years, and offer relief to county taxpayers and insured families who are making up the shortfall without the federal monies. There has never been a better "business case for health", and the state should move expeditiously to plan and implement a state health insurance plan, such as the Texas Prescription (TxRx).

APPENDIX A

TexasRx

Approaches to the Texas Prescription TxRx and TxRxPlus

The Code Red Task Force reviewed options considered in other states that are pursuing state specific programs to provide more health insurance coverage for low income uninsured populations. Provided below are modifications of options proposed in other states that Texas leadership could consider. The intent is that the more personal responsibility an enrollee takes for his or her own health care, the greater the benefits the enrollee may obtain.

TxRx would offer a basic benefit package for enrollees with incomes up to 133 percent of the Federal Poverty Level. The basic benefit package could be designed to provide only those benefits necessary to meet federal requirements. Individuals participating in an annual health assessment or wellness program might receive a smart card/bank card that they could use to purchase additional health services. Texas could also consider other enhanced options, or TxRx Plus. The first option, for those with the lowest incomes, is based on a modification of the plan developed by Arkansas, and a second option for those with slightly higher incomes based on modification of the Federal Basic Health Plan. A third option is based on a modified version of a plan proposed in Indiana. (See descriptions below).

1. Under the first TxRxPlus option newly eligible adults, including both childless adults and parents with incomes up to 138 percent of the Federal Poverty Level would enroll in an insurance plan offered by a qualified health plan with premiums paid by Medicaid. Enrollees with income in excess of 50 percent of the Federal Poverty Level would pay up to two percent of their income toward the premium on a sliding scale. This plan would provide a full benefit package including dental and vision care. It might also include nutrition counseling or other special counselling services focused on chronic disease management. Enrollees who obtain an annual physical exam and/or participate in a wellness program would make no premium payment. Failure to pay the premium or engage in a wellness program would place the enrollee in the TxRx program.

2. The second TxRxPlus option would focus on enrollees with income between 133 and 200 percent of the Federal Poverty Level. This coverage is modeled on the Federal Basic Health Plan which gives states the option to tailor plan benefits. It might be purchased through the insurance marketplace (state or federal). Texas could define the standard health coverage and determine premium levels with cost sharing by the enrollee on a sliding scale based on income. Enrollee premiums may be up to five percent of income. Participation in an annual health assessment or wellness program could decrease or eliminate the cost sharing component...

3. The third TxRxPlus option, based on modified version of a plan developed in Indiana, would allow an enrollee to participate in a health savings account in which Medicaid and the enrollee contribute up to $2000 annually. The enrollees' contribution would be on a sliding scale. These funds would be used to purchase health care and could be carried over from year to year if the enrollee completed a health assessment or participated in a wellness program annually. If the funds were totally expended in a given year, care would be limited to TxRx benefits, that is, the basic plan based on minimum federal requirements.

APPENDIX B

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APPENDIX C

Individuals Who Testified Before the Task Force

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ANNE DUNKLEBERG, MPA	ASSOCIATE DIRECTOR, CENTER FOR PUBLIC POLICY PRIORITIES
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ROSE GOWEN, MD	BROWNSVILLE CITY COMMISSIONER
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DAVID LAKEY, MD	COMMISSIONER, DEPARTMENT OF STATE HEALTH SERVICES
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SCHUYLER MARSHALL, JD	CHAIRMAN OF THE BOARD, THE ROSEWOOD CORPORATION, DALLAS
MAUREEN MILLIGAN, PHD	PRESIDENT/CEO, TEACHING HOSPITALS OF TEXAS
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ARLENE WOHLGEMUTH	EXECUTIVE DIRECTOR, TEXAS PUBLIC POLICY FOUNDATION

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