National
Family Planning
& Reproductive Health Association

August 3, 2017

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: **"Healthy Texas Women" 1115(a) Medicaid Demonstration Application**

Dear Sir/Madam:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments in response to Texas' § 1115(a) Medicaid demonstration application, "Healthy Texas Women." For the reasons outlined below, we urge the Department of Health & Human Services (HHS) to reject the application as proposed.

NFPRHA is a national membership organization representing the nation's publicly funded family planning providers – nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private non-profit organizations.

NFPRHA is deeply troubled by Texas' application, which seeks to receive federal dollars to maintain its existing, failed program. NFPRHA is especially concerned by several of the provisions in Texas' application that would perpetuate current approaches to the provision of family planning in the state that have proven detrimental to the women of Texas. NFPRHA strongly supports expanding coverage of and access to family planning services and supplies for low-income patients; however, NFPRHA is troubled by Texas' ongoing efforts to exclude qualified providers from its Medicaid program and to impose administrative hurdles that undermine the State's stated goal of increasing access to family planning and other preventive care for women.

***

HHS Authority and § 1115 Waivers

Under § 1115 of the Social Security Act, the Secretary may only approve an application that proposes an experiment, pilot, or demonstration that is likely to promote the objectives of the Medicaid Act.[1] The purpose of the Medicaid Act is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care.[2] In addition, the Secretary may only waive Medicaid requirements that appear in 42 U.S.C. § 1396a and only for the extent and period necessary to enable the state to carry out the project.[3] As explained in detail below, Texas' application does not meet these requirements, and as a result, cannot be approved.

***

Freedom of Choice

Texas is seeking to waive the longstanding federal "freedom of choice" protection – 42 U.S.C. § 1396a(a)(23) – for the purpose of excluding providers who perform or promote abortions or affiliate with providers who do so. The request is not approvable, as it has no experimental value and is not likely to promote the objectives of the Medicaid Act.

Section 1396a(a)(23) ensures that Medicaid patients can receive medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services . . . who undertakes to provide . . . such services."[4] The statute includes a general exception for patients enrolled in certain Medicaid managed care plans. However, recognizing the value of family planning services and supplies and the importance of specialized, trusted providers and patient choice in receiving family planning services, Congress explicitly protected the right of managed care enrollees to receive family planning services from any qualified Medicaid provider, even if the provider is outside of their plan's provider network.[5]

Both the Centers for Medicare & Medicaid Services (CMS) and the courts have consistently made clear that § 1396a(a)(23) prohibits states from excluding providers from Medicaid for reasons other than their fitness to provide covered services or to appropriately bill for such services.[6] States may not target "disfavored providers" simply because they provide the "full range of

---

[1] 42 U.S.C. § 1315(a).

[2] *Id.* § 1396-1.

[3] *Id.* § 1315(a).

[4] *Id.* § 1396a(a)(23).

[5] *Id.* §§ 1396a(a)(23)(B), 1396n(b).

[6] *See, e.g.*, CMS, Dear State Medicaid Director Letter (April 19, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf; *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 2017 WL 2805637 (5th Cir. 2017); *Planned Parenthood of Ariz v. Betlach*, 727 F.3d 960, 963 (9th Cir. 2013); *Planned Parenthood of Ind. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 974 (7th Cir. 2012). *See also Planned Parenthood of Greater Texas Family Planning & Preventive Health Servs., Inc. v. Smith,* 2017 WL 692518 (W.D. Tex. 2017).

legally permissible gynecological and obstetric care, including abortion services (not funded by federal Medicaid dollars, consistent with the federal prohibition), as part of their scope of practice."[7]

As CMS has recognized, Texas cannot use § 1115 to avoid these protections, as excluding providers for reasons unrelated to their qualifications does not further the objectives of the Medicaid Act.[8] In addition, the State has already demonstrated that excluding qualified providers from the family planning network severely reduces low-income women's access to family planning and other preventive services.

In 2007, Texas implemented a family planning expansion project under § 1115. According to the State's own data, the project improved access to contraception, reduced unintended pregnancies, and lowered the number of Medicaid-funded births.[9] However, as part of its waiver renewal application in 2011, the State sought permission to waive § 1396a(a)(23) to exclude providers who perform or promote abortions or affiliate with providers who do so.

CMS denied Texas' request in December 2011, rightly stating that such a waiver:

> would eliminate Medicaid beneficiaries' ability to receive family planning services from specific providers for reasons not related to their qualifications to provide such services. In light of the specific Congressional interest in assuring free choice of family planning providers, and the absence of any Medicaid purpose for the proposed restrictions, we have concluded, after consultation with the Secretary, that nonapplication of this provision to the Demonstration is not likely to assist in promoting the statutory purposes.[10]

Thereafter, the State chose to run its family planning program entirely with state dollars. Beginning in 2013, Texas excluded from its state-funded program "many of the very safety-net providers most able to provide high-quality contraceptive care to large numbers of women."[11] A

---

[7] CMS, Dear State Medicaid Director Letter (April 19, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf.

[8] *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to Billy Millwee, Deputy Exec. Comm'r, Tex. Health & Human Servs. Comm'n (Dec. 12, 2011).

[9] Tex. Health & Human Servs. Comm'n, *2010 Annual Savings and Performance Report for the Women's Health Program* 1(2011) (reporting over 100,000 clients receiving services annually, preventing 6,721 births), https://hhs.texas.gov/sites/default/files//rider64-womens-health-0811.pdf.

[10] Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to Billy Millwee, Deputy Exec. Comm'r, Tex. Health & Human Servs. Comm'n (Dec. 12, 2011).

[11] Kinsey Hasstedt and Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFAIRS BLOG, (July 18, 2017), http://healthaffairs.org/blog/2017/07/18/at-it-again-texas-continues-to-undercut-access-to-reproductive-health-care/. *See also* Kari White et al, *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 Am. J. Pub. Health 851, 851 (2016) (reporting that, prior to the exclusion, nearly half of the program's clients received services at Planned Parenthood clinics); Tex. Health & Human Servs. Comm'n,

large body of research shows the devastating effect of this decision on women's access to family planning and other preventive services.

Between 2011 and 2015—pre- and post-provider exclusion in Texas—access to qualified, trusted family planning providers was severely curtailed. "By excluding numerous safety-net health centers and relying primarily on private doctors, the state developed a provider network incapable of serving high volumes of family planning clients. In turn, the state reported a nearly 15% decrease in enrollees statewide over the four-year period."[12] Further, by 2016, "26% [of] Texas women who the state reported as enrolled in the program had in fact never received health care services from a participating provider, up from only 10% in 2011."[13] This dramatic decrease in access to services occurred despite the addition of "thousands more private practices and clinicians" by the State, as these providers on average serve significantly fewer patients than family planning health centers.[14] For example, in 2012—the last year this metric was published—Texas reported that out of 100,480 total unduplicated clients with a paid claim, 64,700 (64%) received services from a family planning health center, while just 25,141 (25%) received services from a private physician or physician practice.[15] The State's report for 2015 acknowledges the large difference between the numbers of patients served by different provider types, stating:

> half of all participating providers saw 12 or fewer clients during fiscal year 2015, while a small fraction of providers treated large numbers of clients during the same period. Further . . . from fiscal years 2011 to 2015 the number of providers who saw large numbers of [Texas Women's Health Program (TWHP)] participants declined, while for the same period the numbers of providers with small TWHP panels (approximately eight per provider) increased.[16]

2010 Annual Savings and Performance Report for the Women's Health Program 5 (2011) (reporting that 80% of program clients received services at dedicated family planning health centers).

[12] Kinsey Hasstedt and Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFAIRS BLOG (July 18, 2017) (citing Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* (2017), https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance). *See also* Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 4-5 (2017) (reporting that, as of 2015, the median number of clients served annually per provider in the network was only 12).

[13] Kinsey Hasstedt and Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFAIRS BLOG, (July 18, 2017) (citing analysis included in Letter from Stacey Pogue, Senior Policy Analyst, Ctr. for Pub. Policy Priorities, to Jami Snyder, Assoc. Comm'r, Medicaid & CHIP Servs., Tex. Health & Human Servs. Comm'n (June 12, 2017), https://forabettertexas.org/images/CPPP_comments_on_HTW_draft_waiver_application.pdf).

[14] *Id.*

[15] Tex. Health & Human Servs. Comm'n, *2012 Annual Savings and Performance Report for the Women's Health Program* 9 (2013), https://hhs.texas.gov/sites/default/files/rider-48-whp-08-16-13.pdf.

[16] Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 5 (2017).

Similarly, the State's own data show a precipitous decline in utilization of contraception among women enrolled in the program. Between 2011 and 2015, claims or prescriptions filed for all contraceptive methods dropped 41%, including dramatic decreases in enrollees obtaining injectable contraceptives, oral contraceptives, condoms, and the contraceptive patch and ring.[17]

In addition, according to research published in the *New England Journal of Medicine* examining claims data from 2011 through 2014, claims for long-acting reversible contraceptives (LARCs) – the most effective reversible contraceptive method – fell by nearly 36% after the State excluded providers from its family planning expansion project.[18] Moreover, while rates of on-time contraceptive injections were going up in areas of the state where women did not rely on excluded providers, the rates were plummeting in areas where once relied-upon providers were excluded; after the exclusion, the proportion of women returning to their providers for on-time contraceptive injections fell from 57% to 38% in counties with Planned Parenthood affiliates, while increasing from 55% to 59% in counties without Planned Parenthood affiliates.[19] Patients who chose to return to an excluded provider had to pay for injections themselves. Women who instead chose to find a new provider "were often required to undergo additional examinations or office visits or were charged a copayment before receiving the injection."[20] Such barriers correlate with an increase in Medicaid-funded births in the State.[21]

The evidence from Texas is overwhelmingly clear – prohibiting low-income women from receiving family planning services from qualified providers because those providers perform or promote abortion services reduces access to health care and places women's health at risk. The State's proposal to continue implementing this failed policy lacks any experimental value and runs counter to both the purpose of the Medicaid program and the State's stated intent to expand access to family planning services and supplies. Consequently, Texas' request to waive § 1396a(a)(23) must be rejected.

***

[17] Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 8 (2017) (reporting 32% decrease in claims for injection methods, 47% decrease for oral contraceptives, and 59% decrease for condoms), https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance.

[18] Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016).

[19] *Id*.

[20] *Id* (citing C. Junda Woo et al., *Women's Experiences After Planned Parenthood's Exclusion from a Family Planning Program in Texas,* 93 CONTRACEPTION 298 (2016)).

[21] Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016).

Modified Adjusted Gross Income

Texas is seeking federal approval to deviate from the standard methodology used to determine financial eligibility for Medicaid and other insurance affordability programs. As such, the state is requesting a waiver of 42 U.S.C. § 1396a(e)(14), which requires states to apply the modified adjusted gross income (MAGI) methodology to determine financial eligibility for most Medicaid applicants.

The plain language of §1396a(e)(14) indicates that the MAGI requirement is not waivable under § 1115. Rather, states must use the MAGI methodology to determine income eligibility under the state plan or under any waiver of such plan.[22]

In addition, there is no valid experimental purpose for waiving the MAGI requirement for the Healthy Texas Women (HTW) project. In the application, Texas notes that the financial eligibility rules will be based on the current rules, which were in place prior to the implementation of MAGI in 2014. The state cannot possibly demonstrate something new by using rules for determining financial eligibility that had previously been routinely applied.

Congress enacted the MAGI requirement to simplify and streamline the eligibility determination process for multiple insurance affordability programs, including Medicaid, the Children's Health Insurance Program (CHIP), and plans available on the exchange. Aligning the financial eligibility process for these programs has eliminated unnecessary complexity—for individuals seeking coverage and for the state—and improves consistency and accuracy in the eligibility determination process.[23] There is no basis for permitting Texas to ignore the MAGI requirement.

***

Minor Consent

Texas' proposed project would require a parent or legal guardian to apply, renew, and report changes to a minor's case on her behalf. This would operate as a de facto parental consent/notification requirement for family planning services that runs counter to public health policy and a stated purpose of Texas' project. In addition, while somewhat unclear, Texas' application could be read to also include a parental consent/notification requirement for the services themselves.

---

[22] 42 U.S.C. § 1396a(e)(14)(A), (B), (C), (F).

[23] *See* Tricia Brooks & Jennifer Mezey, Georgetown Univ. Health Pol'y Inst. & Nat'l Women's Law Ctr., *Fulfilling the Promise of 2014: Aligning and Simplifying Medicaid and CHIP Enrollment for Children and Parents* (2011), http://ccf.georgetown.edu/wp-content/uploads/2012/03/Health-reform_alignment_paper.pdf.

From both a clinical and a public policy perspective, confidential access to family planning and other sensitive services is critical to ensuring that adolescents seek out and receive these essential health services. Lack of confidentiality or concerns about confidentiality can prevent minors from seeking services out of fear that a parent or guardian might find out, putting them at risk of physical or emotional harm. Applicants who need to access care—including minors—must be able to apply for, enroll in, and use their family planning coverage.

Ample research shows that concerns about confidentiality prevent adolescents from seeking care.[24] For example, nearly half of single, sexually active females under the age of 18 surveyed in family planning health centers in Wisconsin reported that they would stop using all services if parental notification for prescription contraceptives were mandatory. An additional 12% reported that they would delay or discontinue use of specific services, such as testing or treatment for STDs.[25] Moreover, 99% of adolescent girls who indicated they would stop using family planning services reported that they would continue to have sex, but use less effective contraceptive methods or no contraceptive method at all.[26] A separate national study echoes these findings and also underscores the importance of confidentiality to adolescents. Among adolescents whose parents were unaware that they were accessing services at a family planning health center, 70% reported that they would no longer come to the health center for prescription contraceptives if parental notification became mandatory. Approximately 82% said that they would rely on less effective over-the counter contraceptives and/or withdrawal.[27]

According to recommendations on how to provide quality family planning services, developed by the Centers for Disease Control and Prevention (CDC) and HHS's Office of Population Affairs (OPA), "[c]onfidentiality is critical for adolescents and can greatly influence their willingness to access and use services. As a result, multiple professional medical associations have emphasized the importance of providing confidential services to adolescents."[28]

---

[24] Rachel K. Jones et al., *Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 JAMA 340 (2005); Jonathan D. Klein et al., *Teenager's Self-reported Use of Services and Perceived Access to Confidential Care*, 152 ARCHIVES PEDIATRICS & ADOLESCENT MED. 676 (1998); Jonathan D. Klein et al., *Access to Medical Care for Adolescents: Results From the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls*, 25 J. ADOLESCENT HEALTH 120 (1990); Carol Ford et al., *Foregone Health Care Among Adolescents*, 282 JAMA 2227 (1999); Reddy DM et al., *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 JAMA 710 (2002); Sugerman S et al., *Family Planning Clinic Clients: Their Usual Health Care Providers, Insurance Status, and Implications for Managed Care*, 27 J. ADOLESCENT HEALTH 25 (2000); Marks A et al., *Assessment of Health Needs and Willingness to Utilize Health Care Resources of Adolescents in a Suburban Population*, 102 J. PEDIATRICS 456 (1983); Cheng T et al., *Confidentiality in Health Care: A Survey of Knowledge, Perceptions, and Attitudes Among High School Students*, 269 JAMA 1404 (1993).

[25] Reddy DM et al., *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 JAMA 710 (2002).

[26] *Id.*

[27] Rachel K. Jones et al., *Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 JAMA 340 (2005).

[28] Loretta Gavin et al., Ctrs. for Disease Control & Prevention and U.S. Office of Population Affairs, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, MORBIDITY & MORTALITY

For all of these reasons, CMS should reject any provisions that would have a chilling effect on adolescents' access to and receipt of family planning services under Texas' waiver.

***

Verification of Citizenship or Immigration Status

According to the application, Texas will not follow federal Medicaid requirements regarding verification of citizenship or immigration status. Under federal law, states must provide applicants who are otherwise eligible for Medicaid with a reasonable opportunity (at least 90 days) to verify their citizenship or immigration status. In contrast, Texas will delay providing coverage to otherwise eligible HTW applicants until after they verify their status. The State will deny coverage to applicants who are unable to verify their status within 30 days. In addition, during the eligibility renewal process, Texas will terminate coverage for enrollees who are unable to verify their immigration status within 10 days.

The State's proposed policies directly conflict with the goals and objectives of the HTW project, as outlined in the application. Instead of increasing access to family planning and other preventive services, they create unreasonable administrative hurdles for applicants and enrollees that will delay or completely prevent coverage. Many women who are eligible for HTW will not be able to gather the necessary documentation within 30 days (or 10 days for eligibility renewal). The only reason the state has given for ignoring federal Medicaid protections and implementing these policies—to ensure the stability of the HTW project by maintaining all current rules—cannot justify making it more difficult for eligible women to access services.

***

WEEKLY REP., April 25, 2014, at 37, http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf. *See, e.g.,* Soc'y for Adolescent Health & Med., *Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine*, 54 J. ADOLESCENT HEALTH 491 (2014); Carol Ford, Abigail English, & Garry Sigman, Soc'y for Adolescent Med., *Access to Health Care for Adolescents and Young Adults: Position Paper of the Society for Adolescent Medicine* 35 J. ADOLESCENT HEALTH 342 (2004) ("Adolescents should be able to receive confidential services based on their own consent whenever limitations on confidentiality would serve as an obstacle impeding their access to care. Federal and state laws should support confidential access to health care for adolescents in these circumstances."); Am. Acad. of Pediatrics, Comm. On Adolescence, *Policy Statement: Contraception for Adolescents*, 134 PEDIATRICS e1244 (2014) ("AAP believes that policies supporting adolescent consent and protecting adolescent confidentiality are in the best interests of adolescents."); Am. Acad. of Pediatrics, *Policy Statement RE9151, Confidentiality in Adolescent Health Care* (1989) (endorsed by the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, NAACOG, and the National Medical Association and reaffirmed in 1993, 1997, 2000, and 2004); Am. Med. Ass'n, *Policy H-75.998: Opposition to HHS Regulations on Contraceptive Services for Minors* (Sub. Res. 65, I-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed: BOT Rep. 28, A-03 Reaffirmed: Res. 825, I-04 Reaffirmed: CMS Rep. 1, A-14); Am. Med. Ass'n, *Policy H-60.965: Confidential Health Services for Adolescents* (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98).

Eligibility Renewal

Similarly, when renewing eligibility for HTW enrollees, Texas intends to ignore federal Medicaid law, which requires states to try to renew eligibility based on available data. When a state is unable to do so, it must send the enrollee a pre-populated renewal form. In contrast, Texas will require all HTW enrollees to complete and submit a renewal application every 12 months.

Like the citizenship and immigration verification policies discussed above, the State's eligibility renewal policies create additional administrative hurdles that will cause many women to lose access to family planning and other preventive services. The purpose of the renewal process required under federal law is to facilitate continuous coverage by making eligibility renewal as easy as possible for Medicaid enrollees.[29] There is simply no legitimate reason for Texas to use a more onerous process that will prevent many eligible women from maintaining HTW coverage.

***

NFPRHA appreciates the opportunity to comment on this proposed § 1115 project. If you require additional information about the issues raised in this letter, please contact Robin Summers at rsummers@nfprha.org or 202-552-0150.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO

[29] *See, e.g.*, CMS, Dear State Medicaid Dir. Letter (April 7, 2000), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd040700.pdf; Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17144, 17181 (March 23, 2012).