

National
Family Planning
& Reproductive Health Association

September 23, 2018

VIA ELECTRONIC SUBMISSION

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

Re: **TennCare II Demonstration Application, Amendment 36**

Dear Sir/Madam:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments in response to Tennessee's proposed amendment to its existing § 1115 Medicaid demonstration, "TennCare." For the reasons outlined below, we urge the Department of Health & Human Services (HHS) to reject the application.

NFPRHA is a national, nonprofit membership organization that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially those in the safety net. NFPRHA envisions a nation where all people can access high-quality, client-centered, affordable, and comprehensive family planning and sexual health care from providers of their choice. NFPRHA represents more than 850 health care organizations and individuals in all 50 states, the District of Columbia, and the territories. NFPRHA's organizational members include state, county, and local health departments; private, nonprofit family planning organizations (including Planned Parenthood affiliates and others); family planning councils; hospital-based clinics; and federally qualified health centers. NFPRHA's members operate or fund a network of more than 3,500 health centers that provide high-quality family planning and related preventive health services to more than 3.7 million low-income, uninsured, or underinsured individuals each year.

NFPRHA is deeply troubled by Tennessee's application, which seeks permission to discriminate against a specific class of providers in the state's Medicaid program, in violation of federal law and to the detriment of the low-income women and men of Tennessee. Tennessee's efforts to exclude qualified providers from its Medicaid program, based on ideological objections to the provision of legal and constitutionally protected abortion services outside of the Medicaid program, should be rejected.

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, Tennessee’s application does not meet these requirements, and as a result, cannot be approved.

Freedom of Choice

Tennessee 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

A number of courts have 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 The Centers for Medicare & Medicaid Services (CMS) notably previously reached the same conclusion.⁷

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 *Planned Parenthood of Kansas and Mid-Missouri v. Andersen*, 882 F.3d 1205 (10th Cir. 2018); *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445 (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 South Atlantic v. Baker*, 2018 WL 4095594 (D.S.C. 2018); *Planned Parenthood of Greater Texas Family Planning & Preventive Health Servs., Inc. v. Smith*, 236 F. Supp. 3d 974 (W.D. Tex. 2017); *Planned Parenthood Southeast, Inc. v. Bentley*, 141 F. Supp. 3d 1207 (M.D. Ala 2015).

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

(noting that states may not target “disfavored providers” simply because they provide the “full

In its application, Tennessee admits that the proposal “does not reflect any comment on the part of TennCare regarding the quality of care furnished by these healthcare providers.” As CMS has historically recognized, Tennessee cannot use § 1115 to avoid the free choice of provider protections, as excluding providers for reasons unrelated to their qualifications does not further the objectives of the Medicaid Act.⁸

In addition, data out of the state of Texas 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. 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.”⁹ A 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.”¹⁰ 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.”¹¹ 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.¹² 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

range of 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”). In January 2018, CMS rescinded this supportive guidance and offered no sufficient rationale for its decision.

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), <https://senatorjoserodriguez.com/wp-content/uploads/2012/03/CMS-Letter-to-HHSC-re-WHP.12.12.2011.pdf>.

⁹ 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), <http://sites.utexas.edu/txpep/files/2017/04/White-et-al-Impact-of-Reproductive-Health-Legislation-AJPH-print-2015.pdf>; Tex. Health & Human Servs. Comm’n, *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).

¹⁰ 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), <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/womens-health-program-savings-performance-report-may-2018.pdf>.

¹¹ Kinsey Hasstedt and Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFAIRS BLOG, (July 18, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170718.061085/full/>, (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).

¹² *Id.*

from a private physician or physician practice.¹³ 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.¹⁴

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.¹⁵

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.¹⁶ 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.¹⁷ 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."¹⁸ Such barriers correlate with an increase in Medicaid-funded births in the State.¹⁹

¹³ 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>.

¹⁴ Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 5 (2017).

¹⁵ 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>.

¹⁶ Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016), <https://www.nejm.org/doi/full/10.1056/NEJMsa1511902>.

¹⁷ *Id.*

¹⁸ *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)), [https://www.contraceptionjournal.org/article/S0010-7824\(15\)30038-X/pdf](https://www.contraceptionjournal.org/article/S0010-7824(15)30038-X/pdf).

¹⁹ Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016), <https://www.nejm.org/doi/full/10.1056/NEJMsa1511902>.

The evidence from Texas is overwhelmingly clear - prohibiting low-income women from receiving family planning services from qualified providers because those providers perform abortion services or are affiliated with abortion providers reduces access to health care and places women's health at risk. In the waiver amendment application, the State dismisses these concerns expressed by commenters during the state comment period, while providing no evidence to support its position that this amendment will have no detrimental impact on access. 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, Tennessee's request to waive § 1396a(a)(23) must be rejected.

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,

A handwritten signature in cursive script that reads "Clare M. Coleman".

Clare Coleman
President & CEO