National
Family Planning
& Reproductive Health Association

November 28, 2019

Seema Verma, MPH
Administrator, Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on Idaho's Family Planning Referrals Section 1115 Demonstration Application

Dear Administrator Verma:

The National Family Planning & Reproductive Health Association (NFPRHA) welcomes the opportunity to comment on Idaho's Section 1115 demonstration entitled, "Idaho Family Planning Referrals." For the reasons outlined below, we urge the Department of Health and Human Services (HHS) to reject the application.

NFPRHA is a national, nonprofit membership organization comprised of hundreds of health care providers serving millions of low-income uninsured and underinsured patients each year in all fifty states and the District of Columbia.

NFPRHA is deeply concerned that the proposed waiver would create unnecessary and harmful barriers to accessing timely family planning services and supplies, leading to increases in unintended pregnancies and births and poorer health outcomes for patients. For this and other reasons, the application does not meet the requirements for approval under § 1115.

I. The waiver does not promote the objectives of the Medicaid Act, and is not approvable.

For the Secretary to approve Idaho's project pursuant to § 1115, it must:

- propose an "experiment[], pilot or demonstration;"
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- waive compliance only "to the extent and for the period necessary" to carry out the experiment.[1]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care.[2] As explained in detail below, Idaho's proposed project is inconsistent with the requirements of § 1115.

II. The waiver would restrict access to family planning services and supplies.

Idaho's waiver proposal would unnecessarily restrict Medicaid enrollees' access to essential family planning and sexual health services, causing extreme harm to their health.
Medicaid is an essential source of health coverage for women of reproductive age, covering 21% of U.S.

[1] 42 U.S.C. § 1315(a).
[2] *Id*. § 1396-1.

women ages 15–44 in 2017 and 50% of U.S. women with incomes below the federal poverty line.[3]

Medicaid is central to the U.S. family planning effort. Federal Medicaid law and regulations include strong protections for coverage of family planning services and supplies, without cost-sharing and free of coercion. Medicaid accounts for 75% of all public dollars spent on family planning in the United States.[4] That overall U.S. family planning effort helped women and couples avoid two million unintended pregnancies in 2016, and the unplanned births, abortions, and miscarriages that would otherwise follow.[5]

Medicaid helps patients address risk for HIV and other STIs, breast and cervical cancer, intimate partner violence, and other reproductive health–related issues. That includes vaccinations (such as for human papillomavirus), screening and testing services (such as Pap tests and STI tests), treatment services (ranging from antibiotics for chlamydia to radiation therapy for cancer), and counseling and referral (including for non-medical support services).

All of these services are necessary for the health and well-being of Medicaid enrollees over the course of their whole lives. For example, the typical U.S. woman spends roughly three years pregnant, postpartum, or attempting to become pregnant (and therefore in need of pregnancy-related care) and about three decades trying to avoid pregnancy (and therefore in need of contraceptive care).[6] In addition, all sexually active people may be at risk of HIV and other STIs, and continue to be at risk of reproductive health–related cancers for decades. Restricting access to these critical reproductive health services would inevitably lead to harm.

a. The state's proposal runs counter to the principles of freedom of choice and direct access.

Federal law has long recognized the importance of timely access to family planning services and supplies and protected this access from unnecessary and harmful barriers. For example, as was clarified in 2016, female enrollees in Medicaid managed care plans are guaranteed direct access to a women's health specialist "in addition to the enrollee's designated source of primary care if that source is not a women's health specialist."[7] This provision reduces barriers to access for patients seeking family planning services, and is a critical beneficiary protection. Federal law guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if that provider is outside of the beneficiary's Medicaid managed care network; this principle is referred to as "freedom of choice."[8] Beneficiaries have the right to receive family planning services and supplies from both in- and out-of-network providers, without restrictions as to their choice of provider or contraceptive method,[9] and without additional costs to beneficiaries for family planning services received out-of-network.[10] Yet Idaho's proposed waiver would run directly counter to these principles, imposing a gatekeeper to family planning care, with no countervailing benefit for enrollees.

Section 1396a(a)(23) ensures that Medicaid patients can receive medical services "from any

[3] Guttmacher Institute, Gains in insurance coverage for reproductive-age women at a crossroads, *News in Context, Dec.* 4, 2018, https://www.guttmacher.org/article/2018/12/gains-insurance-coverage-reproductive-age-women-crossroads .
[4] Hasstedt K, Sonfield A and Gold RB, Public Funding for Family Planning and Abortion Services, FY 1980–2015, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.
[5] Frost JJ, et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, New York: Guttmacher Institute, 2019, https://www.guttmacher.org/report/publicly-supported-FP-services-US-2016 .
[6] Sonfield A, Hasstedt K and Gold RB, Moving Forward: Family Planning in the Era of Health Reform, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.
[7] 42 CFR § 438.206(b)(2).
[8] 42 U.S.C. § 1396a(a)(23); 42 U.S.C. § 1396n(b).
[9] 42 U.S.C. § 1396(a)(23)(B); 42 C.F.R. § 441.20.
[10] 42 U.S.C. §§ 1396o(a)(2)(D) and (b)(2)(D); 42 C.F.R. § 447.56(a)(2)(ii); 42 U.S.C. § 1396u-2(b)(6)(C).

institution, agency, community pharmacy, or person, qualified to perform the service or services . . . who undertakes to provide . . . such services."[11] 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.[12]

Indeed, CMS has previously noted that a waiver seeking to circumvent Medicaid's freedom of choice protections for family planning cannot be approved.[13]

The state's proposed waiver of freedom of choice, requiring Medicaid participants to obtain a referral from their primary care provider (PCP) prior to obtaining family planning services from any other provider, would at minimum delay, if not effectively eliminate, the ability of some Medicaid beneficiaries' to receive family planning services.

Idaho's proposed waiver of freedom of choice is, in reality, an attempt to prevent abortion providers, including Planned Parenthood, from participating in their state Medicaid programs. The legislative history of Senate Bill 1204 and several media articles reveal the true motivations behind the waiver: to restrict patients from accessing Planned Parenthood health centers.[14]

Idaho asserts that the waiver's purpose is to increase interactions with the primary care provider, which purportedly would result in better health outcomes for participants and cost savings for the state. Even assuming those are Idaho's true goals, the proposal will not achieve them, as described in detail in section III below.

There is ample evidence showing that prohibiting low-income women from receiving family

[11] 42 U.S.C. § 1396a(a)(23).
[12] 42 U.S.C. §§ 1396a(a)(23)(B), 1396n(b).
[13] In denying a 2011 waiver request from Texas, CMS rightly further stated, "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. 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).
[14] In a House Committee hearing on March 20, 2019, Representative Ilana Rubel (D-18) questioned one of the sponsors of the bill, "This legislation...aims to force them away from using Planned Parenthood, and actually...that's costly as well. My understanding is that's $200,000 for just that piece [the referral requirement]...If the goal is to allow people to stay with their preferred providers…[why is] this portion that forces people away from Planned Parenthood when that is their preferred provider?" H. 277, Idaho Health & Welfare Committee Audio (Mar. 21, 2019), available at https://legislature.idaho.gov/sessioninfo/2019/standingcommittees/HHEA/. Moreover, in a following Senate Committee hearing on March 27, 2019 Senator Maryanne Jordan (D-17) reiterated that lawmakers had been "getting a huge number of phone calls and emails saying that people want us to support this bill [SB 1204] because this language will defund Planned Parenthood." H. 277, Idaho Senate Health & Welfare Committee Audio (Mar. 27, 2019), available at https://legislature.idaho.gov/sessioninfo/2019/standingcommittees/SHW/. In addition, other lawmakers, such as former Representative Ron Nate, also expressed support for the bill, which "diverts money from Planned Parenthood abortion centers and redirects it to true family care centers who favor protecting life rather than murdering innocent babies." Nate, Ron, "Disappointed in Raybould," Post Register (Apr. 3, 2019), available at https://www.postregister.com/opinion/columns/disappointed-in-raybould/article_bb5e4949-fb10-560e-91d0-b7c9b134a41c.html. Finally, a recent column revealed that this legislation was sponsored by anti-choice group Idaho Chooses Life and its Director, David Ripley, stated that he is "not aware of any other viable strategy for states to sever their...partnership with Planned Parenthood." Fischer, Bryan, "A novel way to defund Planned Parenthood," ONE News Now (Oct. 31, 2019), available at https://onenewsnow.com/perspectives/bryan-fischer/2019/10/31/a-novel-way-to-defund-planned-parenthood. Taken together, these statements make it clear this legislation and waiver is a targeted attack towards defunding Planned Parenthood.

planning services from the qualified provider of their choice reduces access to health care and places women's health at risk.[15] For all these reasons, Idaho's proposed waiver of freedom of choice lacks any experimental value and runs counter to the purpose of the Medicaid program, and therefore must be rejected.

b. The state's proposed cost sharing would both violate the Medicaid Act and restrict access to services

The Medicaid Act requires states to cover family planning services and supplies[16] and prohibits them from charging any cost sharing for that care.[17]

Although Idaho states in its waiver proposal that the waiver "will not impose any new cost-sharing on beneficiaries seeking family planning services,"[18] this is simply untrue. As commenters at the state level pointed out, Medicaid enrollees "would be subject to a copayment charge of $3.65 for an office visit to the primary care provider to obtain the referral to the chosen provider of family planning services."[19] This cost sharing violates the Medicaid Act. To impose the charge, Idaho would need to request a waiver under section 1396o(f), which it has not done. Even if the state were to have requested that waiver authority, the proposal could not be approved, as the project does not (and cannot) meet the conditions set forth in that provision.

In addition, there is ample evidence that the charge will be a significant barrier to obtaining care. According to a comprehensive literature review conducted by the Kaiser Family Foundation, "a wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services."[20] Furthermore, research has shown that cost-sharing can decrease adherence to medications among individuals with low incomes and deter individuals from seeking care at all.[21]

Moreover, the proposed waiver fails to consider significant additional costs it would impose on patients. For many patients, making an extra visit to a primary care provider purely to obtain a referral could mean lost wages for those without paid leave and additional expenses for child care and transportation. For example, only 31% of workers in the lowest-wage jobs have access to paid sick days.[22]

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[15] *See* 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); 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); Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016); C. Junda Woo et al., *Women's Experiences After Planned Parenthood's Exclusion from a Family Planning Program in Texas,* 93 CONTRACEPTION 298 (2016).

[16] 42 U.S.C §§ 1396a(a)(10)(A), 1396d(a)(4)(C).

[17] 42 U.S.C §§ 1396o(a)(2)(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii); 42 CFR § 447.53(b)(5).

[18] Idaho Department of Health and Welfare, Division of Medicaid, "Idaho Family Planning Referrals, Section 1115 Medicaid Waiver Demonstration Project Application," October 18, 2019, page 18.

[19] Idaho Department of Health and Welfare, Division of Medicaid, "Idaho Family Planning Referrals, Section 1115 Medicaid Waiver Demonstration Project Application," October 18, 2019, page 17.

[20] *See* Samantha Artiga, Petry Ubri, and Julia Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* ((Washington, DC: Kaiser Family Foundation, June 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[21] Powell, V., Saloner, B., & Sabik, L. M. (2016). Cost Sharing in Medicaid: Assumptions, Evidence, and Future Directions. *Medical care research and review : MCRR*, *73*(4), 383–409. doi:10.1177/1077558715617381

[22] Bureau of Labor Statistics, Employee benefits in the United States–March 2019, https://www.bls.gov/news.release/pdf/ebs2.pdf.

c. The state's proposal will entrench barriers to care due to religious refusals and amplify their impact.

Access to family planning providers without a referral is critical to ensuring Medicaid enrollees are not denied care due to providers' or institutions' objections. The proliferation of health care institutions in Idaho that do not provide or refer for family planning services means that many individuals seeking family planning care already face challenges accessing it.[23] The state's proposed waiver will exacerbate that problem - people would not be able to get a referral from many institutions or providers in the state, meaning they would not receive the care they need, either in a timely manner or at all.[24]

The state defends its proposal by pointing out that enrollees can switch primary care providers at any time if the primary care provider limits treatment options on moral or religious grounds. While important, this protection is not enough. Medicaid enrollees seeking family planning care should never face a delay or denial of care, particularly for a time-sensitive service like family planning. Moreover, Medicaid enrollees in Idaho likely will have difficulty determining which primary care providers do not provide (and refuse to refer for) family planning care. Low-income women seeking care are less likely than other women to be able to identify that a health care institution is religiously affiliated or the restrictions on reproductive health care that result from that affiliation.[25] Thus, they are less likely to avoid those institutions altogether and more likely to be refused care, including referrals. Faced with yet another barrier to care, some people will be forced to delay getting a referral and the care they need, while others will be unable to access it at all, leaving them at risk for unintended pregnancies.

III. Research shows that the project will not achieve Idaho's stated goals.

As described above, the Idaho Department of Health and Welfare proposal to require referral for family planning services will delay and interfere with access to family planning care, as well as other preventive services, resulting in reduced access to care and more unintended pregnancies. As a result, the project will likely lead to worse health outcomes for Medicaid enrollees.

a. Unrestricted access to Medicaid–supported family planning improves health outcomes.

At last estimate, Medicaid accounted for 58% of all public dollars spent on family planning in Idaho.[26] This investment is central to the family planning services provided by publicly supported

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[23] Health care providers invoke personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control and sterilization. *See, e.g., Health Care Refusals Harm Patients: The Threat to Reproductive Health Care*, Nat'l Women's Law Ctr. (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf.; *see also Health Care Denied*, Am. Civil Liberties Union (May 2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

[24] For example, Catholic-affiliated institutions have already saturated the hospital industry in Idaho. Over a quarter of all hospital beds in Idaho are at Catholic-affiliated institutions. (http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=l4u%2BGse9t2XPa0Z5MXTLiHhGNmI%3D) In the Lewiston, ID area, St. Joseph Regional Medical Center is the sole community hospital, but it restricts access to family planning. (http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=l4u%2BGse9t2XPa0Z5MXTLiHhGNmI%3D) Similar trends have been increasing among private health care practices affiliating with large Catholic healt hcare entities and ceasing to provider family planning services.

[25] https://onlinelibrary.wiley.com/doi/full/10.1363/psrh.12118

[26] Hasstedt K, Sonfield A and Gold RB, *Public Funding for Family Planning and Abortion Services, FY 1980–2015,* New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.

health centers in Idaho, which collectively served about 21,000 female contraceptive patients in 2016, helping them avoid about 4,500 pregnancies and 1,500 abortions.[27]

By helping people avoid pregnancies they do not want and time and space the pregnancies they do want, contraceptive use also decreases pregnancy-related illness, injury, and death, especially for women who have medical conditions that may be exacerbated by pregnancy.[28] While Idaho suggests that the project will lead to better birth outcomes, research shows that restricting access to contraceptive services will have the opposite result. By helping women to plan and space wanted pregnancies, contraceptive use has the potential to reduce the risk of having a premature or low-birth-weight delivery. In addition, pregnancy planning can allow women to address chronic conditions before they become pregnant and to start prenatal care as early as possible in pregnancy; both of those steps also have the potential to improve maternal and infant health outcomes. Moreover, the other preventive services offered as part of a family planning visit can help people avoid or address HIV and other STIs, infertility, cervical cancer, intimate partner violence, and other negative health outcomes.

b. Previous efforts to undermine access to family planning services have led to poorer health outcomes.

Efforts by other states to interfere with access to family planning providers for Medicaid enrollees have had devastating consequences. For example, after CMS denied Texas' request to exclude abortion providers from its Medicaid family planning expansion project, the state chose to forgo federal funding and run the project with the provider exclusion in place. Research shows that the provider exclusion severely restricted access to family planning services across the state.[29] Utilization of contraception among women enrolled in the Texas program dropped significantly, leading to increases in Medicaid-funded births, significantly decreased rates of clinical breast exams, cervical cancer screenings, and for some women, secondary health care services such as mammograms (for which family planning providers refer patients if they are unable to provide these on-site).[30]

As the case study from Texas makes abundantly clear, erecting barriers for low-income individuals to receive family planning services from qualified providers of their choice reduces access to health care and puts individuals' health at risk. Idaho's application acknowledges that

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[27] Frost JJ et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016,* New York: Guttmacher Institute, 2019, https://www.guttmacher.org/report/publicly-supported-FP-services-US-2016.

[28] Kavanaugh ML and Anderson RM, Contraception and Beyond: *The Health Benefits of Services Provided at Family Planning Centers,* New York: Guttmacher Institute, 2013, http://www.guttmacher.org/pubs/health-benefits.pdf.

[29] Kinsey Hasstedt and Adam Sonfield, At It Again: Texas Continues to Undercut Access to Reproductive Health, HEALTH AFFAIRS BLOG (Jul. 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 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386528/pdf/AJPH.2014.302515.pdf, (reporting that prior to the exclusion, nearly half of all enrollees received services at Planned Parenthood clinics); Tex. Health & Human Servs. Comm'n, 2010 Annual Savings and Performance Report for the Women's Health Program at 5 (2011) (reporting that 80% of program enrollees who received services in 2010 did so at a dedicated family planning health center).

[30] See Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance at 8, https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/former-tx-womens- health-program-fy2015-savings-performance.pdf (reporting a 32% decrease in claims for contraceptive injections, 47% decrease for oral contraceptives, and 59% decrease for condoms). See also Stevenson AJ, Flores-Vazquez IM, Allgeyer RL, Schenkkan P, Potter JE. Effect of removal of Planned Parenthood from Texas's Women's Health Program. N Engl J Med. 2016;374(9):853–860 (Mar. 3, 2016), available at http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article; Yao Lu & David J.G. Slusky. "The Impact of Women's Health Clinic Closures on Preventive Care." 8 Am. Econ. J.: App. Econ. 100 (Jul. 2016), available at https://pubs.aeaweb.org/doi/pdfplus/10.1257/app.20140405.

39 of the state's 44 counties are considered health professional shortage areas.[31] That evidence underscores the need for significantly increased – not obstructed – access to family planning.

c. Specialized family planning providers play a unique role in serving the needs of low-income populations.

Family planning providers often serve as an entry point to health care for patients, providing family planning and other preventive services and connecting individuals to primary care providers and specialists. In many cases, these providers may be the only health care providers that a patient sees all year. For example, in a 2016 survey, 60% of patients at Title X–supported family planning health centers said that the site where they sought family planning care was their only source of broader health care over the past year.[32] Requiring a referral from a primary care provider—a provider the patient may have little or no relationship with—may lead many of these patients to forgo care altogether.

In its waiver application, the Idaho Department of Health and Welfare claims that requiring referrals for family planning will improve patients' "perceptions of primary care engagement, including the convenience of receiving all their care within one care organization/location." Yet, there is nothing stopping Medicaid patients now from receiving all of their care, including family planning services, from a primary care provider, if that is their preference *and* if their primary care provider offers such care.

What Idaho ignores is that many patients prefer, and receive better, more comprehensive family planning care at providers that specialize in reproductive health care. Six in 10 women obtaining services at a reproductive health–focused provider report having made a visit to another provider in the last year, but chose the specialized provider for their contraceptive care; the remaining four in 10 of these women report that the reproductive health–focused provider was their only source of care in the last year, despite having other options in their communities.[33]

Indeed, many patients choose such providers, even when there is a primary care-focused site available, because they feel more respected, know they are able to obtain confidential services, and recognize that staff members at specialized providers are especially well-versed in family planning and sexual health.[34] In addition, research indicates that the quality of care at specialized providers is higher.[35]

Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Certain groups, including adolescents

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[31] ID waiver application, at 20, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/id/id-family-planning-referrals-pa.pdf.

[32] Kavanaugh ML, Zolna MR and Burke KL, Use of health insurance among clients seeking contraceptive services at Title X-funded facilities in 2016, *Perspectives on Sexual and Reproductive Health,* 2018, 50(3):101–109, https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x.

[33] Frost J, Gold RB and Bucek A, Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs, *Women's Health Issues,* 2012, 22(6):519–525,https://www.guttmacher.org/article/2012/11/specialized-family-planning-clinics-united-states-why-women-choosethem-and-their.

[34] *See* Frost et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, at 519.

[35] Zolna MR and Frost JJ, Publicly Funded Family Planning Clinics in 2015: *Patterns and Trends in Service Delivery Practices and Protocols,* New York: Guttmacher Institute, 2016, http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.

and young adults, and people at risk of domestic or intimate partner violence, have special privacy concerns.[36] Decades of research findings have shown that privacy concerns influence the behavior of patients with respect to whether they seek care, where they do so, which services they accept, and how candid they are with their health care providers.[37] This data suggests that some individuals might delay seeking family planning services or forgo that care entirely if they are unable to visit the specialized provider of their choice without barriers.

d. Idaho's proposed waiver cannot be approved because it is not budget neutral.

It is long-standing HHS policy that Section 1115 waivers must be at least budget neutral to the federal government. This means that federal Medicaid expenditures with this demonstration project must not be greater than federal expenditures without the demonstration.[38] Family planning services have the added benefit of federal and state savings. In 2016, the family planning services provided by Idaho clinics (funded primarily through Medicaid) resulted in $11.2 million in net government savings, or close to $5 saved for every public dollar invested.

However, Idaho's waiver proposal will not continue this savings trend and will likely increase federal Medicaid expenditures. By restricting Medicaid enrollees' access to specialized family planning providers, Idaho will likely see an increase in undiagnosed cancers, untreated STIs, and unintended pregnancies, all of which would increase federal Medicaid costs.

For all of these reasons, Idaho's waiver proposal should not be approved.

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NFPRHA appreciates the opportunity to comment on Idaho's proposed § 1115 project. If you require additional information about the issues raised in this letter, please contact Mindy McGrath at mmcgrath@nfprha.org or 202-552-0144.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO

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[36] Pamela J. Burke et al., *Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine*, 54 J. ADOLESCENT HEALTH 491, 491-496, (2014), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf; Diane M. Reddy, Raymond Fleming, & Carolyne Swain, *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 J. AM. MED. ASS'N 710, 710–714 (2002); 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 J. AM. MED. ASS'N 340, 340–348; Liza Fuentes, Meghan Ingerick, Rachel Jones, & Laura Lindberg, *Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. ADOLESCENT HEALTH 36, 36-43; *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings,* Family Violence Prevention Fund (2004), http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf.

[37] Pamela J. Burke et al, *Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine*, 54 J. ADOLESCENT HEALTH 491, 491-496, (2014), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf; Alina Salganicoff, Usha Ranji, Adara Beamesderfer, and Nisha Kuran, *Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey*, Henry J. Kaiser Family Foundation, 28, 38-39 (2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf.

[38] CMS, State Medicaid Director Letter (Aug. 22, 2018), available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf.