

August 4, 2017

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

Via electronic submission: <https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1891235>

Re: Comments on the Healthy Texas Women Section 1115(a) Demonstration Waiver Application

Dear Administrator Verma:

The Center for Public Policy Priorities appreciates the opportunity to comment on the Texas Health and Human Services Commission's (HHSC) application to request a new waiver under Section 1115(a) of the Social Security Act for the Healthy Texas Women Section demonstration. For the reasons outlined below, we urge you to reject the application as proposed.

The Center for Public Policy Priorities (CPPP) is a nonpartisan, nonprofit 501(c)(3) public policy organization that uses data and analysis to advocate for solutions that enable Texans of all backgrounds to reach their full potential. Improving access to health care for Texans has been at the core of our mission and activities since our founding more than 30 years ago. CPPP has been a vocal advocate for improving access to publicly funded, quality family planning services because making sure that all Texans have access to the tools they need to plan the timing and size of their families is a critical piece of the puzzle in building equal economic opportunity for Texans.

Requirements for § 1115 Waivers

The Secretary may only approve an application under § 1115 of the Social Security Act that meets the following requirements:

- The waiver must implement an “experimental, pilot, or demonstration” project;
- The waiver must be limited to Medicaid provisions in 42 U.S.C. § 1396a (Section 1902 of the Social Security Act);
- The experiment must be likely to promote Medicaid’s objectives; *and*
- The waiver of Medicaid’s requirements must be limited to the extent and period needed to carry out the experiment.¹

The general criteria that CMS uses to determine whether a demonstration will promote Medicaid program objectives include whether the demonstration will:²

1. increase and strengthen overall coverage of low-income individuals in the state;
2. increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;

¹ 42 U.S.C. § 1315(a)

² About Section 1115 Demonstrations, <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.

3. improve health outcomes for Medicaid and other low-income populations in the state; or
4. increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations must also be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the demonstration.³

With this as background, we will address Texas' application below. In summary, Texas' application does not meet the requirements for a § 1115 waiver, and thus, 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 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.

³ Ibid

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).

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).

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

After Texas implemented a provider exclusion, access to qualified, trusted family planning providers was severely curtailed and many women lost access to covered services as a result. CPPP documented program outcomes using the most recent data available from the state and academic research between FY 2011 and FY 2016—pre- and post-provider exclusion in Texas—in a report that we have attached to these comments. Key findings include:

- Provider capacity to deliver health care in the Texas Women's Health Program declined after Planned Parenthood was excluded, despite substantial efforts from the state that greatly increased the number of participating providers.
- After Planned Parenthood was excluded, fewer women accessed health care through the program generally and contraception specifically. The sharp declines in women accessing services and contraception raise troubling questions about the ability of the program with its provider exclusion to achieve its primary intention of helping women avoid unintended pregnancies.

We look more closely at these finding below.

⁹ Tex. Health & Human Servs. Comm'n, *2010 Annual Savings and Performance Report for the Women's Health Program*, (2011).

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/>.

Network capacity to deliver covered services is greatly diminished

HHSC data published in March 2017 show a significant decline from FY 2011 to FY 2015 in program participation by high-volume providers.¹² The average number of clients receiving services per provider fell from 150 clients per provider during FY 2011 to 103 clients per provider during FY 2015. Over the same period the state added many providers to the program who serve relatively few clients, increasing the unique number of certified providers from 1,328 in FY 2011 to 4,603 in FY 2015.¹³ However, the state's efforts to sign up providers failed to address capacity issues, as evidenced by a sharp drop in the number of clients served, the percentage of enrolled women who actually received health care services, and the number of clients who received contraception, even as the number of providers technically certified climbed. HHSC added 3,695 providers to the Women's Health Program and successor programs between FY 2010 and FY 2016, yet over the same period, 36,375 fewer women received health care services – for each nominal provider added to the program, 10 women lost health care services.

It has always been the case in the Women's Health Program and successor programs that a relatively small number of high-volume, safety-net providers deliver the bulk of the services, while many "enrolled" providers serve no women at all and others serve just one or two per year. In FY 2010, 62 percent of WHP participating providers served 10 or fewer clients.¹⁴ Given this well-known dynamic, the raw number of providers enrolled is an essentially meaningless number and the growth over time in unique providers signed up in no way reflects the capacity of the provider network—yet HHSC relies on these metrics in the draft waiver application and elsewhere without providing an alternate, more meaningful way to evaluate network capacity.

Fewer Women Received Health Care, Including Contraception

According to HHSC data, the number of women enrolled in the Women's Health Program/Texas Women's Health Program/Healthy Texas Women declined by 26 percent from FY 2011 to FY 2016, from 127,536 to 94,851 women.¹⁵ The decline in access to services was even more severe – the number of women getting health care services in the program declined 39 percent, from 115,226 in FY 2011 to 70,336 in FY 2016. This dynamic – access to services dropping even faster than enrollment – points to serious issues with provider capacity. In FY 2011, 90 percent of all women enrolled in the Medicaid Women's Health Program accessed health care services. By FY 2016, only 74 percent of women enrolled in the Texas Women's Health Program/Healthy Texas Women received health care services (see Figure 2). In other words, by FY 2016, one in four women technically enrolled in the Texas Women's Health Program/Healthy Texas Women were never seen by a health care provider for covered family planning services.

¹² Health and Human Services Commission, "Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance," House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 41), March 2017. <https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance>.

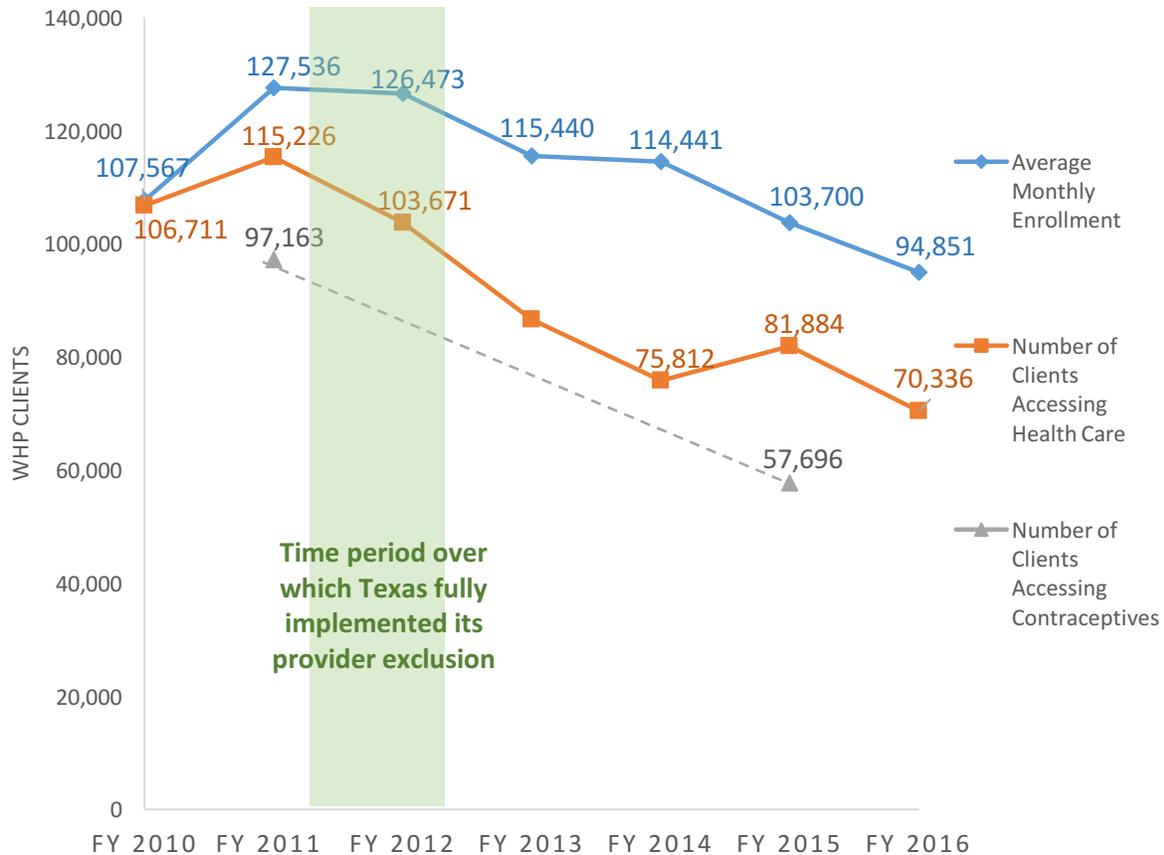
¹³ Texas Health and Human Services, HHS Women's Health Update, April 2017, Slide 23, http://d31hzhk6di2h5.cloudfront.net/20170508/c5/6d/0e/8c/2da14dec29fc4aecabb2863/HHSC_Presentation_April_2017_1_.pdf.

¹⁴ Shin, P., Sharac, J., and Rosenbaum, S., "An Early Assessment of the Potential Impact of Texas' 'Affiliation' Regulation on Access to Care for Low-Income Women," Geiger Gibson / RCHN Community Health Foundation Research Collaborative, 2012, <http://www.rchnfoundation.org/wp-content/uploads/2013/02/GG-FP-study-0504-revised.pdf>.

¹⁵ Texas Health and Human Services, HHS Women's Health Update, May 15, 2017, Slide 13, <https://hhs.texas.gov/sites/hhs/files/documents/about-hhs/leadership/advisory-committees/whac/zika-may-15-2017/whac-women-health-update-may-15-2017.pdf>. Data for FY 2016 combines the unduplicated client counts for women enrolled and clients served for the Texas Women's Health Program, which ended in June 2016, and HTW, which started in July 2016.

The number of women specifically accessing contraceptives (as opposed to other covered services) also dropped sharply, from 97,163 in FY 2011 to 57,696 in FY 2015, a drop of 41 percent.¹⁶ This sharp drop cannot be explained by overall declining enrollment and declining services in the program. During the same time enrollees accessing contraceptives fell by 41 percent, enrollees accessing any health care service in the program dropped by only 29 percent.

Access to Family Planning Services and Contraception Declined Sharply in the Texas Women's Health Program After Provider Exclusions Were Implemented



Source: HHSC, *HHS Women's Health Update, May 15, 2017 and Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance, March 2017*. Number of clients who accessed contraceptives is available only for fiscal years 2011 and 2015. Data for FY 2016 combines the unduplicated client counts for women enrolled and clients served for the Texas Women's Health Program, which ended in June 2016, and HTW, which started in July 2016. Time period over which Texas fully implemented its provider exclusion: Texas submitted waiver application that included provider exclusions in Oct 2011 and final program reimbursements to excluded providers were made in Dec 2012.

As HHSC notes in its report, some of the decrease in access to contraceptives in any one year can be explained by the small increase (5.4 percent increase from FY 2011 to FY 2015) in women choosing long-acting reversible contraception (LARC) methods, which often do not necessitate annual visits/services.

¹⁶ HHSC, "Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance," March 2017. FY 2015 data for the number of clients who accessed contraception is the most recent available.

While true, the estimated number of program clients who have received LARC since FY 2011 is not high enough to fully explain why 39,500 fewer enrollees received contraception between FY 2011 and FY 2015.¹⁷

It is troubling that even among the declining share of enrollees who accessed any health care services, fewer still received a contraceptive method. These data point not only to issues with provider capacity in general, but raise questions about the ability of the program's remaining provider network in general, with exclusions in place, to facilitate a patient's choice and use of a contraceptive method.

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.

Financial Eligibility and Modified Adjusted Gross Income (MAGI)

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.

¹⁷ This section of comments was revised after it was submitted, to correct an error. HHSC's data provides LARC client counts for only FY 2011 (6,264 clients getting LARC) and FY 2015 (6,581 clients getting LARC). The number of women getting LARC in the intervening years would need to be taken into account to determine if the total number of clients established on LARC, and therefore not needing other contraceptives for some number of years, could account for the total drop in contraceptive clients of 39,467 women from FY 2011 to FY 2015. To be conservative, we assumed that 6,581 clients accessed LARC in each of FY 2012, 2013 and 2014—the same number as received LARC in 2015. Taken together, we conservatively estimate that 26,000 program clients accessed LARC from FY 2011-14, which would only explain about two-thirds of the drop in women accessing contraceptives in the program.

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).

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 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 subsidies for 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.

Reasonable Opportunity to Provide Verification of Citizenship or Immigration Status

As stated in the application, federal regulations require the state Medicaid agency to enroll otherwise-eligible applicants who have attested to be U.S. citizens or to have an eligible immigration status for a period of 90 days during which they can receive services. The clients must provide adequate proof of citizenship or immigration status by the end of those 90 days in order to remain enrolled (42 CFR §435.956(a)(5)). Medicaid rules (42 CFR § 435.406(ii)) make clear that this provision must also apply to “applicants under a section 1115 demonstration (including a family planning demonstration project).”

This provision allows clients to begin immediately receiving health services while they work with the agency in gathering adequate documentation. This process helps to streamline enrollment and supports the overall goals of the Medicaid program. In the waiver application, the state proposes to not follow these federal requirements and instead delay coverage until after verifying status and deny coverage to new applicants unable to verify status within 30 days and renewal applicants unable to verify within 10 days. The state does not provide a justification for ignoring federal requirements other than to maintain the current program’s policies.

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 proposed process would delay enrollment and receipt of services for those women who are found to be otherwise eligible, but whose citizenship or immigration status cannot be immediately verified using electronic verification sources.

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.

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 proposed 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.²⁴ There is simply no legitimate reason for Texas to use a more onerous process that will prevent many eligible women from maintaining HTW coverage.

Minor Consent for Enrollment and Services

The HTW waiver application indicates that only a parent or legal guardian can only apply for HTW on behalf of a minor, a continuation of the policy in place today for the existing program. This would operate as a de facto parental consent/notification requirement for family planning services that runs counter to public health policy and Texas' stated purpose of its project. Furthermore, this policy conflicts with federal Medicaid regulations at 42 CFR §435.907 that require states to allow "someone acting responsibly for the applicant" to be able to submit an application on behalf of the minor.

In addition, while the language in the waiver application is somewhat unclear, it appears that Texas' application also includes a parental consent/notification requirement for services. Today in HTW, a minor age 15-17 has to get consent from parent, managing conservator, or guardian for HTW services other than pregnancy testing, HIV/STD testing, and STD treatment. Parental consent for contraception is required as a separate step, after a parent or legal guardian has already applied for the program on behalf of the teen. The waiver makes clear that Texas is proposing no changes to current program policy or practice, but is instead planning to "maintain current program policy for the HTW demonstration."

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.²⁵ For example, nearly half of single, sexually active females under the age of 18 surveyed in family planning

²⁴ 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).

²⁵ 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*

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.²⁶ 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.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

Parental consent for family planning services is unnecessarily burdensome and, for some teens, will impose insurmountable barriers to care. Texas' teen pregnancy rate is well above the national average, and Texas has the worst rate of repeat teen pregnancy. Given these serious public health challenges, Texas should focus on eliminating obstacles to timely and comprehensive family planning services.

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.

Experiment or Demonstration and Budget Neutrality

Federal law requires that a waiver must implement an "experimental, pilot, or demonstration" project and policy requires that demonstrations must also be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the demonstration.²⁹ Texas' application fails both of these tests.

The Texas application makes clear that the state is seeking a waiver to simply refinance an existing program that is fully state funded and to do so without making any changes to the program. In response to public comments received by the state, the state repeatedly refuses any changes to the existing

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).

²⁶ Reddy DM et al., *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 JAMA 710 (2002).

²⁷ *Id.*

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 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).

²⁹ 42 U.S.C. § 1315(a) and About Section 1115 Demonstrations, <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>

program, even to come into compliance with federal law, in service of “maintaining current program policy.” The project described in the application is not an experiment, pilot, or demonstration.

The proposed project would also fail to be budget neutral for the federal government. The project would supplant existing state dollars with federal ones with no additional savings created. The state’s budget neutrality calculations compare the costs/savings under the proposed waiver to a fictitious scenario in which the state ends the state-funded program in the absence of the waiver. As Texas clearly states in its application, “HHSC does not intend to end the program if this application is not approved.” The intention to continue running the program with state-only funding if federal funding is not available conforms with the intent of the Texas Legislature. Key budget writers clearly stated their intent to continue and fully fund with state dollars the Healthy Texas Women Program in the event that a federal waiver was delayed or denied during the process to adopt the state budget during the 85th Regular Session of the Texas Legislature.

To truly determine the costs to the federal government with and without a waiver, CMS would need to consider the costs and savings that accrue to federal sources with the existing program (which has no federal costs) and under the waiver (which has a cost of over \$300 million to the federal government over 5 years and no additional savings above what the state-funded program produces). In other words, the Texas proposal is in no way budget neutral for the federal government.

Thank you for consideration of our comments on this waiver application. If you have any questions regarding these comments, please contact Stacey Pogue, senior policy analyst with the Center for Public Policy Priorities at pogue@cPPP.org or (512) 320-0222 x 117.

Sincerely,

A handwritten signature in black ink that reads "Stacey Pogue". The signature is written in a cursive, flowing style.

Stacey Pogue
Senior Policy Analyst

Excluding Planned Parenthood has been Terrible for Texas Women

AND TEXAS STILL WANTS MEDICAID TO PAY FOR ITS BAD IDEA

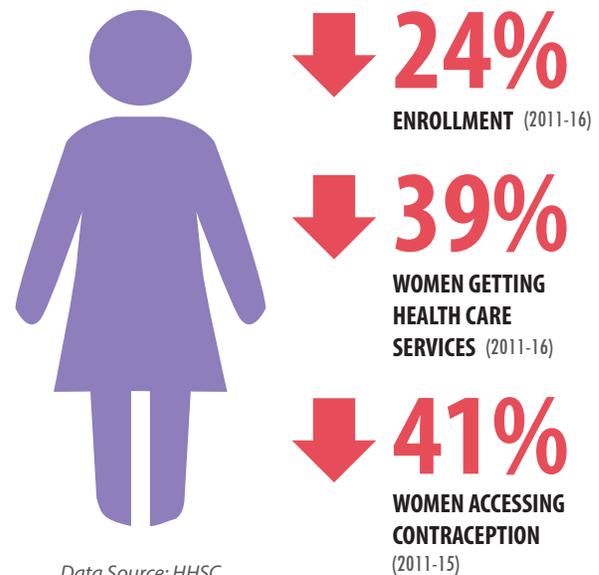
Summary

The stakes are high as Texas, once again, asks for permission to use federal Medicaid funds for a family planning program that excludes Planned Parenthood – this time asking the Trump administration. This paper reviews what we have learned over the last four-and-a-half years since Texas took the ill-advised step of removing its largest family planning provider, Planned Parenthood, from the Women’s Health Program.

Overwhelming evidence shows that women in Texas lost access to critical health care services after Planned Parenthood was excluded. Texas’ efforts to boost provider enrollment after removing Planned Parenthood resulted in thousands of additional providers technically signed up for the program, but failed to address the network capacity issues created by the state’s actions. It is time to reverse course. Given the Texas track record, it should be clear to the federal government and other states wanting to avoid Texas’ missteps that excluding efficient and trusted family planning providers, like Planned Parenthood, from women’s health programs runs directly counter to the goal of expanding access to family planning services and causes unnecessary harm to women, their families, and the state.

WOMEN’S HEALTH PROGRAM

Texas Women Lost Access to Health Care After State Excluded Planned Parenthood



Ensuring all Texans have access to family planning services so they can plan the timing and size of their families is critical to building equal economic and social opportunity. In addition, family planning helps women avoid unplanned pregnancy and prepare for healthy pregnancies, improving the well-being of both women and their babies.

Texas has a large and growing unmet need for affordable family planning services, but has made ill-advised and politically motivated decisions that limit access to critical services. The results have been harmful

to Texas women and families. Texas' most recent step could set a dangerous national precedent, so it's critical that we explore the history and implications of this policy decision.

On June 30, 2017, the state formally asked the federal Medicaid program to pay for an existing, state-funded family planning program called Healthy Texas Women, even though the program excludes Planned Parenthood. Planned Parenthood is an essential part of the fabric of the family planning safety net in Texas, relied on by low-income and uninsured Texans to provide birth control, cancer screenings, and other preventive health care. Texas forfeited the same federal Medicaid funding it now seeks at the end of 2012 when, in an earlier version of the program, the state banned all providers that "affiliate with entities that perform or promote elective abortions." This move, which conflicted with federal law, was explicitly aimed at removing Planned Parenthood from the program. Outcomes from this policy change have been extensively studied over the last four-and-a-half years. Overwhelming evidence shows that, after Planned Parenthood was removed from the program, women in Texas lost access to critical health care services.

As Texas asks again for permission to use federal Medicaid funds for a program that excludes Planned Parenthood – this time asking the Trump administration – the stakes are high. If the federal government approves Texas' request, it will be a dangerous and unprecedented departure from long-standing federal protections that ensure Medicaid clients can access family planning services from the provider of their choice. While the damage from excluding Planned Parenthood from state family planning programs in Texas is already done, if federal Medicaid funds are made available for programs with politically motivated provider exclusions, it will be easier for other states to follow Texas' misguided path without fiscal consequences, if they fail to learn from our mistakes.

The first stated goal of Texas' proposed family planning waiver is to "increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families." The easiest way to achieve this worthy

goal would be for Texas to ensure that all large, efficient, and trusted providers like Planned Parenthood are full program participants. If either Texas or federal Medicaid administrators are serious about expanding access to family planning services in Texas, they will realize that excluding Planned Parenthood runs directly counter to that goal, causing unnecessary harm to women, their families, and our state.

Women's Health Program History

The Women's Health Program (WHP), launched on January 1, 2007, provided essential well-woman services including Pap smears, breast exams, and birth control to low-income women. WHP was what's known as a Medicaid 1115 family planning waiver program. Through an 1115 waiver, the federal Centers for Medicare and Medicaid Services (CMS) can grant permission to states to opt out of certain Medicaid laws, if doing so helps create new, innovative demonstration projects that are "likely to assist in promoting the objectives" of the Medicaid program.¹

Through the waiver process, Texas received federal approval to provide contraceptives and related services to women who would otherwise not have been eligible for the Medicaid program (i.e., under pre-Affordable Care Act law). Texas also received substantial federal funding through the waiver – for every one dollar Texas spent on the program, the federal government kicked in nine more.

Texas received federal approval to run the Women's Health Program through December 31, 2011. At legislative direction, when the Texas Health and Human Services Commission (HHSC) applied to renew the waiver for future years in October 2011, it indicated the program moving forward would exclude providers that "affiliate with entities that perform or promote elective abortions."² (The Women's Health Program only covered preventive care and never covered abortion care.) The "affiliate rule" change, which bars providers not based on their qualifications to provide medical care but on whether they "affiliate" with providers that perform abortion, was aimed explicitly at removing Planned Parenthood from the program.

CMS denied Texas' request, concluding that blocking access to certain health care providers based on reasons unrelated to the providers' qualifications to deliver family planning services would circumvent long-standing federal law protections ensuring Medicaid clients the right to freely choose their family planning providers, and was inconsistent with the goals of the Medicaid program.³ Texas then chose to forfeit federal funding and instead converted WHP into a fully state-funded program that did not include Planned Parenthood. Ultimately, CMS maintained federal funding for the waiver program through December 31, 2012, giving Texas time to transition to the new Texas Women's Health Program.

In 2014, the Sunset Advisory Commission recommended that HHSC consolidate the Texas Women's Health Program with another state-funded program that provided family planning services. HHSC launched the new program, Healthy Texas Women, on July 1, 2016.

Bad Idea Makes a Comeback

During the 2017 legislative session, lawmakers expressed interest in converting the Healthy Texas Women program back into an 1115 family planning waiver program, a move that would shift the bulk of costs in the program from the state budget to the federal budget. The 2018-19 state budget passed by the Texas Legislature in May 2017 contains a directive for HHSC to apply for an 1115 waiver and an expectation that, once approved, the waiver will replace \$90 million of state General Revenue (GR) dollars with federal Medicaid funding.⁴

On May 12, 2017, HHSC posted a draft 1115 family planning waiver application for HTW, starting a federally required 30-day state comment period.⁵ HHSC formally submitted a final waiver application on June 30, 2017, and CMS is accepting public comment on Texas' waiver request through August 4, 2017. In its application, HHSC essentially seeks permission to refinance the state-funded program with federal Medicaid funds with no changes to the program. Texas is now seeking the same federal funding it previously forfeited for a new program that

Timeline

Women's Health Program (Jan 2007 – Dec 2012)

Medicaid 1115 waiver program, includes participation by Planned Parenthood

Jan 2007 – Women's Health Program (WHP) launches

Oct 2011 – Texas submits renewal application with affiliate ban excluding Planned Parenthood

Dec 2011 – CMS denies renewal, offers 3-month extension

Mar 2012

- Texas announces intention to convert WHP to a state-funded program
- New WHP "affiliate rule" takes effect, excluding Planned Parenthood
- CMS allows temporary extension of federal funds during transition through 2012

Dec 2012 – last month Planned Parenthood is reimbursed under the program

Texas Women's Health Program (Jan 2013 – Jun 2016)

Fully GR-funded program that excludes Planned Parenthood

Jan 2013 – TWHP launches

2014 – Sunset Commission recommends consolidation of TWHP with EPHC to create new Healthy Texas Women program

Healthy Texas Women (Jul 2016 – Aug 2018)

Jul 2016 – HTW launches

May 2017

- Texas budget instructs HHSC to seek federal funds for HTW

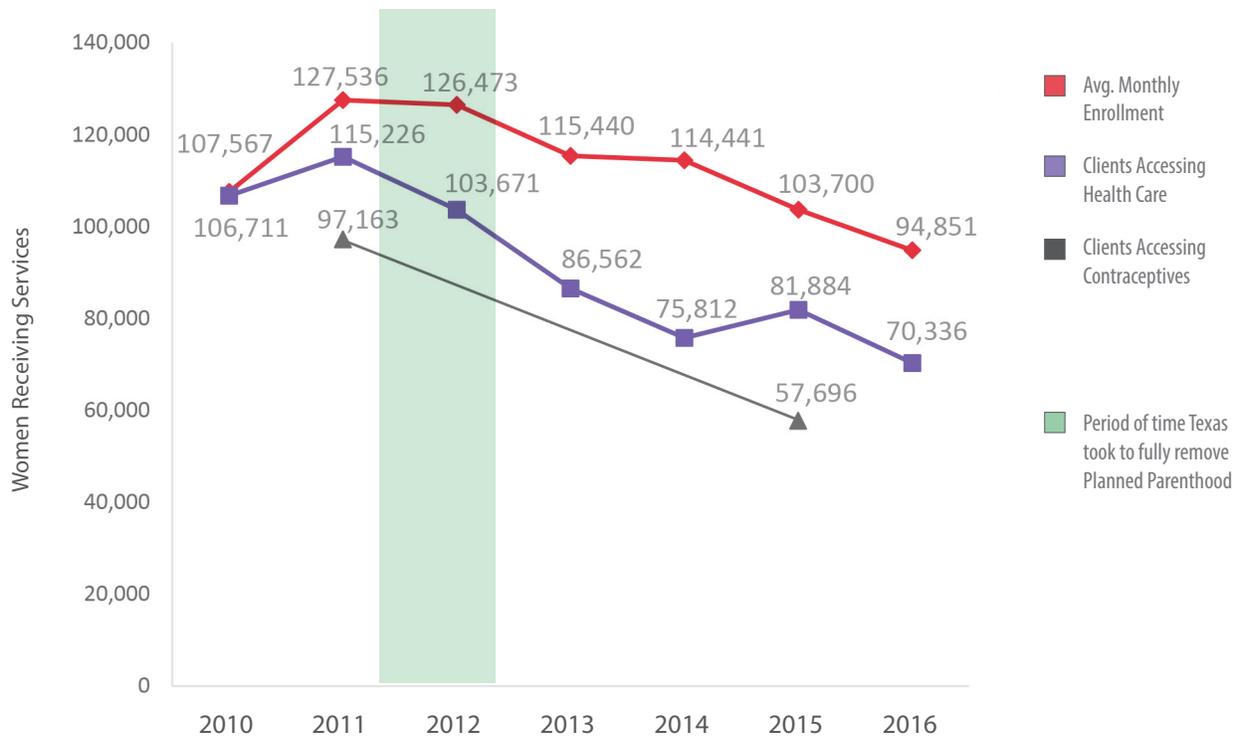
Jun 2017 – HHSC formally submits its request for federal funds for HTW to CMS, which excludes Planned Parenthood

Aug 2017 – end of federal public comment period for HTW request

Healthy Texas Women waiver program (to start Sep 2018)

FIGURE 1

DOWNTURN: Access to Family Planning Services and Contraception Drops After Texas Excludes Planned Parenthood



Source: HHSC, HHS Women’s Health Update, May 15, 2017 and Final Report of the Former Texas Women’s Health Program: Fiscal Year 2015 Savings and Performance, March 2017. Number of clients who accessed contraceptives is available only for fiscal years 2011 and 2015. Data for FY 2016 combines the unduplicated client counts for women enrolled and clients served for the Texas Women’s Health Program, which ended in June 2016, and HTW, which started in July 2016.

Period of time Texas took to fully remove Planned Parenthood: Texas submitted waiver application to remove Planned Parenthood in Oct 2011 and final program reimbursements to Planned Parenthood were in Dec 2012.

continues to exclude Planned Parenthood. In other words, Texas is asking the same question it asked to CMS in 2011—can the state ignore federal protections ensuring Medicaid clients the right to choose their providers while using federal funding—but hoping that it will get a different answer from the Trump administration.

Harm to Women after Planned Parenthood Excluded

Texas has now run its ill-advised experiment to exclude organizations “affiliated” with abortion providers from participating in the Medicaid Women’s Health Program, and its successor programs, the Texas Women’s Health

Program and Healthy Texas Women, for four-and-a-half years. Outcomes have been extensively studied over that period. Several different measures and studies, including the state’s own data, show that provider capacity has declined as have the number of women getting services and the quality of those services. In other words, it is clear that the state’s decision to remove Planned Parenthood from the Women’s Health Program has harmed access to health care and resulted in worse health outcomes.

Network Capacity Dropped Even as the Number of Providers Technically Enrolled Grew

When Texas removed Planned Parenthood from the Women’s Health Program, it was the state’s largest

women's health provider, serving more than 40 percent of clients in WHP. In fact, the state's own provider capacity study showed that in Fiscal Year 2012, the 51 participating Planned Parenthood clinics served more WHP clients than all of the other 1,948 nearby providers (located within a 30-mile radius of a Planned Parenthood) combined.⁶ Texas made the rosy prediction that former Planned Parenthood clients would be able to readily find alternate providers, but actual experience has shown this is not the case, despite concerted state efforts to boost the capacity of its provider network without Planned Parenthood.

HHSC data published in March 2017 show a significant decline from FY 2011 to FY 2015 in program participation by high-volume providers.⁷ The average number of clients receiving services per provider fell from 150 clients per

provider during FY 2011 to 103 clients per provider during FY 2015. Over the same period the state added many providers to the program who serve relatively few clients, increasing the unique number of certified providers from 1,328 in FY 2011 to 4,603 in FY 2015.⁸ However, the state's efforts to sign up providers failed to address capacity issues, as evidenced by a sharp drop in the number of clients served, the percentage of enrolled women who get health care services, and the number of clients who received contraception, even as the number of providers technically certified climbed. HHSC added 3,695 providers to the Women's Health Program and successor programs between FY 2010 and FY 2016, yet over the same period, 36,375 fewer women received health care services – for each nominal provider added to the program, 10 women lost health care services (see Figure 2).

Concurrent Changes to Other Texas Family Planning Programs

Excluding Planned Parenthood from WHP was one of several ill-advised policy changes Texas made from 2011-12. In 2011, the Texas Legislature also took aim at a separate women's health program called Family Planning, housed at the Department of State Health Services (DSHS). In an effort to defund Planned Parenthood through that program, the Legislature introduced a hierarchy for receiving funding and placed dedicated family planning clinics, including Planned Parenthood, in the bottom tier. The Legislature simultaneously slashed funding to the program – cutting DSHS Family Planning funding by two-thirds.

Taken together with excluding Planned Parenthood from WHP, these policy changes left the Texas family planning safety net in tatters. Eighty-two clinics closed or eliminated family planning services (only one-third were Planned Parenthood clinics), dramatically fewer women received care, access to the most effective forms of contraception was reduced, and costs to Medicaid increased.^{1,2}

The state wisely reversed course on the deep funding cuts to DSHS Family Planning. The 2013 Legislature restored state funding cut from DSHS Family Planning through a newly created parallel program, the Expanded Primary Healthcare Program (EPHC). By FY 2016, access had improved in these two programs, though together they still did not serve as many clients served as in FY 2010, before the cuts.³ The state did not, however, reverse course on its unwise decision to exclude Planned Parenthood from the Texas Women's Health Program.

It is noteworthy that funding was not cut to WHP (or later programs) even when it was gutted for DSHS Family Planning. In other words, worsening outcomes in WHP are not due to direct funding cuts. Rather, the sharp reduction in access to care and negative family planning outcomes in WHP and successor programs stem from both excluding the program's largest provider, Planned Parenthood, and the weakened capacity of safety net family planning providers more generally following the 2011 funding cuts to DSHS Family Planning.

1 Dr. Kari White, Co-investigator on Texas Policy Evaluation Project, Testimony to the Texas Senate Health and Human Services Committee, September 13, 2016, <http://liberalarts.utexas.edu/txpep/legislative-testimony/HHSC%20White.php>.

2 Stevenson, A., Flores-Vazquez, I., Allgeyer, R., Schenkkan, P., and Potter, J. Effect of Removal of Planned Parenthood from the Texas Women's Health Program, *N Engl J Med* 2016; 374:853-860, <http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article>.

3 Texas Health and Human Services, HHS Women's Health Update, May 15, 2017, Slide 13, <https://hhs.texas.gov/sites/default/files/documents/about-hhs/leadership/advisory-committees/whac/zika-may-15-2017/whac-women-health-update-may-15-2017.pdf>.

It has always been the case in the Women’s Health Program and successor programs that a relatively small number of high-volume, safety-net providers deliver the bulk of the services, while many “enrolled” providers serve no women at all and others serve just one or two a year. In FY 2010, 62 percent of WHP participating providers served 10 or fewer clients.⁹ Given this well-known dynamic, the raw number of providers enrolled is an essentially meaningless number and the growth over time in unique providers signed-up in no way reflects the capacity of the provider network—yet HHSC relies on these metrics in

the draft waiver application and elsewhere and does not provide an alternate, more meaningful way to evaluate network capacity.

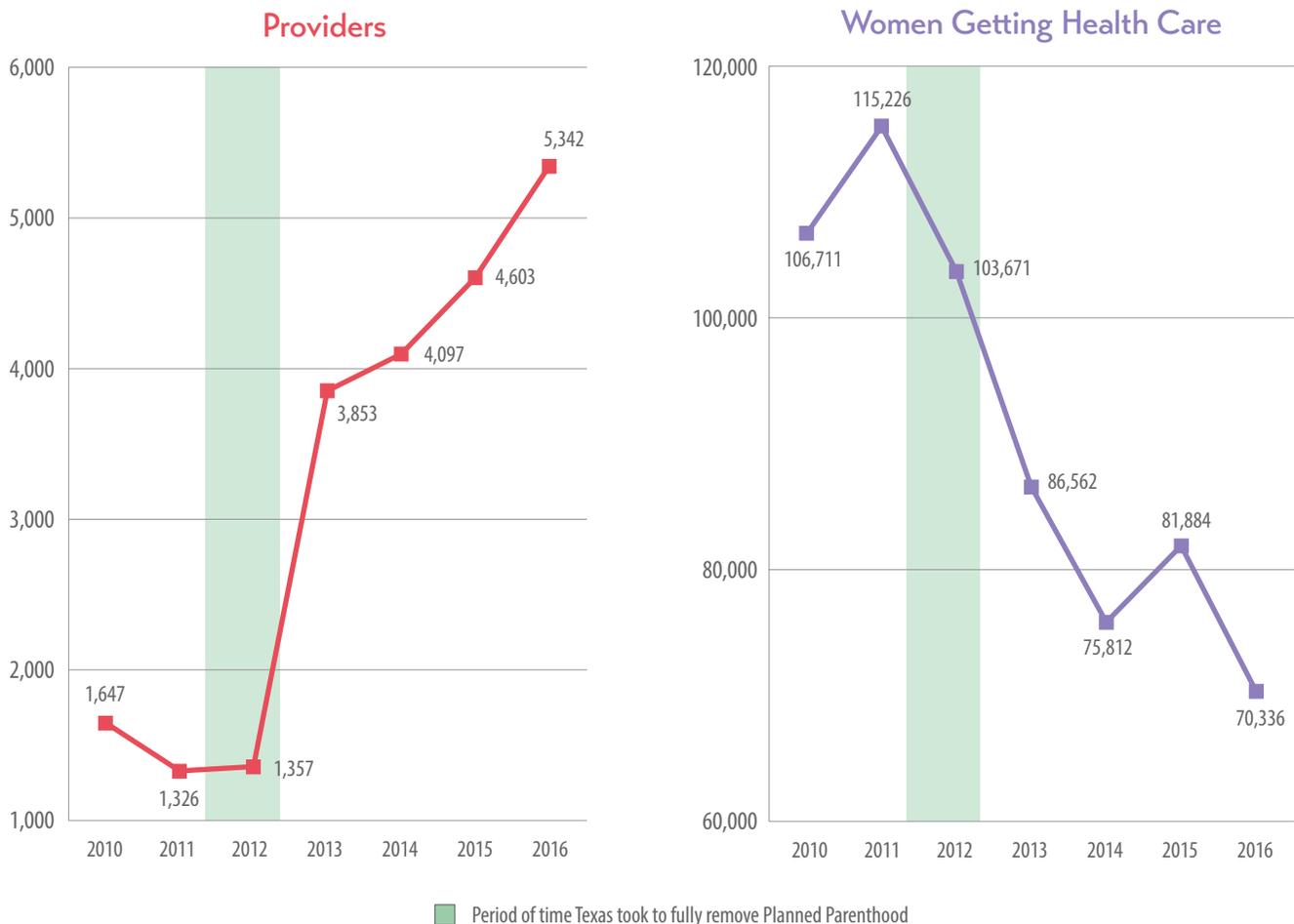
Fewer Women Received Health Care, Including Contraception

According to HHSC data, the number of women enrolled in the Women’s Health Program/Texas Women’s Health Program/Healthy Texas Women declined by 26 percent from FY 2011 to FY 2016, from 127,536 to 94,851 women.¹⁰ Program enrollment started increasing at the end of FY

FIGURE 2 **AFTER PLANNED PARENTHOOD EXCLUSION**

With More Providers, Why Are Fewer Women Getting Services?

Adding Thousands of Low-Volume Providers Did Not Reverse Dramatic Declines in Access to Health Care



Source: HHSC, HHS Women’s Health Update, April 2017 and Final Report of the Former Texas Women’s Health Program: Fiscal Year 2015 Savings and Performance, March 2017. Data for WHP/TWHP/HTW. Clients served data for FY 2016 combines the unduplicated client served for the Texas Women’s Health Program, which ended in June 2016, and HTW, which started in July 2016. Period of time Texas took to fully remove Planned Parenthood: Texas submitted waiver application to remove Planned Parenthood in Oct 2011 and final program reimbursements to Planned Parenthood were in Dec 2012.

2016 when HHSC implemented an automatic transition into the program for women losing coverage in Medicaid for Pregnant Women 60 days after they give birth. HHSC automatically enrolls about 4,000 clients a month from Medicaid for Pregnant Women.¹¹ Moving forward, it will be important to look at indicators other than just program enrollment to understand how the program is working and whether clients are accessing health care services.

After Planned Parenthood was excluded, the decline in access to services was even more severe than the enrollment drop. The number of women getting health care services in the program declined 39 percent, from 115,226 in FY 2011 to 70,336 in FY 2016. This dynamic – access to services dropping even faster than enrollment – points to serious issues with provider capacity. In FY 2011, 90 percent of all women enrolled in the Medicaid Women’s Health Program accessed health care services. By FY 2016, only 74 percent of women enrolled in the Texas Women’s Health Program/Healthy Texas Women received health care services (see Figure 1). In other words, by FY 2016, one in four women technically enrolled in the Texas Women’s Health Program/Healthy Texas Women was never seen by a health care provider for covered family planning services.

The number of women specifically accessing contraceptives (as opposed to other covered services) also dropped sharply, from 97,163 in FY 2011 to 57,696 in FY 2015, a drop of 41 percent.¹² This sharp drop cannot be explained by overall declining enrollment and declining services in the program. During the same time clients accessing contraceptives fell by 41 percent, clients accessing any health care service in the program dropped by only 29 percent. Looked at another way, in FY 2011, 76 percent of women enrolled in WHP received contraceptives, and in FY 2015, only 56 percent of TWHP clients did.

It is troubling that even among the declining share of clients who accessed any health care services, fewer still received a contraceptive method. The primary goal of WHP/TWHP was to help women avoid unintended pregnancy, and the very limited benefits covered in the program were centered around a family planning exam and contraception. Data showing declining contraceptive

access within a family planning program raise questions about how the program’s changing provider network has affected the ability of patients to access and adhere to their preferred contraceptive method.

As HHSC notes in its report, some of the decrease in access to contraceptives in any one year can be explained by an uptick (5.4 percent increase from FY 2011 to FY 2015) in women choosing long-acting reversible contraception (LARC) methods, which remain effective for three or more years. While true, the estimated number of program clients who have received LARC since FY 2011 is not high enough to fully explain why 39,500 fewer enrollees received contraception between FY 2011 and FY 2015.¹³

Program Changes Have Been Bad for Women’s Health

Such dramatic reductions in access to services inevitably led to poorer outcomes. After Texas excluded Planned Parenthood from its family planning programs including the Women’s Health Program, Texas has experienced a reduction in the provision of highly effective methods of contraception, interruptions in contraceptive continuation, and increased rates of Medicaid births. Research has shown that counties which lost Planned Parenthood services saw a reduction in the utilization of highly effective contraceptive methods as well as injectable contraception. LARC utilization was reduced by 35 percent and injectable contraception by 31 percent.¹⁴ Continuation of injectable contraception by clients using that method decreased from 60 percent to 38 percent in counties that previously had participating Planned Parenthoods clinics. Researchers also found that the birth rate shot up among former Planned Parenthood clients who relied on injectable contraceptives. Between 2011 and 2014, the number of births from this population, paid for through Medicaid, increased by 27 percent.

Women Face Added Barriers to Care

Finding alternate providers is not as easy as it sounds. Midland, Texas provides a case study of the barriers faced by former Planned Parenthood clients. The Planned Parenthood in Midland closed in 2013. Other local comprehensive clinics that wanted to pick up the slack expressed doubt about their capacity to do so. Planned

Parenthood transferred 2,000 active patient records to the local federally qualified health center, but more than three years later, the center reports that fewer than 200 former Planned Parenthood patients have been seen.¹⁵

Women must find providers who offer services near them; have available, timely appointments; stock, prescribe, or administer their desired contraceptive method; and charge fees they can afford. Researchers interviewed women who lost services at Planned Parenthood in Houston and Midland and found that many had difficulties finding a new provider, had to go to multiple appointments before getting a contraceptive method, were charged more for services, and ended up on less-effective contraceptive methods.¹⁶

Conclusion

The state's request for a new 1115 Medicaid family planning waiver to fund Healthy Texas Women provides a good opportunity to review the program and ensure it is equipped to best serve Texas women and advance the goals of the Medicaid program. There is no question that WHP successor programs have been less successful at providing access to family planning services than the original Women's Health Program was, with Planned Parenthood as its largest provider. Texas' efforts to boost provider enrollment resulted in thousands of providers technically signed up for the program, but failed to address the network capacity issues created when Planned Parenthood was excluded. Given the well-documented harm to women's access to health care caused by Texas' ill-advised experiment, it is clearly time to reverse course. If either Texas or CMS is serious about expanding access to family planning services in Texas, they will realize that excluding Planned Parenthood runs directly counter to that goal, causing unnecessary harm to women, their families, and our state.

ENDNOTES

- 1 Section 1115, Social Security Act
- 2 Human Resources Code section 32.024(c-1)
- 3 Letter from Cindy Mann, Director of the CMS Center for Medicaid and CHIP Services, to Billy Millwee, Texas HHSC Associate Commissioner for Medicaid and CHIP, December 12, 2011. Federal "freedom of choice" protections for people enrolled in Medicaid are in Section 1902(a)(23)(A) of the Social Security Act. Relevant parts of this section: (a) A State plan for medical assistance must (23) provide that . . . (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required. . . who undertakes to provide him such services, . . .
- 4 Conference Committee Report for Senate Bill 1, 2018-19 State Budget, HHSC Rider 161, passed May 2017, http://www.lbb.state.tx.us/Documents/Appropriations_Bills/85/Conference_Bills/SB1_Conference_Bill.pdf
- 5 CPPP's comments to HHSC on the Healthy Texas Women draft 1115 family planning waiver application are available at https://forabettertexas.org/images/CPPP_comments_on_HTW_draft_waiver_application.pdf
- 6 Texas Health and Human Services Commission, "Texas Women's Health Program Provider Survey Patient Capacity Report," January 7, 2013, <https://hhs.texas.gov/reports/2013/01/texas-womens-health-program-provider-survey-patient-capacity-report>
- 7 Health and Human Services Commission, "Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance," House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 41), March 2017. <https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance>.
- 8 Texas Health and Human Services, HHS Women's Health Update, April 2017, Slide 23, http://d31hzhk6di2h5.cloudfront.net/20170508/c5/6d/0e/8c/2da14decd29fc4aecabb2863/HHSC_Presentation_April_2017_1_.pdf.
- 9 Shin, P., Sharac, J., and Rosenbaum, S., "An Early Assessment of the Potential Impact of Texas' 'Affiliation' Regulation on Access to Care for Low-Income Women," Geiger Gibson / RCHN Community Health Foundation Research Collaborative, 2012, <http://www.rchnfoundation.org/wp-content/uploads/2013/02/GG-FP-study-0504-revised.pdf>.
- 10 Texas Health and Human Services, HHS Women's Health Update, May 15, 2017, Slide 13, <https://hhs.texas.gov/sites/default/files/documents/about-hhs/leadership/advisory-committees/whac/zika-may-15-2017/whac-women-health-update-may-15-2017.pdf> Data for FY 2016 combines the unduplicated client counts for women enrolled and clients served for the Texas Women's Health Program, which ended in June 2016, and HTW, which started in July 2016.
- 11 Texas Health and Human Services, HHS Women's Health Update, April 2017, Slide 5, http://d31hzhk6di2h5.cloudfront.net/20170508/c5/6d/0e/8c/2da14decd29fc4aecabb2863/HHSC_Presentation_April_2017_1_.pdf.
- 12 HHSC, "Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance," March 2017. FY 2015 data for the number of clients who accessed contraception is the most recent available.
- 13 HHSC's data provides LARC client counts for only FY 2011 (6,264 clients getting LARC) and FY 2015 (6,581 clients getting LARC). The number of women getting LARC in the intervening years would need to be taken into account to determine if the total number of clients established on LARC, and therefore not needing other contraceptives for some number of years, could account for the total drop in contraceptive clients of 39,467 women from FY 2011 to FY 2015. To be conservative, we assumed that 6,581 clients accessed LARC in each of FY 2012, 2013 and 2014—the same number as received LARC in 2015. Taken together, we estimate that 26,000 program clients accessed LARC from FY 2011-14, which cannot fully explain the drop of 39,467 women accessing contraceptives in the program by FY 2015.
- 14 Stevenson, A., et al, Effect of Removal of Planned Parenthood from the Texas Women's Health Program.
- 15 Kate Zernike, "Cutting Planned Parenthood Would Increase Medicaid Births, C.B.O. Says," New York Times, March 14, 2017, https://www.nytimes.com/2017/03/14/health/cutting-planned-parenthood-would-increase-medicaid-births-cbo-says.html?_r=0; and Erin Stone, "Planned Parenthood closures test women's health care resources in Midland," Midland Reporter-Telegram, June 11, 2016, <http://www.mrt.com/news/article/Planned-Parenthood-closures-test-women-s-health-9286706.php>.
- 16 Junda Woo, Hasanat Alamgir, Joseph E. Potter, "Women's Experiences After Planned Parenthood's Exclusion from a Family Planning Program in Texas," *Contraception* 2016; 93(4): 298-302, <http://sites.utexas.edu/txpep/files/2017/04/Woo-et-al-Womens-Experiences-Contraception-post-print-2015.pdf>; and Joseph E. Potter and Kari White, "Defunding Planned Parenthood a disaster in Texas," San Antonio Express-News, April 8, 2017, <http://www.mysanantonio.com/opinion/commentary/article/Defunding-Planned-Parenthood-a-disaster-in-Texas-11058931.php>.

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