CENTER for PUBLIC POLICY PRIORITIES

June 12, 2017

Jami Snyder
Associate Commissioner, Medicaid and CHIP Services
Texas Health and Human Services Commission
4900 N. Lamar Boulevard
Austin, TX 78751

Via Email: TX_Medicaid_Waivers@hhsc.state.tx.us

Re: Comments on the Draft Healthy Texas Women Section 1115 Demonstration Waiver Application

Dear Ms. Snyder:

The Center for Public Policy Priorities (CPPP) appreciates the opportunity to comment on the Texas Health and Human Services Commission's (HHSC) draft application to the Centers for Medicare & Medicaid Services (CMS) to request a new waiver under Section 1115 of the Social Security Act for a Healthy Texas Women Section 1115 Demonstration Waiver (waiver).

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. We urge HHSC to amend its waiver application, as outlined below, before submitting it to CMS, to ensure that any future waiver program can maximize access to quality family planning services.

Excluding Planned Parenthood from Family Planning Programs Harms Women's Health

Our primary concern with the waiver application as posted is that the program excludes access to certain well-qualified family planning providers—Planned Parenthood and similar clinics—which will needlessly harm access to health care.

In 2011-2012, Texas implemented a series of ill-advised changes in its family planning programs including, ending participation by Planned Parenthood, implementing a tiered funding structure, and making dramatic funding cuts. The changes left the Texas family planning safety net in tatters, with 82 clinics closing or eliminating family planning services, dramatic reductions in the numbers of women served, reduced access to the most effective forms of contraception, and increased costs to Medicaid.[1,2] Though state funding has since been restored, Texas has maintained its ill-advised experiment to exclude organizations "affiliated" with abortion providers from participating in the Medicaid Women's

[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

Health Program, and its successor programs, the Texas Women's Health Program and Healthy Texas Women. By every measure, this policy decision has harmed access to health care and resulted in worse health outcomes.

When Planned Parenthood was removed from the Women's Health Program, it had been the state's largest provider, serving more than 40 percent of clients in the program. 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. Even while Texas focused on boosting the capacity of its provider network without Planned Parenthood and with full restoration of funding during the 2013 Legislative Session, several different measures and studies, including the state's own data, show that provider capacity has declined, and along with it, the number of women getting services and the quality of services.

True Provider Capacity Dropped Even as Nominal Provider Enrollment Grew

HHSC data published in March 2017 shows a significant decline from FY 2011 to FY 2015 in program participation by **high-volume providers**.[3] 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 low-volume providers to the program, increasing the unique number of certified providers from 1,328 in FY 2011 to 4,603 in FY 2015.[4] However, these efforts 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 nominal provider enrollment 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 1).

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.[5] 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.

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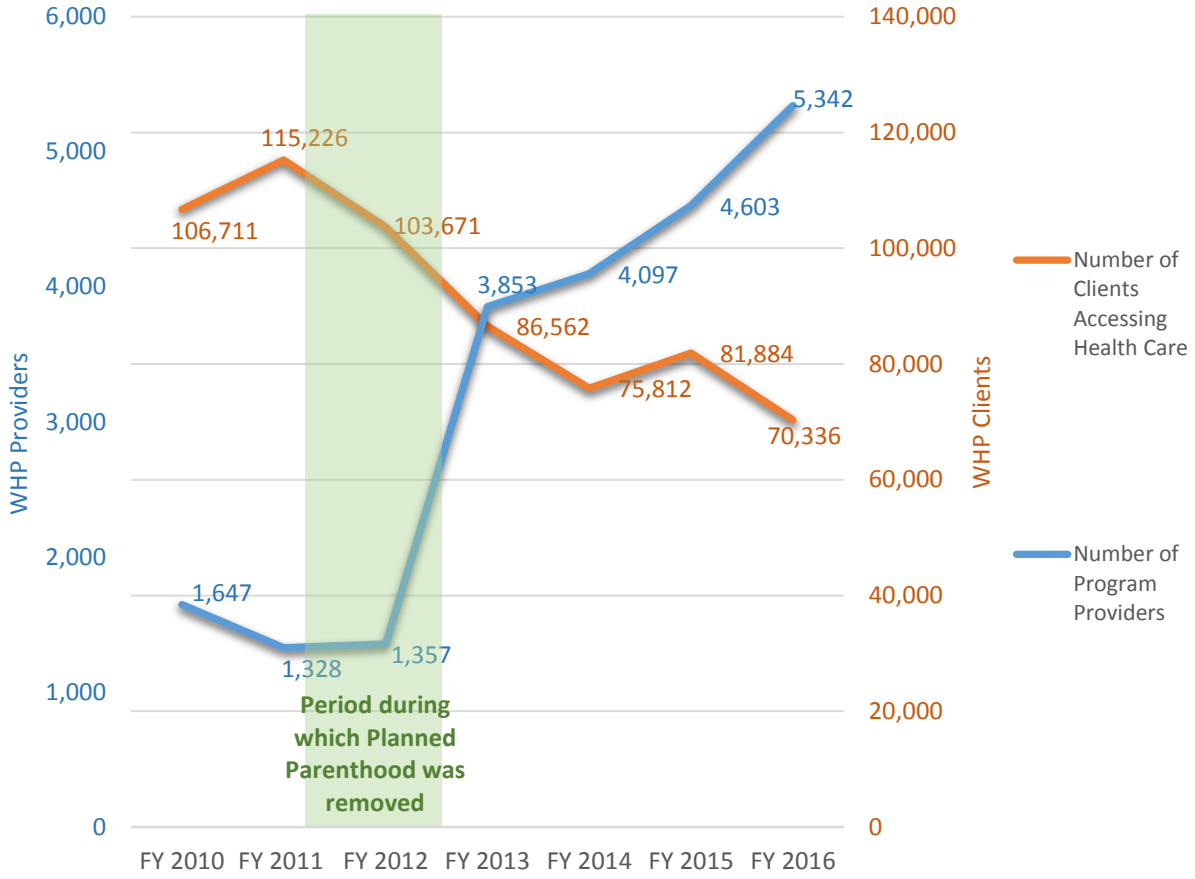
[3] Health and Human Services Commission, "Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance," House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 41), March 2017. https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/reports-presentations/2017/former-tx-womens-health-program-fy2015-savings-performance.pdf.

[4] Texas Health and Human Services, HHS Women's Health Update, April 2017, Slide 23, http://d31hzlhk6di2h5.cloudfront.net/20170508/c5/6d/0e/8c/2da14decd29fc4aecabb2863/HHSC_Presentation_April_2017__1_.pdf.

[5] 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.

Figure 1: Adding Thousands of Nominal Providers to the Program After Planned Parenthood was Removed 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. Texas submitted waiver application to remove Planned Parenthood in Oct 2011 and final program reimbursements to Planned Parenthood were in Dec 2012.

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.[6] 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.

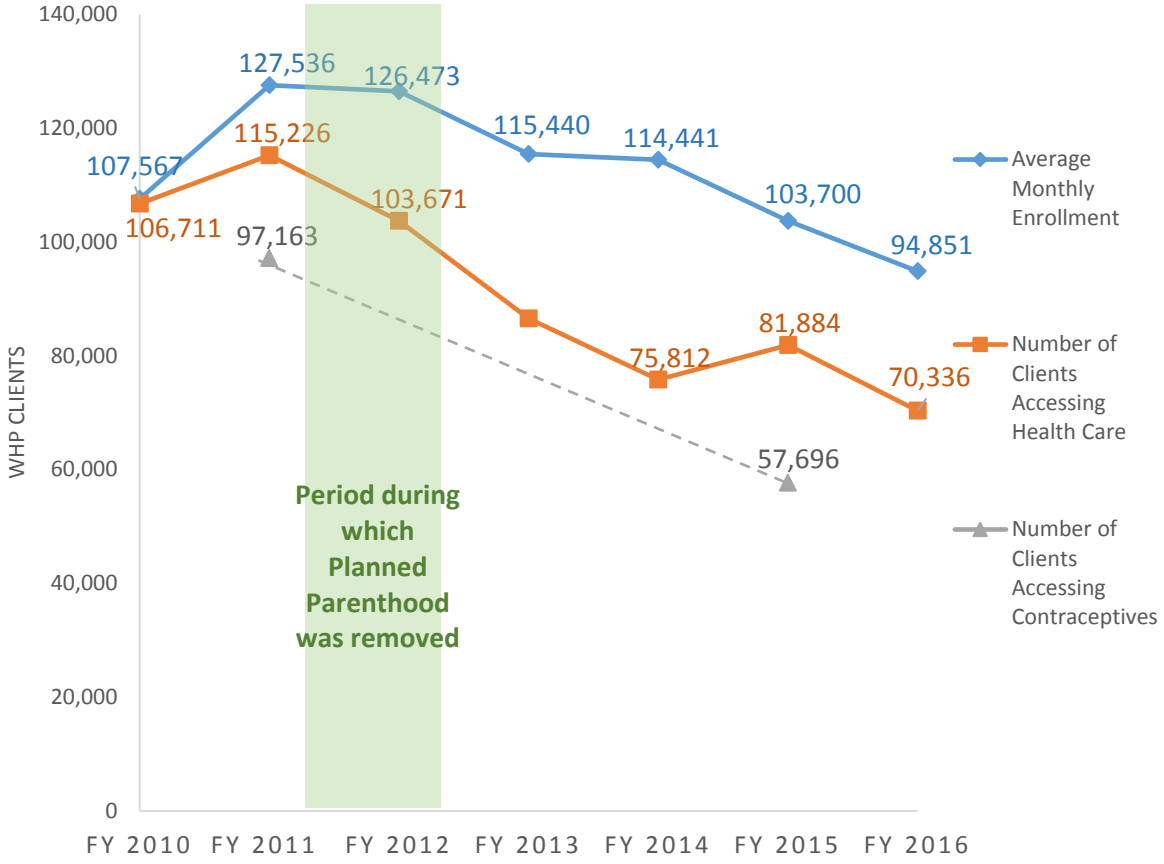
As HHSC notes in its report, some of the decrease in access to contraceptives in any one year can be explained by the small increase (5.4 percent increase from FY 2011 to FY 2015) in women choosing long-acting reversible contraception (LARC) methods, which often do not necessitate annual visits/services.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

[6] 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.

enough to fully explain why 39,500 fewer enrollees received contraception between FY 2011 and FY 2015.[7]

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 provider network in general, with Planned Parenthood excluded, to facilitate a patient's choice and use of a contraceptive method.

Figure 2: Access to Family Planning Services and Contraception Declined Sharply in the Women's Health Program After Planned Parenthood was Removed



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. Texas submitted waiver application to remove Planned Parenthood in October 2011 and final program reimbursements to Planned Parenthood were in December 2012.

[7] 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.

Women Had Poorer Health Care Outcomes

Such dramatic reductions in access to services inevitably led to poorer family planning 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.[8] 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 population, covered by Medicaid, increased by 27 percent.

Case Study: Women Report Added Barriers to Care

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 ability 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.[9]

Finding alternate providers is often not as easy as it sounds. 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.[10]

Waiving Freedom of Choice Rights Does Not Further the Goals of Medicaid

Overwhelming evidence shows that expelling Planned Parenthood—a well-qualified, trusted family planning provider—from the Texas Women's Health Program/Healthy Texas Women has had adverse effects on women's access to critical preventive health care. This policy and its negative outcomes directly conflict with the purpose of 1115(a) waivers in Medicaid. This bad policy has no place in a Medicaid waiver program.

> **Recommendation: Remove the request to waive federal freedom of choice protections Section 1902(2)(23) and the requirement that waiver providers adhere to Texas Human Resources Code section 32.024(c-1) before submitting the waiver to CMS.**

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[8] Stevenson, A., et al, *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*.

[9] 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, https://www.nytimes.com/2017/03/14/health/cutting-planned-parenthood-would-increase-medicaid-births-cbo-says.html?_r=0.

[10] 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.

Aligning Healthy Texas Women with Federal Laws

The state's request for federal Medicaid funding for Healthy Texas Women creates an opportunity to review program rules and policies and align them with federal laws and rules, as described below.

Financial Eligibility and Modified Adjusted Gross Income (MAGI)
Under the Affordable Care Act (ACA) financial eligibility for income-based Medicaid and other insurance affordability programs must be determined through the use of Modified Adjusted Gross Income (MAGI). By aligning the financial eligibility guidelines across all programs, this provision allows for a more streamlined application process for applicants. Aligning the financial eligibility of the Healthy Texas Women's program with insurance affordability programs would support these efforts to streamline enrollment. Furthermore, the use of MAGI methodologies for financial eligibility in Medicaid programs cannot be waived as per 1902(e)(14)(A) and (F) of the Act.

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 has provided no justification for the HTW program to not follow this federal requirement. The current verification process for citizenship and immigration status in the state-funded HTW program does not align with federal regulations and 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.

In addition, the description in the "Citizenship and Alien Status Verification (Reasonable Opportunity)" section of the application appears to indicate that clients will be required to re-verify citizenship or immigration status at renewal. It is our understanding that this is not the current policy or practice for HTW. Furthermore, federal rules prohibit the state Medicaid agency from requiring that client re-verify citizenship at renewal or when there is a break in services unless, "the individual reports a change in citizenship or the agency has received information indicating a potential change in the individual's citizenship" (42 CFR §435.9564(ii)). We ask the agency to please clarify if the description in application represents a change in current policy for the HTW program regarding the verification of citizenship and immigration status at renewal.

Auto-Enrollment into HTW from Pregnant Women's Medicaid
CPPP supports the agency's efforts to ensure continuity of care after a women's eligibility for Medicaid for pregnant women has ended by automatically enrolling them into the Healthy Texas Women's program. However, formal responses from HHSC to proposed rule comments published as part of the HTW program rules adoption order in the June 24, 2016 *Texas Register*, have raised questions as to whether the HTW policies and processes comply with federal law and regulation. Specifically, an agency

response related to auto-enrollment stated that "HHSC declines to transfer the female's application information to the Health Insurance Marketplace due to concerns about ensuring client privacy."

We see this waiver application process as an opportunity for the agency to either clarify that its current process follows federal requirements regarding transfer of account information to the Marketplace, or to make adjustments to the process to align with federal requirements.

Therefore, we ask that the agency to confirm that it takes the following federally required steps at the end of a person's certification for Medicaid for pregnant women prior to auto-enrollment into HTW:

- Assess the women's eligibility for other Medicaid benefits such as Medicaid for low-income parents (as required under 42 CFR Sect. 435.916(f));
- If assessed as ineligible for any other MAGI-based Medicaid program determined to be "minimum essential coverage" (MEC) by the IRS or CMS, transfer the women's account information to the federally-facilitated Health Insurance Marketplace (as required under 42 CFR Sect. 435.1200(e)); and
- Include on the women's Medicaid denial notice that she may be eligible for coverage through the Health Insurance Marketplace.

As cited above, federal regulations clearly require that HHSC refer all former Medicaid for Pregnant Women enrollees who do not qualify for transfer to another Texas Medicaid eligibility category to the Health Insurance Marketplace, and to inform those women that they may be eligible for marketplace coverage. Model notices generated in CMS guidance make it clear that notification of possible Marketplace eligibility is expected of all state Medicaid programs.

Application Requirements

The HTW waiver application indicates that only a parent or legal guardian can only apply for HTW on behalf of a minor. CPPP urges the state to broaden this requirement to allow individuals acting in the best interest of the minor to also apply for services on behalf of the minor. Limiting who can help a minor apply for services to only parents and legal guardians could impede the ability of minors who are not in communication with their parent's from participating in the program. Many minors live with informal caregivers such as grandparents or aunts and uncles, who are not legal guardians of the child. Federal Medicaid regulations at 42 CFR §435.907 require states to allow "someone acting responsibly for the applicant" to be able to submit an application on behalf of the minor. Aligning HTW policy with these federal requirements for Medicaid would increase access to the program for minors.

Improving Upon HTW

The HTW waiver application also presents an opportunity to evaluate the program, and take steps improve policies and operations to better connect more Texas women in need of family planning to health care services. The most needed change is allowing all highly-qualified providers, including Planned Parenthood, to participate in the program, as discussed earlier in these comments, but other changes discussed below would also add value.

Ensuring Full Medicaid/CHIP Determinations First

Given that the agency *must* use MAGI methodologies for any Medicaid or waiver program per federal law, we strongly encourage the agency to collect sufficient information on the application for HTW to assess the applicant's eligibility for full Medicaid benefits and the Children's Health Insurance Program

(CHIP), and rule out eligibility for full benefits before enrolling the client into the Healthy Texas Women's program, which does not provide comprehensive medical coverage. Please also see our comments on dual enrollment into HTW and CHIP.

Non-Citizen Eligibility for HTW

The current waiver application indicates that "qualified immigrants" are eligible for HTW, but there is some confusion whether this term refers to Qualified Immigrants as defined in Section 431 in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Currently, most qualified immigrants (as defined in federal law) residing in Texas would not be eligible for HTW. Most notably, under current HTW rules, lawful permanent residents (considered qualified immigrants under federal law) are only eligible if they meet one of the narrow exceptions listed in the Texas Administrative Code §366.513(3), such as having 40 qualifying quarters of work with the Social Security Administration. We ask the agency to please clarify what is meant by "qualified immigrant" in the waiver application. CPPP strongly urges HHSC to ensure that all qualified immigrants are eligible for HTW, including lawful permanent residents.

Adjunctive Income Eligibility

CPPP supports the agency's efforts to streamlined enrollment and renewal into HTW by using adjunctive eligibility. In addition to the current HTW policy and process, we ask that the agency also consider a HTW applicant or client to be adjunctively eligible at an initial or renewal application, if she is in the budget group of a child under 19 who is receiving CHIP. With the income limit for HTW set at 200% of the federal poverty line (FPL) it now almost perfectly aligns with the income guideline for CHIP which is at 201% of the FPL. Updating the HTW policy to include this addition to adjunctive eligibility will help to further streamline enrollment into the program and reduce the administrative burden on the client, clinic staff who assist the client in applying, and the state agency.

Also, the waiver application states that a woman will be considered adjunctively eligible if, "She is in the budget group of a child under 18 or a parent and other caretaker relative who is receiving Medicaid." As written, this language would exclude women in the budget group of an 18-year-old receiving Medicaid. However, current HTW rules would allow a woman to be considered adjunctively eligible if she in the budget group of any child who receiving Medicaid, which includes 18 year olds (Texas Administrative Code §382.11(b)). We ask that the agency clarify if they meant for the adjunctive eligibility under the waiver to be more restrictive or if this section of the waiver application should state that they a woman will be adjunctively eligible if "She is in the budget group of a child under age 19…who is receiving Medicaid" to align with current HTW rules.

Allow Dual Enrollment with CHIP and Medicare

Texas CHIP and Medicare Parts A and B do not cover contraceptive services for enrollees. Both teens enrolled in CHIP and women enrolled in Medicare are barred from HTW, even if otherwise eligible. This unnecessary barrier limits access to contraception for low-income teens and women in Texas. We understand that a technological glitch in the state's eligibility and enrollment system prevents dual enrollment today with CHIP. Because of this glitch, teens must choose between either full health care in CHIP or contraceptive access in HTW. Texas has the highest rate of repeat teen pregnancy in the country. We need to do a much better job of ensuring that teens can prevent unintended pregnancies. HHSC should update its policy to allow for dual enrollment in programs that cover low-income women but do not provide contraception, and HHSC should prioritize changes to the TIERS system that would enable it to accept HTW clients who are enrolled in CHIP or Medicare. HHSC should implement "work around" policies to allow this policy change until TIERS system changes can be put into place.

Expand Presumptive Eligibility
Providers who help women apply for HTW and provide services the same day, carry financial risk if the applicant is later denied HTW eligibility. HHSC should work with providers to gauge interest in and pilot expanded presumptive eligibility, as is allowed by CMS in family planning State Plan Amendments. Expanding presumptive eligibility would allow authorized providers to grant temporary eligibility to individuals, with providers paid for any care provided to individuals during the presumptive eligibility period using federal matching funds. Today, GR-funded grants that support HTW providers can be used to pay for services provided in the presumptive eligibility period, but this GR funding is not available to all HTW providers that assist with program application at the point of service. Expanding presumptive eligibility would help increase the number of women able to receive services, reduce financial risks for providers, and reduce the demands for services paid for with GR-funded grants.

Ensure Access to Confidential Contraceptive Services for Teens
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. 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.

Methods of Contraception
We echo comments made by the Texas Women's Healthcare Coalition requesting language be added to the waiver application clarifying that all FDA-approved methods of contraception, including Long-Acting Reversible Contraception (LARC), must be made available to clients, and that Texas pursue innovative strategies to increase access to LARC.

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,

Stacey Pogue
Senior Policy Analyst

cc: Lesley French, Associate Commissioner, Health Development and Independent Services