November 26, 2019

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Idaho's Family Planning Referrals Section 1115 Waiver Application

Dear Secretary Azar:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on Idaho's § 1115 waiver application.

NHeLP recommends that the Department of Health & Human Services (HHS) reject Idaho's application. The proposed change does not comply with the requirements of § 1115 of the Social Security Act, as it will hinder, rather than facilitate, access to critical preventive services, placing the health and well-being of individuals with low incomes at risk.

I. HHS authority and § 1115

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

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

- waive compliance only "to the extent and for the period necessary" to carry out the experiment.[1]

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

II. The proposed project will reduce access to medically necessary care.

Idaho is requesting permission to require individuals enrolled in primary care case management to obtain a referral from their primary care provider before receiving family planning services from a different provider.[3] The restriction is unnecessary, as people are fully capable of determining if and when they need family planning services and whether they want to receive those services from their primary care provider or someone else. What is more, Idaho's effort to steer individuals to their primary care provider for family planning care will delay and impede timely access to critical preventive services.

Research shows that many people prefer to see a specialized reproductive health care provider for family planning services. Six in 10 women who obtained services from a reproductive health-focused provider reported going to another provider within the previous year, but chose the specialized provider for their contraceptive care; the remaining four in 10 of these women reported that the reproductive health-focused provider was their only source of care in the last year, despite having other options for care in their communities.[4] Patients provided the following reasons for preferring to visit reproductive-health focused sites over other, non-specialized sites: "The staff here treat me respectfully" (84%); "Services here are confidential" (82%); and "The staff here know about women's health" (80%). This data suggests that some individuals could choose to forgo family planning care entirely if they are unable to visit the specialized provider of their choice.

The referral requirement would make it more difficult – or even impossible – for individuals to visit the specialized provider of their choice. Some individuals will simply not feel

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[1] 42 U.S.C. § 1315(a).
[2] *Id*. § 1396-1.
[3] *See* Idaho Dep't of Health & Welfare, *Idaho Family Planning Referrals Section 1115 Medicaid Waiver Demonstration Project Application* (2019) (hereinafter "Application").
[4] Jennifer J. Frost et al. *Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs*, 22 Women's Health Issues 519 (2012), https://www.whijournal.com/article/S1049-3867(12)00073-4/fulltext.

comfortable discussing their family planning needs with their primary care provider, and as a result, will not feel comfortable asking for a referral. Provider mistrust is prevalent among low-income women and women of color, due in large part to the reproductive coercion and oppression these and other populations have long endured.[5] In addition, many adolescents and survivors of domestic violence have privacy concerns that could prevent them from discussing contraceptive care with their primary care provider. Decades of research demonstrates that confidentiality concerns affect whether individuals seek care, where they do so, which services they accept, and how candid they are with their health care providers.[6]

Idaho's proposed project would allow primary care providers to charge certain individuals $3.65 for an office visit simply to obtain a referral for family planning services.[7] That charge will prevent some individuals from seeking a referral. Repeated research, conducted over the course of decades, has established that cost sharing – even in relatively small amounts – deters and reduces low-income people's access to medically necessary care.[8] Cost sharing has posed a particular problem for women for a variety of

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[5] *See, e.g.*, In our Own Voice, Nat'l Black Women's Reproductive Justice Agenda, *Our Bodies, Our Lives, Our Voices, The State of Black Women & Reproductive Justice* 28-29 (2017), http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf; *see also* Christine Dehlendorf et al., *Recommendations for Intrauterine Contraception: A Randomized Trial of the Effects of Patients' Race/Ethnicity and Socioeconomic Status*, 203 Am J. Obstet. Gynecol. 319e1 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3012124/ (finding that providers recommend IUDs to low-income black and Latina women more often than to low-income white women).

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

[7] Application at 9. Idaho explains that providers are free to provide a referral to a patient without an office visit. *Id*. at 20. However, nothing prevents providers from requiring an office visit to obtain a referral.

[8] *See, e.g.*, Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/; David Machledt & Jane Perkins, Nat'l Health Law Program, *Medicaid Premiums and Cost Sharing* 2-14 (2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/; Leighton Ku & Victoria Wachino, Ctr. on Budget & Policy Priorities, *The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings* (2005), https://www.cbpp.org/archiveSite/5-31-05health2.pdf.The research also finds that cost sharing is correlated with an increased risk of poor health outcomes.

reasons. They are more likely than men to have low incomes and on average, need more preventive care than men.[9] Not surprisingly, studies have shown that compared with men, women are more likely to report cost-related barriers to receiving care and to forgo preventive services due to cost.[10] Research has also demonstrated that cost sharing deters women from receiving preventive care, such as mammograms and Pap smears.[11]

Even when an enrollee does seek a referral, some primary care providers could refuse to provide one. Primary care providers could take the position that individuals do not need a referral because they are able to provide the services themselves. This is troubling, as it could result in individuals not receiving high-quality family planning care, including timely access to the contraceptive methods that best fit their needs. Specialized family planning providers offer a wider array of contraceptive methods than primary care providers. Overall, 74% of reproductive health-focused clinics offered the full range of Food and Drug Administration (FDA)-approved reversible contraceptive methods in 2015, compared with only 48% of primary care-focused sites.[12] Those specialized clinics were also more likely to offer the most effective methods: 83% vs. 60% for IUDs and 74% vs. 51% for contraceptive implants.[13] In addition, specialized clinics are more likely to meet current standards for high-quality family planning care that ensure access to contraception without delay. For example, in 2015 reproductive health-focused clinics were more likely to dispense contraceptive supplies on-site, rather than forcing patients to make a separate trip to a pharmacy (72% vs, 40%); to offer "quick start" protocols that allow patients to begin using oral contraceptives immediately (88% vs. 66%); to offer same-day insertion for IUDs (49% vs. 32%) and contraceptive implants (57% vs. 43%); and to offer emergency contraception in advance, so that patients can have it on hand in case they need it (53% vs. 32%).[14]

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[9] Inst. of Med. of the Nat'l Academies, *Clinical Preventive Services for Women, Closing the Gaps* 19 (2011), https://www.nap.edu/read/13181/chapter/1 (hereinafter "IOM").
[10] *Id*. (citing Kaiser Family Found., *Health Reform: Impact of Health Reform on Women's Access to Coverage and Care* (2010), https://www.kff.org/wp-content/uploads/2012/03/7987-03-health-reform-implications-for-women_s-access-to-coverage-and-care.pdf; Sheila D. Rustgi et al., The Commonwealth Fund, *Women at Risk: Why Many Women are Foregoing Needed Health Care* (2009), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2009_may_women_at_risk_pdf_1262_rustgi_women_at_risk_issue_brief_final.pdf).
[11] IOM, *supra* n. 9, at 19.
[12] Mia R. Zolna & Jennifer J. Frost, Guttmacher Inst., *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols* 20 (2016), http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.
[13] *Id*. at 35.
[14] *Id*. at 38.

Primary care providers could also refuse to provide a referral because they have a religious objection to one or more contraceptive methods.[15] Or, providers who have a religious objection to abortion could refuse to refer a patient to a reproductive-health focused provider that also offers abortion care.[16] Research indicates this could be a particular problem for adolescents and women of color, who have reported being shamed by providers for seeking family planning care.[17]

Idaho counters that in such a situation, individuals are free to switch to a different primary care provider at any time.[18] However, many individuals enrolled in Medicaid are not aware of that right. Even when individuals are aware of that right, it will take time for them to choose a new primary care provider and obtain a referral from that provider. Large swaths of the State have been designated as primary care health professional shortage areas.[19] Individuals living in those areas could have to wait a significant amount of time to connect with a new primary care provider. As discussed in detail below, any delay in access to family planning services can result in unintended pregnancy.

Finally, some enrollees who do receive a referral will not ultimately receive necessary family planning services. Logistical and financial barriers prevent individuals from attending two appointments in a short period of time. Visiting a provider often results in lost wages (as few low-income individuals have paid leave or flexible work schedules), additional child care expenses, and/or additional transportation costs. These added costs could prevent individuals from actually receiving services from the family planning provider of their choice. In fact, studies have consistently shown significant gaps in completed

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[15] *See, e.g.*, Nat'l Health Law Program, *Health Care Refusals, Undermining Quality Care for Women* 36-45 (2010), https://healthlaw.org/resource/health-care-refusals-undermining-quality-care-for-women/ (describing religious directives that prevent Catholic-affiliated health care providers from providing contraceptive services).
[16] *See, e.g.*, *id*. at 51-53.
[17] *See* SisterSong, Nat'l Latina Inst. for Reproductive Health, Ctr. for Reproductive Rights, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* (2014), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf
[18] Application at 19.
[19] *See* Idaho Dep't of Health & Welfare, *Idaho Primary Care Health Professional Shortage Area Service Areas* (2018), https://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/Idaho%20Primary%20Care%20HPSAs%202018.pdf.

referral appointments from a primary care provider to a specialist. In one study, only 35% of referrals resulted in completed appointments.[20]

III. Reduced access to family planning services will have serious health consequences for low-income people in Idaho.

The history of the proposed project reveals that its true purpose is to limit access to certain specialized family planning providers.[21] Nevertheless, the Idaho Department of Health & Welfare now contends the purpose of the project is to "encourage" individuals to see their primary care provider, which will ultimately result in better health outcomes. As discussed above, the referral requirement could cause "an increase in contacts" between primary care providers and individuals enrolled in Medicaid, as some individuals will actually seek a referral.[22] However, the idea that this "increase in contacts" – which could be over-the-phone or in-person contacts – will increase use of preventive services and improve health outcomes among individuals subject to the requirement does not withstand even minimal scrutiny.

Research shows that women who have access to the contraceptive method of their choice are more likely to use the method consistently and effectively.[23] When women use

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[20] *See* Malhar Patel et al., *Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System*, 33 J Gen Intern Med 715 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5910374/.

[21] An anti-choice group, Idaho Chooses Life, sponsored the bill. Bryan Fischer, *A novel way to defund Planned Parenthood*, ONE News Now (Oct. 31, 2019), https://onenewsnow.com/perspectives/bryan-fischer/2019/10/31/a-novel-way-to-defund-planned-parenthood. The Director of the group said he is "not aware of any other viable strategy for states to sever their…partnership with Planned Parenthood." *Id*. Other lawmakers also described the purpose of the bill as preventing Medicaid enrollees from receiving services from Planned Parenthood. *See, e.g.*, Idaho House Health & Welfare Committee Hearing on H277 (Mar. 20, 2019), https://legislature.idaho.gov/sessioninfo/2019/standingcommittees/HHEA/ (statement of representative Rubel noting the legislation "aims to force [individuals] away from using Planned Parenthood"); Idaho Senate Health & Welfare Committee Hearing on H277 (Mar. 27, 2019), https://legislature.idaho.gov/sessioninfo/2019/standingcommittees/SHW/ (statement of Senator Jordan stating that the "language will defund Planned Parenthood"). *See also* Ron Nate, *Disappointed in Raybould*, Post Register (April 3, 2019), https://www.postregister.com/opinion/columns/disappointed-in-raybould/article_bb5e4949-fb10-560e-91d0-b7c9b134a41c.html (former Idaho representative Ron Nate stating the bill "diverts money from Planned Parenthood abortion centers and redirects it to true family care centers who favor protection life rather than murdering innocent babies").

[22] Application at 5.

[23] *See, e.g.,* Caroline Moreau et al., *Social, Demographic and Situational Characteristics Associated with Inconsistent Use of Oral Contraceptives: Evidence from France*, 38(4)

contraception consistently, their risk of unintended pregnancy drops significantly.[24] Unintended pregnancies and births are associated with poorer health outcomes for the pregnant individual, including later engagement in prenatal care and increased risk of maternal depression.[25] They are also associated with an increased risk of adverse birth outcomes, including preterm birth and low birthweight.[26] By helping people avoid pregnancies they do not want and time and space the pregnancies they do want, contraceptive use also decreases pregnancy-related illness, injury, and death, especially for women who have medical conditions that may be exacerbated by pregnancy.[27]

In addition, contraceptive care is often provided in tandem with other preventive services, such as screening for sexually transmitted infections, breast and cervical cancer, and intimate partner violence. Timely access to screening is critical to detect and address these conditions.[28]

Yet, as described above, the waiver will make it more difficult for people to get timely access to family planning services. And, Medicaid enrollees who are compelled to access family planning services from their primary care provider will be less likely to have access

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Perspectives on Sexual and Reproductive Health 190 (2006), https://pdfs.semanticscholar.org/c3cd/dc571e5648f98c8382ec9c7197ee9d967557.pdf?_ga=2.134277169.1905262457.1574790387-544665431.1574790387; Joanne Noone, *Finding the Best Fit: A Grounded Theory of Contraceptive Decision Making in Women*, 39(4) Nursing Forum 13 (2004) (attached); Loretta Gavin et al., Ctrs. for Disease Control and Prevention & U.S. Office of Population Affairs, *Providing Qualify Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*, Morbidity & Mortality Weekly Rep., April 25, 2014, at 37, https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm.

[24] Guttmacher Inst., *Improving Contraceptive Use in the United States* (2008), https://www.guttmacher.org/pubs/2008/05/09/ImprovingContraceptiveUse.pdf.

[25] HRSA, Women's Health USA 2011, Unintended Pregnancy and Contraception, https://mchb.hrsa.gov/whusa11/hstat/hsrmh/pages/227upc.html; Dep't of Health & Human Servs., Office of Disease Prevention & Health Promotion, Healthy People 2020: Family Planning (last updated Nov. 21, 2019), https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning#one.

[26] *Id.*; March of Dimes, *Fact Sheet: Birth Spacing and Birth Outcomes* (2015), https://www.marchofdimes.org/MOD-Birth-Spacing-Factsheet-November-2015.pdf.

[27] Megan L. Kavanaugh and Ragnar Anderson, Guttmacher Inst., *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers* (2013), https://www.guttmacher.org/report/contraception-and-beyond-health-benefits-services-provided-family-planning-centers.

[28] *See, e.g.*, Jill Jin, *Screening for Cervical Cancer*, 320 JAMA 732 (2018), https://jamanetwork.com/journals/jama/fullarticle/2697698; Sepideh Saadatmand et al., *Influence of tumour stage at breast cancer detection on survival in modern times: population based study in 173, 797 patients*, 351 BMJ (2015) https://www.bmj.com/content/351/bmj.h4901.

to their contraceptive method of choice. Data from Idaho underscores the need for significantly increased – not restricted – access to family planning services. In Idaho, almost a third of all pregnancies are unwanted or wanted later.[29] These pregnancies are due at least in part to lack of access to family planning services. In 2014, more than 113,000 women in Idaho were in need of publicly funded contraceptive services, but only 23,950 women received publicly funded contraceptive services.[30] Idaho's proposed project will result in even fewer low-income individuals accessing necessary care, leading to worse health outcomes for people across the State.

The referral requirement could also cause negative health outcomes through another mechanism – by harming the quality of primary care provider-patient relationships. Managed care policies that emphasize primary care physicians as gatekeepers impeding access to specialists have been found to undermine patients' trust and confidence in their primary care physicians.[31] Patients' trust in their health care professional is needed to encourage patients to be involved in their health care decisions and is associated with better health outcomes. [32] While Idaho purports to seek those results, evidence suggests that the waiver will have the opposite effect.

IV. Imposing cost sharing for a referral visit violates the Medicaid Act.

The Medicaid Act prohibits states from charging any cost sharing or similar charge for family planning services.[33] However, as noted above, the project would allow primary care providers to charge certain individuals $3.65 for an office visit to obtain a referral for family planning services. Idaho argues that such a charge would not violate the Medicaid Act because individuals are not receiving any family planning services during the primary care visit.[34] Idaho's interpretation is far too narrow. Imposing cost sharing for a primary care visit, the only purpose of which is to obtain a required referral for family planning services, is effectively imposing cost sharing on the family planning services themselves. To comply

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[29] Guttmacher Inst., Data Center, U.S. States, https://data.guttmacher.org/states/table?topics=161+156+280&dataset=data&state=ID (last visited Nov. 21, 2019).
[30] Jennifer J. Frost et al., Guttmacher Inst., *Contraceptive Needs and Services, 2014 Update* (2016), https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.
[31] Kevin Grumbach et al, *Resolving the Gatekeeper Conundrum*, 282 JAMA 261 (1999), https://jamanetwork.com/journals/jama/fullarticle/190758.
[32] *See* Johanna Birkhauer et al., *Trust in the health care professional and health outcome: A meta-analysis*, 12 PLoS One (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5295692/.
[33] 42 U.S.C. §§ 1396o(a)(2)(d), 1396o(b)(2)(d), 1396o-1(b)(3)(B)(vii).
[34] Application at 19.

with the Medicaid Act, Idaho would need to request a waiver under § 1396o(f).[35] Notably, the proposed project does not meet the conditions set forth in that provision.[36]

Conclusion

In summary, while NHeLP supports the use of § 1115 to implement true demonstration projects that are likely to promote the objectives of the Medicaid Act, we strongly object to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in their best interests. As demonstrated above, Idaho's proposed project is inconsistent with the standards of § 1115.

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these citations part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Catherine McKee (mckee@healthlaw.org) or Priscilla Huang (huang@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director

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[35] Application at 10 (noting that Idaho is not requesting a waiver of the cost sharing requirements).
[36] *See* 42 U.S.C. § 1396o(f)(1)-(5). The cost sharing also violates federal Medicaid regulations that require Alternative Benefit Plan enrollees to receive contraceptive services free of cost. *See* 42 C.F.R. § 440.347(a) (requiring ABPs to cover the Essential Health Benefits); 45 C.F.R. §§ 156.115(a)(4) (defining EHBs to include preventive health services), 147.130(a)(1)(iv) (setting forth preventive health services, including women's preventive care as provided for in HRSA guidelines, that must be covered without cost sharing). *See also* Health Resources & Servs. Admin., *Women's Preventive Services Guidelines* (last reviewed Oct. 2019), https://www.hrsa.gov/womens-guidelines-2016/index.html.