May 3, 2024

Chiquita Brooks-LaSure, MPP, Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd., Mail Stop S2-01-16
Baltimore, MD 21244-1850

Submitted electronically via Medicaid.gov

RE: Request for Comments on "Healthy Texas Women" § 1115(a) Medicaid Demonstration Extension

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care, including the full range of reproductive health services, and protect the legal rights of low-income and under-served individuals. We appreciate the opportunity to provide these comments on the "Healthy Texas Women" demonstration extension request.

NHeLP strongly supports expanding coverage of and access to family planning services and supplies for low-income individuals. NHeLP is deeply concerned by the State's request to continue to exclude qualified providers from the project. Texas has already experimented with this very policy – both over the last four years and previously in its state-funded family planning program, and shown that it dramatically reduces access to services. The State's unprecedented request to receive federal Medicaid funding to continue pursuing this failed and harmful policy does not meet the requirements of §1115.

HHS Authority and § 1115 Waivers

For the Secretary to approve a project pursuant to § 1115, the project must:

- be an "experimental, pilot, or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;

- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only to the extent and for the period necessary to carry out the experiment.

Discussing each of these limitations a bit further:

First, the state must propose to conduct an "experimental, pilot, or demonstration" project. This demands a "novel approach" to program administration.[1] To evaluate whether a proposed project is a valid experiment, the Secretary needs to know what will be tested and how, at the point in time when the project is being approved.

Second, the project must promote the Medicaid Act's objectives. According to Congress, the purpose of Medicaid is to enable states "to furnish[] medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[2] Thus, the "central objective" of the Medicaid Act is "to provide medical assistance," that is, to provide health coverage.[3]

Third, the Secretary can only waive provisions set forth in § 1396a of the Medicaid Act. The Secretary cannot waive requirements contained in § 1396b through 1396w-6.[4] Once the Secretary has acted under § 1115(a)(1) to waive compliance with designated provisions in § 1396a, § 1115(a)(2) provides that the costs of "such project" are "regarded as expenditures under the State plan" and, thus, paid for under the same statutory formula that applies for a state's expenditures under its State plan.[5] Section 1115(a)(2) does not create an independent "expenditure authority" for the Secretary to allow a state to ignore provisions of the Medicaid Act outside of § 1396a or to rewrite the provisions in § 1396a or any other provision outside of § 1396a. To the contrary, it is a "clean-up" provision that merely provides the authorization necessary for federal reimbursement of expenditures for a project that has been approved under § 1115(a)(1). To be clear, as worded, § 1115 does not include an independent, freestanding expenditure authority.[6] As the Supreme Court's recent opinion involving the EPA illustrates, the words of statutes must control—and limit—the actions of the federal agency, in

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[1] *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).
[2] 42 U.S.C. § 1396-1; *id.* § 1396d(a) (defining "medical assistance" as provision of, or payment for, specified health care and services).
[3] *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019); *id.* at 144 (rejecting "promoting health" as an independent objective because the Medicaid Act is "designed … to address not health generally but the provision of care to needy populations" through a health insurance program).
[4] *See* 42 U.S.C. § 1315(a)(1).
[5] *Id.* § 1315(a)(2).
[6] *See, e.g., Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1097 (9th Cir. 2005) (stating "Section 1115 does not establish a new, independent funding source. It authorizes the Secretary to 'waive compliance with any of the requirements of' a series of provisions of the Social Security Act in approving demonstration projects.").

this case limiting HHS to using federal Medicaid funding only for experimental projects that are consistent with Medicaid's objectives and that waive only provisions set forth in § 1396a.[7]

Fourth, § 1115 allows approvals only "to the extent and for the period . . . necessary" to carry out the experiment.[8] The Secretary cannot use § 1115 to permit states to make long-term policy changes.

As explained in detail below, Texas' request to continue waiving the freedom of choice protection does not meet these requirements, and as a result, should not be approved.

Freedom of Choice

The Medicaid Act's free choice of provider guarantee—42 U.S.C. § 1396a(a)(23)— is a fundamental protection designed to ensure that beneficiaries have their choice of quality health care providers. Texas is seeking to once again waive this longstanding federal protection for the purpose of excluding providers who perform or promote abortions or affiliate with providers who do. Texas' request to renew this waiver 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."[9] 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.[10]

Congress recognized that people being able to access care from the provider of their choice is especially critical in the context of family planning services. Certain groups—including young adults and people at risk of domestic or intimate partner violence—have special privacy concerns when accessing this care.[11] In addition, not only is there significant evidence showing

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[7] *See West Virginia v. EPA*, 142 S. Ct. 2587 (2022).
[8] 42 U.S.C. § 1315(a); *see also id.* §§ 1315(e)(2), (f)(6) (limiting the extension of "state-wide, comprehensive demonstration projects" to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers)).
[9] *Id*. § 1396a(a)(23).
[10] *Id.* §§ 1396a(a)(23)(B), 1396n(b).
[11] *See generally* Kinsey Hasstedt & Andrea Rowan, *Understanding Intimate Partner Violence as a Sexual and Reproductive Health and Rights Issue in the U.S.*, Guttmacher Inst. (July 16, 2016), https://www.guttmacher.org/gpr/2016/07/understanding-intimate-partner-violence-sexual-and-reproductive-health-and-rights-issue.

that many women prefer to receive this critical care from family planning providers, there is also evidence revealing that many women rely on this care and that it is their only recent source of health care.[12]

Both the Centers for Medicare & Medicaid Services (CMS) and the courts have found 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.[13] CMS rescinded its April 19, 2016 guidance that any standards for participation should be related to the fitness of the provider to perform covered medical services—*i.e*., the provider's capability to perform, or bill for, the required services.[14] Regardless of the rescission, the statute is clear that provider qualification standards should be applied in an evenhanded manner and not target a provider or set of providers for reasons unrelated to their ability to provide or bill for the Medicaid service.

Moreover, if a state determines that a provider does not meet the state's provider qualification standards, that determination should be supported by evidence demonstrating that the provider's ability to provide or bill for the service is compromised, such as in the case of fraud or abuse or non-compliance with federal requirements.[15] Providers should not be excluded from participation in their state Medicaid programs simply because they provide the full spectrum of gynecological and obstetric care as part of their scope of practice.

Prior to the last administration granting Texas approval to waive freedom of choice in this program, (a)(23) had long been upheld as the cornerstone for family planning access. CMS had previously recognized that Texas could not use § 1115 to avoid these protections, as

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[12] 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*, Women's Health Issues (Nov/Dec. 2012), https://pubmed.ncbi.nlm.nih.gov/23122212/ (finding that 41% of respondents, or 4 in 10, relied on family planning clinics as their only recent source of health care); *Examining the Health Care Needs and Preferences of Women Ages 18 to 44*, PerryUndem for Planned Parenthood Action Fund (Jul. 2017), https://www.plannedparenthood.org/uploads/filer_public/31/28/312868ed-0dcf-48a2-b146-03087fccff02/perryundem_research_july_2017.pdf (finding 9 in 10 women prefer having a choice of a specialized sexual and reproductive health care provider and general practitioner as their main provider).

[13] *See, e.g.*, *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* CMS, Dear State Medicaid Director Letter (April 19, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf.

[14] CMS, Dear State Medicaid Director Letter (April 19, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16005.pdf. And further finding that 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."

[15] *See Planned Parenthood S. Atl. v. Baker*, 941 F.3d 687, 704 (4th Cir. 2019); *Planned Parenthood of Indiana, Inc. v. Comm'r of Indiana State Dep't Health*, 699 F.3d 962 (7th Cir. 2012).

excluding providers for reasons unrelated to their qualifications does not further the objectives of the Medicaid Act.[16] Indeed, excluding qualified reproductive health providers only delays care and impedes timely access to critical health services.

Continuing to Waive Freedom of Choice Does Not Further Medicaid's Objectives and Harms Women's Health

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. In 2007, Texas implemented a family planning expansion project under § 1115. According to the State's own data, the project improved access to contraception and reduced unintended pregnancies.[17] 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.[18]

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."[19] A

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[16] *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).
[17] Tex. Health & Human Servs. Comm'n, *2010 Annual Savings and Performance Report for the Women's Health Program*, (2011), https://hhs.texas.gov/sites/default/files//rider64-womens-health-0811.pdf.
[18] 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).
[19] Kinsey Hasstedt and Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFAIRS BLOG, (July 18, 2017), http://healthaffairs.org/blog/2017/07/18/at-it-again-texas-continues-to-undercut-access-to-reproductive-health-care/. *See also* Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUB. HEALTH 851 (2016) (reporting that prior to the exclusion, nearly half of all enrollees received services at Planned Parenthood clinics); Tex. Health & Human Servs. Comm'n, *2010 Annual Savings and Performance Report for the Women's Health Program* 5 (2011) (reporting that 80% of program enrollees who received services in 2010 did so at a dedicated family planning health center).

large body of research shows the devastating effect this decision had on women's access to family planning and other preventive services.[20]

Between 2011 and 2015—pre- and post-provider exclusion in Texas—access to qualified, trusted family planning providers was severely curtailed. "By excluding numerous safety-net health centers and relying primarily on private doctors, the state developed a provider network incapable of serving high volumes of family planning clients. In turn, the state reported a nearly 15% decrease in enrollees statewide over the four-year period."[21] Further, by 2016, "26% [of] Texas women who the state reported as enrolled in the program had in fact never received health care services from a participating provider, up from only 10% in 2011."[22] This dramatic decrease in access to services occurred despite the addition of "thousands more private practices and clinicians" by the State, as these providers serve significantly fewer patients annually than family planning health centers.[23]

Similarly, the State's own data shows a precipitous decline in utilization of contraception among women enrolled in the program. Between 2011 and 2015, claims or prescriptions filed for all contraceptive methods dropped 41%, including dramatic decreases in enrollees

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[20] C. Junda Woo et al., *Women's Experiences After Planned Parenthood's Exclusion from a Family Planning Program in Texas*, 93 CONTRACEPTION 298 (2016), https://www.contraceptionjournal.org/article/S0010-7824(15)30038-X/abstract; Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016); Alexa Ura, *Study: Half of Texas Women Face Barriers to Reproductive Health Care*, The Texas Tribune (May 12, 2015), https://www.texastribune.org/2015/05/12/more-half-women-face-barriers-reproductive-service/; Sophie Novack, *Without Planned Parenthood, Almost Half the Providers in Texas' Women's Health Program Saw No Patients*, Texas Observer (Oct. 16, 2018), https://www.texasobserver.org/without-planned-parenthood-almost-half-the-providers-in-texas-womens-health-program-saw-no-patients/;*Excluding Planned Parenthood Has Been Terrible for Texas Women*, Every Texan (Aug. 2017), https://everytexan.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf; Kinsey Hasstedt and Adam Sonfield, *supra* note 19.

[21] Kinsey Hasstedt and Adam Sonfield, *supra* note 19 (citing Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* (2017), https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance).

[22] *Id.* (citing analysis included in Letter from Stacey Pogue, Senior Policy Analyst, Ctr. for Pub. Policy Priorities, to Jami Snyder, Assoc. Comm'r, Medicaid & CHIP Servs., Tex. Health & Human Servs. Comm'n (June 12, 2017), https://forabettertexas.org/images/CPPP_comments_on_HTW_draft_waiver_application.pdf). *See also* Ctr. for Pub. Policy Priorities, *Excluding Planned Parenthood has been Terrible for Texas Women and Texas Still Wants Medicaid to Pay for its Bad Idea* (2017), https://forabettertexas.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf.

[23] *Id. See also* Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 4-5 (2017) (reporting that from 2011 to 2015, the number of providers seeing large numbers of enrollees declined, while the number of providers seeing relatively few enrollees (approximately 8 per provider) increased).

obtaining injectable contraceptives, oral contraceptives, condoms, and the contraceptive patch and ring.[24]

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.[25] 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.[26] 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."[27] These issues exasperate the numerous existing barriers that women in Texas face when attempting to access sexual and reproductive health care.[28]

Records show that Texas has still failed to fill the gap left by Planned Parenthood and other established family planning providers, leaving many women with inadequate access to contraception and preventive screenings.[29] Though the number of providers increased from just over 1,300 in the predecessor program in 2011 to about 5,400 in "Healthy Texas Women" in 2017, the average number of patients seen by each dropped from 150 to 85 during that time.[30] And in 2017, among participating providers, half did not deliver care to a single patient, and 700 providers only saw a single person enrolled in the program.[31] Furthermore, less than a

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[24] *Id.* at 8 (2017) (reporting a 32% decrease in claims for contraceptive injections, 47% decrease for oral contraceptives, and 59% decrease for condoms).
[25] Amanda Stevenson et al., *supra* note 20.
[26] *Id.*
[27] *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)).
[28] Power to Decide, Factsheet: Contraceptive Access in Texas (Nov. 2022), https://powertodecide.org/sites/default/files/2022-11/State%20Factsheet_Texas.pdf. These barriers to contraception fall hardest on Black, Indigenous, and people of color (BIPOC), young people, LGBTQ+ individuals, those working to make ends meet, and people with disabilities.
[29] Sophie Novack, *Without Planned Parenthood, Almost Half the Providers in Texas' Women's Health Program Saw No Patients*, Texas Observer (Oct. 16, 2018), https://www.texasobserver.org/without-planned-parenthood-almost-half-the-providers-in-texas-womens-health-program-saw-no-patients/;
[30] *Id.*; Sophie Novack, *Lawmaker: State Metric For Success Of Women's Health Program Is 'Totally Misleading'*, Texas Observer (May 2, 2018), https://www.texasobserver.org/lawmaker-state-metric-success-womens-health-program-totally-misleading/.
[31] Sophie Novack, *Without Planned Parenthood, Almost Half the Providers in Texas' Women's Health Program Saw No Patients*, Texas Observer (Oct. 16, 2018), https://www.texasobserver.org/without-planned-parenthood-almost-half-the-providers-in-texas-womens-health-program-saw-no-patients.

quarter of the nearly two million Texas women who need publicly funded contraception and preventive care are getting that care.[32]

Even making the dubious assumption that there was an experiment when the § 1115 waiver was approved, the redundant and consistent research establishes that there is certainly not an experiment now. For purposes of the Secretary's § 1115 review authority, approval of the Texas request is not "necessary" for the State to complete an experiment, and it certainly would not further the objectives of the Medicaid Act. The evidence from Texas is overwhelmingly clear—prohibiting low-income women from receiving family planning services from qualified providers of their choice because those providers perform or promote abortion services or affiliate with providers who do so reduces access to health care and places women's health at risk. Texas' request to continue waiving § 1396a(a)(23) must be rejected.

Conclusion

We appreciate your consideration of our comments. If you have questions about these comments, please contact Christina Piecora (piecora@healthlaw.org) or Jane Perkins (perkins@healthlaw.org).

Respectfully submitted,

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[32] Texas Women's Healthcare Coalition, Healthy Texas Women Factsheet, https://www.texaswhc.org/wp-content/uploads/2024/04/Healthy-Texas-Women-HTW.pdf.