

Geiger Gibson Program in Community Health Policy
Comments Regarding the Texas Health and Human Services Commission's Draft
Medicaid 1115 Family Planning Demonstration Proposal

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Sara Rosenbaum, JD

Harold and Jane Hirsh Professor, Health Law and Policy

Peter Shin, PhD, MPH

Associate Professor and Director of Research

Geiger Gibson Program in Community Health Policy

Jessica Sharac, MSc, MPH

Senior Research Associate and Assistant Director of Research

Geiger Gibson Program in Community Health Policy

Rachel Gunsalus

Assistant Director

Geiger Gibson Program in Community Health Policy

Milken Institute School of Public Health

The George Washington University

Introduction

Pursuant to 42 C.F.R. §431.408(a),¹ the Geiger Gibson Program in Community Health Policy at the Milken Institute School of Public Health at the George Washington University, submits these comments regarding the Healthy Texas Women Draft Section 1115 Demonstration Waiver Application.²

Established in 2004, the Geiger Gibson Program focuses on the nation's community health centers and the medically underserved communities and populations they serve. Program faculty and staff possess extensive expertise in community health centers, women's health, Medicaid, and health care financing for medically underserved populations. In recent years, the Geiger Gibson program has placed particular attention on health centers' role in women's health, including provision of family planning and related

¹ 42 §400 et seq. 77 Fed Reg. 11677 (Feb. 27, 2012) See <https://www.medicaid.gov/medicaid/section-1115-demo/transparency/index.html> (Accessed online May 22, 2017)

² Available at <https://hhs.texas.gov/sites/hhs/files/documents/laws-regulations/policies-rules/1115-waiver/HTW/htw-1115-waiver-application-draft.pdf> (Accessed online May 22, 2017)

women's preventive health services. Our studies on health centers and family planning, undertaken with the George Washington University's Jacobs Institute of Women's Health, have been widely cited and our research has documented the extent of health centers' involvement in family planning and related services in medically underserved communities and populations.³

Based on the evidence, we have reached two conclusions. First, health centers are an integral part of any system of publicly funded family planning providers for low-income and medically underserved women. In this regard, Texas's reliance on health centers is well placed.

Second, Texas's health centers are not in a position to replace the loss of access to women's preventive health services – much less help dramatically expand access as the state proposes to do in the time frame provided – if Planned Parenthood's operational capacity is crippled by the state's proposed Medicaid exclusion. Simply put, excluding Planned Parenthood from the state's Medicaid family planning demonstration program will diminish access, not expand it, an inevitable result of eliminating a key source of health care for women in hundreds of medically underserved urban and rural communities identified by HHS as experiencing extensive primary health care shortages. These communities need all possible primary care access points; excluding qualified providers will have precisely the opposite impact. Health centers simply cannot make up the deficit in the near-term, much less help the state achieve its goal of actually improving access over the long term.

By Excluding Planned Parenthood, Texas Would Impede Access to Care, Not Expand It, in Direct Contravention of Its Stated Demonstration Goal

In its proposal, Texas states that the objective of its demonstration is to expand access to women's preventive health services. Specifically, the proposal states that its purpose is to “increase access to women's health and family planning [and] preventive care.”⁴ This objective is essential in the context of § 1115 of the Social Security Act, which limits the HHS Secretary's power to waive federal laws to demonstrations that further Medicaid's objectives. For medically underserved, heavily uninsured low-income women, the only reasonably plausible objective under § 1115 is to improve access to women's preventive health care, not deplete it.

At the same time, however, the state proposes to exacerbate the state's serious medical underservice problem by excluding from the demonstration as a qualified provider any entity not in compliance with Texas Human Resource Code § 32.024 (c-1) (Proposal p. 30), meaning any entity that either provides elective abortions or is affiliated with one that does. Presumably this would exclude Planned Parenthood and certain other family planning clinics that currently receive funding under Title X of the Public Health Service Act. Yet according to the Guttmacher Institute, Texas's Planned Parenthood clinics served more than 1 in 4 of the more than 411,000 Texas women who depend on publicly funded family planning

³ See, e.g., S.F. Wood et al. (2013). Health Centers and Family Planning: results of a Nationwide Study, available at http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1059&context=sphhs_policy_facpubs (Accessed online May 22, 2017); S. Rosenbaum et al. (2015). Using Payment Reform Strategies to Strengthen Family Planning Services at Community Health Centers, available at https://publichealth.gwu.edu/pdf/eIR/GGRCHN_PolicyResearchBrief_38.pdf (Accessed online May 22, 2017); S.F. Wood et al. (2015). Patient Experiences with Family Planning in Community Health Centers, available at https://publichealth.gwu.edu/sites/default/files/Geiger_Gibson_Family_Planning_Report_2015.pdf (Accessed online May 22, 2017)

⁴ Draft proposal, p. 3

programs.⁵ Presumably, Texas’s proposed provider participation standard also would exclude clinics operated by hospitals that perform what the state terms “elective” abortions, as well as physicians who do so, thereby further constraining access.

That the state’s proposal to exclude highly qualified providers offering access to preventive health care raises serious concerns for hundreds of thousands of low-income women, a reality underscored by the immense size of the population eligible for the demonstration – over 690,000 women of childbearing age in Year 1, swelling by Year 5 to three quarters of a million women. Census data indicate that this group represents one-third of the 2.18 million low-income women of childbearing age in the state (ages 15-44 and under 200 percent of the federal poverty level).⁶

Indeed, the state’s proposed provider participation rules would affect nearly all women of childbearing age in Texas who qualify for Medicaid, since the state’s full-benefit program for women is so limited. The significance of this demonstration in terms of Medicaid policy both in Texas and as a matter of national precedent can be traced to two factors. The first is the extent of poverty in Texas, which in turn creates an enormous need for Medicaid coverage; poverty rates are so high – nearly 1 in 6 nonelderly women⁷ – that women inevitably depend on public insurance to be able to afford even basic medical care.

The second reason, as noted, is the diminished reach of Texas’s “full benefit” Medicaid program for women of childbearing age. These women appear to be exempt from the terms of the demonstration but given the highly restricted nature of the Texas Medicaid program, they are relatively few in number. As a non-ACA expansion state, Texas provides full Medicaid benefits to a very small number of women of childbearing age (the target demonstration group); the only women in this demographic cohort who qualify for full benefits would be those who are also poverty-level children under 18, parents of minor children with household incomes below 18 percent of the federal poverty level,⁸ or deeply impoverished women with disabilities. All other women in the demographic group would qualify for Medicaid as demonstration beneficiaries and thus will be subject to the demonstration’s access restrictions for preventive women’s health services. Presumably, this would also include post-partum women who currently enjoy full access to qualified Medicaid providers but may receive only limited benefits during the post-partum period.

Imposing provider restrictions will seriously constrain women’s access to the full range of preventive health care since beneficiaries will be able to exercise their coverage at a portion of all of the providers qualified to serve them. Among the services affected are preventive screenings for cancer and early intervention for problems such as post-partum depression. Also affected would be access to birth control, identified by the Centers for Disease Control and Prevention as one of the most important public health advances of the 20th century.⁹ These restrictions, moreover, would come at a time of a resurgence in

⁵ Memorandum from Jennifer Frost to Senator Patty Murray. (May 3, 2017). Available at <https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017> (Accessed online May 30, 2017)

⁶ US Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2016. <http://www.census.gov/cps/data/cpstablescreator.html>

⁷ Kaiser Family Foundation. (2015). Nonelderly Adult Poverty Rate by Gender. State Health Facts. (Accessed online June 5, 2017), available at <http://www.kff.org/other/state-indicator/adult-poverty-rate-by-gender>

⁸ Kaiser Family Foundation. (2017). Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level. State Health Facts. (Accessed online May 30, 2017), available at <http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁹ Centers for Disease Control and Prevention. (1999). Achievements in public health, 1900–1999: Family planning. *MMWR Weekly*, 48 (47): 1073-80.

sexually transmitted diseases as well as the emergence of the Zika virus, which poses a profound public health threat, especially for women with unintended pregnancies who, unaware of their condition, will not have taken early precautions. There is no more urgent time to reduce the unintended pregnancy rate, and yet the state's demonstration would constrain, rather than expand, access. Without question, such a result would defeat rather than promote Medicaid's objectives, in direct contravention of § 1115 requirements and the agency's own stated objectives.

In order to be able to improve access to care – the core purpose of the proposal – the demonstration will have to generate a massive new number of access points for newly insured women. This is evident from the large number of women eligible for coverage and the limited number of access points shown on the state's map. Yet the proposal would have precisely the opposite effect: by eliminating clinics serving 1 in 4 Texas women who depend on publicly funded clinics for their care, the state already will start with an enormous access deficit. Not only will the state have to expand the number of qualified providers, but it will have to overcome the hole it has dug for itself by excluding such an important group of clinics. Evidence from the state itself (Draft proposal, map p. 31) shows wide swaths of the state where access is critically lacking. By expanding the Healthy Texas Women program through the provision of insurance benefits, the state will increase demand even as it blocks participation by essential providers.

For the state's plan to succeed, publicly funded clinics such as community health centers and Planned Parenthood are critical, because beneficiaries are concentrated in medically underserved communities; it is in these communities that publicly-supported health care providers play an outsize role in the provision of primary health care, including preventive women's health care. While there may be several types of providers that accept Healthy Texas Women program patients, our previous analysis¹⁰ of the Texas Women's Health Program (WHP) – the precursor to Healthy Texas Women – showed that in Fiscal Year 2010, 62 percent of the 1,469 participating providers in the predecessor program served ten or fewer patients. The state does not show evidence in its proposal that it has been able to overcome the problem of very low participation rates among those providers that do, in fact, see some number of eligible women.

Given the presence of so many providers that so severely limit the number of patients served, the role of Planned Parenthood hardly can be overstated. Indeed, the impact of excluding Planned Parenthood can be seen in the 26 percent decrease overall in WHP utilization from 2011 to 2013 after Planned Parenthood was eliminated as a WHP eligible provider, with regional reductions amounting to a 64 percent decline in utilization in West Texas and a 53 percent decline in the High Plains.¹¹ By restoring Medicaid coverage for women's preventive care, the state will elevate demand even as it eliminates a crucial source of health care.

In Texas – whose medical underservice problems make it the 2nd state in the nation in both the number of Primary Care Health Professional Shortage Areas (HPSAs) and the population living in primary care HPSAs¹² – community health centers (known for Medicaid and CHIP payment purposes as “federally

¹⁰ Shin, P., Sharac, J., & Rosenbaum, S. (2012). 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. <http://www.rchnfoundation.org/wp-content/uploads/2013/02/GG-FP-study-0504-revised.pdf>

¹¹ Texas Health and Human Services Commission. (2015). Texas Women's Health Programs: Savings and Performance Reporting. <https://hhs.texas.gov/sites/hhs/files/tx-womens-health-program-rider-44-report.pdf>

¹² Kaiser Family Foundation. (2017). Primary Care Health Professional Shortage Areas (HPSAs). State Health Facts. <http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas->

qualified health centers”) play a key role. But the Guttmacher Institute points out that health centers in the state would have to more than double their capacity in order to simply offset the elimination of Planned Parenthood as a participating provider.¹³ Health centers, of course, will need to do far more than this in order to actually increase access to care, consistent with the proposal’s core objective. Furthermore, health centers would have to double their capacity in an absurdly rapid time frame, given the state’s intention to start its demonstration in 2018. And of course even the Guttmacher estimates – by far the gold standard – assume that every community whose women will lose a Planned Parenthood clinic also lies within the existing service area of a health center.

The Geiger Gibson Program therefore undertook a closer examination of the status of the state’s health centers in order to determine whether such a result is even minimally supported by objective evidence sufficient to support federal approval of a demonstration that would eliminate a source of health care that 1 in 4 Texas women using publicly-supported family planning services depend on. What is the current capacity of health centers? How much has health center capacity grown in recent years? And realistically, how much might health center capacity grow in the coming years, particularly at a time when the state continues to reject the Affordable Care Act adult Medicaid expansion while proposing over \$1 billion in additional Medicaid funding reductions? These questions also come at a time when health centers’ continued ability to grow is highly uncertain as a result of continued federal inaction over health center grant funding, federal Medicaid funding reductions exceeding \$800 billion, and the continuation of CHIP funding.

The challenges faced by health centers in attempting to replace lost Planned Parenthood capacity – something they already were demonstrably unable to do, as the initial elimination of Planned Parenthood from the Women’s Health Program already has shown¹⁴ – are further magnified by the fact that by the state’s own definition, demonstration-eligible women will be entitled to only limited Medicaid benefits, leaving them uninsured for all other essential health center services. It is also unclear whether health centers will be paid the full PPS rate for the services that are, in fact, covered, thereby further reducing their ability to expand to meet additional need.

Health centers offer comprehensive primary care services to their patients; indeed, this is their strength. But this also means that women who must depend on health centers for their family planning and related preventive services will be insured only for a limited amount of care. Health centers will in effect face the pressure to expand services for patients who remain uninsured for most types of primary health care, ranging from vision and oral health care to treatment of depression or serious and chronic health conditions.

https://www.guttmacher.org/sites/default/files/article_files/gpr2006717_0.pdf

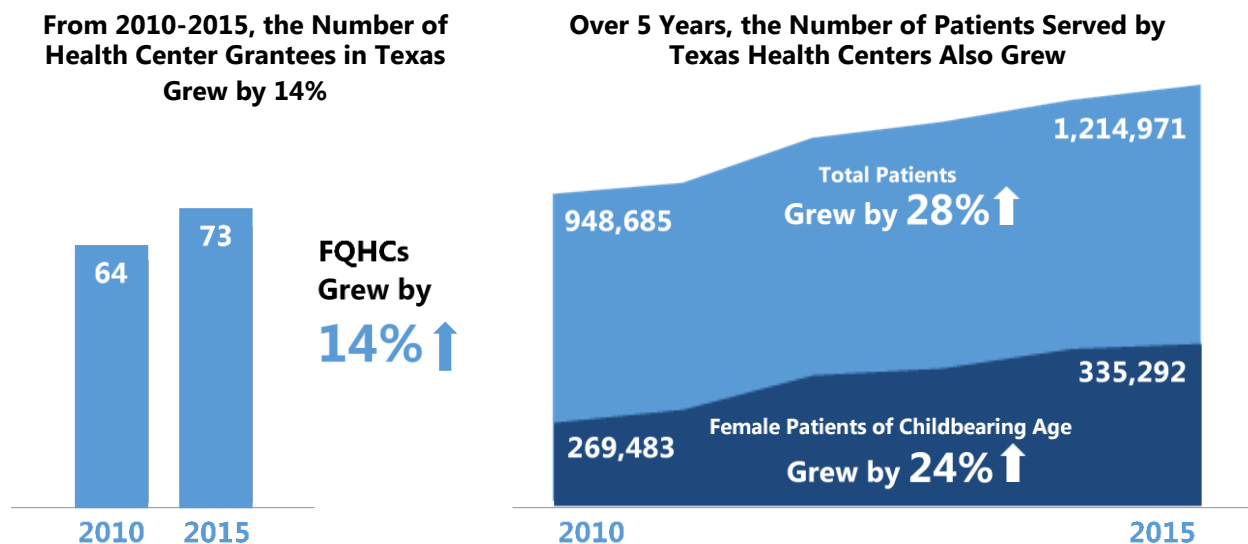
¹³ Hasstedt, K. (2017). Federally Qualified Health Centers: vital sources of care, no substitute for the family planning safety net. *Guttmacher Policy Review*, 20. https://www.guttmacher.org/sites/default/files/article_files/gpr2006717_0.pdf

¹⁴ Stevenson, A.J., Flores-Vasquez, I.M., Allgeyer, R.L., Schenckan, P., and Potter, J.E. (2016). Effect of removal of Planned Parenthood from the Texas Women’s Health Program. *New England Journal of Medicine*, 374:853-860. <http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article>

Given the Challenges Currently Facing Health Centers in the Face of Funding Uncertainty, Texas’s Health Centers Lack the Capacity to Grow at the Rate Necessary to Replace Lost Planned Parenthood Services; Furthermore, Many Communities Losing Planned Parenthood Also Lack Any – or a Sufficient Supply of – Health Centers

Health centers are remarkably effective at caring for low-income and medically underserved patients. But despite their quality and efficiency, they cannot hope to fill the void that would be created by the state’s demonstration. The data we present below are taken from the Uniform Data System (UDS), the federal government’s database on health center grantees, patients, staffing, revenue, and performance. The UDS represents a rich and ongoing source of information about health center growth and performance.

The figures below compare Texas health centers in 2010 and 2015. In 2015, 73 community health center grantees in Texas, averaging 6.2 sites each, served over 1.2 million patients.¹⁵ This figure represents growth of 14 percent in the number of grantees, up from 64 grantees in 2010, and 28 percent growth in the number of patients served over 5 years, up from 948,685 patients in 2010.¹⁶ In 2015, health centers in Texas served 335,292 women of childbearing age, over a quarter (28%) of their total patient population. The number of women of childbearing age served in 2015 represents a 24 percent increase over the 2010 figure of 269,483.



SOURCE: Texas Uniform Data System reports, 2010-2015. <https://bphc.hrsa.gov/uds/datacenter.aspx?year=2015&state=TX>

Because they are located in a non-expansion state, Texas health centers serve a deeply impoverished, extensively uninsured patient population unable to meet the cost of necessary care without heavily discounted fees and nominal cost-sharing. In 2015, 72 percent of health center patients had incomes at or below poverty, while 94 percent of patients reported income at or below 200 percent of the federal

¹⁵ Bureau of Primary Health Care. (2016). 2015 Health Center Data: Texas Data. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2015&state=TX>

¹⁶ Bureau of Primary Health Care. (2011). 2010 Health Center Data: Texas Data. <https://bphc.hrsa.gov/uds/view.aspx?q=tall&year=2010&state=TX&fd=>

poverty level. In 2015, 42 percent of health center patients were completely uninsured, a figure 2.6 times higher than the overall uninsured rate of 16 percent in Texas that year.¹⁷

By both law and mission, health centers offer comprehensive primary health care, including preventive health services for women of childbearing age. Health centers in Texas in 2015 employed 3,452 FTE medical staff. This group included only 77 obstetrician/gynecologist FTEs and 16 certified nurse midwife FTEs for 335,000-plus women of childbearing age. The UDS does not provide information on certified family planning counselors, but for the entire state, health centers employed only 115 FTE Patient/Community Education Specialists in 2015.

As in other states, Texas health centers provide a wide range of services including extensive care to women of reproductive health age. According to the UDS, in 2015, health centers furnished HIV tests for 81,078 patients, Pap tests for 116,038 patients, and contraceptive management for 82,293 patients. This figure is somewhat lower than the total number of contraceptive patients served by health centers according to the Guttmacher data, which reports slightly more than 98,000 served.¹⁸ These figures – whether the conservative numbers reported in the UDS or the more generous figures reported in the Guttmacher data – represent only a fraction of the demonstration-eligible population. As Guttmacher researchers note, the health center figures they report would need to more than double in order to simply replace the lost Planned Parenthood capacity, and the UDS figures suggest an even greater deficit.

In sum, in 2015, Texas health centers served one in eight low-income residents and one in seven low-income women of childbearing age.¹⁹ The table below shows that Texas health centers provided contraceptive services to 98,501 women in 2015, or 24 percent of all female contraceptive patients served at publicly funded clinics. Health center capacity grew significantly between 2010 and 2015, but not anywhere close to the more than doubling that would be required were health centers to, at a minimum, assume responsibility for the 111,700 patients who would be insured for women’s health benefits but without access to Planned Parenthood clinics, or 27 percent of all female contraceptive patients served across the state at publicly funded clinics. Health centers would need roughly another two decades to be able to replace the lost care.²⁰

¹⁷ US Census Bureau. Current Population Survey, Annual Social and Economic Supplement, 2016. <http://www.census.gov/cps/data/cpstablecreator.html>

¹⁸ Memorandum from Jennifer Frost to Senator Patty Murray, op. cit.

¹⁹ Calculated by using 2015 UDS data to multiply each health center’s low-income percentage by the number of total patients and women of childbearing age and summing for each for the state, then dividing by the number of low-income Texas residents and low-income women of childbearing age reported by CPS data for 2015

²⁰ Based on six percent annual growth of health centers with at least 10,000 patients

**Number of Female Contraceptive Patients Served at Planned Parenthood
and Health Centers in Counties with Planned Parenthood Sites, 2015**

County	Number of Planned Parenthood Clinics	Parenthood Female Contraceptive Patients	Health Centers	Center Female Contraceptive Patients
Texas (State)	37	111,700	286	98,501
Bexar	6	14,150	13	7,770
Dallas	5	14,280	10	1,330
Tarrant	5	14,310	1	1,750
Harris	4	18,900	24	14,270
Collin	3	8,890	2	620
Denton	3	6,690	6	5,840
Travis	3	15,320	17	10,010
Cameron	2	2,700	3	3,590
Fort Bend	2	5,340	11	4,490
Galveston	1	2,220	2	460
Lamar	1	2,000	0	NA
McLennan	1	4,320	16	2,780
Smith	1	2,570	3	100

SOURCE: Frost JJ, et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, New York: Guttmacher Institute, 2017

Furthermore, because health centers are responsible for medically underserved patients of all ages, not just women of childbearing age, their ability to grow expansively and rapidly for any one single patient population is constrained, as is their ability to grow one particular service. When health centers move to increase patient capacity, they need to think about all of the services they offer, not just one subset. Thus, adding tens of thousands of family planning and women’s preventive health patients also means having the capacity to provide dental care and vision care, and full treatment for conditions such as depression, diabetes, and hypertension found during a screening exam. Simply to be able to replicate what is lost when Planned Parenthood is eliminated as a provider, health centers would have to hire an additional 64 physicians and 246 additional medical support staff (i.e., nurse practitioners, physician assistants, certified nurse midwives, nurses, lab personnel, and other medical personnel).²¹ This is a major upscaling of health center capacity given that the largest health centers in Texas employ 70 physicians and 247 clinical support staff and serve less than 90,000 patients. On average, Texas health centers with at least 10,000 patients employ 12 physicians and 65 clinical support staff.²² Furthermore, health centers, unlike a specialized primary care provider such as Planned Parenthood, cannot focus all of their expansion efforts on a single cluster of patient needs – the demands they face span all ages and populations.

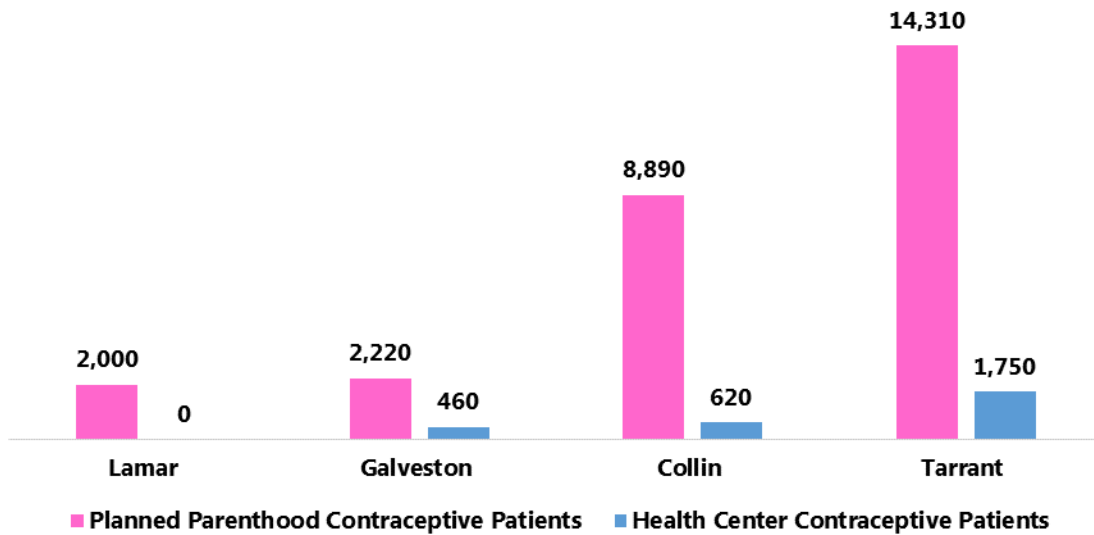
Furthermore, the notion that health centers can grow to replace what is lost assumes that health centers cover all of the service areas that will lose Planned Parenthood capacity under the demonstrations. In fact, however, in Lamar County whose women would lose access to Planned Parenthood, there are no health centers in operation to absorb these patients. In another three counties with Planned Parenthood

²¹ Staffing estimates based on 2015 UDS data from eight health centers nationwide serving between 98,000 and 119,000 patients. Six of the eight health centers serve less than 110,000 patients.

²² Texas health centers with less than 10,000 patients were excluded due to irregular staffing patterns.

sites (Tarrant, Collin, Galveston), there are only one to two health centers per county.²³ In these four counties alone, shown in the following figure, women served by these Planned Parenthood sites account for one quarter of all of the Planned Parenthood patients in all of Texas. Even where health centers are co-located in the same county, health centers are unlikely to have the capacity to serve all of the patients who will not be able to use Medicaid at Planned Parenthood clinics. For example, in Collin County, nearly 9,000 patients use the three Planned Parenthood sites, while two health centers in the county provide contraceptive services for only 620 female patients. To the extent that other providers exist, there is no evidence in the state’s proposal that it is in any position to overcome the capacity lost once Planned Parenthood is eliminated as a provider.

In Counties with Few to No Health Centers, Planned Parenthood Sites Serve an Overwhelming Majority of Female Contraceptive Patients



SOURCE: Frost JJ, et al., *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*, New York: Guttmacher Institute, 2017

Conclusion

Health centers will continue to play an important role in enhancing access to preventive women’s health services, particularly in underserved areas where few or no provider options exist for low-income women. However, as the findings show, if Texas eliminates a critical source of care in these areas, health centers cannot grow their capacity quickly enough to meet the increased demand in services from the demonstration’s eligible women. Indeed, health centers will be unable to replicate what has been lost, much less move the state – and women’s health – forward.

²³ Frost JJ, et al. (2017). *Publicly Funded Contraceptive Services at U.S. Clinics, 2015*. New York: Guttmacher Institute. <https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015>

Appendix: Methodology

Texas health center trends and projections are based on data from the Uniform Data System (UDS), a national information system covering all federally funded health centers. The UDS is maintained by the U.S. Department of Health and Human Services' Health Resources and Services Administration and is updated annually on a calendar year basis. Planned Parenthood profiles are drawn from available public sources. Only health centers and Planned Parenthood clinics are included in the analysis due to their shared mission to serve predominately low-income and underserved patients. The estimates do not account for key differences that may affect whether or not Planned Parenthood patients may access health center services, including distance to and knowledge of health center services. Compared to health centers, Planned Parenthood clinics also tend to serve younger women and provide a more robust range of family planning services. To the extent possible, comparable data are used to illustrate the relative scale and size of their capacity to provide preventive women's health services.