

January 15, 2021

The Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Texas' Healthy Texas Women Section 1115 Demonstration Amendment

Dear Secretary Azar,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Texas' amendment to its section 1115 demonstration entitled, "Healthy Texas Women." The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Under Texas' proposal, women in the postpartum period would receive a limited benefit package for the first year after delivery once the 60-day postpartum period ends. The proposal is an amendment to the state's approved Healthy Texas Women (HTW) demonstration, which allows Texas to receive federal matching funds for family planning and some preventive services provided to women age 18-44 who are not pregnant, while excluding certain qualified providers.¹

Texas has been characterized as a dangerous place to be pregnant.² The state has the nation's highest uninsured rate for women of childbearing age and a maternal mortality rate above the national average, at 18.5 deaths per 100,000 births.^{3,4}

¹ Centers for Medicare and Medicaid Services (CMS), "Healthy Texas Women Demonstration Approval," January 22, 2020, <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/tx-healthy-women-demo-appvl-01222020.pdf>.

² Nina Martin, ProPublica and Julia Bellux, Vox, "The extraordinary danger of being pregnant and uninsured in Texas," *The Texas Tribune*, December 6, 2019, <https://www.texastribune.org/2019/12/06/extraordinary-danger-being-pregnant-and-uninsured-texas/>.

³ Adam Searing and Donna Cohen Ross, "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies," Georgetown University Center for Children and Families, May 2019, <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>.

⁴ Center for Disease Control and Prevention, "Maternal Mortality by State, 2018," <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf>.

While we support the state's goal to reduce maternal mortality and morbidity, we do not believe the proposed amendment with its limited benefit package is an adequate response to the problem. Furthermore, the amendment builds on a flawed demonstration that limits provider choice and adds administrative burden for providers and women seeking care, as CBPP's August 2017 comments on the initial HTW application noted and opposed. As such, we urge you to deny the state's amendment request and restore Medicaid's freedom of choice of provider protection in the existing Healthy Texas Women demonstration.

Texas' proposal does not go far enough to meet the needs of postpartum women.

We are concerned that the state's approach to add a limited postpartum benefit package to its HTW plan does not go nearly far enough to reduce maternal mortality and morbidity in Texas, especially for Black women who are more than twice as likely to experience pregnancy-related death than non-Hispanic White women.⁵

Instead, CMS should encourage Texas and any other states seeking postpartum coverage extensions to follow the recommendation of the American College of Obstetricians and Gynecologists (ACOG) and the Texas Maternal Mortality Review Committee (MMRC) to extend comprehensive Medicaid coverage to all women for one year postpartum to ensure that women have access to full-benefits health coverage that addresses their individual needs.^{6,7} A broader demonstration that extends postpartum coverage for a longer period follows the guidance of scientific experts and is more likely to reduce maternal mortality and morbidity for lower income women and promote the objectives of the Medicaid program.

The state does not adequately address the coverage gaps that exist for postpartum women by neglecting to align its proposal with the recommendations of the state's MMRC and its continued failure to expand Medicaid.

Texas is a leader among states in researching and documenting the state's maternal mortality and morbidity rates. Since its creation by the legislature in 2013, the Texas Maternal Mortality and Morbidity Review Committee has issued three sets of recommendations based on extensive data and research into the causes of maternal mortality and morbidity in Texas. Each time, the committee's top recommendation has been for the state to "increase access to comprehensive health services during pregnancy, the year after pregnancy, and throughout the preconception and interpregnancy periods to facilitate continuity of care, enable effective care transitions, promote safe birth spacing, and improve the lifelong health of women."⁸

The committee's findings also emphasize the constellation of factors that contribute to maternal mortality and morbidity in Texas and highlight the racial disparities in outcomes for mothers and

⁵ Texas Health and Human Services, "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report," September 2018, <https://www.dshs.texas.gov/mch/pdf/MMMTFJointReport2018.pdf>.

⁶ The American College of Obstetricians and Gynecologists, "ACOG Statement on AMA Support for 12 Months of Postpartum Coverage Under Medicaid," June 12, 2019, <https://www.acog.org/news/news-releases/2019/06/acog-statement-on-ama-support-for-12-months-of-postpartum-coverage-under-medicaid>.

⁷ Texas Health and Human Services, "Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report," September 2020, <https://www.dshs.texas.gov/mch/pdf/DSHS-MMMRC-2020-UPDATED-11282020.pdf>.

⁸ Texas Health and Human Services, September 2020.

infants in the state. In the committee's latest report reviewing maternal deaths from 2013, they found that while only 11 percent of live births in 2013 were among Non-Hispanic Black women, these women accounted for 31 percent of deaths. Black and Hispanic women also experience higher rates of severe maternal morbidity than their White peers.⁹

However, the state's proposed section 1115 demonstration amendment seeks to "develop enhanced, cost-effective, and limited postpartum care services...", far from the comprehensive care repeatedly recommended by the committee. Also, the state's section 1115 amendment proposal is silent on racial disparities in maternal mortality and morbidity and any efforts to address this persistent problem. This is unacceptable.

Texas is one of twelve states that has not adopted the Affordable Care Act's (ACA) Medicaid expansion. Expanding Medicaid to 138 percent of the federal poverty line would best serve women in the state, and more specifically, the maternal health problems that the proposal aims to address. Currently, Texas's parent eligibility limit is 17 percent of the poverty line, while its pregnancy coverage eligibility is 203 percent of poverty.¹⁰ This means that after 60 days postpartum, the vast majority of women lose Medicaid coverage and likely become uninsured, despite postpartum care needs that extend even beyond one year after the end of the pregnancy. The state's proposal to provide limited postpartum services through HTW would result in women remaining without access to regular preventive care or well woman care, ongoing prescription coverage and other essential benefits.

Educational guidance for clinicians issued in 2018 by the American College of Obstetricians and Gynecologists (ACOG) and other health professionals, such as the American College of Nurse-Midwives, recommends that postpartum care extend beyond the standard one-time postpartum visit which normally occurs four to six weeks after delivery.¹¹ Instead, ACOG et al recommends an ongoing, comprehensive postpartum care approach -- including coverage before pregnancy. By expanding Medicaid, the state would provide mothers with greater continuity of care to enable receipt of critical postpartum care and would ensure fewer coverage gaps after delivery, resulting in healthier parents, and therefore healthier children.¹²

Texas' proposal is an ineffective use of federal matching funds when compared with Medicaid coverage.

The state aims to secure federal matching funds for discrete services delivered to postpartum women through a new benefits program provided through the state's family planning demonstration, known as HTW Plus. The following services are currently available to eligible women contributing to maternal morbidity and mortality in Texas through a state-funded program:

⁹ Ibid.

¹⁰ A. Searing, *et al.*

¹¹ The American College of Obstetricians and Gynecologists, "ACOG Committee Opinion: Optimizing Postpartum Care," May 2018, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care?utm_source=redirect&utm_medium=web&utm_campaign=otn.

¹² Searing, *et al.*; Hannah Katch, "Medicaid Expansion Improves Postpartum Coverage, Access to Care," Center on Budget and Policy Priorities, October 21, 2020, <https://www.cbpp.org/blog/medicaid-expansion-improves-postpartum-coverage-access-to-care>.

treatment of postpartum depression and other mental health conditions, cardiovascular and coronary conditions, substance use disorders, diabetes, and asthma.

While the recognition of postpartum health needs is a step forward, covering these services alone is by no means comparable to providing comprehensive postpartum Medicaid coverage. The HTW Plus benefit package is not minimum essential coverage consistent with the guidance set forth in the State Health Official Letter #14-002, issued by CMS on November 7, 2014.¹³ Unlike Medicaid coverage, HTW Plus services do not include hospital inpatient or outpatient acute care, surgical care, a full prescription drug formulary, primary care, case coordination or transportation support.

This means other than their access to specific benefits in HTW Plus, Texas women will continue to be uninsured after Medicaid pregnancy coverage ends just 60 days after the end of pregnancy, unless she receives insurance through her own job or spouse's job. The state only provides Medicaid coverage to parents deep in poverty, so Medicaid and coverage via the federal health care marketplace are generally not available to non-pregnant Texas women below the poverty line.

Women referred by their providers for medically necessary care outside of the limited HTW Plus benefit package would face unaffordable costs and unmet health needs, undermining the goals of the HTW Plus program and leaving the health system on the hook for uncompensated care costs. Texas has the nation's highest uninsured rate for adults with 24.5 percent of non-elderly adults uninsured in 2019.¹⁴ Recent analysis found between 40 and 46 percent of women in Texas are uninsured for at least one period between the month before they become pregnant and the sixth month after delivery.¹⁵

To achieve the goals of the HTW demonstration, CMS should work with Texas to develop a robust postpartum coverage solution for Texas women that addresses the state's maternal mortality crisis, rather than the state's limited proposal.

Ending auto-enrollment from Medicaid for Pregnant Women into HTW Plus will create significant administrative burdens.

As part of the implementation of the proposed HTW Plus, Texas proposes to eliminate autoenrollment for women from Medicaid for Pregnant Women into HTW Plus after they reach 60 days following the end of their pregnancy. Elimination of autoenrollment from Medicaid for Pregnant Women to HTW Plus, which was approved as part of the January 2020 HTW 1115 demonstration, directly undermines the goals of HTW Plus to improve continuity of health care for new mothers and reduce maternal mortality and morbidity.¹⁶

¹³ Centers for Medicare and Medicaid Services, "SHO#14-002: Minimum Essential Coverage," November 7, 2014, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf>.

¹⁴ Kaiser Family Foundation, "Health Insurance Coverage of Adults 19-64, 2019," <https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁵ Jamie R. Daw, Katy Backes Kozhimannil, and Lindsay K. Admon, "High Rates of Perinatal Insurance Churn Persist After the ACA," Health Affairs Blog, September 16, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190913.387157/full/>.

¹⁶ CMS, January 22, 2020.

Current autoenrollment from Medicaid for pregnant Women to the existing HTW has led to more than 80,000 new mothers being auto-enrolled into HTW in fiscal year 2019 alone, about 30 percent of the total HTW enrollment that year.¹⁷

In the state's response to questions about eliminating autoenrollment, it stated it will use electronic data to confirm eligibility without contacting women, and will only ask for verification if it finds any inconsistencies. Texas has struggled to implement a similar process to conduct administrative renewals for children enrolled in Medicaid and CHIP, and fewer than nine percent of clients are renewed administratively.¹⁸ According to a 50-state survey from the Kaiser Family Foundation, Texas is one of only eight states with an administrative renewal rate of less than 25 percent.¹⁹ State data show that 47,014 children in 2017 and 52,875 children in 2018 lost Medicaid coverage as a result of cumbersome bureaucratic processes.²⁰ About 40 percent of the children disenrolled return to Medicaid and CHIP coverage within six months, suggesting that they were in fact eligible all along.

As a result of the ongoing public health emergency due to the COVID-19 pandemic, no one is currently being transitioned into HTW Plus. As required by federal legislation, Texas must maintain Medicaid coverage for women enrolled in Medicaid on or before March 18, 2020 who otherwise would have lost it 60 days after delivery.²¹ This means that new mothers can maintain full Medicaid coverage during the federal Public Health Emergency (PHE), which has been extended to April 21, 2021, with the opportunity for further extension. Once the PHE ends, women who lose Medicaid coverage may be eligible for HTW or HTW Plus.

Administering the postpartum benefit package through the HTW Plus program could make it challenging for the state to recruit and retain providers willing to serve the women enrolled.

The existing HTW program operates separately from the Medicaid program and only offers family planning services and some preventive care. Many of the specialists who needed to provide the new services included--such as cardiologists, pulmonologists, endocrinologists, and addiction medicine specialists--are not currently enrolled in the HTW program and do not have experience serving HTW beneficiaries.

¹⁷ Texas Health and Human Services, "Texas Women's Health Programs Report Fiscal Year 2019," May 2020, <https://hhs.texas.gov/reports/2020/05/texas-womens-health-programs-report-fiscal-year-2019>.

¹⁸ Letter from Every Texan to Texas Health and Human Services, November 16, 2020, <https://static1.squarespace.com/static/5b02e658ec4eb7435dcd44d4/t/5fbd4f08e87ab474be9c270e/1606242056734/memo-hhsc-admin-renewal-2020.pdf>.

¹⁹ Tricia Brooks, *et al*, "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey," Kaiser Family Foundation, March 26, 2020, <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/>.

²⁰ Melissa McChesney, "Legislators Should Prevent Texas Kids from Getting Booted off Health Insurance," Every Texan, April 10, 2019, <https://everytexan.org/2019/04/10/legislators-should-prevent-texas-kids-from-getting-booted-off-health-insurance/>.

²¹ H.R. 6201, "Families First Coronavirus Response Act," 116th Congress, March 18, 2020, <https://www.congress.gov/bill/116th-congress/house-bill/6201/text>.

Setting up a new provider network to serve postpartum women eligible for HTW Plus services will take time and add administrative burden for providers -- particularly as Texas providers continue to combat the COVID-19 pandemic. Texas HHSC requires providers who want to treat HTW Plus beneficiaries to be credentialed both as a Medicaid provider and separately as an HTW provider. This will likely deter many specialists who do not have experience with either program. A limited provider network will undermine the goal of increasing access to postpartum services for new mothers in Texas.

Continuing to Waive Freedom of Choice Does Not Further Medicaid's Objectives

The proposed amendment to add postpartum services builds on Texas' existing and flawed section 1115 demonstration, which waives Medicaid's freedom of choice of provider protection and excludes qualified providers who provide the full spectrum of family planning services or affiliate with providers who do so from participating in the HTW demonstration. Continuing this authority provides no experimental purpose and does not promote the objectives of Medicaid, statutory requirements for section 1115 demonstration approval.

Section 1902(a)(23) of the Act gives Medicaid beneficiaries the right to obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services . . . who undertakes to provide . . . such services." The freedom of choice provision includes a general exception for beneficiaries enrolled in certain Medicaid managed care plans who can be required to obtain services from providers within the plans' provider networks. However, Congress recognized the importance of patient choice of specialized, trusted providers of family planning services by limiting states' ability to restrict a beneficiary's choice of family planning provider and explicitly protecting 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

Section 1902(a)(23) of the Act is explicit that states cannot exclude providers based on criteria other than the state's established provider qualification standards. 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.²² But 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. Providers shouldn't be excluded from participation in their state Medicaid programs because they provide the full spectrum of gynecological and obstetric care as part of their scope of practice.

Courts have weighed in on this issue, and almost all federal courts considering the issue have upheld Medicaid beneficiaries' right to obtain health care from any willing and qualified provider. The Seventh and Ninth Circuit Courts of Appeals, as well as a number of lower courts, have

²² Centers for Medicare & Medicaid Services, "SMD #16-005: Clarifying 'Free Choice of Provider' Requirement in Conjunction with State Authority to Take Action against Medicaid Providers," April 19, 2016, <https://www.medicare.gov/federal-policy-guidance/downloads/SMD16005.pdf>

affirmed that the Medicaid statute prevents states from excluding providers from their Medicaid programs for reasons unrelated to their ability to provide covered medical services in a professionally competent, safe, legal, and ethical manner.²³

Excluding providers for reasons unrelated to their qualifications does not further the objectives of the Medicaid program because it severely reduces low-income women's access to family planning and other preventive services, as the state's own evidence shows. A large body of research shows the devastating effect of Texas' 2011 decision to end its federally funded family planning demonstration so it could exclude certain qualified providers on women's access to family planning and other preventive services.

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 percent decrease in enrollees statewide over the four-year period.”²⁴ Further, by 2016, “26 percent [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 percent in 2011.”²⁵ 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 the nearly 3,000 that each Planned Parenthood affiliate across the country serves on average each year.²⁶

Similarly, the state's own data show 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 percent, including dramatic decreases in enrollees obtaining injectable contraceptives, oral contraceptives, condoms, and the contraceptive patch and ring.²⁷

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 percent after the state excluded providers from its family planning expansion project.²⁸ Moreover, while rates of on-time contraceptive injections were going up in areas of the state where women did not rely on excluded

²³ See *Planned Parenthood of Ariz. v. Belach*, 727 F.3d 960, 963 (9th Cir. 2013); *Planned Parenthood of Ind. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 974 (7th Cir. 2012). See also *Planned Parenthood of Greater Texas Family Planning & Preventive Health Servs., Inc. v. Smith*, 2017 WL 692518 (W.D. Tex. 2017).

²⁴ *Ibid.* (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>).

²⁵ Kinsey Hasstedt and Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health*, HEALTH AFFAIRS BLOG, (July 18, 2017) (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).

²⁶ *Ibid.*

²⁷ Tex. Health & Human Servs. Comm'n, *Final Report of the Former Texas Women's Health Program: Fiscal Year 2015 Savings and Performance* 8 (2017), <https://hhs.texas.gov/reports/2017/03/former-texas-womens-health-program-fiscal-year-2015-savings-performance>.

²⁸ Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 NEJM 853 (2016).

providers, the rates were plummeting in areas where once relied-upon providers were excluded; after the exclusion, the proportion of women returning to their providers for on-time contraceptive injections fell from 57 percent to 38 percent in counties with Planned Parenthood affiliates, while increasing from 55 percent to 59 percent in counties without Planned Parenthood affiliates.²⁹ 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.”³⁰ Such barriers correlate with an increase in Medicaid-funded births in the state.³¹

The evidence from Texas is overwhelmingly clear - prohibiting low-income women from receiving family planning services from qualified providers because those providers provide the full spectrum of gynecological and obstetric care as part of their scope of practice reduces access to health care and places women’s health at risk. Continuing to implement this failed policy runs directly counter to both the purpose of the Medicaid program and the demonstration’s stated objective of expanding. We urge CMS to rescind the waiver of section 1902(a)(23) and restore Medicaid’s important freedom of choice protection.

Conclusion

In conclusion, we urge CMS to reject the state’s amendment proposal and to restore the freedom of choice protection in the HTW demonstration. While we appreciate Texas’s recognition of the need to support access to postpartum health care services, neither the amendment nor the underlying demonstration are sufficient to provide access to comprehensive health coverage before, during and after pregnancy. Restoring Medicaid’s freedom of choice protection will help to ensure access to needed care; without this important beneficiary protection, it is unclear how the HTW demonstration furthers the objectives of the Medicaid program.

We urge CMS to work with the state to revise its proposal to extend full Medicaid benefits to all pregnant women for one year after the end of their pregnancy. Comprehensive 12-month postpartum Medicaid coverage, paired with Medicaid expansion for all adults earning less than 138 percent of the federal poverty line, would best promote improved maternal and infant health outcomes in Texas.

Our comments include citations to supporting research, including direct links to the research for HHS’s benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered as part of the administrative record in this matter for the purposes of the Administrative Procedures Act.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

²⁹ *Ibid.*

³⁰ *Ibid* (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)).

³¹ Amanda Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women’s Health Program*, 374 *NEJM* 853 (2016).