Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted online to:

Re: Healthy Texas Women 1115(a) Medicaid Demonstration Waiver Application

Dear Sir/Madam:

As a group of academic researchers with the Texas Policy Evaluation Project (TxPEP), we appreciate the opportunity to comment on the Texas Health and Human Services Commission’s Section 1115(a) family planning waiver application to the Center for Medicare & Medicaid (CMS). Based at The University of Texas at Austin Population Research Center, TxPEP’s mission is to conduct methodologically principled research that evaluates the impact of reproductive health policies and programs in the state of Texas. Over the past several years, we have conducted and published scientific research on the impact of Texas’s exclusion of Planned Parenthood from the Medicaid funded fee-for-service family planning demonstration program that took place on January 1, 2013. We have assessed the size and nature of the impact, how the exclusion affected contraceptive users enrolled in the program as Planned Parenthood clients, as well as the barriers that stand in the way of recruiting new or existing providers to fill the void created by the exclusion. In this comment, we will review this research, the results of which demonstrate that excluding a major provider from an existing family planning program has a dramatic negative impact on access to highly effective contraception.

The size and nature of the impact of Planned Parenthood’s exclusion on service provision in Texas

Texas provides a remarkable opportunity to assess the impact of the exclusion of a major provider on family planning service provision and its consequences. Texas first implemented a Medicaid family planning demonstration program in 2007, extending family planning services to women with incomes at or below 185% of the federal poverty line. From the beginning, the Women’s Health Program (WHP) excluded providers of abortion care. In 2011, the Texas legislature directed the Texas Health and Human Services Commission (HHSC) to further exclude all affiliates of abortion providers, even if the affiliates did not provide abortion care themselves. This exclusion included all Planned Parenthood affiliates, who were at that time providing more than 40% of all family planning services through the program. After litigation held up the directive’s implementation, CMS indicated that such an exclusion violated Medicaid’s rules requiring the reimbursement of all qualified providers and ended federal funding for Texas’ waiver on December 31, 2012. Texas immediately replaced WHP with an otherwise identical state-funded program that excluded all Planned Parenthood affiliates. Supporters of these efforts claimed that other providers would step in to replace the care previously provided by Planned Parenthood. When Texas ended its family planning Medicaid demonstration program and began funding a similar program entirely from state dollars in 2013, it was the first state to successfully exclude Planned Parenthood affiliates from providing care using a public healthcare funding stream.

Two aspects of this experience permitted us to conduct a methodologically rigorous assessment of this policy change. First, the exclusion took place at a single point in time and affected all Planned Parenthood affiliates. Second, Planned Parenthood did not provide services all over Texas, but only had
clinics in 23 counties which included about half of the low-income women who were eligible for the program. Thus, by examining services provided before and after the exclusion, we could compare the change in services in the counties with Planned Parenthood clinics that were affected by the exclusion and those without such clinics that were not affected.

To assess the impact of the exclusion, we partnered with scientists at the Strategic Decision Support division of Texas HHSC and accessed the universe of Medicaid and WHP/ replacement program medical and pharmacy claims. These claims data enabled us to determine the volume of individual methods of contraception provided in each quarter of the two years preceding and the two years following the exclusion. The volume of claims is shown on the left-hand side in the figure below taken from the published report (Stevenson et al. 2016, Figure 1).
In this figure, we distinguish between three categories of contraceptive methods: long-acting reversible contraceptives (LARC; contraceptive implants and intrauterine devices), an injectable contraceptive (depot medroxyprogesterone acetate), and short-acting hormonal methods (oral contraceptive pills, transdermal contraceptive patches, and contraceptive rings). We also separate claims according to type of county. Those that were filed in counties that had a Planned Parenthood affiliate in 2011 are represented as blue circles, and those that were filed in counties without such an affiliate at that time are represented as red triangles. A large decline in the number of claims for LARC and injectables at the time of the exclusion is apparent in the counties with a Planned Parenthood affiliate, but not in the counties without an affiliate. There is no noticeable change in the number of claims for short-acting hormonal methods in either type of county.

To determine whether the changes that took place in counties with and without a Planned Parenthood affiliate was statistically significant, we calculated the quarterly difference in submitted claims between the counties with and without affiliates and fitted local linear regression. We used an indicator for the period after January 1, 2013 and interacted this indicator with time. The indicator for the period after the exclusion was therefore a measure of the absolute change in the difference. The regression lines and confidence bands are displayed on the right side of the figure (Panel B). We then computed the relative change in the difference (since different methods of contraception are delivered at different frequencies). Using this approach, we estimated a relative reduction of 31.1% in LARC methods and a relative reduction of 35.5% in injectable contraceptives. For both methods, the indicator for the point at which the exclusion took effect was statistically significant at the P<0.001 level, indicating that the relative decreases in the delivery of LARCs and injectables were highly statistically significant. The change in hormonal methods was not statistically significant.

We also measured the impact of the exclusion on contraceptive continuation and subsequent births, by identifying a population of women who were using a contraceptive method requiring regular provider visits and for which the length of contraceptive efficacy was consistent and short enough to allow for pregnancies within the timeframe between the exclusion and the 18 months of complete Medicaid births data available at the time of our analysis. Injectable contraceptives met both of these requirements. We constructed two cohorts of injectable contraceptive users. The first cohort received an injection in the fourth quarter of 2011 and thus had a year to continue receiving services before the exclusion of Planned Parenthood affiliates took effect. The second cohort received an injection in the fourth quarter of 2012 and thus was subject to the influence of the exclusion before the due date for the next injection. For each cohort and county group, we computed the proportions of women who received an on-time injection in the next quarter and who had a Medicaid-paid delivery in the following 18 months. For continuation and births, we calculated the difference in differences between the two cohorts and groups of counties.

The proportion of women returning for a subsequent on-time contraceptive injection in counties with Planned Parenthood affiliates was lower after the exclusion. Specifically, the percentage of women decreased from 56.9% to 37.7% in counties with Planned Parenthood affiliates but increased from 54.9% to 58.5% in counties without such affiliates (estimated difference in differences for counties with Planned Parenthood affiliates as compared with those without affiliates, −22.9%; P<0.001). This represents a relative decrease in continuation of 40.2% (−22.9% divided by 56.9%).

The percentage of women who had a birth covered by Medicaid within 18 months increased from 7.0% to 8.4% in the counties with Planned Parenthood affiliates and decreased from 6.4% to 5.9% in the counties without Planned Parenthood affiliates (estimated difference in differences, 1.9%; P=0.01). This change represents a relative increase of 27.1% from baseline (1.9% divided by 7.0%) in the proportion of women using injectable contraceptives who had a birth by Medicaid within 18 months after the claim.

In summary, the number of claims for LARC methods declined, as did the number of claims for contraceptive injections. Among women using injectable contraceptives, fewer women who received an injection in the quarter preceding the exclusion continued to receive an injection through the program
than did those in an earlier cohort. In addition, there was a disproportionate increase in the rate of childbirth covered by Medicaid.

How the exclusion affected women enrolled in the Women’s Health Program (WHP) at Planned Parenthood

To find out how easy it was for women who were receiving services through WHP at Planned Parenthood to find a new provider after the exclusion, we conducted a study of women who had received a dose of injectable contraception from the Planned Parenthood affiliates in Houston and Midland in the last quarter of 2012 (Woo et al. 2015). We interviewed 224 of these women by telephone between April and October 2014 and asked them about their current method of contraception and any difficulty obtaining the method before May 2013, pregnancy occurrence in 2013, and demographic characteristics. The experiences captured in these interviews pointed to challenges and barriers women may face when seeking a new provider of contraception including unnecessary physical exams, multiple visits and unauthorized copayments.

Of the 148 interviewees who remained enrolled in WHP when the next injection was due and also sought another injection, 80% obtained the dose, but only 56.8% did so at no cost and on time. By comparison, in the corresponding months of 2012 in Houston, 92% of all injectable contraception patients obtained their doses at no cost and on time. While the WHP was intended to provide contraception without cost, 9.5% of interviewees with WHP reported paying because they chose a nonparticipating provider; bought the medicine themselves at a pharmacy because it was unavailable at the health provider's office; or were charged an “injection fee” or “co-pay”. Among all women who successfully obtained a repeat dose, regardless of WHP enrollment status (n= 129), more than 85% reported no barriers. Among those who experienced barriers, the most common were difficulty making an appointment and affording the injection. In addition, more than half of women were required to have a physical exam first, 17.0% needed more than one visit, and 11.0% said the injection was out of stock at their initial visit. Of the 148 women with WHP, 30 missed their next dose. They gave multiple reasons for doing so, most commonly: difficulty finding a provider, the cost of the injection and trouble getting an appointment.

Another lesson may be drawn from the large difference we found between clients at the Midland and Houston sites in the proportion returning to Planned Parenthood after the exclusion to get another dose of injectable contraception and having to pay nearly $100 for the injection. This proportion was much greater in Midland than Houston. This finding corresponds with the greater number of alternative providers in Houston, the fourth largest city in the US. Finally, at 18 or more months after the exclusion, the former Planned Parenthood clients we interviewed used an ineffective mix of contraceptive methods in comparison with a nationally representative cohort of DMPA users.

Difficulties and challenges faced by alternative providers after the exclusion

During the 2013 legislative session, the state legislature allocated $100 million to a new Expanded Primary Health Care (EPHC) program in an effort to repair the reproductive health care safety net and expand the network of family planning providers. Organizations participating in the EPHC program were required to integrate family planning with existing primary care services and provide contraceptive counseling and on-site access to reversible contraceptive methods for the majority of women they served through the program. The majority of EPHC-funded organizations were FQHCs and public health departments and hospitals (Department of State Health Services 2015); specialized family planning organizations also received funding from the program, but agencies affiliated with an organization that provides abortion were ineligible, which effectively excluded Planned Parenthood.

In interviews we conducted with program administrators and clinicians at 30 EPHC-funded organizations about their experiences implementing or expanding family planning services during the program’s first year, we found that many primary care organizations initially lacked capacity to provide evidence-based family planning services, and therefore, did not immediately offer the same level of services that women’s health contractors already provided. In particular, primary care organizations, such as FQHCs and public health departments, that were first-time recipients of family planning contracts reported
numerous operational challenges to launching a family planning program. These agencies often had a delayed start because they needed to establish contracts with vendors to purchase contraceptive methods and other supplies to offer routine reproductive health services to the new clients they expected to serve. They also had to hire new staff or train existing staff about the sexual and reproductive health issues that need to be addressed when women presented at their clinics. Additionally, clinicians who were already employed at both established and new primary care contractors often lacked training to provide IUDs and implants.

Even after hiring and training staff, respondents stated it was difficult to accommodate the EPHC program’s focus on family planning because of their existing patient population’s extensive primary care needs and the time constraints during a single visit to address a range of health concerns; therefore, clinicians only addressed health issues that women raised. We also found that some clinicians who received training to provide IUDs and implants did not feel competent and comfortable enough to insert the methods, which limited their availability to women who wanted them. Furthermore, clinicians at some of these organizations described protocols for providing IUDs and implants that did not follow the US Medical Eligibility Criteria (Centers for Disease Control and Prevention 2010), and instead restricted provision to adult women with children and required them to make multiple visits for medically unnecessary services.

Access to long-acting reversible contraception in Texas after the exclusion

While we cannot provide current estimates of the demand for and use of LARC for all women of reproductive age in Texas in the last few years, we have collected this information for a large and critical sub-population: women who have recently given birth (Potter et al. 2017). We conducted a prospective study of 1,700 women with public or no insurance who gave birth at eight hospitals in six cities (Austin, Dallas, Edinburg, El Paso, Houston and Odessa). Participants were recruited shortly after delivery, and were interviewed in person while still in the hospital, and by telephone three months after delivery, and again at six months after delivery. By six months after delivery, only half of the women who had a preference for LARC were actually using it.

The high demand for LARC that we found among postpartum women in Texas is consistent with the results of several initiatives aimed at increasing LARC access by providing these methods at no cost in Colorado, Iowa and St. Louis, Missouri which resulted in substantially higher use of IUDs and implants as well as injectables, and to well documented declines in rates of unintended pregnancy and abortion (Ricketts et al. 2014; Biggs et al. 2015; Peipert et al. 2012). The relationship between use of these highly effective methods and declines in unintended pregnancy makes sense. The intrauterine device (IUD) and contraceptive implant are the most effective reversible methods of contraception. These methods require minimal user effort to provide effective contraceptive coverage, and have a greater impact on reducing unintended pregnancy compared to methods like oral contraceptive pills or contraceptive injections (e.g., Depo Provera). While still low, use of LARC has been increasing at the national level (Kavanaugh et al. 2015).

The harsh negative impact that Texas’s reproductive health policies have had on access to LARC in this state stands in contrast to the progress in LARC provision at the national level and in other states. In all three of the well-documented initiatives to increase access to LARC (Iowa, Colorado, and Missouri), there were no exclusions of specific types of providers, and Planned Parenthood clinics played an important role in each instance. The first stated goal of Texas’ proposed family planning waiver application is to “increase access to women’s health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.” Yet Texas’s own experience provides a clear demonstration of the substantial negative consequences of one of the key provisions of the proposed program, the exclusion of Planned Parenthood.
Approving this waiver application would only help to facilitate and encourage the adoption of similar limitations on freedom of choice in other states. Apart from budgetary relief, the proposed waiver would have little effect on Texas. The damage has already been done.

We at the Texas Policy Evaluation Project appreciate the opportunity to submit comments on the proposed Healthy Texas Women 1115(a) waiver application. If you would like additional information, please contact Dr. Joseph Potter at joe@prc.utexas.edu or at 512-471-8341.

Sincerely,

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References


