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RCHN Community Health Foundation Research Collaborative

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at http://sphhs.gwu.edu/departments/healthpolicy/ggprogram or at rchnfoundation.org.

Executive Summary

Texas operates a family planning program for more than one hundred thousand low-income women called the Women's Health Program (WHP); it is currently administered under a waiver from the Medicaid program. Earlier this year, the state adopted a policy to exclude family planning clinics that are Planned Parenthood affiliates from participating in the WHP. The federal Centers for Medicare and Medicaid Services determined that this was contrary to policies permitting patients' freedom to choose their health care providers, leading to the termination of federal participation as early as November 1, 2012, thereby also eliminating 90% of the funding for the program. The state has announced it would continue the program entirely with state funding. Two lawsuits are now pending: one in which the state of Texas is suing the federal government and one in which several Planned Parenthood affiliates are suing the state of Texas. In April, a district court ruling imposed an injunction delaying implementation of the "affiliate" rule, but a subsequent appellate court decision lifted the injunction and remanded it back to the district court level. Planned Parenthood clinics could be barred from WHP within several weeks; a petition for rehearing is pending in the Fifth Circuit Court of Appeals.

The purpose of this research project is to investigate the potential impact of these policies in five market areas in Texas where Planned Parenthood clinics currently participate in the WHP (Bexar, Dallas, Hidalgo, Lubbock and Midland Counties). Representatives of Planned Parenthood and of larger non-Planned Parenthood clinics that serve WHP patients in the immediate vicinity were surveyed to ask about their current operations and the expected consequences. We also analyzed data about WHP participation, based on a list of providers and participation in fiscal year 2011.

Key findings include:

- Planned Parenthood affiliates are the dominant providers of care in the WHP in their markets, serving between half and four-fifths of the WHP patients in the five areas we examined. If their patients must be served by other clinics, the facilities in those areas would need to expand their capacity by two- to five-fold, in order to absorb the patients now being served by Planned Parenthood.

- Some larger non-Planned Parenthood facilities report that they could serve some of the patients who would be lost if Planned Parenthood clinics are excluded. However, they are generally at, or close to, the limits of their capacity and will not be able to expand much, if at all, due to other resource or staffing constraints. There is no evidence that they are prepared to sustain the very large caseload increases that would be required to fill the gaps left after Planned Parenthood affiliates are excluded. The problems would be particularly serious in poorer, less urban areas, like Hidalgo or Midland Counties, where there are fewer alternative providers.

- As a result, tens of thousands of low-income Texas women could lose access to affordable family planning services and to other women's health services. Local health care providers, including the non-Planned Parenthood clinics, expect this will lead to a substantial increase in the number of unplanned pregnancies in Texas.

- Although they want to continue to serve their low-income patients, Planned Parenthood affiliates would need to dramatically change operations in order to accommodate the loss of WHP revenue. A number of Planned Parenthood clinics will have to close because of the financial losses. Those that remain would have to increase fees for patients, making it harder for low-income patients to afford care.

Planned Parenthood affiliates and a majority of the other WHP clinics we interviewed have already sustained financial losses because the state of Texas reduced family planning funding by two-thirds in 2011. Thus, family planning clinics have already experienced losses that have contributed to a deterioration of services to low-income women. It is worth noting that the WHP not only provides contraceptive services, but also other women's health services, such as screening for breast and cervical cancer, diabetes, hypertension, and sexually transmitted infections. Thus, the loss of WHP services may have broader implications for women's health, in addition to the consequences for family planning.

Earlier this year, the Texas Health and Human Services Commission reported to its state legislature that WHP has been effective in reducing unplanned births and has saved the state millions of dollars due to the reduction in Medicaid costs associated with those births. It estimated that over 8,000 births were averted in 2011, yielding $54 million in net savings (federal plus state), including more than $23 million in state savings. We estimate that, if Planned Parenthood affiliates had been excluded in 2011, the resulting reduction in family planning services would mean that 2,000 to 3,000 *fewer* births would be averted. The loss of the 90% federal matching funds would also mean that the state would bear the entire program cost. As a result, rather than saving $23 million, the state of Texas would have pay for the full cost of serving the remaining women, between $23 and $27 million, but save only $17 to $20 million in state costs associated with Medicaid births averted, yielding a *net state loss* of $5.5 to $6.6 million. This loss suggests that the state may try to limit funding for WHP when federal matching funds become unavailable. This could create serious difficulties for the remaining non-Planned Parenthood clinics and the patients they serve.

Introduction

The Texas Women's Health Program (WHP) provides family planning and preventive health services to low-income women under a Medicaid family planning waiver program. As of February 2012, the WHP provided care to about 127,000 low-income Texas women.[1] The total program cost was $35.6 million in 2011, of which the federal government paid $32 million – about 90% of the total cost -- while the state paid $3.6 million.[2]

In early 2012, the Texas Health and Human Services Commission (HHSC) adopted an "affiliate" rule,[3] which excludes Planned Parenthood Federation of America (PPFA) clinics from participating in the WHP. When and if fully implemented, the affiliate rule will exclude all Planned Parenthood clinics from WHP, even if the clinics do not provide abortion services. The state had earlier barred all abortion providers from the program. As a result, Texas Planned Parenthood clinics will no longer qualify for WHP reimbursements for family planning services provided to eligible low-income Texas women. In 2011, Planned Parenthood clinics provided care for more than 50,000 WHP clients, roughly half of the statewide total.

In response to Texas's affiliate rule, the federal Centers for Medicare and Medicaid Services (CMS) announced that it would no longer provide federal matching funds for the program because the rule denies beneficiaries the freedom to choose providers, as assured under federal policy and stated that the waiver and federal funding would terminate after six months.[4] Two lawsuits are now in progress as a result of these decisions. The state of Texas has sued CMS to prevent the loss of federal funds and a group of Planned Parenthood clinics has sued the state to prevent implementation of the affiliate rule. We discuss legal issues in more detail later in this report.

Governor Rick Perry's office declared that state funds would be used to keep the program running if federal funds are lost and Texas will take full control of the WHP starting November 1, 2012.[5] However, HHSC also proposed to delay the start of the state-funded WHP until 90 days after the outcome of Planned Parenthood lawsuit, whenever that may be. CMS has not yet responded to that proposal.[6] The Governor also noted that Planned Parenthood clinics represent less than 2% of WHP providers.[7] However, an analysis of 2010 WHP data found that Planned Parenthood clinics provided care to about half of all WHP clients and that most alternative (i.e.,

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[1] Texas Health and Human Services Commission. Women's Health Program Enrollment. http://www.hhsc.state.tx.us/research/wh-final-count.asp. (Note: Counts of WHP participants vary across state reports, in part depending on whether they report unduplicated counts or not. In this report, we describe the source of data used, because of these discrepancies.)

[2] Texas Health and Human Services Commission. Rider 48 Report: 2011 Annual Savings and Performance Report for the Women's Health Program. Report to the Texas Legislature. May 2012. http://www.hhsc.state.tx.us/reports/2013/Rider-48-Annual-Report.pdf

[3] Tx. Admin. Code 354.1361-64§§.

[4] Forsyth, J. (March 16, 2012). Government to shut down Texas women's health program. http://www.reuters.com/article/2012/03/16/us-usa-contraception-texas-idUSBRE82E1CR20120316

[5] Tan, T. (August 16, 2012). State-run Women's Health Program faces questions. *The Texas Tribune.* http://www.texastribune.org/texas-health-resources/reproductive-health/whats-status-womens-health-program/

[6] Texas Health and Human Services Commission. Letter to Cindy Mann, CMS., Aug. 20, 2012.

[7] Office of the Governor Rick Perry. http://governor.state.tx.us/initiatives/womens_health/

non-PPFA) providers served very few (ten or less) patients.[8] This suggested the possibility that alternative health care providers who remained in the WHP may not have sufficient capacity to serve the half of WHP beneficiaries who received care at Planned Parenthood clinics.

The purpose of this report is to more closely examine the markets for family planning services in Texas communities served by Planned Parenthood clinics, in order to understand the potential effects of their exclusion from WHP. We selected five areas in Texas served by Planned Parenthood clinics (Bexar, Dallas, Hidalgo, Lubbock and Midland Counties) and conducted interviews between July and September 2012 with Planned Parenthood and non-PPFA health care providers that participate in the WHP.

Overview of the Women's Health Program

The WHP is a family planning program authorized by the federal Centers for Medicare & Medicaid Services (CMS) that allows Texas to expand Medicaid eligibility for family planning services under federal waiver authority. Participants gain access to family planning services and counseling, certain screening services, and free access to contraceptives. WHP clients are not eligible for the full range of medical coverage under Medicaid, but gain coverage for contraceptive and certain related services, so that they can avoid unplanned pregnancies and sexually transmitted infections (STIs) and be screened for breast and cervical cancer and other diseases.[9] The coverage does not include abortions, which are not covered by Medicaid.[10] The WHP is available for low-income (at or below 185% of poverty) female U.S. citizens or legal immigrants in Texas age 18-44 who are ineligible for Medicare Part A or B, CHIP, or Medicaid.[11] In Texas, pregnant women with incomes up to 185% of poverty are eligible for Medicaid, so WHP seeks to provide eligibility for family planning services for women up to the same income level. The federal government covers 90% of the cost of Medicaid family planning services, so the state's share of costs is just 10%.

Prior to the affiliate rule, Texas cut state family planning funding by about two-thirds, which reduced access to family planning services. In state biennium 2010-2011, the state allocated $111.5 million to family planning funds but only $37.9 million for 2012-2013.[12] This included federal funds provided under programs including the Title X Family Planning Program, the Title XX Social Services Block Grant and the Title V Maternal and Child Health Services Block Grant. As a result, of 240 public and private family planning clinics that existed in Texas before the funding cuts, 53 closed and 38 reduced their hours. The cuts were more severe for private clinics, such as Planned Parenthood, even though they served about two-fifths of all

[8] 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, George Washington University. Policy Research Brief No. 29. http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_0900DA16-5056-9D20-3DFD539FF662D155.pdf.

[9] Texas Women's Health Program. Benefits. http://www.texaswomenshealth.org/page/benefits

[10] Except in the cases of rape, incest or the life of the mother.

[11] http://www.texaswomenshealth.org/page/who-can-get-womens-health-program-benefits.

[12] Legislative Budget Board, Eighty-second Texas Legislature. (2012). Legislative Budget Board Fiscal Size-Up 2012–13 Biennium. (p. 190). http://www.lbb.state.tx.us/Fiscal_Size-up/Fiscal%20Size-up%202012-13.pdf.

publicly-funded family planning clients.[13] In 2008, approximately 2.86 million women in Texas were in need of contraceptive services and supplies, and of this population, 1.46 million were in need of publicly-funded services and supplies.[14] About a third of women (32.5%, or 475,410 women) in need of publicly-funded family planning services were served at publicly funded clinics and Title X clinics in Texas in 2008, which averted 98,700 unintended pregnancies, resulting in a net savings of $538 million to the state in Medicaid costs for averted births.[15]

A body of research has determined that, by expanding the availability of low cost family planning services to a broader set of low-income women, the savings associated with averted unplanned pregnancies and other health improvements substantially exceed the cost of additional family planning services.[16] Research has demonstrated that publicly funded family planning services are effective in promoting contraceptive use among low-income women and in averting unplanned pregnancies.[17] It has been estimated that every dollar invested in family planning services leads to as much as $5.60 in Medicaid savings.[18] A recent randomized experiment in Oregon, conducted by researchers from Harvard University and Providence Health and Services, found that when Medicaid coverage for adults was expanded, women were more likely to obtain screening for breast and cervical cancer and that prescription drug utilization also increased.[19]

In May 2012, the Texas Health and Human Services Commission (HHSC) issued a report about the savings from and performance of Texas's WHP Program. Using a federally approved methodology, HHSC estimated that the WHP had averted 8,215 births to low-income women in 2010, or about two-thirds of the births expected of participants. It was estimated that each birth would have cost Medicaid $10,980. The total expenditures and savings are estimated in the table below. Since the federal government covers 90% of the medical costs, the state's expenditures were just $3.6 million out of a total cost of $36 million. HHSC estimated that the total Medicaid savings due to averted births was $90 million, of which the state share was $27 million. (The

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[13] White, K., Grossman, D., Hopkins, K., & Potter, J. (2012). Cutting Family Planning in Texas. *New England Journal of Medicine, 367*(13):1179-81.

[14] "Women in need" is based on an estimate of the number of women of childbearing age who are able to become pregnant (i.e., are not sterile) and who are not planning to become pregnant. Frost, J.J., Henshaw, S.K., & Sonfield, A. (2010). Contraceptive Needs and Services: National and State Data, 2008 Update. New York: Guttmacher Institute. http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf.

[15] Ibid.

[16] For example, see Edwards, J., Bronstein, J., & Adams, K. (2003). Evaluation of Medicaid Family Planning Demonstrations. The CNA Corporation, CMS Contract No. 752-2-415921.; Amaral, G., Foster, D., Biggs, M.A., Jasik, C.B. , Judd, S. & Brindis, C. (2007) Public Savings from the Prevention of Unintended Pregnancy: A Cost Analysis of Family Planning Services in California, *Health Services Research, 42*(5): 1960-80. ; Maternal Child Health and Education Research and Data Center. (2007). *Evaluation of Florida's Family Planning Waiver Program: Cost Effectiveness of First Eight Years 1998-2006*, University of Florida College of Medicine.; Sills, S. (2007). Cost Effectiveness of Medicaid Family Planning Demonstrations, National Academy of State Health Policy.

[17] Institute of Medicine. (2009). *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results.* Washington, DC: National Academy Press.

[18] Thomas, A. (2012). *Policy Solutions for Preventing Unplanned Pregnancy*. Center on Children and Families, Brookings Institution. Frost, J. J., Finer, L.B., & Tapales, A. (2008). The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. *Journal of Health Care for the Poor and Underserved, 19*(3):778–796.

[19] Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J.P., et al. (2011). The Oregon health insurance experiment: Evidence from the first year. NBER Working Paper 17190.Available from: http://www.nber.org/papers/w17190. The Medicaid expansion in this study was broader than just family planning services.

state share of savings is higher since the state's share of birth-related costs is based on the regular Medicaid match rate -- 60.6% in fiscal year 2011-- rate rather than the enhanced 90% family planning match rate. Thus, the state pays only 10% of Medicaid family planning costs, but recoups about 40% of Medicaid birth savings.) Overall, the total Medicaid program (federal plus state) saved $2.50 for every $1 invested, while the state of Texas saved $7.56 for every state dollar spent. Insofar as about half of the WHP patients were served at Planned Parenthood clinics, it is reasonable to assume that about half of the pregnancies averted and half of the savings were from Planned Parenthood affiliates.

Table 1: Estimated Savings and Expenditures Due to WHP, 2010[20]

	Total Cost/Savings (Federal + State)	State Cost/Savings
Savings due to averted births among WHP women	$90.2 million	$27.2 million
Total WHP expenditures	$36.0 million	$3.6 million
Program savings	$54.2 million	$23.6 million
Savings to cost ratio	$2.51 saved for every $1 spent	$7.56 saved for every $1 spent

The Health of Texas Women

The WHP addresses a number of fundamental health needs for women in Texas. While its principal focus is providing contraceptive services to low-income women, it also provides screening for key health problems, including screening for breast and cervical cancer, diabetes, hypertension, and sexually transmitted infections.

Except for California, Texas had the most unintended pregnancies (309,000) of any state in the nation, according to data for 2006. Texas has a very high rate of unintended (i.e., unwanted or mistimed) pregnancies (62 per 1,000 women, compared to a rate of 51 per 1,000 women in the median U.S. state). Texas was ranked 40th of the 50 states and the District of Columbia in unintended pregnancy rates. More than half (53%) of all pregnancies in Texas were unplanned.[21]

In addition to family planning services, the WHP offers preventive health screening services. For many women, the periodic family planning visit may be their only point of contact for preventive care and screening. An analysis of patients at family planning centers found that the majority (62%) considered the center their usual source of care and that poor (73%) and uninsured (75%) women were even more likely to depend on the centers as their usual source of care.[22] If cancer, diabetes, hypertension or sexually transmitted infections are not detected early, these diseases may become more severe and lead to death or disability as well as very high medical costs. As shown in Table 2, Texas women are in high need of these services, based on their health status and receipt of health services, when compared to women in other states.

[20] HHSC, Rider 48 Report, *op cit.*

[21] Finer, L.B. & Kost, K. (2011). Unintended pregnancy rates at the state level. *Perspectives on Sexual and Reproductive Health, 43*(2):78–87.

[22] Frost, J. (2008). US women's reliance on publicly funded family planning clinics as their usual source of medical care. Paper presented at National Survey of Family Growth Research Conference; Hyattsville, MD.

Table 2: Comparisons of Texas and US women on rates of diseases and receipt of health services[18, 23]

	US (or median state) rate	Texas rate	Texas's rank among 50 states and DC
Unintended pregnancy rate	51/1,000 women (median state)	62/1,000 women	40th
Mammogram rate for women age 40+	75.4%	70.1%	42nd
Pap smear rate in the past 3 years for women age 18 and older	80.9%	79.4%	41st
Diabetes prevalence for women	4.1%	6.1%	50th
Hypertension prevalence for women	28.3%	29.4%	34th
Rates of reported Chlamydia	610.6/100,000 women	748.5/100,000 women	43rd
Rates of reported Syphilis	1.1/100,000 women	2.7/100,000 women	47th
Rates of reported Gonorrhea	106.5/100,000 women	139.0/100,000 women	40th

The low utilization of women's preventive health services and poor health status in Texas may be partly attributed to the fact that the state has the highest uninsurance rate in the country. According to recently released Census data, in 2011, 34% of Texas women between the ages of 18 and 44 were uninsured. The uninsurance rate is even higher for low-income women of child-bearing age who are the target population for WHP services, as over half (58%) of Texan women age 18-44 below 200% of poverty lacked health insurance coverage.[24] An analysis of health insurance coverage for our target counties for low-income women age 18-39 in 2009 is presented Table 3.[25] Texas has very limited income eligibility levels for Medicaid for parents – 26% of the poverty line—and non-disabled childless adults are not covered at all.[26] In the absence of free or

Table 3: Uninsurance rates for low-income women age 18-39 in five Texas counties

County	Percent of low-income women age 18-39 who are uninsured, 2009
Bexar	48.3%
Dallas	62.5%
Hidalgo	66.2%
Lubbock	46.6%
Midland	53.4%

[23] Kaiser Family Foundation. Women's Health: 50 State Comparisons. http://statehealthfacts.org/comparecat.jsp?cat=10&rgn=6&rgn=1

[24] GW analysis of the March 2012 Current Population Survey, Annual Social and Economic Supplement.

[25] US Census Bureau. (2011). 2009 Health Insurance Coverage Status for Counties and States: Interactive Tables. http://www.census.gov/did/www/sahie/data/2009/tables.html.

[26] Kaiser Family Foundation. Medicaid Income Eligibility Limits for Adults as a Percent of Federal Poverty Level, July 2012. http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4.

low-cost family planning services and the WHP, low-income women who are unable to afford family planning services may go without them.

Another factor that makes it harder for women to access key services is the shortage of primary care providers, such as family practitioners, internists, obstetrician/gynecologists, or others who provide routine primary and preventive care services. Texas has one of the most severe primary care shortages in the nation. Texas currently ranks 47th in primary care providers per 100,000 population among states, with just 70 active primary care physicians per 100,000 population compared to 90.5 per 100,000 population nationally.[27] These shortages are particularly severe in areas outside of the major metropolitan areas of Texas, such as Houston, Dallas, or San Antonio. About half of the 254 counties in Texas are considered Primary Care Health Professional Shortage Areas. It has been reported that 29 counties have no primary care physicians at all and 76 counties have fewer primary care physicians now than they did a decade ago.[28] There are also relative shortages of other primary care clinicians such as nurse practitioners and physician assistants. These shortages mean that Texans, particularly low-income or uninsured Texans, can have serious problems finding a health care provider to provide care and facilities like family planning clinics and community health centers become all the more important because of a shortage of alternatives.

Legal and Regulatory History of the Women's Health Program

In 2003, the Texas legislature attempted to prevent state funds from going to entities that "contract with or provide funds to individuals or entities for the performance of elective abortion procedures."[29] Planned Parenthood clinics brought suit to prevent the funding ban from taking effect. In 2005, the Fifth Circuit Court of Appeals ruled that Planned Parenthood clinics could create separate legal entities to provide abortion services who could not receive state and federal funds while allowing Planned Parenthood-affiliated family planning services providers who do not provide abortions to continue to receive state and federal funds.[30] The Court held that the state rule would be preempted by federal law if "the burden of forming affiliates . . . would in practical terms frustrate [Planned Parenthood's] ability to receive federal funds."[31]

Since the WHP program began in 2007, Planned Parenthood-affiliated family planning clinics (which do not provide abortion services) have received state and federal funds through the program. The WHP program's authorization was set to expire at the end of 2011. Therefore, in mid-2011, the Texas legislature authorized a renewal of the WHP using Medicaid funding, which would require another Section 1115(a) waiver.[32] The authorizing legislation required the

[27] Association of American Medical Colleges. (2011). 2011 State Physician Workforce Data Book, Table 3. Center for Workforce Studies. https://www.aamc.org/download/263512/data/statedata2011.pdf.
[28] Health Professions Resource Center, Texas Dept. of State Health Services. (2012). "Supply Trends Among Licensed Health Professions: 1980-2011." http://www.dshs.state.tx.us/chs/hprc/Supply-Trends-Among-Licensed-Health-Professions,-Texas,-1980-2011/
[29] 78th Leg., R.S., Tex. H.B. 1 (2003) (using the same language excluding abortion providers as the WHP authorizing legislation, Tex. Hum. Res. Code § 32.0248(h) (2005)).
[30] Planned Parenthood of Houston and Se. Tex. v. Sanchez, 403 F.3d 324, 341 (5th Cir. 2005).
[31] Id. at 342.
[32] Rider 62 to Article II, Health and Human Services, House Bill 1 (2011).

HHSC to "ensure that money spent for purposes of the demonstration project for women's health care services … is not used to perform or promote elective abortions, or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions,"[33] but did not define "affiliate" or "promote."

On October 25, 2011, Texas applied for a renewal of the WHP's Medicaid waiver. The application included a conditional request to waive Medicaid's "any willing provider" rule, which requires state Medicaid programs to allow reimbursement to any qualified provider who provides covered services to Medicaid beneficiaries.[34] Although Medicaid did not give beneficiaries free choice of provider at its enactment, it was amended in 1967 to codify this right in the wake of evidence from Medicaid's first two years of existence that states had acted to limit beneficiaries' access to health care settings of states' choosing or had restricted payments to providers in certain settings.[35] States can "impos[e] reasonable and objective qualification standards" for providers, but "[t]he purpose of the free choice provision is to allow [Medicaid] recipients the same opportunities to choose among available providers of covered health care and services as are normally offered to the general population."[36] The "any willing provider" amendment was intended to give states the authority to prevent fraud and abuse in Medicaid the same way HHS could exclude providers from Medicare, as the Senate Finance Committee's Report explained: "The Committee bill clarifies current Medicaid Law by expressly granting States the authority to exclude individuals or entities from participation in their Medicaid programs for any reason that constitutes a basis for an exclusion from Medicare . . . ."[37]

Texas maintained that affiliation with an entity that provides abortion alone renders a provider "unqualified," even though CMS had not agreed with that interpretation in the past.[38] In December 2011, CMS informed Texas that it would not waive the "any willing provider" rule and gave Texas a six-month extension of the existing waiver funding the WHP program to consider and revise its renewal application. However, on February 23, 2012, HHSC proceeded to adopt the "affiliate rule," which would exclude Planned Parenthood-affiliated family planning providers from the WHP as of April 31, 2012. Unlike the 2005 law, which did not define "affiliate" and allowed WHP funding to flow to legally separate family planning clinics, as delineated by the Fifth Circuit, the 2012 regulation defined "affiliate" in a way that would exclude such separate family planning clinics from WHP if they are authorized to use the name "Planned Parenthood" or gave any other sign of association with Planned Parenthood, among other criteria for exclusion.[39] The rule was designed explicitly "to prohibit the participation of

[33] Tex. Hum. Res. Code § 32.024(c-1).
[34] 42 U.S.C. § 1396a(a)(23).
[35] For example, Puerto Rico had limited Medicaid beneficiaries to government facilities, and Massachusetts had refused to reimburse private physicians in teaching hospitals for services to Medicaid beneficiaries. President's Proposals for Revision in the Social Security System, Hearing on H.R. 5710 before the H. Comm. on Ways and Means, Part 4 (April 6 and April 11, 1967), at 2273 (Letter from Association de Hospitales de Puerto Rico) and 2301 (Letter from the Massachusetts Medical Society).
[36] Centers for Medicare and Medicaid Services (CMS), State Medicaid Manual, § 2100.
[37] S. Rep. 100-109, at 20 (1987), reprinted in 1987 U.S.C.C.A.N. at 700. *See also* First Med. Health Plan, Inc. v. Vega-Ramos, 479 F.3d 46, 53 (1st Cir. 2007) ("The history of this provision illustrates that the intention was to strengthen states' power to protect patients from incompetent providers and to prevent fraud and abuse".)
[38] Planned Parenthood of Ind. v. Comm'r of the Ind. State Dep't of Health, No. 1:11-cv-630-TWP-TAB (S.D. Ind. June 24, 2011) (Statement of Interest of the United States, p. 9-10).
[39] 1 Tex. Admin. Code § 354.1362(1). The regulation defines "affiliate," for purposes of the WHP authorizing statute, as: " An individual or entity that has a legal relationship with another entity, which relationship is created or

specialty providers that share a common mission or purpose with entities that perform or promote elective abortions,"[40] a category that includes only Planned Parenthood-affiliated family planning providers. Because this rule violated Medicaid's "any willing provider" rule, as CMS had explained, the agency informed Texas on March 15, 2012, that its waiver application was denied and set forth terms for transitioning WHP beneficiaries to an entirely state-funded program or, alternatively, informing beneficiaries and transitioning them off the program. Texas elected to phase out WHP and transition to a state program, taking effect as early as November 1, 2012. Beginning on that date, no WHP funding can go to a family planning clinic associated with PPFA, assuming the WHP program is continued using only state funds.

On April 11, 2012, several Planned Parenthood affiliates in Texas that provide only family planning services, not abortion, filed suit against Texas, alleging that their exclusion from the WHP violates the First Amendment's guarantee of free speech and free association and the Fourteenth Amendment's guarantee of equal protection, as well as state law.[41] On April 30, 2012, the district court granted a preliminary injunction that prevented the affiliate rule from taking effect.

The day after CMS' decision letter, the state of Texas filed suit against CMS, claiming that it exceeded its authority under the Social Security Act and violated the Constitution in denying the waiver.[42] The state also proposed that the transition to full state funding be delayed until 90 days after the outcome of the Planned Parenthood suit, whenever that may be. However, CMS has not yet responded to that proposal. The trial in that case is set for March 2013 in the Federal District Court for the Western District of Texas.

On August 21, 2012, the Court of Appeals for the Fifth Circuit overturned the lower court and lifted the preliminary injunction, reasoning that "Texas's authority to directly regulate the content of its own program necessarily includes the power to limit the identifying marks that program grantees are authorized to use" and therefore, "Texas may deny WHP funds from organizations that promote elective abortions through identifying marks," such as the Planned Parenthood name and logo.[43] Although the Fifth Circuit's decision was limited to the preliminary injunction and it remanded the case to the district court, its analysis foreshadows how it would rule on appeal. The case has been placed on hold in the district court pending a rehearing in the Fifth Circuit of the issue or state rulemaking for an entirely state-funded WHP.

Methodology

In this project, we focused more closely on the potential consequences of the exclusion of Planned Parenthood clinics from the WHP in five local markets where Planned Parenthood (PPFA) clinics are located. Those five markets consisted of two large urban areas (Bexar County

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governed by at least one written instrument that demonstrates: (i) common ownership, management, or control; (ii) a franchise; or (iii) the granting or extension of a license or other agreement that authorizes the affiliate to use the other entity's brand name, trademark, service mark, or other registered identification mark. . . ."

[40] 37 Tex. Reg. 1696 (Mar. 9, 2012).

[41] Planned Parenthood of Austin Family Planning, et al. v. Suehs, No. 1:12-CV-00322 (W.D.TX, Apr. 11, 2012).

[42] Texas v. Sebelius, No. 6:12-cv-62 (W.D.TX, Mar. 16, 2012).

[43] Planned Parenthood of Austin Family Planning, et al. v. Suehs, No. No. 12-50377 (5th Cir. Aug. 21, 2012).

and Dallas County), one midsize area (Hidalgo County, near the Mexican border), and two more rural areas (Lubbock County and Midland County). These areas are spread across the state (Bexar County in south central Texas, Dallas in the northeast, Hidalgo in south Texas, Lubbock in the north central area and Midland in the west.)

Our list of providers was determined from the HHSC's list of providers who billed the WHP in state fiscal year 2011. In each county, Planned Parenthood centers saw the largest number of WHP patients, based on statistics for state fiscal year 2011, as shown in Table 4.[44] Planned Parenthood affiliates often operate multiple clinics or sites, particularly in the larger urban areas. In this report, we use the term "affiliate" to refer to a Planned Parenthood organization, which may have multiple clinics or sites. The WHP provider list is based on the billing address of providers. In some cases, the listed provider is a Planned Parenthood affiliate (such as in Dallas and Bexar Counties) which includes multiple sites under that listing; in some other cases the list refers to individual Planned Parenthood clinics, which are part of the same affiliate (as in Hidalgo County). Non-PPFA providers are also based on their billing addresses; they could include larger clinics, such as publicly-owned clinics or community health centers, but could also represent individual clinicians practicing on their own or in a larger practice.

The counties associated with the WHP providers in Tables 4 and 5 below are based on the billing address of the organization, not its actual site locations or the residences of its patients. For example, the WHP list indicates that 10,176 patients were served by Planned Parenthood of North Texas (now called Planned Parenthood of Greater Texas) in 2011. That affiliate has a billing address in Dallas County, but some of its sites are in other adjacent counties and some of the patients served may be residents of other counties. The list does not indicate how many of the 10,176 patients were served in Dallas County sites, nor how many are Dallas

Table 4: Number of patients served by Planned Parenthood (PPFA) clinics and other providers in FY2011 in Texas

County	Total # of WHP clients	# WHP clients served by PPFA affiliates	% of WHP clients served by PPFA affiliates	# WHP clients served by other providers	% of WHP clients served by other providers
Bexar County	11,761	5,953	51%	5,808	49%
Dallas County	15,894	10,176	64%	5,718	36%
Hidalgo County	6,583	5,779	84%	1,074	16%
Lubbock County	3,278	2,342	71%	936	29%
Midland County	1,058	892	84%	166	16%
Texas Total	119,083	53,473	45%	65,830	55%

Note: To reduce double counting, we focused on providers of direct primary care services and excluded patient counts for laboratories, anesthesiologists, ambulatory surgery centers and long-term, limited or specialized hospitals. County locations are based on the address of the provider's billing address, not the residence of the patient.

[44] In order to focus on the facilities that provide regular primary care services, we excluded WHP providers that were laboratories, anesthesiologists, ambulatory surgery centers or long term care, limited or specialized hospitals. To a great extent, this avoids double counting of patients.

County residents. Similarly, some of the alternative non-PPFA organizations may have clinic sites in other counties and their patients may also reside elsewhere. Because of these data limitations, readers should be cautious in interpreting the county-specific data.

We contacted Planned Parenthood centers to determine which of their clinics in the county (two clinics each were chosen for Bexar County and Dallas County) saw the greatest number of WHP clients in 2011. Based upon the assumption that clients who attend those Planned Parenthood clinics would seek care at providers in the same proximate area, we identified non-PPFA providers within 30 miles of the chosen Planned Parenthood clinics and chose four non-PPFA providers who served the largest number of WHP clients in 2011 for interviews. Thus, our original sampling plan included 33 interviewees—a CEO or other senior staff member of each county's Planned Parenthood affiliate, 8 alternative clinics or providers each in Bexar County and Dallas County, and 4 alternative clinics or providers each in Hidalgo, Lubbock, and Midland Counties. While we were able to interview all the Planned Parenthood affiliates, which included a varying number of sites, some non-PPFA sites either were unable to participate or did not complete the interview process by the end of the field period.

Providers who agreed to participate and scheduled an interview were sent a consent form for the study and a baseline questionnaire (on services provided, type of clinical staff employed, and number of WHP clients served) by email or fax to be returned to the interviewers. The phone interviews lasted approximately 20-30 minutes each, were conducted by 2 researchers in order for one to take notes, and were based upon interview guides developed for PPFA providers and non-PPFA providers. Recognizing that responses on this topic could be sensitive, respondents were guaranteed that their identities would remain confidential and the non-Planned Parenthood clinics were assured that the names of their clinics would not be reported. Nearly half of providers indicated their interest in participating but limited time availability resulted in them completing both the baseline questionnaire and interview by email or mail. Results from the baseline questionnaire were for only descriptive purposes and were not further analyzed. Findings from the transcripts of the phone interviews were analyzed to identify common themes and experiences. Our final sample included 5 Planned Parenthood affiliates and 16 non-PPFA or "alternative" providers (although one did not complete the baseline profile). Interviews were conducted over a three-month period, from July to September 2012.

Results

Share of WHP Patients Served by Planned Parenthood

As previously noted, Planned Parenthood affiliates are currently the dominant WHP providers in their markets. While Planned Parenthood clinics served slightly below half (45%) of the patients statewide (as seen in Table 4), they provided care to an even higher proportion of patients in the market areas in which they are located. In the five markets examined, Planned Parenthood affiliates serve more than half of the WHP patients. In Hidalgo and Lubbock Counties, Planned Parenthood affiliates serve more than four-fifths (84% each) of WHP patients. The dominance of Planned Parenthood clinics in their markets signals the problems that WHP patients may encounter if those facilities are not available. The extent to which such a large share of WHP patients choose Planned Parenthood clinics also indicates that a large share of

patients prefer Planned Parenthood facilities, whether because of their locations, the nature and quality of services provided, their reputations, the quality or attentiveness of staff, or for other reasons.

The governor's office has expressed the view that, since Planned Parenthood affiliates constitute just 2% of WHP providers, patients would have little difficulty finding alternative providers. Our analysis indicates that in the markets they serve, Planned Parenthood affiliates serve half, and sometimes much more than half, of all WHP patients. The bulk of the remaining WHP patients are seen by a small number of primary care clinics, such as federally qualified health centers, or public facilities, such as clinics of the Bexar County Hospital District in Bexar County or the Community-Oriented Primary Care Centers of Parkland Hospital, the public hospital in Dallas County. Most of the remaining providers are small practices that see fewer than 10 patients a year.

As seen in Table 5, the average WHP caseload of non-PPFA facilities in the five areas ranges from 21 per provider in Hidalgo County to 112 in Dallas. If Planned Parenthood affiliates were excluded from WHP, the remaining non-PPFA clinics would have to absorb a massive increase in WHP patients in order to maintain the overall 2011 caseload level. Non-PPFA clinics in Bexar and Dallas Counties would have to double their capacity. Lubbock County providers would need to expand by 250% if the Planned Parenthood affiliate was excluded. In Hidalgo and Midland Counties, the average non-PPFA clinics would have to serve more than five times their current caseloads. In these five markets, the WHP caseloads would need to expand by two to five times their current capacity in order to absorb the patients already served by Planned Parenthood.

Table 5: Number of patients served by clinic type and the average increase in WHP caseloads required by non-Planned Parenthood providers to absorb the loss of Planned Parenthood as a WHP provider

County	# WHP clients served by PPFA affiliates	# WHP clients served by other clinics	# of non-PPFA clinics in county	Average # of WHP clients per non-PPFA clinic	Average % increase in non-PPFA caseloads required to replace PPFA
Bexar County	5,953	5,808	63	92	102%
Dallas County	10,176	5,718	51	112	178%
Hidalgo County	5,779	1,074	51	21	531%
Lubbock County	2,342	936	17	55	250%
Midland County	892	166	4	42	537%
Texas Total	53,473	65,830	1,066	62	81%

Note: County counts are based on the billing addresses of the providers, not patients' residence.

Clinical Staff of WHP Facilities

As seen in Table 6, the clinical staffing for Planned Parenthood and other WHP clinics is broadly similar. Based on our interviews, most employ both obstetricians/gynecologists and nurse practitioners/nurse midwives. Most Planned Parenthood clinics have family planning counselors or health educators available, as do a majority if other providers. Registered nurses are more common at non-PPFA clinics, but this is probably because many provide a broad range of primary care services beyond family planning.

Table 6: Clinical staff available at WHP providers

	Non-PPFA clinics (n=15)	PPFA affiliates (n=5)	Total (n=20)
Type of Provider			
Obstetricians/gynecologists	87%	80%	85%
Other physicians	27%	40%	30%
Nurse practitioners/midwives	87%	100%	90%
Physician assistants	7%	20%	10%
Registered nurses	60%	20%	50%
Family planning counselors/health educators	60%	80%	65%

Range of Services

As seen in Table 7, both Planned Parenthood and other WHP clinics typically offer a comprehensive range of contraceptive methods. The methods include oral contraceptives (the Pill) as well as long-acting reversible contraceptives (LARCs) such as intrauterine devices (IUDs), implants (e.g., Implanon), or injectables (e.g., Depo-Provera). LARCs are particularly important because they are the most effective in preventing unintended pregnancies and have lower failure rates.[45] However, they have higher initial costs, compared to methods like oral contraceptives or condoms, which tend to have higher failure rates, particularly if they are used intermittently.

WHP patients can get access to a comprehensive range of contraceptives, including LARCs. Many WHP clinics, particularly the Planned Parenthood clinics, can dispense contraceptives on-site. The Planned Parenthood clinics have their own pharmacies where they can dispense contraceptives, but the loss of Title X funding in 2011 means that they are unable to purchase them at a discounted rate using the Public Health Services 340B drug program. WHP patients should be able to get contraceptives free, but if they can get them from the clinic, it is more convenient and assures faster use, which can help prevent unintended pregnancies.

Most of the clinics also provide other on-site services, such as HIV and sexually transmitted infection testing, breast exams, Pap smears, hypertension and diabetes screening, but tend to refer patients for mammograms. The WHP pays for screening for these diseases, but does

[45] Centers for Disease Control and Prevention. "U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 Adapted from the World Health Organization Medical Eligibility Criteria for Contraceptive Use, 4th edition", *Morbidity and Mortality Weekly Report*, May 29, 2010.

not pay for treatment if the disease is found. Some of the women may qualify for Medicaid, which would pay for treatment services.

Table 7: WHP-covered services provided at participating providers

Services	Non-PPFA clinics (n=15)		PPFA affiliates (n=5)		Total (n=20)	
	Provided on-site	Provided through referral	Provided on-site	Provided through referral	Provided on-site	Provided through referral
Oral contraceptives	93%	7%	100%	0%	95%	5%
Hormone patch	87%	7%	80%	20%	85%	10%
Intrauterine device (IUD)	87%	7%	100%	0%	90%	5%
Implants (Implanon)	87%	7%	100%	0%	90%	5%
Injectables (Depo-provera)	93%	0%	100%	0%	95%	0%
Diaphragm	47%	7%	40%	40%	45%	15%
Cervical cap	20%	13%	0%	80%	15%	30%
Nuvaring	87%	7%	80%	20%	85%	10%
Sponge (Today sponge)	33%	7%	20%	60%	30%	20%
Spermicide	93%	0%	60%	20%	85%	5%
Condoms (male)	80%	0%	100%	0%	85%	0%
Condoms (female)	20%	13%	80%	20%	35%	15%
Natural family planning	73%	7%	100%	0%	80%	5%
Sterilization/tubal ligation/Essure	67%	20%	40%	60%	60%	30%
Pregnancy testing	100%	0%	100%	0%	100%	0%
STI and HIV testing	100%	0%	100%	0%	100%	0%
FP counseling and education	87%	7%	100%	0%	90%	5%
Pap smears	93%	0%	100%	0%	95%	0%
Breast exams	93%	0%	100%	0%	95%	0%
Mammograms	13%	80%	0%	100%	10%	85%
Hypertension screening	93%	0%	80%	20%	90%	5%
Diabetes screening	87%	7%	80%	20%	85%	10%

On-site Applications

The eligibility criteria for the WHP are established by HHSC and applications must be approved by the state agency. All the Planned Parenthood clinics could accept WHP applications, as could 69% of the alternative providers. On-site applications make it more convenient to help low-income uninsured women get assistance when they first come to the clinic for care.

Relationships with Other Local Health Care Providers

Both Planned Parenthood and the alternative sites we interviewed typically had relationships with other local health care providers. Thus, changes that affect one set of clinics, like Planned Parenthood, may have repercussions for other providers in the communities. Clinics often refer patients for care at other facilities if they cannot provide the services themselves. For example, if a woman is diagnosed with diabetes in a WHP exam at a family planning clinic, she would be referred to a community health center or public primary care clinic for further follow-up and care. Some of those that we interviewed mentioned that the recent statewide reduction in family planning funds led to rearrangements of care within the communities. Planned Parenthood affiliates explained:

> *"We're not as able to help women [as we would like], and yet [other] providers are sending patients to Planned Parenthood who they can't see."*

> *"The facilities around us would refer women to us…so they are now having to tell them to come up with the funds or they will go without. They weren't providing family planning services, we did thanks to the grants, so they would refer to us. We are very close-knit, we provide family planning services, while they primarily provide primary care and the health department does immunizations and WIC. We each had our own specialty."*

The Effects of Reductions in Family Planning Funds

As noted earlier, the planned changes in the WHP follow on major reductions in funding for family planning services in Texas beginning in 2011.[46] It was important to ask respondents about how this affected them, since this has already dramatically affected the market for family planning in Texas. All the Planned Parenthood affiliates said that they had lost funding and that this has had a serious impact on their operations. One affiliate stated:

> *"Yes, we were, we were deeply affected by [the funding cuts], almost 50-60% of our budget was cut. We reduced locations from 8 to 4, had to cut 50-60% of staff and 12,000-15,000 women annually were displaced due to the grants being removed by the state."*

Two-thirds of the alternative providers we interviewed also reported reductions in family planning funds, but the remaining third did not.

We asked both Planned Parenthood and alternative clinics that lost family planning funds how this affected their operations and how they changed operations. The loss of funding, which included federal Title X family planning funds, also had indirect consequences, such as the loss of access to discounted prices under the federal 340B prescription drug pricing program.[47] At

[46] The Population Research Center of the University of Texas is conducting a 3 year study of the recent changes for Texas family planning clinics, led by Prof. Joseph Potter. Some initial findings are presented in White, K., Grossman, D., Hopkins, K, and Potter, J, *op cit.*.

[47] The 340B prescription drug program, operated by the federal Health Resources and Services Administration, provides access to a number of prescription drugs at heavily discounted prices to certain types of safety net facilities, including clinics that receive Title X family planning grants, federally qualified health centers, and disproportionate share and children's hospitals. This can reduce the purchase price of medications by 20 to 50%.

the most severe, some clinics had to close. Those that remained had to make changes, which included:

- Increasing the amount that patients must pay for family planning services,
- Limiting the number of family planning patients served,
- Reducing staff,
- Stopping the direct provision of contraceptives to patients, including long-acting reversible contraceptive methods (LARCs), which are more expensive to offer.

Statements by Planned Parenthood clinics that raised copayments for services included:

> *"We're charging $40-50 a visit which includes [a] Pap smear and exam but many women can't afford that."*
>
> *"Regrettably, that means our most financially vulnerable patients must try to find a provider who offers care at no cost."*

One non-Planned Parenthood provider mentioned that after they increased family planning copayments to $25, the volume of patients seen fell by about 10%. The respondent added:

> *"We're trying to monitor and see if our delivery population will go up, we anticipate that those patients who can't afford to come in will come in later on the OB side."*

The financial consequences of the funding reductions appeared more serious for Planned Parenthood affiliates, since the alternative providers were usually part of larger health facilities, such as community health centers or primary care clinics, so family planning services formed a smaller portion of their overall book of business. The Planned Parenthood affiliates sought, often with difficulty, to increase revenues from local charities and other private sources; they commented:

> *"It has put us at great risk, going to self-pay model which is very difficult in this poor area but we're still here and will be fund-raising but [we] can't make up$ 3.2 million in a year's time."*
>
> *"With a significant reduction in patient volume because they cannot pay cash, long term sustainability is in question."*

Expected Consequences of the Exclusion of Planned Parenthood from WHP

We asked both Planned Parenthood and alternative clinics about what might happen if the Planned Parenthood affiliates were actually excluded from WHP. At the time of our survey, there was substantial uncertainty, both because of the two lawsuits and a lack of clarity about the availability of state funding. While the Governor of Texas has said that the state is prepared to finance WHP with state funds if federal matching funds are not available, the level of state funding that will be available is unknown. As noted earlier, the federal government currently

pays 90% of WHP cost. Whether the state will replace that full amount or not is unclear. Given the state's recent action to curtail family planning funding by two-thirds, some respondents were skeptical about the state's level of commitment to bear the additional financial burden. If state WHP funding is not sufficient to replace the loss of federal funds, it is possible that non-PPFA clinics could also be jeopardized.

Earlier in the year, when the affiliate rule was first implemented, the state expected that the planned expansion of Medicaid to non-elderly adults with incomes under 133% of poverty under the Affordable Care Act in 2014 would ensure that most of the low-income WHP clients would become eligible for Medicaid and that additional support might only be needed for those women with incomes between 138% and 185% of poverty. However, the Supreme Court's subsequent decision to make the Medicaid expansion optional and Governor Perry's declaration that Texas would not undertake the Medicaid expansion has thrown that option into doubt.

While both Planned Parenthood and non-PPFA providers expressed their commitment to try to meet the needs of low-income women patients even if WHP funding was lost or curtailed, they generally expected that many women would lose access to family planning services and, as a result, unplanned pregnancies would increase.

Planned Parenthood affiliates generally stated that they would continue to provide care to low-income uninsured women to the extent that they could; this was a fundamental part of their mission. However, the loss of WHP funding, following the previous loss of state family planning funding, created serious challenges. Planned Parenthood representatives said that despite their desire to continue to serve their patients, they expected that their waiting lists would grow longer and that they would see fewer patients. Other expected consequences included:

- A continued search for alternative sources of funding, including charitable giving and other private sources, to help stem the loss of revenue.
- Greatly increasing fees for uninsured women, which would reduce overall participation and limit access for the poorest patients.
- Operational restructuring, such as by closing some sites and reducing staff, in light of the loss of operating funds.
- Reexamination of their services, perhaps reducing the use of long-acting reversible contraceptive methods (LARCs) because they are more costly, even though they are more effective,

At the time of our survey, Planned Parenthood representatives said that they had not begun referring patients to other facilities. In part, this was because they remained hopeful that more desirable alternatives would turn up that would enable them to maintain operations, but some acknowledged that they might have to begin such discussions in the near future.

Views from Planned Parenthood affiliates include the following:

"We would only be able to serve a small number and would have to ask them to pay for some services. We couldn't keep our doors open with no funding."

"We will continue to serve women as best we can; we are in the process now of looking at our fees to see that we are the most affordable, high-quality care in the community but we might have to change our fees… The poorest of the poor are on Medicaid here, you can get on it when you're pregnant but it's hard to keep it for family planning. It's the in-between crowd that you do have to worry about, the ones that are low-income but can't get Medicaid."

"We will try to sustain on a cash basis and are looking for some large donations or private grants."

"60% of our patient load is on the Women's Health Program."

"Women here put their children, their electricity bill etc. before their health care, women will come in with lumps in their breasts they've had for 9 months and they haven't come in until now because they didn't have the money. And women who have their Pap smears and need further testing; you don't know what money will cover that. It's very rural out here and there are not a lot of clinics, and some women might drive up to 5 hours to come here… We have women coming in from all over… who drive hours because they trust us."

"This makes me angry, because I don't like the thought of women being callously used in these political games."

Non-Planned Parenthood clinics typically reported that they would try to serve additional WHP patients if Planned Parenthood clinics could not, but they generally felt that they were already at or close to their maximum capacity. Some, such as public clinics or community health centers, are unable to turn away clients, because of their charters to serve all patients regardless of their insurance status. However, they may be limited in their ability to serve them due to resource limitations, so new clients may be placed on waiting lists or displace existing patients. When we asked how many additional WHP patients they could serve, none of the respondents were able to make an estimate. As described earlier in our report, the average WHP caseloads of non-PPFA clinics would have to double to quintuple, if they were going to fully absorb the patients served by Planned Parenthood clinics in their areas in 2011.

We asked if they would be able to hire more clinicians or otherwise expand resources to care for more WHP patients. Some clinics felt that they might be able increase the number of family planning staff a little if there were sufficient funds, but most responded that they would not be able to increase staffing in any case because of their broader fiscal limits or their limited space.

Non-PPFA providers made the following assessments:

"The women's health nurse practitioners see 25-30 patients a day – combination of OB and family planning patients. We would not increase this number for quality of care and patient safety."

"It's going to be a practical matter, you don't dump 6,000 patients over the middle of the night, and our OB/GYN can only see so many patients. I would like to bring in additional help but we don't have the resources. It's going to be grim...We are running at that [maximum patient capacity] right now."

"We are seeing a ton of uninsured now so that probably won't change. We will probably see more people that we can't cover through Title V [Maternal and Child Health Services Block Grant] or Medicaid."

"We have only 8 rooms so even if we could hire 10 docs they have nowhere to go. We could really use a new doctor but I don't think we will get state funds to do so."

"[We would need] more providers [to serve more WHP patients]– with this more educators and more ancillary staff. [We can't say how many more we could serve] because we currently are booking new family planning patients to our clinic 6 months out."

"[The ability to add clinical staff or resources] really depends on the volume we see. Last year, we had $10 million in expenses and we got $7 million in revenue so already we're at a $3 million deficit. We at least know that when we had all the funding, Title V, X, XX, WHP, Medicaid, we still had a deficit."

"I don't believe we would increase staff for this reason alone. We will work within the capacity we have."

"[We are not able to extend clinic hours to see more patients], all that would do is run the OB into the ground."

"Some women, if they are going to Planned Parenthood every quarter on their sliding scale system, they will probably come to us but if our costs are too high they will likely skip their appointments. They may have sticker shock when they see our prices compared to Planned Parenthood. We will likely see more pregnancies."

We also raised the possibility that WHP might entirely disappear, as have some have suggested might occur. In that case, non-Planned Parenthood clinics would face the same type of problems that Planned Parenthood clinics now face. Some reported that they would no longer provide family planning services for low-income uninsured women if WHP funding disappeared. Others said they would try to continue to do so, but would face severe limits and would have to try to find alternative funding sources, such as further increases in patient charges. They pointed out that some patients may remain eligible for full Medicaid coverage or be supported under their Title V or X grants, but the rest would have to pay much higher fees for services. In some cases, they may be able to arrange sliding fee scales or other extended payment plans. One facility noted that it was already operating at a loss, so if they lost their $1 million in WHP payments, it would add to their existing debt.

In considering the current situation in Texas, a representative of a non-Planned Parenthood facility offered the following summation:

"The assault on Planned Parenthood has worked out here. They are struggling to make ends meet, even though they provide a great service. We're all waiting to see what happens with the courts. Closing Planned Parenthood would be a huge blow. The governor says he has a plan to continue WHP, but a lot of people are skeptical and it

would be a very difficult situation.… I think the big question is, even if [the governor] thinks we can do it [keep running the WHP or replace it with a new program], where are they going to get the money? They've already cut a lot of the programs to pretty bare-bones numbers. There will be nothing left to cut. There might be more revenue, but it's hard to say that they'll give money to the WHP."

Discussion

Family planning clinics in Texas face an unsettled and uncertain future, not knowing what an entirely state-financed WHP program will look like or what the level of funding will be when or if Planned Parenthood affiliates are terminated from WHP. Many family planning providers have already been strained by the reductions in family planning funding in 2011 and the interviews that we conducted indicate that their capacity to absorb new patients is quite limited. But if Planned Parenthood clinics are excluded, more than 50,000 WHP patients may need to find alternative providers. Planned Parenthood affiliates would like to continue to serve these low-income women, but the loss of funding will decimate their ability to do so.

Our analyses indicate that if non-PPFA clinics had to absorb the WHP patients now, non-PPFA clinics would need to expand radically, at least doubling the caseload of WHP patients and, in the cases of poor, less populated areas like Hidalgo or Midland Counties, having to support a five-fold increase in capacity. While the providers we surveyed – the larger alternative facilities in each area – may be able to absorb some new patients, none were ready to sustain such large increases in the next few months or even on a longer term basis. The non-PPFA facilities are frequently already at or close to the limits of their capacity in the near term and financial constraints will make it difficult for them to expand to fill the remaining gaps.

Planned Parenthood affiliates know that if the current state policy is upheld, they will be excluded from WHP in the near future. The pending lawsuit by Planned Parenthood against Texas might eventually result in the restoration of funding, but only after a year or more of litigation. For Planned Parenthood clinics struggling to survive in the wake of the significant family planning funding cuts that occurred in 2011, the loss of WHP funding will impose an additional burden on clinic staffing capacity and long-term sustainability. The ability of Planned Parenthood clinics to survive will depend on the extent to which they are able to raise additional funds from charities and other private sources and to raise patient fees.

The problem with raising fees for family planning services for low-income women is that research has clearly and repeatedly demonstrated that increasing the amount low-income people must pay for health care reduces utilization of services and that use of preventive services like family planning or preventive screening is particularly affected by the price of care.[48, 49] Analyses have demonstrated that cost is a major factor in reducing the use of effective methods

[48] Swartz, K. (2010). "Cost-sharing: Effects on Spending and Outcomes," Robert Wood Johnson Foundation Synthesis Report No. 20.http://www.statecoverage.org/files/RWJF_Cost_Sharing_Effects_on_spending_and_outcomes.pdf

[49] Ku, L. & Wachino, V. (2005). "The Effect Of Increased Cost-Sharing in Medicaid: A Summary Of Research Findings" Washington, DC: Center on Budget and Policy Priorities. http://www.cbpp.org/cms/?fa=view&id=321

of contraception.[50] A recent study found that when women were able to receive a comprehensive range of contraceptive methods without cost-sharing the use of long acting reversible contraceptive (LARC) methods, such as use of IUDs, implants or Depo-provera, climbed and, as a result, repeat abortions and teen births decreased.[51] A similar study from Kaiser Permanente also found that elimination of cost-sharing for contraceptives increased the use of LARCs and the level of contraceptive failure dropped.[52] Research has found that publicly-funded family planning providers routinely report that more than half of their family planning patients encounter cost-related barriers to obtaining care.[53] Research about Medicaid family planning waivers has found that after enrolling in programs like the WHP, women are far more likely to use effective contraceptive methods.[54] In this study, providers who had already increased prices for family planning services reported that the volume of patients dropped because of the cost barriers.

While Planned Parenthood affiliates would like to continue to offer family planning care to low-income uninsured women, the combination of the loss of public funding due to earlier state budget cuts as well as the new exclusion from WHP will force them to scale back services and raise prices. More clinics would be forced to close. These changes will reduce women's ability to obtain contraception. A small share of the women previously served by Planned Parenthood may be able to obtain care from other WHP providers, but this survey indicates that the alternative sites are not able to handle the massive caseload increases that would be necessary to preserve the current level of care.

The expected impact is that tens of thousands of low-income women who would like to avoid unplanned pregnancies will be unable to obtain affordable contraceptive care. Even if they can obtain care, it may be delayed because of long waiting lists at the remaining available providers. Further, the most effective forms of contraception, such as long-acting reversible contraceptive methods, may be too expensive to access. Consequently, more women may be exposed to gaps in contraceptive protection because of problems affording or scheduling care. Health care providers in Texas expect an increase in unexpected pregnancies among low-income women and the state can expect an increase in Medicaid costs for delivery and infant care.

As noted earlier, HHSC's analysis of the WHP found that the program averted 8,215 unplanned births and generated a total (federal plus state) net savings of $54.2 million and state savings of $23.6 million in 2011 (see Table 1).[55] Using some basic assumptions, we can recalculate the potential impact of a WHP that excludes Planned Parenthood providers. Right

[50] Frost, J. & Darroch, J. (2008). Factors associated with contraceptive choice and inconsistent method use, United States, 2004. *Perspectives on Sexual and Reproductive Health, 40*(2):94–104.
[51] Peipert, J., Madden, T., Allsworth, J. & Securra, G. (2012) "Preventing Unintended Pregnancies by Providing No-Cost Contraception," *Obstetrics & Gynecology*, e-published ahead Oct 3, 2012. doi: 10.1097/AOG.0b013e318273eb56
[52] Postlethwaite D., et al. (2007). A comparison of contraceptive procurement pre- and post-benefit change, *Contraception, 76*(5) 360–365.
[53] Landry, D., Wei, J. & Frost, J. (2008).Public and private providers' involvement in improving their patients' contraceptive use. *Contraception, 78*(1):42–51.
[54] Research and Data Analysis Division, Washington Department of Social and Health Services. (2006). *Take Charge: Final Evaluation, First Five Years: July 2001–June 2006*.http://www.dshs.wa.gov/pdf/ms/rda/research/9/83.pdf
[55] HHSC, Rider 48 Report, *op cit.*

now, Planned Parenthood provides care to about half of the WHP caseload. For this estimate, we assume that, as a result of that exclusion, between one-quarter and one-half of the Planned Parenthood patients could be served by other providers and that the program's efficacy is similar regardless of provider type. We further assume that the 90% federal matching rate is no longer available to the WHP and the state must bear all the costs.

Based on these assumptions, we estimate the program impacts and costs and savings as if the new policy had been in effect during 2011. Under this scenario, due to the exclusion, about one-half to three-quarters of the current Planned Parenthood WHP caseload goes unserved, so the total number of women served by the WHP falls to about 62.5% to 75% of its previous levels. As can be seen in Table 8, if Planned Parenthood affiliates had been excluded in 2011, the program would have averted about 2,000 to 3,000 *fewer* births than the 8,215 births that were actually averted, as estimated by HHSC. There would be substantial savings in total Medicaid costs due to the births that were averted, ranging from $56 to $68 million in total costs or $17 to $20 million in state funds.

Table 8: Estimated Program Impacts If Planned Parenthood Affiliates Had Been Excluded in 2011

	If three-quarters of PPFA patients had dropped off		**If one-half of PPFA patients had dropped off**	
Reduction in births averted (from 8,215 births averted)	3,081		2,084	
	Total (federal + state)	**State only**	**Total (federal + state)**	**State only**
Savings due to averted births	$56.4 mil.	$17.0 mil.	$67.7 mil	$20.4 mil.
Program costs	$22.5 mil.	$22.5 mil.	$27.0 mil.	$27.0 mil.
Net program savings or cost	$33.9 mil.	-$5.5 mil	$40.7 mil.	-$6.6 mil.

Since federal matching funds – which bore 90% of the costs –are no longer available under this scenario, the costs of WHP ($23 to $27 million) would be borne entirely by the state. The state's share of WHP costs would rise from $3.6 million under the existing policy to almost six to eight times that level, due to the loss of federal matching funds, or $23 to $27 million in state dollars. Because the births averted would be regular Medicaid births, there would still be a substantial net reduction in total federal and state costs – between $34 and $41 million per year – but the state's share of the savings would be only $17 to $20 million. On balance, the state of Texas would experience *a net loss of $5.5 to $6.6 million* because the state's share of the costs would rise several-fold. Paradoxically, as the number of WHP patients who can continue to be served climbs, the state's budget losses grow larger. These are estimates based on some basic assumptions; the actual outcomes may differ based on how many Planned Parenthood patients can still be served in WHP and whether the program remains as effective as before.

The effects of the exclusion of Planned Parenthood affiliates may extend beyond family planning. WHP also provides coverage for other preventive services, such as breast and cervical cancer screening, diabetes and hypertension screening, and testing for HIV and sexually transmitted infections. For many women, particularly younger low-income women, the periodic

family planning visit may be the only preventive medical care they obtain. Texas has very high rates of unplanned pregnancies, low rates of breast and cervical cancer and other disease screening and high incidence of STIs. The WHP policy changes would reduce access to screening services and therefore reduce access to early treatment for these diseases as well.

It is unclear how Texas's policies will change in the near future, both because of the lawsuits that are ongoing and the uncertainty of the state's actions if its Medicaid waiver ends. Another factor that might affect the eventual outcome is whether Texas decides to expand Medicaid eligibility for low-income adults under the Affordable Care Act in 2014. On June 25, the Texas Department of State Health Services filed proposed rules that "assum[ed] that all clients will be eligible for Medicaid following the expansion of the Medicaid program in January 2014." On July 9, 2012, the state submitted this proposed regulation to the federal court of appeals as supplemental authority in the case. [56] On that same day, however, the Governor of Texas informed the Secretary of Health and Human Services (HHS) that Texas would not be expanding its Medicaid program under the Affordable Care Act, in light of the recent Supreme Court decision making the Medicaid expansion optional for states.

If Medicaid eligibility were expanded as permitted under the Affordable Care Act, most of the WHP patients—those with incomes below 133% of poverty[57]—could be served as regular Medicaid beneficiaries and could continue to receive care at Planned Parenthood affiliates or other clinics. Given Governor Perry's aversion to a Medicaid expansion, this seems unlikely, despite political pressure from hospitals and other providers in favor of the expansion.[58]

Key conclusions of this study are:

- Planned Parenthood affiliates are the dominant providers of care in the Women's Health Program in the markets in which they are located, serving from 51% to 84% of the WHP patients in the five markets we examined.

- While other clinics may be able to care for some of the displaced patients if Planned Parenthood is excluded, there is no evidence that they are prepared to sustain the very large caseload increases that would be required to fill the gaps left after Planned Parenthood clinics are excluded.

- As a result, tens of thousands of low-income Texas women could lose access to affordable family planning services and to other women's health services. This would likely lead to a substantial increase in the number of unplanned pregnancies to low-income women in Texas.

- More Planned Parenthood clinics will have to close because of the financial losses.

[56] Supplemental Authorities Letter from Defendant-Appellant's Brief, Planned Parenthood Ass'n, et al. v. Suehs, No. 12-50377 (5th Cir. July 9, 2012); Proposed Administrative Rules for the Texas Women's Health Program, 37 Tex. Reg. 5074-5080 (July 6, 2012).

[57] Under the Affordable Care Act, Medicaid eligibility could be expanded to 133% of the poverty line for non-elderly adults and there would also be a 5% standard deduction, leading to a net income limit of 138% of poverty.

[58] For example, Hawkins, J. and Banda, J. *THA's Senate Testimony Urges Texas Legislature to Accept Medicaid Expansion*, Texas Hospital Association (Aug. 2, 2012). http://www.tha.org/HealthCareProviders/AboutTHA/Publications/HealthCareAdvocate/AugCC0BC/THAsSenateTestimony0972.asp.

- Instead of the current situation in which the state of Texas gains between $7 and $8 in state savings for every dollar invested in WHP, the loss of federal funds could turn WHP into a net cost to the state. This suggests that the state may try to limit funding for WHP if federal matching funds become unavailable. This also could cause difficulties for the remaining non-Planned Parenthood providers, as well as the patients they serve.