KEN PAXTON
ATTORNEY GENERAL OF TEXAS

May 7, 2018

Mr. Alex Azar, Secretary
U.S. Department of Health & Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Mr. Timothy Hill, Acting Director
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Blvd., Mail Stop S2-26-12
Baltimore, MD 21244-1850

Re: Texas's Section 1115 Waiver Application for the Healthy Texas Women Program

Dear Secretary Azar and Acting Director Hill:

At the request of Governor Greg Abbott and on behalf of the Texas Health and Human Services Commission, I write to urge your approval of Texas's proposal for a waiver under Section 1115 of the Social Security Act for the Healthy Texas Women program (referred to as "the Program"). As you know, the State of Texas submitted its proposal on June 28, 2017. The proposed effective date for the waiver begins on September 1, 2018. But to date, we have not received a determination on our application.

The State of Texas urges you to take prompt action on this application in order to provide needed funding for the State's Program, which will increase access to women's health, family planning, and preventative health services for lower income women in the State. This program will not only reduce the overall costs of publicly funded healthcare (including federally funded healthcare), but it will also implement both state and federal policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care.

Texas law provides that program money may not be "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." Tex. Hum. Res. Code § 32.024(c-1). Federal law generally prohibits using federal funds to pay for abortions. *See, e.g.,* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2018, tit. V, § 506(a).

In order to comply with State law, Texas's Section 1115 waiver proposal included a request for a

waiver of section 1902(a)(23) of the Social Security Act, to the extent CMS determines it is necessary. Texas believes that this waiver is unnecessary because the proposed program does not violate section 1902(a)(23); however, if CMS disagrees, there is no reason why CMS should not grant the waiver.

I. Excluding abortion providers from Texas's proposed demonstration program does not violate section 1902(a)(23).

States have discretion in implementing the Medicaid Act, including in setting qualifications for providers. Section 1902(a)(23) provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." The Medicaid Act does not define "qualified," and although it lists some grounds under which the HHS Secretary and the States must or may exclude providers, that list is not exhaustive. *See* 42 U.S.C. § 1320a-7.

The Act contemplates that States will fill in the blanks and set their own standards for qualification. *See id*. § 1320a-7(b)(5) (authorizing the Secretary to exclude providers who have been excluded on state law grounds); 42 C.F.R. § 1002.3(b) (granting States the authority to exclude a Medicaid provider as a state contractor "for any reason or period authorized by State law"). Accordingly, Texas and the Healthy Texas Women program should not be penalized through the continued withholding of federal funds merely because Texas has exercised the authority that federal law has granted to it—namely, the authority to refuse to be a conduit for channeling taxpayer funds to abortion providers pursuant to state law.

Moreover, there is nothing in the Social Security Act or its implementing regulations which provides a clear indication that excluding abortion providers from Medicaid is inconsistent with section 1902(a)(23).[1] And in jointly administered programs like Medicaid, if "Congress intends to impose a condition on the grant of federal moneys [to States], it must do so unambiguously." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *see also NFIB v. Sebelius*, 567 U.S. 519, 582-83 (2012) (opinion of Roberts, C.J., joined by Breyer and Kagan, JJ.). In assessing whether federal funding conditions on the States are ambiguous, courts "must ask whether such a state official would clearly understand . . . the obligations of the Act" or whether the law provides "clear

[1] Although a few courts have reached contrary conclusions regarding whether excluding abortion providers would conflict with the courts' interpretation of section 1902(a)(23), those opinions are neither binding on you nor persuasive in their reasoning, and they did not consider the arguments contained in this letter. *See, e.g.*, *Planned Parenthood of Gulf Coast, Inc., v. Gee,* 862 F.3d 445 (5th Cir. 2017); *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960 (9th Cir. 2013); *Planned Parenthood of Indiana, Inc., v. Comm'r, Ind. State Dep't of Health,* 699 F.3d 962 (7th Cir. 2012). Additionally, those cases did not address your waiver authority under section 1115, which is discussed below. Moreover, Texas has terminated Planned Parenthood's Medicaid provider agreements based on reasons related to their professional competence, though that decision is the subject of a legal challenge that is pending on appeal. *See Planned Parenthood of Greater Texas Family Planning and Preventative Health Services Inc., v. Smith*, No.17-50282 (5th Cir. filed Mar. 30, 2017).

notice." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006); *see also NFIB,* 567 U.S. at 676 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) ("[A]ny such conditions [on the receipt of federal funds] must be unambiguous so that a State at least knows what it is getting into.").

The lack of a clear statement on this topic is presumably what prompted the Obama Administration to issue a guidance letter in 2016. This letter—State Medicaid Director Letter #16-005 (Apr. 19, 2016)—opined that excluding abortion providers from Medicaid was inconsistent with section 1902(a)(23), in furtherance of the Obama Administration's pro-abortion agenda. In January of this year, CMS rescinded that letter with State Medicaid Director Letter #18-003 (Jan. 19, 2018), stating, "We are concerned that the 2016 Letter raises legal issues under the Administrative Procedure Act, and limited states' flexibility with regard to establishing reasonable Medicaid provider qualification standards." Flexibility with respect to setting provider qualifications—including on the issue of whether the provider promotes or performs abortions—is therefore not only consistent with the statutory and regulatory scheme, but also with the express policy of this Administration. And importantly, any attempt like the one from the Obama Administration to add a restriction on federal funding that is not in the unambiguous text of the federal law would violate the Constitution. *Murphy*, 548, U.S. at 296.

In addition, Section 1902(a)(23) should be interpreted consistently with Section 1802(a), the analogous provision that ensures "basic freedom of choice" for Medicare beneficiaries. *See Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980) (describing the two free-choice-of-provider provisions as "similar"). Section 1802 prohibits governmental interference with a beneficiary's "choice of health care providers from among those qualified to participate in the Medicare program," but it does not prohibit limitations on which providers are qualified to participate. *MacArthur v. San Juan Cty.*, 416 F. Supp. 1098, 1141–42 (D. Utah 2005). For example, the Medicare program limits provider participation based on numerous criteria, including which types of patients the provider is willing to serve. *See, e.g.*, 42 U.S.C. § 1395cc(a)(1)(L) (veterans), *id.* § 1395cc(a)(1)(U) (beneficiaries of the Indian Health Service). No one disputes that requiring Medicare providers to do business with certain patients is consistent with Medicare's free-choice-of-provider provision. Similarly, prohibiting Medicaid providers from doing certain types of business with abortion providers (i.e., affiliating) is consistent with Medicaid's free-choice-of-provider provision.

Allowing states to exclude providers who perform or promote abortion is also consistent with federal policy. Most notably, the Hyde Amendment prohibits using federal funds to pay for abortions in almost all cases (except for cases involving rape, incest, or danger to the life of the mother). Texas attempted to allow Planned Parenthood to remain a Medicaid provider notwithstanding section 32.024(c-1) of the Human Resources Code if it separated its abortion-providing functions from the rest of its services. The Texas Planned Parenthood affiliates purported to have done so by separately incorporating its abortion-providing operations. But further litigation has revealed that these abortion entities are not separated in a meaningful way

from the entity that receives Medicaid reimbursements. For instance, the abortion entity at Planned Parenthood Gulf Coast shares facilities with the Medicaid provider affiliate, employs no staff of its own, and has the same officers and board as the rest of the affiliate. In fact, the director of Planned Parenthood Gulf Coast's abortion clinic is an employee of the Medicaid-fund-receiving affiliate.[2] In reality, there is no meaningful separation of the Medicaid provider and the abortion provider. And because money is fungible, giving federal and state Medicaid dollars to Planned Parenthood funds abortions and Planned Parenthood's abortion-promoting activities. This is inconsistent with federal and state law prohibiting public funds from paying for abortions.

The State's proposed restriction of Program funds to only providers which do not promote or provide abortion does not conflict with section 1902(a)(23), and it is consistent with the policy of the federal government—particularly the policy of this Administration. Thus, Texas law and the Program is fully compliant with section 1902(a)(23), and federal funds should immediately be released to provide these important services.

II. Alternatively, CMS should grant Texas's requested waiver because the Program's success does not depend on Planned Parenthood.

The Program provides needed services to women who are not covered by traditional Medicaid in Texas. In addition to the $29 billion Texas spends on Medicaid—over one-fourth of the state's annual budget—to serve approximately 4.3 million people, Texas has spent an additional $95 million annually to fund the Program. In 2017, the Program served approximately 122,406 with annual monthly enrollment of 167,178 women. Currently, the program has over 240,798 women enrolled. If federal funds are made available to strengthen this program, Texas expects to provide even more women with needed healthcare services and reduce the costs of Medicaid-paid births in the State. This reduction in costs is estimated to offset the costs of providing additional services, rendering the program revenue-neutral. If Texas's demonstration program is successful, it could pave the way for more states to provide better healthcare for women while simultaneously reducing costs.

Texas has expanded its women's health provider base by over 250% in the past five years and the Program currently has over 5,000 women's health providers. Program providers offer the same services as Planned Parenthood clinics, including pelvic exams, contraceptives, sexually-transmitted-infection screenings, and breast- and cervical-cancer screenings and diagnostic tests. These program providers also deliver additional services for conditions found to affect reproductive health but which are not provided by Planned Parenthood, such as the screening, diagnosis, and treatment of hypertension, cholesterol, and diabetes. Simply put, the addition of federal funding to the Program will result in better healthcare for Texas women, and Planned Parenthood's exclusion from the Program will not impact Texas women's access to care.

[2] The information discussed in this letter relating to Planned Parenthood affiliates in Texas is part of the litigation record in *Planned Parenthood of Greater Texas Family Planning and Preventative Health Services Inc., v. Smith*, No.17-50282 (5th Cir. filed Mar. 30, 2017).

In short, the success of the Healthy Texas Women program is not dependent on Planned Parenthood's participation. If successful, the Program will be a significant innovation in providing women's healthcare while simultaneously reducing costs. CMS should not hesitate in approving this section 1115 waiver proposal, regardless of whether CMS determines a waiver of section 1902(a)(23) is necessary.

Texas requests that CMS approve the section 1115 Program waiver proposal as soon as possible. If you have any questions or require any further information, please feel free to contact my office.

Sincerely,

Ken Paxton
Attorney General of Texas

cc: Governor Greg Abbott
Executive Commissioner Charles Smith, Texas Health and Human Services Commission