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Access to care following Planned Parenthood's termination from Texas' Medicaid network: A qualitative study☆,☆☆

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ABSTRACT

Objectives: This study aimed to explore Planned Parenthood Medicaid patients' experiences getting reproductive health care in Texas after the state terminated Planned Parenthood providers from its Medicaid program in 2021.
Study design: Between January and September 2021, we recruited Medicaid patients who obtained care at Planned Parenthood health centers prior to the state termination using direct mailers, electronic messages, community outreach, and flyers in health centers. We conducted baseline and 2-month follow-up semistructured phone interviews about patients' previous experiences using Medicaid at Planned Parenthood and other providers and how the termination affected their care. We qualitatively analyzed the data using the principles of grounded theory.
Results: We interviewed 30 patients, 24 of whom completed follow-up interviews. Participants reported that Planned Parenthood reliably accepted different Medicaid plans, worked with patients to ameliorate the structural barriers they face to care, and referred them to other providers as needed. After Planned Parenthood's termination from the Texas Medicaid program, participants faced difficulties accessing care elsewhere, including same-day appointments and on-site medications. Consequences included delayed or forgone reproductive health care, including contraception, and emotional distress.
Conclusions: Planned Parenthood Medicaid patients found it difficult to connect with other providers for reproductive health care and to obtain evidence-based care following the organization's termination from Medicaid. Ensuring all Medicaid patients have freedom to choose providers would improve access to quality contraception and other reproductive health care.
Implications: Medicaid-funded reproductive health care access is restricted for people living on low incomes when providers do not reliably accept all Medicaid plans or cannot participate in Medicaid. This situation can lead to lower quality care, delayed or forgone care, and emotional distress.

1. Introduction

Texas uses a combination of state and federal funds to support programs that cover reproductive health services for residents living on low incomes, including the 34% of residents who live below 200% of the federal poverty level [1]. Medicaid is one of these programs, but coverage in Texas is extremely limited: the state has not expanded Medicaid under the Affordable Care Act, and adults are only Medicaid eligible if they are parents of minor children and their income is ≤17% of the federal poverty level ($230 per month for a single parent of two). Between 2011 and 2015, Texas terminated Planned Parenthood from multiple safety net reproductive health programs, including a family planning Medicaid waiver program, state-funded family planning programs, and a breast and cervical

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cancer screening program [2]. In 2015, the state Health and Human Services Commission also attempted to terminate Texas' Planned Parenthood affiliates from the state's full-benefit Medicaid program. After years of legal challenges, the Fifth Circuit Court of Appeals ruled in November 2020 that the state could move forward with the termination—despite federal policy allowing all qualified providers to participate in Medicaid programs [3,4]. When the termination took effect in March 2021, thousands of Texans lost coverage for health care services at and prescriptions written from Planned Parenthood health centers [5], with effects likely exacerbated by the coronavirus disease 2019 (COVID-19) pandemic. This group included approximately 8000 Texans annually enrolled in Medicaid who used Planned Parenthood health centers, as well as many others who had retained time-limited Medicaid coverage (e.g., pregnancy Medicaid) due to the COVID-19 public health emergency [5,6].

Texas' previous terminations of Planned Parenthood from publicly funded programs adversely affected low-income residents' access to essential reproductive health services, resulting in delayed care and increases in births, many of which researchers identified as likely unintended [7,8]. These effects stem, in part, from the fact that other providers may not have the capacity to serve displaced Planned Parenthood patients and may not provide the same reproductive health services or services of similar quality. For example, a 2016 report showed that fewer than one in three Texas obstetricians and gynecologists were accepting new Medicaid patients [9]; even fewer providers offer a broad spectrum of evidence-based preventive reproductive health care near Planned Parenthood health centers [10]. However, the structural and service delivery reasons that make it difficult for patients affected by these terminations to identify and navigate to other sources of reproductive health care and meet their health care needs are not clear. Drawing on in-depth interviews with 30 Texas Planned Parenthood Medicaid patients, this study explores patients' experiences following the termination.

2. Materials and methods

Beginning in January 2021, we recruited Texas Planned Parenthood Medicaid patients to participate in two in-depth interviews. Health center staff and community outreach workers informed patients about the study via patient portal messages, letters, and flyers, which directed patients to an online eligibility screening form. Eligible participants were people aged between 15 and 64 years who were enrolled in Medicaid, spoke English or Spanish, and had attended at least one appointment at a Texas Planned Parenthood health center in the previous 6 months. The second author (E.V., a Hispanic researcher with qualitative research experience working with Texans living on low incomes and with uninsured or underinsured Texans) scheduled the first in-depth interviews by phone, identifying herself as a non–Planned Parenthood, university-based researcher. Participants provided verbal consent to participation in and recording of interviews. We monitored enrollment to ensure we included participants throughout the state, capturing experiences in diverse geographic health care settings.

Non–Planned Parenthood authors developed the interview guide, eliciting feedback from B.K., S.D., and A.B. to ensure questions captured the organization of care at their health centers. Between February and September 2021, E.V. conducted baseline interviews focused on participants' experiences using Planned Parenthood health centers and specific services received, their experiences learning they could no longer use Medicaid at Planned Parenthood, and their efforts to find another health care provider. The interview guide included questions about class-based structural barriers to care as Medicaid providers' efforts to overcome these barriers could ameliorate race-based health care inequities because race and poverty are so closely intertwined [11]. The non–Planned Parenthood research team members met regularly during data collection to review interview summaries for new information. In the follow-up phone interview, conducted approximately 2 months later (to allow time to locate a new source of reproductive health care), E.V. asked participants about insurance changes, establishing care with a new provider, current contraceptive use, and any health concerns. Interviews lasted a median of 30 minutes (range: 22–74 minutes); we gave participants gift cards of $30 for the baseline interview and $20 for the follow-up interview. We transcribed the interview recordings, reviewed all transcripts for accuracy, and removed identifying information. The University of Texas at Austin's Institutional Review Board approved the study.

The non–Planned Parenthood authors analyzed the data qualitatively using NVivo Lumivero (version 11). A.C., a White postdoctoral researcher and sociologist, and E.V. developed a codebook using inductive and deductive codes, identifying key data themes with particular attention to the experiences described earlier, and iteratively revised the codebook as needed. Then, they coded the same five interviews and discussed the results to ensure intercoder reliability and to revise the codebook as necessary. A.C., E.V., and another research team member used the revised codebook to code the remaining transcripts, consulting with each other to ensure consistency. They reviewed and discussed information in the coding reports in an iterative process that grouped thematic content related to patients' experiences finding Medicaid providers, their experiences of structural barriers to care, and the effects of the termination on their access to care. The research team met to share preliminary findings with the Planned Parenthood authors (B.K., S.D., and A.B.), seeking their feedback on the findings at a broad level. The Planned Parenthood authors offered feedback on findings and drafts but were not involved in data collection, analysis, or drafting findings.

3. Results

3.1. Participant characteristics

We screened 111 people for eligibility. Of the 55 who were eligible and interested, 30 completed the initial interview; we could not reach the remainder after multiple attempts. Twenty-four participants completed the follow-up interview, and we were unable to recontact the other six. All participants were cis women; most were aged between 18 and 45 years and identified as Hispanic or Mexican (n = 10) or Black or African American (n = 8; Table). Eleven had been Planned Parenthood patients for < 2 years; several had been patients for 3 to 10 years (n = 8), and the remainder for longer.

Patients highlighted how Planned Parenthood worked to enable access to Medicaid-funded care, noted that other providers could not fill the gap left when Planned Parenthood was no longer able to accept Medicaid, and emphasized that, as a result, they were unable to access time-sensitive, affordable reproductive health care following the termination. We illustrate these themes below using representative quotations. All participants expressed at least one of these concerns; nearly all (n = 27) expressed at least two, and over half (n = 16) expressed all three.

3.2. Finding providers who accept Medicaid

Participants frequently emphasized that Planned Parenthood made Medicaid-funded reproductive health care possible by reliably accepting Medicaid (n = 23), including plans that other providers did not accept, thereby minimizing the time and effort needed to find a provider. A young mother was uncertain whether her care would be covered when she initially contacted Planned Parenthood before the termination: "They asked me, did I have Medicaid and what plan did I have, and I was really afraid because, with the Amerigroup, they're not really accepted, like, anywhere." Relieved to learn that Planned

Table
Characteristics of participants who used Medicaid at Planned Parenthood health centers in Texas, 2021 (n = 30)

Characteristics	Values, n (%)
Gender	
Female	30 (100)
Male	0 (0)
Age (years)	
15–17	1 (3)
18–25	13 (43)
26–35	8 (27)
36–45	7 (23)
≥46	1 (3)
Race and ethnicity	
Hispanic or Mexican	11 (37)
Black or African American	8 (27)
White	3 (10)
Asian	1 (3)
More than one race	2 (7)
Unknown	5 (17)
Years as a Planned Parenthood patient	
0–2	11 (37)
3–10	8 (27)
11–19	7 (23)
≥20	4 (13)
Number of children	
0	11 (37)
1	7 (23)
2	6 (20)
3	1 (3)
≥4	5 (17)
Affiliated health center	
Planned Parenthood Greater Texas[a]	9 (30)
Planned Parenthood Gulf Coast[b]	12 (40)
Planned Parenthood South Texas[c]	9 (30)

[a] Health centers located in/around Austin, Dallas, Denton, El Paso, Fort Worth, Lubbock, Paris, Plano, Tyler, and Waco.
[b] Texas-based health centers located in and around Houston.
[c] Health centers located in Brownsville, Harlingen, and San Antonio.

Parenthood accepted Amerigroup, she obtained contraception there for about a year before the termination forced her to find another Medicaid provider. Another participant who had reliably used her Medicaid plan during her 10 years seeking contraceptive and sexual health care at Planned Parenthood described difficulty using it elsewhere:

> I don't like my current plan because no one likes Aetna. The [non-Planned Parenthood] doctors that I always used to go get my services, they don't deal with Aetna. When I went to get my prescriptions at certain pharmacies, they don't deal with Aetna Medicaid anymore.

Participants also commented that they often encountered barriers when they attempted to access reproductive health care or other care before the termination. They cited outdated and rapidly changing Medicaid provider lists. A participant with epilepsy who had experienced substantial administrative difficulties at non–Planned Parenthood providers explained:

> In the past, I have been misinformed by the insurance company when changes have been made and the insurance company hasn't properly been updated or the doctor is no longer accepting any more patients. I usually call [my insurance company] and get […] a list of three to five providers. […] It's about a two- to three-hour process overall, unless I hit the jackpot and get lucky on the first strike.

These challenges in navigating the Medicaid provider network made it difficult for many participants to find another suitable provider quickly enough to ensure uninterrupted care, including time-sensitive care such as contraception. A participant who was new to Planned Parenthood before the termination noted:

> I've been looking for the past three months to find another healthcare provider that's closer to me, but I have to travel almost an hour away just to get the services that I need. […] I think in the past two months I have called at least about 20 to 30 [possible providers].

Others added that the process of reestablishing care elsewhere was burdensome enough that they had not found a new provider by the follow-up interview and worried they never would. Expressing the frustrations of many who felt they had few realistic alternatives to Planned Parenthood, a mother of two stated, "words can't even express how upsetting it is." She recounted spending up to 30 minutes researching each possible replacement reproductive health care provider, trying to determine if they accepted her Medicaid plan and were taking new patients, and felt that she had experienced "prejudice" against Medicaid patients in some of these phone calls.

In contrast to these experiences, three participants reported that they had already found a non–Planned Parenthood provider, and a fourth participant explained that she did not anticipate difficulty doing so. Three others had not yet sought a new provider; one of these intended to pay out of pocket at Planned Parenthood rather than establishing care somewhere else.

3.3. Overcoming other structural barriers to care

Most participants (n = 27) highlighted that Planned Parenthood health centers helped them overcome other structural barriers to care related to poverty, such as frequently changing work schedules for entry-level jobs, lack of transportation options, and difficulty accessing childcare. The three participants who did not describe similar experiences all lived in major metropolitan areas and often had more flexible schedules, which may have reduced the structural barriers to care they faced. Participants who experienced structural barriers recounted that staff accommodated their sometimes-unpredictable schedules, often offering same-day appointments or allowing patients' children to attend appointments, indicators of quality care [10]. Because health centers provided a range of services and prescriptions on-site, patients could receive time-sensitive care such as contraception and screening or treatment for sexually transmitted infections. As a 32-year-old participant who had been a Planned Parenthood client since adolescence explained:

> Convenience-wise, it's a lot easier to be able to get an appointment to be seen at Planned Parenthood. Sometimes you can even get lucky and have a same-day appointment, but if not, you can still find an appointment that's within the same week […] as compared to an actual doctor's office, where it can be months.

Another participant, who had a history of sexual violence and relied on her Planned Parenthood clinician as a trusted provider, described the ease of accessing contraceptive care at Planned Parenthood:

> Planned Parenthood is so much easier [than other providers]. Way less stress. […] It's not only the special arrangements [so I don't have to find childcare], but it's also the [Depo-Provera] medication is there, you're not going to have to run here, run there, do this, do that, jump through this hoop […]. You're not going to have to go through all of that. You call up and [they] say, […] 'Are you ready to come in [right now]?' […] It's easy.

In contrast, even when participants found non–Planned Parenthood Medicaid providers accepting new patients, they often found it difficult to fully utilize their coverage because these providers were less willing to accommodate structural barriers. Instead of same-day appointments, participants encountered long wait times for appointments. They also reported having to travel farther for care and noted that when they were unable to secure childcare, other

Medicaid providers did not always work with them to enable access. One patient explained:

> I've always been a single mom with four kids, so just depending on whether I had gas money, whether I could even get off of work, whether I had a babysitter, or something like that, [I wasn't always able to access care]. Those things make it harder when you go to other providers.

Another participant who had, in her words, two "special needs" children found it exceptionally hard to secure care, largely due to difficulty finding childcare or a provider who allowed her children to attend appointments.

> [The termination] has completely screwed up everything. There's no options for me. I'm a single mother with two children. […] There's nobody else that is willing to say, "Okay, we'll take you in even though you have a special needs child." Nobody's going to treat me. There's nothing. For the future, I don't know what I'm going to do.

She emphasized that the high level of support provided by Planned Parenthood staff and clinicians—including watching her children while she was in the examination room—was crucial to her ability to access contraception. In turn, access to contraception enabled her to hold a job, care for her children, and retain housing, she said.

Moreover, participants commented that Planned Parenthood health centers connected them to the broader health care system. For patients without a primary care provider, this was essential: Planned Parenthood centers referred them to a wider network of providers and often followed up to ensure they received care. One participant, who had been a Planned Parenthood client for two decades, explained, "It's like a frontline appointment situation. They're very quick to get you in and to be able to triage you or to look and see, 'What's the issue? Can we handle them? If not, we can refer you out.'" Exemplifying the ease of access at Planned Parenthood health centers, another participant noted, "I could either [schedule an appointment] online or call and set one up. They said if they don't have a time available, they'll call other [locations] and set me up an appointment themselves over there." This participant, who experienced chronic pain following childbirth, added:

> When you get there, if they're unable to help you [with more specialized care], they'll set you up with an appointment somewhere else, same day […]. They make sure that you're taken care of. […] Then when they see I have a kid, they really try to help me out, so I'm not there all day.

One participant, who was in treatment for colon cancer that a Planned Parenthood clinician had identified, concluded:

> Planned Parenthood […] are the ones that really make a difference. […] If you've never been to the doctor before, and you start getting regular care, and you have an open environment to talk. It's [also] easy to get in there. […] Those are the things that make a difference.

As these participants reported, Planned Parenthood staff and clinicians provided supports beyond their usual services, and these additional efforts were crucial for clients' access to care.

3.4. Consequences of the termination

Most participants (n = 23) relayed that their struggles to find another provider resulted in postponed or missed medical care, including contraception, and contributed to emotional distress. Participants noted that their care was delayed because new providers required them to make "new patient" consultation appointments before receiving services and had less streamlined processes for providing contraception and test results. A young mother recounted that she needed multiple appointments, separated by several weeks, at her new provider before receiving her needed contraceptive injection:

> Now that I'm not able to go [to Planned Parenthood], I am a week behind on my Depo-Provera shot […] any other time, I'd just be able to call [Planned Parenthood] and set up my appointment, and be there some time that week and get my shot and go on with my day. […] Now that I can't, I'm just on the rope right now, trying to see what else is going to happen next.

Echoing this patient's and many others' experiences of care delays, a participant who described herself as a "three-time breast cancer survivor" and struggled with recurrent yeast infections explained that Planned Parenthood was better equipped than her new obstetrician-gynecologist to treat her wide-ranging health care needs. In her experience, few available appointments and the lack of an on-site laboratory at her new doctor meant long waits for appointments and test results, leading to delayed care: "It sucks because with my [new] OBG[YN] I'm having to wait longer to get an appointment, and then […] wait to get [my lab] results, to get the prescription."

While some participants were able to find care (albeit often delayed or interrupted), others noted that without Planned Parenthood, they functionally lacked access to reproductive health care. This outcome was more common among participants who had been Planned Parenthood patients for at least a decade. One of these participants said:

> I still don't want to go to the [new] doctor. I don't want to do any of my women's health things […] until after I'm able to go back to Planned Parenthood or just pay out of pocket. […] We've always known that Planned Parenthood was a go-to. So, because Planned Parenthood is not a place we can go to anymore […] people are delaying STD checkups. People are delaying HIV checkups. People are delaying [care].

Because the reproductive health care they received at Planned Parenthood health centers was not easily replaced, participants described the termination as "upsetting" and "devastating." A Planned Parenthood patient of over 20 years captured the feelings many other participants reported once they learned of the policy change, saying: "I was in shock. I was devastated. I actually felt comfortable with this doctor and now I have to start all over again. […] I felt very sad […] To find that again is going to be really hard."

The seven participants who did not recount these struggles or consequences nonetheless reacted negatively to the termination. They made statements such as, "I really love Planned Parenthood, and I wish they would accept Medicare, but we all have to move on" or described the termination as "really disappointing," "disheartening," or "inconvenient."

4. Discussion

We found that Medicaid-enrolled Texans who received care at Planned Parenthood experienced numerous difficulties re-establishing high-quality care following Texas' termination of Planned Parenthood from the state's Medicaid program. These challenges highlight the barriers to care stemming from structural poverty and racism that Texans living on low incomes routinely face, as well as several limitations of Medicaid for enrollees.

Our findings update and expand on previous research, which demonstrated that terminating Planned Parenthood from other state health programs adversely affected residents' access to care, especially time-sensitive sexual and reproductive health care services [7,8]. Before Texas terminated Planned Parenthood from Medicaid, clients found quality care at health centers that was evidence based,

compassionate, and accessible [10]. Planned Parenthood was able to offer this caliber of care by reliably accepting Medicaid plans and by supporting clients in overcoming structural barriers to care, offering same-day appointments, serving as a "one-stop shop" for a range of reproductive health needs, and connecting clients to other providers as needed [10,12–14]. After the termination, many patients had difficulties finding any care, much less care of similar quality. Limitations in the Medicaid network then compounded existing hardships that functioned similarly to rapid changes or "churn" in insurance coverage, leading to delayed care, missed care, and possibly worse outcomes [15–18].

We also identified nuanced ways in which Medicaid does—or does not—support low-income people's access to reproductive health care in Texas. Even before Planned Parenthood's termination, the Medicaid network in Texas was unable to meet patients' needs due in part to structural weaknesses in its administration, such as inaccurate information about participating providers, and insufficient numbers of participating providers who offered evidence-based care [9,14,19,20]. Participants' frequent statements about plans many providers would not accept and hard-to-reach providers add to existing evidence about Medicaid provider shortages and inability to ensure low-income Texans can obtain health care [9,10,21,22]. The fact that Planned Parenthood reliably participated in different Medicaid plans, despite the program's low reimbursement rates [9], further highlights the important role they played in the health care safety net and reveals how care has become even more difficult to navigate for Texans living on low incomes.

Texas now prevents Planned Parenthood from participating in any state-administered publicly funded health care program. Although federal Medicaid regulations require that states allow Medicaid patients the freedom to choose any qualified provider [3,4], this is the second time since 2020 that Texas has terminated a qualified provider of quality care [10,14] from a joint state and federally funded program without losing federal matching funds. This undermines the goal of Medicaid: to ensure access to care for people living on low incomes. It also compromises access to sexual and reproductive health care for the most vulnerable Texans in a state with high maternal mortality rates and severely restricted access to legal abortion care, both of which disproportionately affect people living on low incomes and people of color [22,23].

The study's strengths include sampling from several Planned Parenthood health centers across Texas and collecting data soon after the termination. The short interval between the termination and data collection minimized recall bias, and the gap between initial and follow-up interviews permitted assessment of whether and where people obtained care afterward. The small sample limits the study's generalizability; along with the short interval between baseline and follow-up interviews, this limits our ability to extrapolate about the number of affected patients in the population at large who had adverse reproductive health outcomes following the termination. Patients with more negative experiences may have been more motivated to participate than those who did not participate. In contrast, participants may also have expressed favorable views of Planned Parenthood due to a mistaken belief that the interviewer worked for Planned Parenthood, despite the interviewer's disclosure to the contrary and the Planned Parenthood authors' lack of involvement in recruitment. Additionally, these interviews were conducted during the COVID-19 pandemic, when strains on the provider network may have been greater than at other points in time because more people retained Medicaid eligibility due to the crisis. Yet, by closely examining a limited number of narratives at two time points, we obtained detailed information about patients' lived experiences of Texas' termination of Planned Parenthood from the Medicaid network.

Our data demonstrate that Planned Parenthood health centers were key to some of the most vulnerable Texans' access to high-quality Medicaid-funded health care [10,14]. Without providers who address structural barriers to care and reliably provide services, people waited for or missed essential, time-sensitive care and experienced a lower caliber of care and emotional distress. Recognizing the complex interplay between people's lived experiences, Medicaid administration, and how Medicaid providers operate in the network is essential for ensuring access to sexual and reproductive health care. Returning to compliance with federal policy would be an important first step toward ensuring Texans' access to sexual and reproductive health care and to reproductive autonomy.

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