July 31, 2018

Diane Foley, MD, FAAP
Deputy Assistant Secretary for Population Affairs
Office of the Assistant Secretary for Health
Office of Population Affairs
US Department of Health and Human Services
Attention: Family Planning
Hubert H. Humphrey Building, Room 716G
200 Independence Avenue SW
Washington, DC 20201

Submitted via: www.regulations.gov

Attn: Compliance with Statutory Program Requirements, RIN 0937-ZA00

Dear Deputy Assistant Secretary Foley:

Thank you for the opportunity to comment in response to the U.S. Department of Health and Human Services' (HHS) notice of proposed rulemaking (NPRM), "Compliance with Statutory Program Requirements," RIN 0937-ZA00. The Center for Public Policy Priorities (CPPP) is a nonpartisan, nonprofit 501(c)(3) public policy organization that uses data and analysis to advocate for solutions that enable Texans of all backgrounds to reach their full potential. Improving access to health care for Texans has been at the core of our mission and activities since our founding more than 30 years ago. CPPP believes that ensuring access to family planning services for all Texans in need is critical to building economic and social opportunity.

CPPP is deeply concerned that the NPRM will have devastating negative effects on the Title X family planning program and the low-income patients for whom Title X provides critical health care. The proposed rule would move Title X away from its proper focus on making modern family planning tools available to all, regardless of income; prevent highly qualified, trusted family planning providers from continuing in their long-standing Title X roles; and destabilize the effective network of Title X providers. For these reasons, we urge HHS to withdraw the proposed rule.

I. Title X is an effective and critical part of the public health safety net in Texas and nationwide

Title X is the only federal grant program dedicated exclusively to providing low-income patients with essential family planning and preventive health services and information. Rates of adverse reproductive health outcomes are higher among low-income women and women of color, and unintended pregnancy rates are highest among those least able to afford contraception.[i] Access to quality family planning and reproductive health services is integral to overall good health for women, men, and adolescents. Title X's positive impact stems in large part from the requirements governing these funds that have emphasized high-quality, science-based, client-centered care, helping people to plan their families and their lives. The Title X Program is a crucial component of the family planning safety net in Texas, providing needed access to preventive and preconception care. In 2016 alone, Title X served 183,000 Texans, preventing an estimated 41,090 unintended pregnancies.[ii] Planned pregnancies are healthier for both mother and

child, with earlier prenatal care and fewer low-birth-weight and pre-term births. Title X also has saved Texas taxpayers money — more than $7 in medical costs for every dollar spent on family planning.[iii]

II. Excluding qualified providers will reduce access to care and worsen outcomes for women, as has been shown in Texas

The NPRM seeks to exclude certain qualified providers from the Title X program, putting at risk access to critical primary and preventive care services for more than 40 percent, or nearly two million Title X patients.[iv] In Texas, we have seen first-hand the tragic consequences of similar family planning program provider exclusions. In 2012, Texas excluded Planned Parenthood and other organizations that "affiliate" with abortion providers from the Texas Women's Health Program, a state-funded family planning program. At the time, Planned Parenthood served more than 40 percent of program participants, the same share of patients it serves nationwide today in Title X.

The Texas experiment shows plainly that when qualified, trusted, high-capacity providers are excluded from a publicly funded family planning program serving low-income patients, other providers are unable to adequately fill the gap. Overwhelming evidence from academic research and the state's own data shows that after Texas implemented its provider exclusion, provider capacity dropped; dramatically fewer women received critical health care services; access to the most effective forms of contraception was reduced; and costs to Medicaid increased.[v] It is clear that Texas' action to remove Planned Parenthood from the Texas Women's Health Program harmed access to health care and resulted in worse health outcomes.

After Planned Parenthood was excluded from the Texas Women's Health Program, the number of women getting health care services in the program declined 39 percent, from 115,226 in FY 2011 to 70,336 in FY 2016, reflecting serious issues with provider capacity. In FY 2011, 90 percent of all women enrolled in the program accessed health care services. By FY 2016, only 74 percent of women enrolled in the program received health care services.[vi] In other words, by FY 2016, one in four women technically enrolled in the program was never seen by a health care provider for covered family planning services.

Following recent, substantial new investments in Texas' program (now renamed Healthy Texas Women) -- a $5 million marketing campaign in 2016-17, new automatic enrollment into the program for moms after they give birth and lose pregnancy-related Medicaid, and an additional $50 million (per biennium) from the state starting in the 2016-17 state budget -- it appears that the number of women receiving health care services in the program was higher in 2017 than 2016. Unfortunately, despite these significant new investments, 2017-service levels still appear to lag well behind 2010 and 2011, the years before the state's provider exclusion and other harmful policies took effect.[vii] Texas changed its methodology for counting the number of women who receive a health care service in its state-funded family planning programs for 2017, making direct comparisons of program data for 2017 to earlier years impossible.

Such dramatic reductions in access to services inevitably led to poorer outcomes. After Texas excluded Planned Parenthood from its family planning programs including the Texas Women's Health Program, Texas has experienced a reduction in the provision of highly effective methods of contraception, interruptions in contraceptive continuation, and increased rates of Medicaid births. Research has shown that counties which lost Planned Parenthood services saw a reduction in the utilization of highly effective contraceptive methods as well as injectable contraception. The number of women utilizing the most effective methods of birth control decreased by 35 percent and use of injectable contraception

dropped by 31 percent.[viii] Continuation of injectable contraception by clients using that method decreased from 60 percent to 38 percent in counties that previously had participating Planned Parenthoods clinics. Researchers also found that the birth rate shot up among former Planned Parenthood clients who relied on injectable contraceptives. Between 2011 and 2014, the number of births from this population, paid for through Medicaid, increased by 27 percent.

III. The NRPM undermines access to evidence-based, effective family planning methods

Providing a broad range of contraceptive methods is a core part of Title X-funded services. Title X has contributed to the dramatic decline in the unintended pregnancy rate in the United States, now at a 30-year low.[ix] Improved access to contraception and information for adolescents, including those provided by Title X projects, has contributed to a record low teen pregnancy rate.[x] The services provided by Title X projects help prevent nearly one million unintended pregnancies each year.[xi] The NRPM threatens to reverse this progress.

The NRPM removes the requirement that methods of family planning be "medically approved," instead placing increased emphasis on the provision of natural family planning and "other fertility-awareness based methods." It also uses more permissive language when allowing participating entities to provide only a single family planning method.

All people seeking care in Title X programs should have access to the contraceptive method that works best for their individual circumstances. We are concerned that the NPRM will harm women by lowering the threshold on the contraceptive services available at Title X-funded organizations and reducing access to safe and effective contraception. Lack of access to effective methods could result in an increase in the number of unintended pregnancies in Texas, as well as across the United States. Unintended pregnancy births are associated with adverse outcomes for both moms and babies, including delayed prenatal care, premature birth, and negative physical and mental health effects for children.

IV. The NRPM undermines an effective and efficient network of participating providers by unnecessarily prioritizing comprehensive primary health care

The proposed rule adds language requiring Title X providers to offer onsite comprehensive primary health services or referral linkages to primary health providers in close physical proximity. This change is proposed even though primary care is not a permissible use of Title X funds and the best referrals for Title X patients are not necessarily defined merely by physical proximity.

Title X patients in Texas today benefit from an effective and efficient network of qualified providers, many of which are clinics that specialize in providing family planning. Current program standards have facilitated an effective provider network. A recent study by the Kaiser Family Foundation and George Washington University found that Title X-funded health centers are far more likely than non-Title X-funded health centers to provide effective family planning methods onsite and to offer services associated with high quality care.[xii]

Emphasizing primary health providers and deemphasizing specialized family planning providers could displace community clinics from the program and shutter clinics operating in rural areas where there are no primary health providers in close physical proximity. Clinics that specialize in family planning are more likely to ensure patients have access to the full range of contraceptive methods and medical technology — while serving a higher volume of patients, often at lower cost per patient.

In Texas, we already have seen that diverting funds away from clinics that specialize in family planning means fewer women are served. We urge HHS to reject these proposed changes that will unnecessarily hinder access to care.

V. The NPRM threatens patient confidentiality, particularly for minors, in ways that could cause many patients to avoid seeking care

The NPRM threatens confidentiality protections, particularly for adolescents. Without these protections, adolescents, especially those without adult support systems, may be more likely to delay or not receive needed, sometimes lifesaving care. According to the American Academy of Pediatrics, "…policies supporting adolescent consent and protecting adolescent confidentiality are in the best interests of adolescents. Accordingly, best practice guidelines recommend confidentiality around sexuality and sexually transmitted infections (STIs) and minor consent for contraception."[xiii]

Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Certain groups, including adolescents and young adults, and people at risk of domestic or intimate partner violence, have special privacy concerns that additionally require strong protection.[xiv]

Congress requires that Title X providers encourage family participation "where practicable."[xv] Title X providers, guided by their training and experience, as well as extensive practice standards and recommendations, already assist adolescents to involve their families in decisions about family planning services and other key health care matters when realistic and appropriate. As a consequence, most adolescents already involve their families in decisions about family planning, or seek family planning services with their parents' or guardians' knowledge.[xvi]

Proposed changes would require Title X providers to ask more questions than medically necessary, as well as push minors to involve family members in decisions regardless of whether or not it is in the best interest of the minor. This would discourage minors from seeking necessary family planning services. One of the main tenets of the Title X program is maintaining confidentiality for all patients, including adolescents. Confidentiality is laid out in Title X statute, the current federal regulations, and relevant case law[xvii]. We urge HHS to maintain the current rules and guidelines related to confidentiality in order to ensure Title X is available to all individuals in need of family planning services.

VI. The NRPM requires practices that contradict medical ethics and interfere in the patient-provider relationship

Our partners in the physician community have expressed deep concern over the precarious ethical situation the proposed rule changes would place them in. The NPRM allows, and even directs, providers to withhold information from patients in violation of medical ethics. If the NPRM is adopted, these concerns may lead qualified providers to withdraw from the program, further eroding the capacity of the provider network and threatening patient access.

The provision of safe and quality medical care relies on a strong patient-provider relationship free from political interference. Patients expect medically accurate, comprehensive information from their providers. The American College of Obstetricians and Gynecologists,[xviii] the American Academy of Family Physicians,[xix] and the American Academy of Pediatrics[xx] endorse this approach in their practice recommendations.

The NPRM would reduce provider capacity in the program, reduce patient access to critical preventive health care services, exacerbate existing health disparities, and harm patient health. We urge HHS to immediately withdraw the NRPM. If you have any questions about these comments, please contact me at pogue@cppp.org. Thank you for your full consideration of our comments.

Sincerely,

Stacey Pogue
Senior Policy Analyst

---

[i] Access to contraception. Committee Opinion No. 615. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:250–5.

[ii] Women's Health and Family Planning Association of Texas, "Annual Impact Report 2016-2017

[iii] Frost et al., "Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program," *The Milbank Quarterly*, Vol, 92.4, 2014.

[iv] Frost J, Frohwirth L, Blades N, Zolna M, Douglas-Hall, A, Bearak, J. Publicly Funded Contraceptive Services at U.S. Clinics, 2015. Guttmacher Institute. April 2017. https://www.guttmacher.org/sites/default/files/report_pdf/publicly_funded_contraceptive_services_2015_3.pdf

[v] Stevenson, A., Flores-Vazquez, I., Allgeyer, R., Schenkkan, P., and Potter, J. Effect of Removal of Planned Parenthood from the Texas Women's Health Program, N Engl J Med 2016; 374:853-860, http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article; Center for Public Policy Priorities, *Excluding Planned Parenthood has been Terrible for Texas Women,* August 2017, https://forabettertexas.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf; and Texas Health and Human Services, HHS Women's Health Update, May 15, 2017.

[vi] Texas Health and Human Services, HHS Women's Health Update, May 15, 2017.

[vii] Center for Public Policy Priorities, "Good and Bad News on Family Planning in New Health and Human Services Report," April 27, 2018, http://bettertexasblog.org/2018/04/good-and-bad-news-on-family-planning-in-new-health-and-human-services-report/.

[viii] Stevenson, A., Flores-Vazquez, I., Allgeyer, R., Schenkkan, P., and Potter, J. Effect of Removal of Planned Parenthood from the Texas Women's Health Program, N Engl J Med 2016; 374:853-860, http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=article.

[ix] Finer LB and Zolna MR, Declines in unintended pregnancy in the United States, 2008–2011. N Engl J Med 2016; 374:843–852.

[x] Martin JA, Hamilton BE, Osterman MJ, Driscoll AK, Drake P. (2018). *Births: Final data for 2016.* Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_01.pdf - PDF.

[xi] Guttmacher Institute. Fact Sheet: Publicly Funded Family Planning Services in the United States. September 2016. https://www.guttmacher.org/sites/default/files/factsheet/fb_contraceptive_serv_0.pdf

[xii] Wood SF et al., George Washington University. Community Health Centers and Family Planning in an Era of Policy Uncertainty. Kaiser Family Foundation. March 2018. http://files.kff.org/attachment/Report-Community-Health-Centers-and-Family-Planning-in-an-Era-of-Policy-Uncertainty

[xiii] Contraception for Adolescents. Committee on Adolescence. Pediatrics. Sep 2014, peds.2014-2299; DOI: 10.1542/peds.2014-2299.

[xiv] *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*. (San Francisco: Family Violence Prevention Fund, 2004). http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf.

[xv] 42 U.S.C. 300.

[xvi] Diane M. Reddy, Raymond Fleming, and Carolyne Swain, "Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services," *JAMA* 288, no. 6 (2002): 710–714; Rachel K. Jones, et al., "Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception," *JAMA* 293, no. 3 (2005): 340–348; Liza Fuentes, Meghan Ingerick, Rachel Jones, and Laura Lindberg, "Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services," *Journal of Adolescent Health* 62, no. 1 (2018):36-43.

[xvii] Rebecca Gudeman and Sarah Madge, "The Federal Title X Family Planning Program: Privacy and Access Rules for Adolescents," Youth Law News, January-March 2011, National Center for Youth Law.

[xviii] American College of Obstetricians and Gynecologists (ACOG), Informed consent, Committee Opinion No. 439, Obstetrics & Gynecology, 2009, 114(2):401–408

[xix] David A. Moss, Matthew J. Snyder, and Lin Lu. "Options for Women with Unintended Pregnancy." American Family Physician 91(8) (April 15, 2015): 544-9.

[xx] Laurie L. Hornberger and AAP Committee on Adolescents. "Diagnosis of Pregnancy and Providing Options Counseling for the Adolescent Patient." Pediatrics 140, no. 3 (September 2017): e20172273.