CLASP
The Center for Law and Social Policy

May 17, 2021

Office of Population Affairs
Office of the Assistant Secretary for Health
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

**Attn: "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services (RIN 0937-AA11)**

The Center for Law and Social Policy (CLASP) is pleased to provide comments to the US Department of Health and Human Services' (HHS) notice of proposed rulemaking (NPRM), "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," RIN 0937-AA11.

The Center for Law and Social Policy (CLASP) is a national, nonpartisan anti-poverty nonprofit based in Washington, D.C., advancing policy solutions for people living in low-income households. CLASP strives to reduce poverty, promote economic security, and advance racial equity. We work at federal, state, and local levels, supporting policy and practice that impacts people living in conditions of poverty. In particular, these comments draw on CLASP's experience with Medicaid and specifically in mental and behavioral health, areas where Title X funding helps to supplement and strengthen current supports to ensure low-income people get and retain benefits.

CLASP strongly supports HHS's NPRM revoking the 2019 Title X regulations (the Trump rule) and reinstating the 2000 regulations with some revisions. Once finalized, the proposed rule would return Title X to its proper focus on "making comprehensive voluntary family planning services readily available to all persons desiring such services."[1] Furthermore, because of the devastating impact of the 2019 Title X regulations on the program's provider network and its patients, CLASP supports finalization of the proposed rule as quickly as possible.

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***Impact of Trump rule/importance of restoring previous rules and network***

CLASP agrees with HHS's statement in the NPRM that "the 2019 rule was a solution in search of a

[1] Public Law 91-572 ("The Family Planning Services and Population Research Act of 1970"), section 2(1).

problem, a solution whose severe public health consequences caused much greater problems."[2] When the 2019 rule was implemented in August 2019, grantees immediately began to withdraw from Title X rather than comply with the Trump rule's requirements. Overall, as the proposed rule notes, the Title X program lost more than 1,000 health centers.[3] Those health centers represented approximately one quarter of all Title X-funded sites in 2019.[4] Nearly two years later, six states continue to have no Title X-funded provider network (Hawaii, Maine, Oregon, Utah, Vermont, and Washington)[5] and an additional six states have a very limited Title X-funded network (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York).[6] The significant damage to the Title X provider network resulted in at least 1.5 million patients losing access to Title X-funded services.[7] Despite the Trump administration's assertion that the Trump Rule would cause new applicants to apply for Title X funding and result in "more clients being served,"[8] OPA has been unable to find new grantees to fill the gaps the Trump Rule created, including in the six states that lost all Title X-funded services, and has served far fewer clients rather than more[9]

As HHS rightly calls out in the proposed rule, federal data shows the rapid and devastating impact of the Trump rule on access to critical family planning and sexual health services. Title X saw 844,083 fewer patients in 2019 compared to 2018 (3.1 million vs. 3.9 million). That dramatic 21% drop in patients was seen with the Trump rule only in effect for less than half of the year. This decrease meant that providers were able to offer 280,000 fewer cancer screenings, 1.3 million fewer sexually transmitted disease screenings, and 278,000 fewer confidential HIV tests. Additionally, hundreds of thousands of people lost access to contraceptive care due to the rule. The preliminary numbers for 2020 as shared in the proposed rule are even worse –only an estimated 1.5 million people received Title X-supported services in 2020, a loss of 2.5 million people from the network in just two years.[10]

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[2] NPRM p. 19817.

[3] NPRM p. 19815.

[4] Mia Zolna et al., *Estimating the impact of changes in the Title X network on patient capacity*, Guttmacher Inst., 2 (Feb. 5, 2020), https://www.guttmacher.org/sites/default/files/article_files/estimating_the_impact_of_changes_in_the_title_x_network_on_patient_capacity_2.pdf; *see also Title X Family Planning Directory*, n.5.

[5] Zolna et al., n.59, at 2.

[6] NPRM p. 19815.

[7] *Title X: Key Facts About Title X*, n.5.

[8] 84 Fed. Reg. at 7,723.

[9] OPA released two competitive FOAs for "areas of high need" on May 29, 2020, intending to provide approximately $18 million through an estimated 10 grants to provide services in areas left without any Title X-funded services. *See* Grants Notice, HHS, *PA-FPH-20-001, FY2020 Title X Services Grants: Providing Publicly-Funded Family Planning Services in Areas of High Need* (May 29, 2020), https://www.grants.gov/web/grants/view-opportunity.html?oppId=323353; Grants Notice, HHS, *PA-FPH-20-002, FY2020 Title X Service Grants: Providing Publicly-Funded Family Planning Services in Areas of High Need—Maryland Service Area Only* (May 29, 2020), https://www.grants.gov/web/grants/view-opportunity.html?oppId=327358. The FOAs yielded only five grantees, four of which were 2019 grantees with current projects and none of which would be providing services in the six states that lost their entire Title X-funded provider network. *See* Press Release, OPA, *OPA Awards $8.5 Million in Grants to Family Planning Services in Unserved & Underserved Areas* (Sept. 18, 2020), https://opa.hhs.gov/about/news/grant-award-announcements/opa-awards-85-million-grants-family-planning-services-unserved. OPA was able to fund only $8.6 million in grants under the FOA, with the remaining funding given as supplemental funding to the existing grantees. *Id.*

[10] NPRM p. 19815.

In a 2016 study, six in ten women seeking contraceptive services at a Title X-funded health center reported that to be their only source of medical care in the past year.[11] Thus, this kind of precipitous decline in patients receiving services through the Title X program has concerning implications for broader access to care.

CLASP's work focused on Girls and Women of Color, as well as our collective work on young adult healing and wellbeing and maternal mental health, highlights the need to strengthen the current system of mental and behavioral health. This is in part due to the challenges presented from historical and cultural trauma, stresses to individuals and families imposed by the pandemic, and adverse childhood experiences (ACEs). Title X providers are often the first line of care for clients for essential services, including mental health screening in preconception care (PCC).[12] Continuing to structure Title X funding by the 2019 Title X rule would create more barriers to needed mental and behavioral health supports, in addition to broader access to healthcare and wellbeing.

*Youth and young adults*

The 2019 rule eliminated the ability for youth and young adults to seek services at a discount calculated by their own income and instead rely on parental consent and family resources. The 2019 rule undermined patient confidentiality, particularly for youth and young adults, which could lead to many patients avoiding care in Title X settings. Having patient confidentiality can be especially critical for lesbian, gay, bisexual, transgender, queer and questioning (LGBTQQ) youth who may not be out to their parents and who may not feel safe sharing their sexuality and/or gender identity with family members. Youth and young adults already faced unnecessary barriers to care, and further taking away a safe, trusted, and confidential space to seek services likely exacerbated already present health disparities in youth of color.

It is critical that youth and young adults have a provider where they can receive comprehensive, medically accurate, evidence-based information in their preferred language from a trusted health care provider. By increasing family involvement beyond what is required in the language of the Title X statute and subverting the judgment and expertise of Title X funded providers to family participation, the 2019 rule could have caused harm to youth and young adults. Providers have the expertise to evaluate the situation of each individual unemancipated[31] youth and young adult, and we should defer to their judgment.

The 2019 Title X rule severely undermined this bedrock public health program that has provided high quality, affordable family planning and sexual health care to millions for 50 years. CLASP strongly supports the revocation of the 2019 rule, and reinstatement of the 2000 regulations with revisions, so that the Title X program can return its focus to its patients and communities.

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[11] Kavanaugh ML, Zolna MR and Burke KL, Use of health insurance among clients seeking contraceptive services at Title X-funded facilities in 2016, *Perspectives on Sexual and Reproductive Health*, 2018, 50(3):101–109.

[12] Frost J. U.S. women's use of sexual and reproductive health services: Trends, sources of care and factors associated with use, 1995-2010. New York, NY: Guttmacher Institute; 2013.

***Health equity***

CLASP strongly supports the administration's emphasis on health equity in the proposed rule. The statutory requirements that Title X-funded health centers prioritize people with low-incomes, and provide care regardless of ability to pay, ensure that the Title X program is well-positioned to advance health equity for the patients it serves. However, the onerous requirements of the 2019 rule diverted attention and resources from this important work and undermined Title X's mission to provide equitable, affordable, client-centered, quality family planning and sexual health services.

CLASP strongly supports the additions the proposed rule makes to the definitions in the Title X regulations, including definitions for health equity and inclusivity. In particular, the transition from using the word "women" to the more inclusive "client" is more reflective of the diverse population of patients served by the Title X program. Gender identity should never be a barrier to receiving the care one needs and all people who are capable of becoming pregnant, including queer, transgender, and nonbinary people, may have a need for family planning care, just as their sexual partners may. The proposed rule's definitions help to illustrate key aspects of quality care including the importance of client-centeredness; culturally and linguistically appropriateness; and recognition of how trauma affects people. Defining how services should be provided is an important skew towards a more equitable Title X program.

In Texas, lawmakers created a Task Force on Maternal Mortality and Morbidity in 2013 to address the issue of increasing rates. They found that black mothers have the highest death risk, delivering 11% of babies from 2012-2015, but comprising 20% of maternal deaths. Likewise, Hispanic women had 48% of the state's births and 38% of maternal deaths, and white women delivered 34% of births and had 39% of deaths.[13]

In many states, a Title X provider is one of the few places women of color can access reproductive health care and preventive health care services. Title X providers are bound by federal law to provide services in a linguistically-appropriate manner and offer a range of reproductive health and family planning services. Title X health care providers also offer services for foreign-born individuals who are less likely to have coverage (46 percent) than U.S.-born people (75 percent).[14] For those who have limited options for care, these services, which are available at an affordable price at Title X funded health centers, can mean the difference of a person receiving care or going without.

Title X funded health centers offer a range of preventive services and life-saving care. Black women have higher breast cancer mortality rates compared to other racial and ethnic groups and Latina women experience cervical cancer at twice the rate of white women. Cancer is the leading cause of death for AAPI communities, and the cervical cancer incidence rate is higher in several Asian-American, Native Hawaiian and Pacific Islander (AA&NHPI) subgroups than in non-Hispanic[15] whites. For instance, the incidence rate is twice as high in Cambodians as in non-Hispanic whites, and 40 percent higher among Vietnamese women. Title X funded health centers enable women of color to access essential health care including breast cancer and cervical cancer screenings. This is critical care since these cancers are highly preventable diseases, which African-

[13] Hollier, Lisa and others, "Preventing Maternal Mortality and Morbidity." Texas Health and Human Services, October 12, 2017.
[14] Kavanaugh, Megan, et al. *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X–Funded Facilities in 2016.* New York: Guttmacher Institute, 2018. https://www.guttmacher.org/journals/psrh/2018/06/use-health-insurance-among-clients-seeking-contraceptive-services-title-x
[15] The term "Hispanic" is used when characterized as such in the primary dataset.

Americans, Latinxs, and AA&NHPIs experience at increased rates compared to white women. Title X providers are required to offer all family planning and sexual health services on a sliding fee scale, allowing prevention to be more accessible for those who need it most.

The COVID-19 pandemic has laid bare the many inequities in our nation's health care system and highlighted how systemic racism and other forms of oppression have resulted in pervasive health disparities and disproportionately poor health outcomes for people of color. The Title X program has a significant role to play in combating these systemic barriers to care and ensuring that all people, regardless of their race, ethnicity, age, sexual orientation, gender identity, immigration status, employer, insurance status, or any other demographic, have timely access to comprehensive, high-quality family planning and sexual health services. The proposed rule's emphasis on health equity will further support these goals.

Particularly in the wake of CDC's recent declaration that racism is a serious threat to public health, CLASP would like to see systemic racism explicitly included and addressed as part of the expectations related to health equity. Systemic racism and other forms of oppression have resulted in structural barriers to health care services. The Title X family planning program and today's provision of family planning services arose out of a history of reproductive coercion and a fundamental devaluing of the bodily autonomy of people of color and people with low incomes. This history has contributed to a justifiable mistrust of the health care system, particularly with respect to family planning. As the administration raises health equity as an important goal of Title X in the proposed rule, CLASP urges HHS to acknowledge and reckon with that history as a part of that work.

Title X and opioid treatment

Title X sites are uniquely positioned to link people to behavioral health treatment and recovery supports when they are diagnosed with substance use disorders, especially in rural areas where the crisis is severe. Early identification and treatment for behavioral health conditions are essential to address the opioid epidemic. Title X providers are obligated to follow guidelines for Quality Family Planning that include screening for substance use and appropriate referrals, playing a key role linking women to treatment for opioid-related disorders. Without access and referrals to mental and behavioral health specialists, substance use disorders and untreated mental illnesses will go untreated, thereby increasing costs to the overall system.

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***State Restrictions on Provider Networks***

CLASP strongly supports ensuring that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients. Despite mounting evidence that expelling well-qualified, trusted family planning providers from publicly funded health programs like Title X has adverse effects on patients' access to critical family planning and sexual health care, states in recent years have increasingly targeted some family planning providers for exclusion from key federal health programs, including Title X. At least 15 states currently have laws on the books that, where funds flow through the state government, could negatively impact the Title X service delivery network. Two additional states have similar bills that are likely to become law this year. Tiering and

other prohibitions against family planning providers often exclude the very providers that are the most qualified and best-equipped to help Title X patients achieve their family planning goals.

The NPRM appropriately recognizes that "state policies restricting eligible subrecipients unnecessarily interfere with beneficiaries' access to the most accessible and qualified providers," and that "denying participation by family planning providers that can provide effective services has resulted in populations in certain geographic areas being left without Title X providers for an extended period of time."[16]

CLASP strongly agrees with HHS that "state restrictions on subrecipient eligibility unrelated to the ability to deliver Title X services undermine the mission of the program to ensure widely available access to services by the most qualified providers."[17]

The intent of the Title X program is to help individuals—regardless of their economic status, but prioritizing low-income individuals—achieve their family planning goals. Title X funding is therefore provided to public and nonprofit entities to "assist in the establishment and operation of voluntary family planning projects" that offer a broad range of effective family planning methods and services.[18] As noted in the NPRM, "[P]roviders with a reproductive health focus often provide a broader range of contraceptive methods on-site and therefore may reduce additional barriers to accessing services."[19]

To best achieve the program's goals, Title X has historically funded a diverse network of service delivery providers—including state, county, and local health departments, as well as hospitals, family planning councils, Planned Parenthood affiliates, federally qualified health centers, and other private non-profit organizations. These networks vary widely across communities because they are specifically established to provide the most effective care to their specific patient populations. It is therefore imperative that HHS "ensure that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients."[20]

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***Confidentiality.***

Two interrelated hallmarks of Title X have been the program's historically strong protections for patient confidentiality and its commitment to serving adolescents. Since the 1970s, federal law has required that both adolescents and adults be able to receive confidential family planning services in Title X projects. Research shows these confidentiality protections are one of the reasons individuals

[16] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021), citing Carter, M.W., Gavin, L., Zapata, L.B., Bornstein, M., Mautone-Smith, N., & Moskosky, S.B. (2016). Four aspects of the scope and quality of family planning services in U.S. publicly funded health centers: Results from a survey of health center administrators. Contraception. doi:10.1016/ j.contraception.2016.04.009.

[17] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021).

[18] 42 U.S.C. § 300.

[19] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021).

[20] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021).

choose to seek care at Title X sites.[21]

Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Patients seeking family planning services encompass a broad spectrum of patient populations.[22] Certain groups, including adolescents and young adults, and people at risk of domestic or intimate partner violence, have special privacy concerns that require particularly strong protection.[23]

Providing confidential and affordable services to unemancipated youth and young adults is a critical tenet of the Title X program. The 2019 rule had the potential to be especially harmful to unemancipated youth and young adults who sought confidential services that they would pay for using their own resources instead of their family's income. By eliminating the ability of youth and young adults to seek services independently and instead rely on parental consent and family resources, this 2019 rule sought to block unemancipated youth and young adults from receiving confidential services for free or at low cost, which is an essential part of accessing affordable and confidential care.

The 2019 Title X rule weakened these protections by requiring providers to encourage family involvement even when it could be harmful; by giving the HHS Secretary oversight authority in the enforcement of complex and nuanced state reporting laws; and by adding new inappropriate reporting and documentation obligations on providers. In doing so, the 2019 rule undermined the provider-patient relationship to the detriment of public health.

The NPRM would reinstate the Title X confidentiality regulations in place prior to the 2019 rule[24] while making important improvements. First, the NPRM eliminates the 2019 rule's unnecessary and harmful requirements to take and document specific actions to encourage family involvement in the family planning decision making of adolescents, without including the statutory limitation "[t]o the extent practicable"[25] and with complete disregard for the expertise, training, and experience Title X providers already use in assisting adolescents to involve their families in decisions about family planning services and other key health care matters when realistic and

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[21] Frost et al., *Specialized Family Planning Clinics in the United States*.

[22] Rachel B. Gold, *A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents*, 16 GUTTMACHER POLICY REVIEW 2, 2 (2013), https://www.guttmacher.org/pubs/gpr/16/4/gpr160402.pdf.

[23] Pamela J. Burke et al., *Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine*, 54 J. ADOLESCENT HEALTH 491, 491-496, (2014), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf; Diane M. Reddy, Raymond Fleming, & Carolyne Swain, *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 J. AM. MED. ASS'N 710, 710–714 (2002); 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*, 293 J. AM. MED. ASS'N 340, 340–348; Liza Fuentes, Meghan Ingerick, Rachel Jones, & Laura Lindberg, *Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. ADOLESCENT HEALTH 36, 36-43; *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings,* Family Violence Prevention Fund (2004), http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf.

[24] Title X's confidentiality requirements are currently largely codified at 42 C.F.R. § 59.11; the NPRM proposes reorganizing the Title X regulations so that the confidentiality section would now be § 59.10.

[25] 42 U.S.C. § 300.

appropriate.

Second, the NPRM eliminates the 2019 rule's attempt to give HHS substantial oversight over compliance with complex state reporting requirements concerning child abuse, child molestation, sexual abuse, rape, incest, or human trafficking. Combined with the 2019 rule's requirements to collect and document specific information in Title X records, as well as that rule's attempt to give HHS the authority to impose harsh penalties if HHS (not the state) believes a Title X project is out of compliance, the 2019 rule pushed providers toward inappropriate screening and over-reporting that would harm patients and undermine the provider-patient relationship, ultimately resulting in fewer patients seeking critical health services.

Determinations regarding compliance with state reporting laws properly rest with state authorities. State reporting laws are complex and vary widely from state to state.[26] They seek a nuanced balance between the need to protect those who experience abuse and ensure that law enforcement can bring victimizers to justice with the need to ensure that patients are able to seek critical health care services they might avoid if they do not trust their health care provider. Thus, many state laws include both specific requirements that clearly trigger an obligation to make a report and others that allow for the exercise of discretion by health care professionals.

Third, the NPRM adds important clarification to how Title X-funded entities are to balance client confidentiality with the program's statutory requirement that "no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge."[27]

CLASP welcomes the NPRM's addition of language codifying a longstanding practice that had been included in the 2014 Title X Program Requirements that reasonable efforts must be made to "collect charges without jeopardizing client confidentiality," along with a new requirement that clients be informed of "any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client."[28] HHS is right to recognize the potential for harm from varied state and local laws regarding the accessibility of client information to insurance policyholders that are not the client. As more and more patients have access to insurance, the potential risks of disclosure of sensitive information have increased. These proposed additions to the Title X regulations will help to ensure that confidentiality remains paramount in Title X.

The NPRM proactively addresses the potential within the Title X regulations themselves for harm related to disclosure of a client's sensitive information to third parties such as policyholders who are not the client. In addition, HHS should evaluate Title X's interaction with other laws and regulations for possible conflicts that could undermine Title X clients' confidentiality and potentially subject them to harm.

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[26] *See, e.g.*, Rebecca Gudeman & Erica Monasterio, *Mandated Child Abuse Reporting Law: Developing and Implementing Policies and Training*, National Center for Youth Law and Family Planning National Training Center for Service Delivery (2014), http://www.cardeaservices.org/documents/resources/Mandated-Child-Abuse-Reporting-Law-GUIDE-20140619.pdf.

[27] 300a-4

[28] "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19820 (April 15, 2021).

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***Purpose of the program/standard of care.***

Title X was expressly created in 1970 to make "'comprehensive family planning services readily available to all persons desiring such services."[29] Specifically, many low-income women had more children than they desired, because both the pill and the other most effective contraceptive method at the time, the copper intrauterine device (IUD), were both expensive medical methods. Congress enacted Title X to help those "medically indigent" persons – low-income individuals who desired but could not access the contraceptive methods that more affluent members of society could, and who were:

> forced to do without, or to rely heavily on the least effective nonmedical techniques for fertility control unless they happen to reside in an area where family planning services are made readily available by public health services or voluntary agencies.[30]

For this reason, the statute requires Title X projects to "offer a broad range of acceptable and effective family planning methods and services," and prioritizes a project's capacity to make rapid and effective use of federal funds for family planning. The 2019 rule undermined this longstanding standard of care in a variety of ways: It eliminated the term "medically approved" from the longstanding regulatory requirement that projects provide "a broad range of acceptable and effective medically approved family planning methods;"[31] included overly permissive language that opened the door to participation in the program by providers who object to fundamental tenets of the Title X program, and diverged from the nationally recognized clinical standards, the Quality Family Planning guidelines, published by the Office of Population Affairs and the Centers for Disease Control and Prevention in 2014. Furthermore, the 2019 rule made drastic changes to pregnancy counseling by Title X providers that violated Congress' explicit, repeated mandates; contradicted central principles of medical ethics; and attempted to enlist clinicians in deceiving and delaying patients who seek information about or access to abortion providers.

CLASP applauds HHS for the proposed rule's return to the core mission of the Title X program, and will once again match patients' expectations that they will receive high-quality client-centered care that includes comprehensive, medically accurate counseling and information, and referrals for any other services sought. Specifically, CLASP strongly supports the following changes and urges the Administration to finalize them:

- The inclusion of "FDA-approved contraceptive services" and reinstatement of the term "medically approved" to the proposed definition of family planning services;
- The requirement that Title X service sites refer patients out if the site does not offer the contraceptive method of the patient's choice;

[29] *Planned Parenthood Federation of America, Inc. v. Heckler*, 712 F.2d 650, 651 (D.C. Cir. 1983) (quoting S. REP. NO. 91-1004, at 2 (1970)).

[30] S. REP. NO. 91-1004, at 9 (1970).

[31] 83 Fed. Reg. at 25530.

- Provide services "in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with national recognized standards of care;"[32]
- The reinstatement of the requirement to offer nondirective options counseling to pregnant patients on each of the three options, if requested by the patient, including referral upon request.
- The elimination of unnecessary, unworkable physical, systems, and administration separation, contrary to the requirements and realities of modern quality health care.

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***Modernizing the Title X regulations is important to the program's future success.***

Despite the Title X program's success over the course of the program's history, including the nearly two decades spent operating under the 2000 regulations that serve as the basis of this NPRM, changes in the health care delivery landscape necessitate updates to the Title X regulations to account for the context in which services currently are delivered in the family planning safety net.

The NPRM makes an important update in § 59.5(b)(1) in recognition that medical services in many Title X-funded health centers can be and are provided by health care providers who are not physicians. In fact, the NPRM preamble specifically mentions physician assistants and nurse practitioners as the types of health care providers that provide consultation in Title X settings. Indeed, nurse practitioners, certified nurse midwives, and physician assistants accounted for 67% of the Title X program's full-time equivalent (FTE) Clinical Services Provider (CSPs) in the 2019; physicians and registered nurses with an expanded scope of practice accounted for 24% and 9% of all CSP FTEs, respectively.

However, it is important to note that "consultation by a [health care] provider" is not and should not be limited only to the examples cited by HHS, as these CSPs represent only one facet of health care providers in Title X settings.[33] In 2019, 23% - or more than 1.07 million – of family planning encounters fell under the primary responsibility of other service providers, including registered nurses practicing within a standard scope of practice, licensed practical nurses, health educators, and social workers.[34] These professionals not only account for a substantial number of Title X encounters on their own, but also provide critical support to CSPs in team-based care models typical to modern health care delivery. They are more likely to be Black, Indigenous, and People of Color (BIPOC)—racial/ethnic groups that are both persistently underrepresented in health care professions and more reflective of clients served through the Title X program.[35] NFPRHA encourages HHS to elevate the critical role these health care professionals play in the Title X program.

Among enhancements it proposes to the 2000 regulations through the NPRM, HHS also specifically

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[32] NPRM, p. 19830

[33] C Fowler, J Gable, B Lasater, and K Asman, *Family Planning Annual Report: 2019 National Summary* (Washington, DC: Office of Population Affairs, 2020).

[34] Ibid.

[35] E Salsberg, C Richwine, and S Westergaard S, et al, "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce," *JAMA Netw Open.* 2021;4(3):e213789. doi:10.1001/jamanetworkopen.2021.3789.

highlights "telemedicine." The importance of telehealth, more broadly, has been growing in recent years and has become particularly clear in the context of the COVID-19 public health emergency. Since spring 2020, use of telehealth modalities has allowed tens – if not hundreds – of thousands of Title X users to remotely access many Title X services without placing themselves at increased risk for potential COVID-19 exposure.

That said, the Department's use of the term "telemedicine" in the NPRM instead of "telehealth" is of concern, with "telehealth" referring to a broader scope of remote health care services than telemedicine and includes non-clinical services like counseling and education. Accordingly, in addition to its change from "physician" to "[health care] provider" in § 59.5(b)(1), HHS can further improve the Title X regulations by explicitly naming and defining "telehealth" to clarify that section as follows:

> 59.5(b)(1): Provide for clinical and other qualifying services related to family planning (including consultation by a healthcare provider, family planning counseling and education, examination, prescription, and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, including audio-only modalities, regardless of the patient's or provider's setting, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

The NPRM also proposes making a "technical correction" to § 59.12 to include 45 CFR part 87, the "Equal Treatment for Faith-based Organizations" rule (faith-based organizations rule) in the list of regulations that apply to Title X. The previous administration, which finalized the faith-based organizations rule on December 17, 2020, explicitly declined to apply this rule to Title X. Furthermore, the faith-based organizations rule, finalized on December 17, 2020, insofar as it applies to HHS grant programs, only "applies to grants awarded in HHS social service programs." As Title X is a health service program, with grants made to entities "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services," 45 CFR part 87 does not rightfully apply, and should therefore not be included in the final Title X rule.

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For 50 years, the Title X family planning program has been a critical underpinning of the public health safety-net infrastructure that serves millions of low-income people each year. CLASP appreciates the opportunity to comment on the NPRM, "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services." If you require additional information about the issues raised in these comments, please contact Isha Weerasinghe, iweerasinghe@clasp.org or Ashley Burnside, aburnside@clasp.org.

Sincerely,

Ashley Burnside and Isha Weerasinghe