October 7, 2016

Susan B. Moskosky, MS, WHNP-BC
Office of Population Affairs
Department of Health and Human Services
200 Independence Avenue SW, Suite 716G
Washington, DC 20201

Re: Comments Submitted to Federal eRulemaking Portal, http://www.regulations.gov, Concerning Regulatory Information Number (RIN) 937-AA04, *Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients*, 81 FR 61639-61646, published Sep. 07, 2016

Dear Ms. Moskosky:

We write to comment upon the Health and Human Services Department (HHS)'s proposed rule, *Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients*, 81 FR 61639-61646, published Sep. 07, 2016. Alliance Defending Freedom (ADF) is a public interest law firm committed, among other purposes, to the wise implementation of public funding that avoids taxpayer subsidization of conscientiously objectionable practices such as elective abortion. The Susan B. Anthony List (SBA List) is a nonprofit organization dedicated to pursuing policies and electing candidates who will reduce and ultimately end abortion. To that end, the SBA List emphasizes the education, promotion, mobilization, and election of pro-life women. The SBA List is a network of more than 465,000 pro-life Americans nationwide. Charlotte Lozier Institute (CLI) is the nonprofit education and research arm of the Susan B. Anthony List. Named after a 19th century feminist physician who, like Susan B. Anthony, championed women's rights without sacrificing either equal opportunity or the lives of the unborn, CLI studies federal and state policies and their impact on women's health and on child and family well-being. Together, we urge HHS to reject the proposed rule, as it contradicts the letter and spirit of Title X not to subsidize elective abortion, and runs contrary to the right of States in our federal system to optimize health care for women by prioritizing public funding to providers who offer primary and preventive care as well as contraception.

"Most Title X funds flow initially to state and local governmental agencies and non-profit organizations[, which] function as intermediaries that in turn distribute the funds to subgrantees who actually administer the programs."[1] The proposed rule responds to HHS's perception that "a number of states have taken actions to restrict participation by certain types of providers as subrecipients in the Title X Program, unrelated to the provider's ability to provide the services required under Title X."[2] HHS contends this has led to disruption or reduction of services.[3] "In several instances," HHS claims, "these restrictions have interfered with the 'capacity [of the applicant] to make rapid and effective use of [Title X federal] assistance.'"[4]

HHS points to several ways in which States have restricted subrecipients from participating in Title X, particularly the "tiered approach" whereby public and primary/preventive care providers are preferred in the distribution of Title X funds. This approach effectively excludes providers focused on reproductive health from receiving funds, HHS claims, even though such providers offer "higher quality services" and "accomplish Title X programmatic objectives more effectively."[5] Other

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[1] *Nat'l Family Planning & Reproductive Health Ass'n, Inc. v. Gonzales*, 468 F.3d 826, 828 (D.C. Cir. 2006).

[2] 81 FR at 61640.

[3] *Id*. HHS notes that "13 states have placed restrictions on or eliminated subawards with specific types of providers based on reasons unrelated to their ability to provide required services in an effective manner," 81 FR at 61640, but fails to make a necessary distinction between cases involving Medicaid provisions and those involving Title X. Obviously, the two contexts are quite dissimilar, since Medicaid is a public insurance program that turns on a fee-for-service payment on behalf of beneficiaries who have been held to have a "free choice of qualified provider" under the Medicaid Act. *See, e.g., Planned Parenthood v. Betlach*, 727 F.3d 960 (9th Cir. 2013); *Planned Parenthood of Indiana, Inc. v. Comm'r, Indiana State Dept. of Health*, 699 F.3d 962 (7th Cir. 2012). Title X, on the other hand, is a federal grant program that mandates reports of "patient encounters," but does not provide direct insurance payments to patients, nor do the Title X statute and regulations provide patients with a "free choice of qualified provider."

[4] 81 FR at 61640, citing Public Health Service Act (PHSA) [42 U.S.C. § 300 et seq.] ("Title X"), sec. 1001(b).

[5] 81 FR at 61640. HHS cites the example of Kansas, which excluded Planned Parenthood in 2011 through a tiered system, and where the State experienced a drop in the number of clients served. 81 FR at 61641. HHS neglects to mention, though, that the Kansas Department of Health terminated Planned Parenthood in June 2011 and sought alternative providers, but was stopped from doing so by a court injunction, which remained in place until the court of appeals lifted it in 2014. *See Planned Parenthood of Kansas and Mid-Missouri*

States have prohibited "specific types of providers" from eligibility, HHS observes, a euphemistic way of referring to elective abortion providers such as Planned Parenthood Federation of America affiliates.[6]

In spite of the fact that prioritization systems have been approved by federal courts for decades, under HHS's proposed rule, "a tiering structure … would not be allowable unless it could be shown that the top tier provider (e.g., community health center or other provider type) more effectively delivered Title X services than a lower tier provider."[7] Actions that favor "comprehensive providers" (scare quotes in original) would require justification that those providers are at least as effective as other subrecipients applying for funds, HHS cautions.[8] "The proposed rule does not limit all types of providers from competing for subrecipient funds, but delimits the criteria by which a project recipient can allocate those funds based on the objectives in Title X," HHS says.[9] Making it clear that such prioritization systems will not pass muster with HHS in future contract awards, HHS warns, "Only those [State] laws which directly distinguish among Title X providers for reasons unrelated to their ability to deliver services would be implicated, and then, only if the state chooses to continue to apply for funding."[10]

HHS's proposed rule "rigs the game" against States that desire to utilize Title X funding to increase primary and preventive health care for women by claiming that such policies "limit access to high quality family planning services by restricting

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v. Moser, 747 F.3d 814, 820 (10th Cir. 2014). Thus, the reduction in demand of 37% in Kansas through 2015 (only 17% more than the national rate of decline) cannot be attributed to the State's law. Likewise in New Hampshire, which HHS also cites, where the Executive Council in 2011 disapproved the State's contract with Planned Parenthood based upon concerns about its financial improprieties. HHS claims there "was significant disruption in the delivery of [Title X] services" in that part of the State for approximately three months, but does not mention that hundreds of FQHCs and CHCs were available to patients for that short period, offering more comprehensive and effective health care than Planned Parenthood.

6 81 FR at 61640. The latter type of exclusion is less common, and may raise First Amendment issues when specific providers are named (*e.g.*, Planned Parenthood affiliates). *See, e.g., Planned Parenthood of Cent. N.C. v. Cansler*, 804 F. Supp. 2d 482 (2011) (specific legislative targeting of Planned Parenthood affiliate led to likelihood of success on merits of First Amendment claim).

7 81 FR at 61643.

8 *Id*.

9 *Id*.

10 81 FR at 61643.

specific types of providers from participating in the Title X program."[11] Such exclusions, HHS maintains, are "associated with a reduction in the quality of family planning services, the number of Title X service sites, reduced geographic availability of Title X services, and fewer Title X clients served."[12] HHS claims, "Data show that specific provider types with a reproductive health focus have been shown to serve disproportionately more clients in need of publicly funded family planning services than do public health departments and federally qualified health centers (FQHCs)."[13] Effectively, says HHS, these policies "may shift funding from relatively high quality family planning service providers to providers of lower quality."[14] By defining "quality of care" in a way that strongly favors providers who focus on contraceptive services, HHS asserts that "reproductive healthcare providers" such as Planned Parenthood are superior to the federal government's own system of public healthcare because they more effectively deliver contraception – a proposition both remarkable and untrue. HHS's proposed rule trammels upon an area traditionally left to the States – State health care policy – and truncates the important task States play in creating innovative and effective new structures for delivery of healthcare services.[15]

State Healthcare Funding Innovations as Good Public Policy.

Although HHS claims that "[n]one of these state restrictions are related to the subrecipients' ability to effectively deliver Title X services," that is far from true. The

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11 81 FR at 61643-44.

12 81 FR at 61644.

13 81 FR at 61642.

14 81 FR at 61645.

15 HHS's action may have the unintended effect of encouraging States to withdraw from the Title X program. Recently, Texas decided that State funds would be expended for its Medicaid family planning waiver program after losing federal funding as a result of deeming providers of abortion and abortion referral non-qualified for family planning funds. *See generally Planned Parenthood v. Suehs*, 692 F.3d 343 (5th Cir. 2012). A key purpose of the reservation of the States' authority in the federal system is to empower them to implement innovative policies that may serve as a model to other States and the Federal government. "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Corp. v. Liebmann*, 285 U.S. 262, 386-87 (1932) (Brandeis, J., dissenting); *Grutter v. Bollinger*, 539 U.S. 306, 342 (2003), citing *United States v. Lopez*, 514 U.S. 549, 581 (1995) (Kennedy, J., concurring) ("[T]he States may perform their role as laboratories for experimentation to devise various solutions where the best solution is far from clear."). If the federal government does not respect that process, other States may follow suit, endangering the federal policy implemented through Title X.

prioritization systems increasingly adopted by States effectively further the Title X program's purpose of providing family planning services based on "the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of [Title X Federal] assistance."[16] Prioritization of public family planning funding to public health departments and clinics, and non-public hospitals and community health centers such as Federally-Qualified Health Centers ("FQHCs") and Rural Health Clinics ("RHCs"), is simply better healthcare policy. Unlike boutique "reproductive healthcare providers" such as Planned Parenthood affiliates, such primary and preventive care centers provide low-income families with access to not only family planning services, but also vital preventive services, including prenatal and perinatal services, well-child services, immunizations against vaccine-preventable diseases, primary care services, diagnostic laboratory and radiological services, emergency medical services, and pharmaceutical services.[17]

The federal administration regards federally-qualified health centers as "a critical component of our country's health care safety net" that will "continue to be essential for the foreseeable future."[18] Health centers ensure access to primary and preventive services, and facilitate access to comprehensive health and social services.[19] Additionally, health centers serve culturally and linguistically diverse populations[20] and provide case management services;[21] services to assist the health center's patients gain financial support for health and social services;[22] referrals to other providers of medical and health-related services including substance abuse and mental health services; and services that enable patients to access health center services such as outreach, transportation and interpretive services.[23] FQHCs also educate patients and the community regarding the availability and appropriate use of health services.[24] Health center programs that receive funding to serve homeless

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16 PHSA sec. 1001(b).

17 *See generally Health Center Program Expectations*, PIN 98-23, dated August 17, 1998, http://www.fachc.org/pdf/cd_programexpectations.pdf and 42 U.S.C. § 254b(b)(1)(A)(i)-(v).

18 *Health Center Program Expectations, supra*, at 2. A "Federally Qualified Health Center" is defined as a health care provider eligible for federal funding under 42 U.S.C. § 1396d(1)(2)(B).

19 *Id*. at 14.

20 *Id*. at 3.

21 *Id*. at 14.

22 *Id*. at 14-15.

23 *Id*. at 15.

24 *Id*.

individuals and families also provide substance abuse services.[25] "All health centers are expected to assess the full health care needs of their target populations, form a comprehensive system of care incorporating appropriate health and social services, and manage the care of their patients throughout the system."[26] Moreover, health centers "must have ongoing referral arrangements with one or more hospitals, and health center clinicians should obtain admitting privileges and hospital staff membership at their referral hospital(s) so health center patients can be followed by health center clinicians."[27] Health centers also have comprehensive and continuous after-hours care, unlike reproductive healthcare facilities that frequently keep irregular hours.[28]

Rural Health Clinics (RHCs) are located in rural areas designated as medically underserved "shortage areas" for health care services.[29] RHCs are staffed by a clinician at all times, in contrast to Planned Parenthood facilities where patients may not see a practitioner at all.[30] RHCs must be "primarily engaged" in "primary medical care (treatment of acute or chronic medical problems which usually bring a patient to a physician's office)."[31] Services provided include "diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system," including "medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions"; "basic laboratory services essential to the immediate diagnosis and treatment of the patient"; and "medical emergency procedures as a first response to common life-threatening injuries and acute illness."[32]

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25 *Id*.

26 *Id*. at 16.

27 *Id*.

28 *Id*.

29 *Interpretive Guidelines - Rural Health Clinics: Conditions for Certification,* Sec. II.A and B (citing 42 C.F.R. 491.5), available at http://www.narhc.org/uploads/ pdf/ interpretive_guidelines.pdf. A "Rural Health Clinic" is a health center that is eligible for preferred federal Medicare and Medicaid funding under 42 U.S.C. § 1395x(aa)(2), which includes provisions for preventative services and patient case management.

30 *Id*., Sec. V.B (citing 42 C.F.R. 491.8(a)). *See United States ex rel Thayer v. Planned Parenthood of the Heartland*, No. 4:11-0129, USDC S.Dist. IA. (False Claims Act claimant and former Planned Parenthood clinic director alleges that most patients did not see a practitioner, and had prescriptions signed after visiting the clinic.)

31 *Id*., Sec. VI.A.2 (citing 42 C.F.R. 491.9).

32 *Id*.; *see* 42 U.S.C. 491.9(c).

Because FQHCs and RHCs provide primary preventive care and access to comprehensive diagnostic care, unlike boutique "reproductive healthcare providers," prioritizing public healthcare funds to such entities is simply better fiscal healthcare policy. The proposed rule should be withdrawn, and the example of State innovation demonstrated by such prioritization systems should be allowed to continue.

Legality of State Funding Innovations.

The legality of prioritization systems has been established for many years. Although HHS maintains that "[l]itigation concerning these restrictions has led to inconsistency across states in how recipients may choose subrecipients,"[33] the truth is that federal courts have upheld state prioritization statutes for Title X funds. The D.C. Circuit affirmed Utah's authority to act as sole grantee for the Title X program within the State (pursuant to statute) through a consolidated grant award from HHS.[34] The federal agency's actions were pursuant to a policy of consolidating grants in the interests of efficiency and in view of limited funds availability.[35] Planned Parenthood and another non-state provider sued, contending that HHS's actions violated their right to apply directly for grants and that its policy of favoring consolidated grants was unlawful.[36] The district court dismissed the lawsuit, holding that "not only did Congress not enact legislation prohibiting consolidated grants, but the pertinent legislative history evidences Congress' approval of consolidated grants where appropriate."[37] The court of appeals affirmed, concluding that Title X protected only the right to apply for a grant, not to receive one,[38] and that the consolidation process was consistent with congressional directions to encourage "better coordination of existing services."[39] In fact, the court noted, federal law required HHS to favor consolidated grant applications where appropriate.[40] HHS remains under that mandate today.

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33 81 FR at 61641.

34 *Planned Parenthood Association of Utah, et al. v. Schweiker*, 700 F.2d 710, 723-24 (D.C. Cir. 1983).

35 In 1982, the court noted, consolidated grants had been awarded in 28 states, with 23 consolidated in state agencies and 5 in non-state agencies. 700 F.2d at 714.

36 *Id*. at 717.

37 *Id*. at 718.

38 *Id*. at 723.

39 *Id*. at 724, quoting 42 U.S.C. § 300z(a)(10)(B).

40 *Id*. at 726, citing 42 U.S.C § 300z-6(a)(4).

Courts have also held that prioritization statutes do not impermissibly condition government benefits on the forfeiture of constitutional rights. The Supreme Court has observed that state governments have "a legitimate and substantial interest in preserving and promoting fetal life."[41] To further that end, States have authority to enact laws and policies that encourage childbirth over abortion,[42] including withholding taxpayer subsidies for abortion. As the Court has stated numerous times, "[T]he State need not commit any resources to facilitating abortions….,"[43] and "[A] woman's freedom of choice [does not] carr[y] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices."[44] Federal law reflects this policy choice through the Hyde Amendment, which prohibits funding for abortion except under certain extreme circumstances. Like the Hyde Amendment upheld by the Supreme Court, prioritization legislation "places no obstacles absolute or otherwise in the pregnant woman's path to an abortion" because she "continues as before to be dependent on private sources for the service she desires."[45]

The courts of appeals have almost uniformly rejected constitutional challenges to State restrictions on public funding for elective abortion providers. The Fifth Circuit Court of Appeals ruled in *Planned Parenthood v. Suehs* that Texas's prohibition on providers of elective abortion and entities associated with abortion providers receiving public funds under the state Medicaid waiver program did not violate their First Amendment right of association or right to equal protection.[46] The Seventh Circuit reached a similar conclusion in assessing Indiana's decision to divest abortion providers of state-controlled funds, reasoning that Indiana's differential treatment of providers of elective abortion was a permissible governmental preference.[47] More recently, the Tenth Circuit held that Planned Parenthood had no

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41 *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007).

42 *Id*. at 146.

43 *Webster v. Reproductive Health Servs*., 492 U.S. 490, 511 (1989), citing *Harris v. McRae*, 448 U.S. 297 (1980); *Poelker v. Doe*, 432 U.S. 519, 521 (1977), and *Maher v. Roe*, 432 U.S. 464 (1977).

44 *Harris, supra*, 448 U.S. at 316.

45 *Maher, supra*, 432 U.S. at 474 (upholding prohibitions on the use of Medicaid to pay for non-therapeutic abortions).

46 692 F.3d 343 (5th Cir. 2012).

47 *Planned Parenthood of Indiana, Inc. v. Comm'r, Indiana State Dept. of Health*, 699 F.3d 962 (7th Cir. 2012). *See also Planned Parenthood of Mid-Missouri and Eastern Kansas v. Dempsey*, 167 F.3d 458, 463 (8th Cir. 1999) (holding that a Missouri law employing similar provisions did not impose an unconstitutional condition on abortion providers' receipt of Title

First Amendment claim against Kansas arising out of its alleged exclusion from Title X eligibility.[48] "Planned Parenthood could qualify under the statute if it expanded its services to satisfy the requirements to be an FQHC," the court noted.[49]

Because State Title X grantees that seek to invest public funds in public primary and preventive healthcare providers are achieving Title X's program goals in innovative ways, and federal courts have consistently held that there is no statutory or constitutional impediment to doing so, HHS's proposed rule should be withdrawn. We appreciate your consideration of these comments, and thank you for your time in doing so.

Respectfully submitted,

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ALLIANCE DEFENDING FREEDOM

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X family-planning funds because recipients could continue "to exercise their constitutionally protected rights through independent affiliates"); *Planned Parenthood v Sanchez*, 403 F.3d 324 (5th Cir. 2005) (upholding abortion exclusion provision that restricted federal family planning funds, including Title X funds, to individuals or entities that did not perform elective abortion procedures and did not contract with or provide funds to individuals or entities for the performance of elective abortion procedures).

48 *Planned Parenthood of Kansas and Mid-Missouri v. Moser*, 747 F.3d 814 (2014).

49 747 F.3d at 839.