Comment

RE: Docket RIN: 0937-AA11
Docket Number: HHS-OS-2021-0010
"Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services"

Attn: Title X Rulemaking, Office of Population Affairs, Office of Assistant Secretary for Health
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Position Summary

On behalf of the 30,000 constituents of Freedom2Care and the 20,000-member Christian Medical Association, this comment strongly opposes the proposed rule and instead urges the continuation of the 2019 rule.

Most egregiously, the proposed rule pays duplicitous lip service to conscience protections while requiring abortion referrals. This violates federal conscience law and effectively bars all but pro-abortion clinics from participation, creating a virtual monopoly for the abortion industry.

An evaluation of the many concerning aspects of the proposed rule follows an overview of the Congressional purpose--and subsequent corruptions of--the Title X program.

Overview: Ideologues have twisted Title X's Congressional intent

On a bipartisan basis, lawmakers passed the original Title X family planning program with a goal of broadening healthcare options, improving healthcare outcomes and enhancing services, especially for families and women of child-bearing age.

Had those lawmakers realized that ideological bureaucrats would turn the program into an abortion-promoting and subsidizing vehicle that by explicit policy discriminates against and excludes life-affirming health providers, the Title X program would never have come into existence.

Congress enacted Title X of the Public Health Service Act in 1970 to provide financial support for healthcare organizations offering voluntary family planning services.[1]

Section 1001 of the Act establishes the general purpose of Title X grants and contracts, and provides certain criteria to be considered for making such grants and contracts, including that Title X projects "shall offer a broad range of acceptable and effective family planning methods

[1] 42 U.S.C § 300 *et seq*.

and services (including natural family planning methods, infertility services, and services for adolescents)."[2]

Section 1008 explicitly excludes abortion from the scope of "family planning" for purposes of Title X, stating that "[n]one of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."[3]

Congressman Dingell, a principal sponsor of section 1008, stated:

> *"With the 'prohibition of abortion' amendment—Title X, Section 1008—the committee members clearly intend that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act" 116 Cong. Rec. 37375 (1970).*

This was Congress's stated understanding in 1970, and it remained Congress's stated understanding in subsequent years.

In 1978, for example, during debate on possible amendments to Title X, Congressman Dornan proposed amending the statute for the claimed purpose of strengthening the abortion funding restriction, as follows:

> *"No grant or contract authorized by this Title may be made or entered into with an entity which directly or indirectly provides abortion, abortion counseling, or any abortion referral services" 124 Cong. Rec. 37045 (1978).*

The House rejected the amendment on the ground that section1008 *already* encompassed the proffered prohibitions. Congressman Rogers, a member of thePublic Health & Welfare Subcommittee at the time Title X was enacted, stated:

> *"Abortion is not a method of family planning. Abortion comes after pregnancy— after pregnancy. And the gentleman misses the point of what we are doing in Title X. It's before—before. It is to let people know how to avoid pregnancy. We cannot use any funds for abortion. The amendment is not needed" Id. at 37046.*

HHS has issued a number of Title X regulations over the years, including most recently in 2019. The 2019 Rule remedied several problems with the prior regulations from 2000.

The 2019 Rule promotes program integrity by ensuring that the Title X program is consistent with the underlying statute and statutory purposes, including that Title X funds are not used to subsidize abortion.

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[2] 42 U.S.C. § 300(a).

[3] 42 U.S.C. § 300a-6.

HHS's current notice of proposed rulemaking (NPRM) proposes a readoption of the 2000 regulations with some additional requirements. The NPRM blanketly claims that the 2019 Rule "undermined the public health of the population the program is meant to serve," without an individualized analysis of each of the provisions and requirements it seeks to change.[4]

The proposed rule runs afoul of Title X's abortion prohibition and federal conscience protections, does not support Title X's purposes, undermines Title X project accountability and transparency, and provides a flawed analysis of the impact of the 2019 Rule and the projected impact of the proposed regulations.

The NPRM should be withdrawn; the 2019 rule should remain.

Instead of restricting tax resources to the original program goals, politically and ideologically motivated HHS appointees and bureaucrats, over the years and continuing under this proposed rule, have funneled Title X funds down a lucrative pipeline that carries fungible funds directly to the abortion industry.

Absent the 2019 rule's meaningful and physical separation of Title X funds and abortion businesses, Title X programs provide a convenient and lucrative way for abortionists to attract clients for legitimate health services and then lead them to the abortion clinic next door or in the next room.

Without checks on these abuses, Title X policies have served to prop up the abortion industry, including billion-dollar businesses such as Planned Parenthood, which annually takes in over half a billion tax dollars while performing nearly a third of a million abortions.

The cycle of favoring the well-funded abortion industry continues through a byzantine Title X grant process that virtually embeds such rich abortion organizations (which can afford to hire an army of grants acquisitions expertsand lobbyists) into the annual funding process. Thus, the same wealthy, tax-funded organizations—abortion businesses that grow even wealthier through Title X-funded abortion referrals--receive Title X grants year after year after year.

The Orwellian-named proposed rule, "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," promises only to reinstate these discriminatory restrictions, excluding many potential partners that would offer a much more holistic health program than abortion-focused businesses offer.

Tragically, this narrowing of options and competition portends worse health outcomes for the population that the Title X program aims to aid.

Requiring abortion referrals contradicts the acknowledgment of conscience law

Federal statutory conscience protection is clear and compelling on the question of whether conscientious objectors may be required to perform or refer for abortion.

[4] 86 Fed. Reg. 19812.

The Weldon Amendment was originally passed as part of the HHS appropriation and has been readopted (or incorporated by reference) in each subsequent HHS appropriations act since 2005. It provides that,

> *"[n]one of the funds made available in this Act [making appropriations for the Departments of Labor, Health and Human Services, and Education] may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or* ***refer for abortions.****"*

The legal answer as to whether HHS may require abortion referrals is an unequivocal *no*. The proposed rule, by contrast, mentions but ultimately *violates* the law. The preamble implies conscience protection, but the legally controlling text of the rule *denies* conscience protection, by explicitly requiring abortion referrals.

In the preamble, the NPRM attempts to assure the reader that federal conscience protections will be applied. But this is a false assurance that will be contradicted later in the legally controlling text of the rule.

The NPRM stipulates, in Section III (FR p. 19817),

> *The Department also recognizes Congress has passed several laws protecting the conscience rights of providers, particularly in the area of abortion. For example, in promulgating the 2000 Title X rules, the Department affirmed: ''under 42 U.S.C. 300a–7(d), grantees may not require individual employees who have such objections [to abortion] to provide such counseling.''65 FR 41270, 41274 (July 3, 2000).*
>
> *Since 2005 Congress has also annually enacted an appropriations rider which extends non-discrimination protections to other ''health care entities'' who refuse to counsel or refer for abortion. See, e.g., Consolidated Appropriations Act, 2021, Public Law 116–260, Div. H, section 507(d) (2020). Under these statutes, objecting providers or Title X grantees are* ***not required to counsel or refer for abortions****. (22) However, such protections for objecting providers and grantees should not prohibit willing providers and grantees from providing information in accordance with the ethical codes of major medical organizations.*

Footnote 22 to this section reads,

> *This has been the consistent position of the Department since 2000. See 65 FR at 41274 (in response to comments on*

> *individual objections to providing abortion counseling or referral, Department stating: ''under 42 U.S.C. 300a–7(d), grantees **may not require** individual employees who have such objections to provide such counseling.'').*

And again in (FR p. 19818):

> *At the same time, the proposed rule will retain the longstanding prohibition on directly promoting or performing abortion that follows from Section 1008's text and subsequent appropriations enactments. And as indicated above, individuals and grantees with conscience objections **will not be required** to follow the proposed rule's requirements regarding **abortion counseling and referral.***

The legally controlling text of the rule, however, rails against the declining of referring for abortion and in fact *requires* referrals.

In the legally controlling text of the proposed rule, in Section 59.5(a) (FR p. 19830) ("What requirements must be met by a family planning project?), stipulates:

> ***"Each project** supported under this part **must** …(i) **Offer** pregnant clients the opportunity to be provided information and **counseling** regarding each of the following options: (A) Prenatal care and delivery; (B) Infant care, foster care, or adoption; and (C) **Pregnancy termination**. (ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and **referral** upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling."*

[Emphases added.]

So the Department appears to acknowledge that federal conscience protections *preclude requiring* referrals for abortion. Yet when it really matters—in the legally controlling text of the rule--then the Department *requires* referrals for abortion upon request.

This is sheer duplicity.

The proposed rule does not correct a long-standing conscience-rights conflict with the 2000 rule. Despite the proposed rule stating that "the 2000 rule also fully recognized the statutory conscience right of individual providers to object to counseling and referral for abortions," the 2000 rule did not address adequately the inconsistency of the requirement and the protection of conscience.

Since 2008, HHS has acknowledged that the requirements for counseling and referrals for abortion run afoul of Church, Coats-Snowe, and Weldon Amendments and as a result, HHS could not require compliance to the abortion counseling/referral mandates. The 2019 rule, for the

first time, made HHS regulation and policy consistent with conscience provisions. HHS must correct this problem in the final rule by removing the requirement and instead make abortion counseling permissible.

Though the NPRM states,

> *"the 2000 rule also fully recognized the statutory conscience right of individual providers to object to counseling and referral for abortions,"*

the rule was woefully insufficient, prompting HHS to state in 2008 conscience regulations that the

> *"current regulatory requirement that grantees must provide counseling and referrals for abortion upon request…is inconsistent with the health care provider conscience protection statutory provisions and this regulation." [73 RF 78072, 78087].*

The 2008 conscience regulation went on to state that the Office of Population Affairs was aware that the referral and counseling requirements ran afoul of the Church, Coats-Snowe, and Weldon Amendments, but that the conflict could not be fully addressed until the 2000 Title X regulations were revised.

HHS has the opportunity to amend this inconsistency in the final rule and should do so, because as currently written in the proposed rule, the same problem confronted in the 2000 regulation will remain.

Requiring abortion referrals eliminates prolife applicants

The Department knows full well that the requirement to refer for abortions will virtually eliminate pro-life applicants. This departure from the 2019 rule, which opened the door to new applicants including pro-life applicants, deliberately and effectively reestablishes the abortion industry monopoly. It closes the door to potential new and holistic health partners--pro-life health professionals and programs that are prevented by ethical commitments from participating in abortion, including through referrals.

Besides the conscience statutory conflict, the abortion counseling and referral requirement in the 2000 regulation also served to quash Title X applications from entities with deeply held convictions opposing abortion. In the ensuing years between 2000 and 2018, very few *new* grant applicants submitted for Title X grant funding.

This changed once the 2018 NPRM was published in the Federal Register, when health professionals learned that the Trump Administration intended to protect the ability of grantees to compassionately serve clients while also protecting the ability of grantees to provide services consistent with deeply held beliefs. As a result, the number of new applicants immediately soared. Reinstating requirements similar to those in the 2000 regulation will stem competitive grant applications once again.

Otherwise, coupled with the administration's well-known embrace of and advocacy for virtually unlimited abortion rights, requiring abortion referrals will strongly dissuade pro-life applicants from even considering applying for Title X grants. Having eliminated pro-life competition, grants will once again be shoveled abundantly into the troughs of the abortion industry.

Failure to remove the abortion referral requirement will lead any rational observer to conclude eliminating all grant competition against the abortion industry is, in fact, a primary, political aim of the rule.

The NPRM counters the goals of Hyde, RFRA and other conscience-protecting laws

In flouting the law, the Department appears to rely on the fact that abortion referrals have been required by previous administrations for so many years that pro-life organizations have long since given up competing for grants--and thus will not be motivated to challenge the abortion referral requirement in court. After all the rhetoric in the rule about ethical obligations to refer, pro-abortion medical organizations requiring referrals, etc., etc., etc., the bottom line is that Department officials know that requiring abortion referrals is illegal but feel confident that they will *get away with it*.

In addition to Title X statutory prohibitions regarding abortion, the federal Hyde Amendment stipulates, "None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion." The proposed rule replaces the 2019 rule, which includes strong stipulations aimed at preventing the comingling of Title X and abortion.

The Religious Freedom Restoration Act applies a “strict scrutiny” standard to ensure that government burdens on religious practice must employ the least restrictive means of furthering a compelling purpose. *Zubik v. Burwell* (2016) brought this principle into focus, over a government policy that forced conscientious objectors to become complicit in issues they found morally objectionable, such as abortion and / or contraception.

The 2019 rule proved that Title X program goals can be achieved without violating RFRA or other conscience-protecting laws. The NPRM now threatens to unravel that progress by adopting a non-accommodation policy, raising not only potential violations of RFRA but of other conscience laws as well.

Under the NPRM, a Title X’s project under § 59.5(a)(1) would be required to provide pregnancy counseling services, which § 59.5(a)(5) states include abortion counseling and referrals.[5]

The NPRM would also amend § 59.5(a)(1) to state:

> *Title X service sites that are unable to provide clients with access to a broad range of acceptable and effective medically approved family planning methods and services, must be able to provide a referral to the client’s method*

[5] *Id.* at 19830.

> *of choice and the referral must not unduly limit the client's access to their method of choice.*[6]

Under this provision, individual subrecipients who provide only one family planning method or service will be required to refer clients to the contraceptive method of their choice, in possible violation of their conscience or organizational policy.

For example, a subrecipient may oppose certain contraceptive methods on the grounds that they conflict with deeply held beliefs and would be forced to either violate their conscience or withdraw from providing professional services needed or wanted by clients in their service area.

To the extent that referrals for contraception will be required, grantees should be allowed to provide referrals to the broad range of family planning methods and services.

In § 59.5(a)(3), the NPRM would require that projects "must . . . provide services in a manner that is client-centered," the definition of which provides that "client values guide all clinical decisions."[7]

As noted, since a client may "value" abortion or contraception, this requirement will push out faith-based providers who cannot due to their conscience and faith refer for abortion or contraception.

The proposed rule deliberately minimizes conscience laws

The NPRM's assertion in the preamble that conscience rights are protected is totally insufficient.

Apart from no explicit conscience exemption in the text of the regulation, there is no discussion in the NPRM how Title X applicants or providers who have conscience objections will be evaluated or how they will be except from the regulation's stated requirements.

Without specific assurances, HHS will limit the pool of potential applicants and providers by excluding those who have moral and religious objections to abortion. This is evidenced by the fact that between 2000 and 2018 there were very few new grant applicants submitted for Title X grant funding.

With the 2019 Rule, the number of new applicants immediately soared, presumably because of the explicit conscience protections. If the abortion counseling and referral requirements are added back to Title X projects, HHS will lose many, if not all, of these new grantees.

If HHS retains the proposed requirements, it will force Title X providers to choose between the health of their patients and their own conscience, and likely lead to providers being forced to remove themselves from the Title X program.

As HHS acknowledged in 2008, the 2000 Rule's "current regulatory requirement that grantees must provide counseling and referrals for abortion upon request" (which is what the NPRM is

[6] *Id.* (emphasis added).

[7] *Id.* at 19829–30.

proposing) "is inconsistent" with the regulation and "with the health care provider conscience protection statutory provisions,"[8] specifically the Church,[9] Coats-Snowe,[10] and Weldon[11] Amendments.

The 2019 Rule's regulations relating to abortion counseling and referrals fixed this conflict and should be retained.

Abortion referrals should be prohibited, though HHS may permit Title X providers to give clients a health care provider referral list that includes some providers who perform abortions. While medically necessary referrals, such as prenatal care for pregnant women and girls, should be required, elective abortion is *never* medically necessary.

These requirements, which the NPRM seeks to rescind, are consistent with section 1008's abortion prohibition and necessary to protect the conscience rights of Title X providers who cannot counsel on or refer for abortion due to their moral or religious beliefs.

Abortion counseling and referrals should not be mandated at all in Title X projects. If abortion counseling and referrals are allowed within Title X projects, the text of the regulations should explicitly acknowledge providers' conscience rights and explain how the application, evaluation, and compliance process with recognize and protect such rights. Further, the Conscience and Religious Freedom Division in HHS's Office for Civil Rights should be consulted to ensure that the regulations comply with all applicable federal conscience protection laws.

Removing conscience protections removes qualified professionals

What happens when conscience freedom is disregarded and participation by pro-life professionals, many of whom are faith-motivated, is precluded?

A national objective survey conducted for CMA's Freedom2Care revealed that 91 percent of faith-based physicians said they would be forced to leave medicine apart from conscience rights that protect them from being coerced into violating the faith tenets and medical ethics principles that guide their practice of medicine.[12] Faith-based health professionals do not, and cannot, separate the faith principles that motivate them to serve the needy from the faith principles that uphold the sanctity of human life.

The end result of the loss of participation by faith-based medical professionals and organizations with pro-life views is that *patients lose access* to excellent and compassionate medical care.

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[8] *See* 73 Fed. Reg. 78072.

[9] 42 U.S.C. § 300a-7 et seq.

[10] Public Health Service Act § 245, 42 U.S.C. § 238n.

[11] "The Weldon Amendment was originally passed as part of the HHS appropriation and has been readopted (or incorporated by reference) in each subsequent HHS appropriations act since 2005." https://www.hhs.gov/conscience/conscience-protections/index.html. Accessed May 14, 2021.

[12] Polling details available at https://www.freedom2care.org/polling .

Polling also shows that a majority of Americans oppose the use of tax dollars for abortion.[13] The expansive presence and aggressive marketing of abortion businesses and the fact that over a million abortions are performed annually in the United States indicate that abortion referrals from a tax-supported government program are hardly necessary to identify an abortion outlet.

Rather than *requiring* abortion referrals, a policy *prohibiting* abortion referrals—not only in the preamble but more importantly in the text of the rule--in this tax-funded program is legally demanded.

Promoting abortion as a method of family planning violates the law

The NPRM proposes removing from § 59.7(a) a requirement that Title X grants will be awarded to the projects that

> *"best promote the purposes of statutory provisions applicable to the Title X program, and ensure that no Title X funds are used where abortion is a method of family planning"*

and replacing it with

> *"best promote the purposes of section 1001 of the Act."*[14]

No reason is given for this substitution. It appears to be, at best, a deliberate way to minimize the impact of section 1008's prohibition against abortion as a method of family planning in grant and contract considerations or, at worst, a way to ignore section 1008's statutory requirements.

The proposed language should not be adopted. The language from the 2019 Rule should be retained.

The NPRM proposes deleting § 59.13 of the 2019 Rule, which requires that

> *"[a] project may not receive funds under this subpart unless it provides assurance satisfactory to the Secretary that, as a Title X grantee, it does not provide abortion and does not include abortion as a method of family planning."*

No explanation is given for why this specific assurance of compliance is "burdensome" or provides no "discernible compliance benefits."[15] Rather, this assurance is necessary to ensure

[13] "Abortion Limits Favored," Marist poll report, January 17, 2018, http://www.kofc.org/en/news/polls/abortion-limits-favored.html accessed May 14, 2021. "More than three quarters of Americans would limit abortion to — at most — the first three months of pregnancy, according to a new Marist Poll. That number has consistently been about three quarters or more for the past decade. This year, the survey found that 76 percent of Americans want such limits. Strong majorities of Republicans (92 percent), Independents (78percent) and Democrats (61 percent) agree, as do a majority of those who identify as pro-choice (60 percent). While a slim majority of Americans (51 percent) identify as pro-choice, even 60 percent of those who identify as such also support substantiallimits."

[14] *Id.* at 19832.

[15] *Id*. at 19817.

that Title X funds are not being used in ways that are contrary to section 1008, and the assurance should be retained.

Proposed definitions conflict with Title X

A number of proposed definitions and additions do not support the text and purpose of Title X law:

Advance practice provider. The NPRM proposes removing the requirement that nondirective pregnancy counseling be provided by physicians or advanced practice providers. No rationale is given for this deletion.

Ensuring that counseling is done by physicians or advanced practice professionals helps preserve the patient/health care provider relationship and promotes optimal health for every Title X client.

This requirement should be retained.

Health equity. The NPRM proposes adding a definition of "health equity," which it defines as "when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."[16]

This definition is vague and overbroad.

It is unclear what "full health potential" means or when it is achieved. There is no discussion in the NPRM as to how existing Title X projects prohibit any one from attaining, or disadvantaging them from achieving "their full health potential" and why such a requirement is consisted with or needed to fulfill Title X's purposes.

Nevertheless, under the NPRM, § 59.5(a)(3) would require Title X projects provide services in a manner that "ensures equitable and quality service delivery."[17]

No explanation is given for how a Title X project can, in fact, ensure equity in general and in a way that does not lead to actual discrimination based on a protected basis. There is no discussion of the increased burden on applicants and providers to ensure equity within their programs.

Moreover, the requirement that "every person ha[ve] the opportunity" conflicts with section 1006 of Title X,[18] § 59.5(a)(6),[19] and § 59.7(a)(1),[20] all of which prioritize "low-income families."

This definition and requirement should not be included.

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[16] 86 Fed. Reg. at 19829.

[17] *Id.* at 19830.

[18] *See* 42 U.S.C. § 300a-4(c)(1).

[19] 86 Fed. Reg. at 19830.

[20] *Id.* at 19831–32.

Client-centered care. The NPRM proposes adding a definition of "client-centered care," which provides "client values guide all clinical decisions."

The NPRM's proposed definition of "quality healthcare" states that such care is "client-centered," and in § 59.5(a)(3), the NPRM would require that projects "must . . . provide services in a manner that is client-centered ...."[21]

The requirement that "client values guide *all* clinical decisions" leaves no room for a Title X provider's conscience objections to abortion counseling and referrals when that client "values" abortion. It also does not leave room for the professional medical judgment of the health care provider when it conflicts with the client's values.

The requirement that "client values guide all clinical decisions" should be dropped from definition of "client-centered care."

Family planning services. The NPRM proposes changing the definition of "family planning services" to include "pregnancy counseling," which it later explains in § 59.5(i) must include: "(A) Prenatal care and delivery; (B) Infant care, foster care, or adoption; and (C) Pregnancy termination."[22]

This redefinition of family planning services to including counseling on "pregnancy termination," a.k.a. abortion, is inconsistent with section 1008's prohibition against abortion as a method of family planning. If a program refers a client to abortion, it is in fact a program where abortion is considered a "family planning related service."

HHS can correct this error by not including abortion counseling under the definition of "family planning services" in Title X.

The proposed definition of "family planning services" deletes, without explanation, the reference to the family planning method of "choosing not to have sex."[23]

Abstinence is an important family planning method and an effective way to not have an unplanned pregnancy or get an STI, both of which Title X seeks to prevent. In fact, HHS's *Family Planning Annual Report* identified that over 90,000 females used abstinence as their primary contraceptive method in 2019.[24]

The removal of this method from family planning undermines the purpose of Tile X to offer a broad range of effective family planning methods.

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[21] 86 Fed. Reg. at 19829–30.

[22] *Id.*

[23] 84 Fed. Reg. at 7787.

[24] Office of Population Affairs, HHS, Title X: Family Planning Annual Report: 2019 National Summary A-20 (2020), https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf accessed May 14, 2021.

The phrase "choosing not to have sex" should be retained in the definition of "family planning services."

The NPRM also proposes deleting the definition's inclusion of "preconception counseling, education, and general reproductive and fertility health care."[25]

No explanation is given for this deletion. Preconception counseling, education, and health care helps improve maternal and infant outcomes, as well as the health of those who seek family planning services, and can help prevent diseases and future complications.

Preconception counseling should also include adoption, since individuals who are not pregnant may also be interested in adoption as a way to grow their families.

The definition of "family planning services" should explicitly include a reference to preconception counseling, education, and health care.

Inclusivity. The NPRM proposes that "[i]nclusivity ensures that all people are fully included and can actively participate in and benefit from family planning, including, but not limited to, individuals who belong to underserved communities . . . ."[26] The proposed definition then provides a list of those whom it deems are part of underserved communities.[27]

The NPRM provides no evidence that all the communities on the list are in fact underserved. Nor does it specify whether the communities are unserved with regards to Title X services or elsewise.

In fact, according to HHS's 2019 annual report, 32% of Title X clients identified with a nonwhite race category, 33% self-identified as Hispanic or Latino, and 15% had limited English proficiency.[28]

The NPRM in § 59.5(a)(3) would require that Title X projects provide services in a manner that is "inclusive."[29]

But ensuring that "all people" are included, can participate in, and benefit from family planning *contradicts* section 1006, which states priority of services is given to persons from "low-income families,"[30] § 59.5(a)(6) requiring that clients from low-income family be given priority,[31] and

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[25] *Id.*

[26] *Id.*at 19829.

[27] *Id.*

[28] Office of Population Affairs, HHS, Title X: Family Planning Annual Report: 2019 National Summary ES-3 (2020), https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf.

[29] 86 Fed. Reg. at 19830.

[30] 42 U.S.C. § 300a-4(c)(1).

[31] 86 Fed. Reg. at 19830.

§ 59.7(a)(1) taking into consideration the number of low-income clients to be served for Title X funding.[32]

This definition and requirement should not be included.

The NPRM also incorporates the list of allegedly "underserved communities" into the composition of the advisory committee in § 59.6(b)(2).[33]

It should be enough for the committee to include individuals that are broadly representative in terms of demographic factors of the population or community for which the materials are intended, without including a list of presumedly underserved communities. The list itself is not necessary, is not inclusive by nature of excluding certain communities, and may not be representative of the population or community to be served in terms of demographics or which communities are underserved.

The description of the committee composition should not be changed and the list of allegedly underserved communities should not be included.

The NPRM also states that "to use inclusive language," it will use the word "client" in § 59.5(a)(5) to replace the word "women" and in § 59.5(a)(6) and (7) to replace the word "persons."[34]

It is unclear how the NPRM is inclusive by erasing women and ignoring science.

Only biological women can get pregnant, and the NPRM's regulatory impact analysis recognizes this fact by discussing statistics involving "women served" and "women served using contraceptives."[35] It is also unclear how the word "clients" is more inclusive than "persons." All clients are persons.

Low-income family. The NPRM's proposed definition of "low-income family" deletes the 2019 Rule's definition reference to providing (only) contraceptive services to women who have

> *"insurance coverage through an employer that does not provide the contraceptive services sought by the woman because the employer has a sincerely held religious or moral objection to providing such coverage."*[36]

No explanation was given for this deletion.

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[32] *Id.* at 19831–32.

[33] *Id.* at 19831.

[34] *Id.* at 19820.

[35] *Id.* at 19824.

[36] 84 Fed. Reg. at 7787.

Consistent with the U.S. Supreme Court decision in *Burwell v. Hobby Lobby Stores, Inc.*,[37] this definition is one of the less restrictive means for the government to provide contraception to women directly, instead of requiring employers to violate their sincerely held religious beliefs. This is a win-win solution to the government's asserted compelling interest in giving women access to contraceptives while still protecting the conscience rights of employer.

It is unclear why HHS would remove this provision, unless providing contraceptives is not a compelling government interest.

This aspect of the definition of "low-income family" should be retained.

Trauma-informed. The NPRM proposes adding a definition of "trauma-informed," explaining:

> *"a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."*[38]

The NPRM in § 59.5(a)(3) would require Title X projects to provide services in a manner that is "trauma-informed."[39]

The definition of "trauma-informed" is vague and does not specify what type of trauma Title X providers must be prepared to respond to. No analysis is offered as to whether existing Title X providers are trauma-informed, the burden it will take providers to become trauma-informed, or whether it will lead to providers dropping out. No evidence is provided for why such a requirement is even necessary for Title X projects and how it supports Title X's purposes.

This definition and requirement should not be included.

Quality healthcare. The NPRM proposes adding a definition of "quality healthcare," which it defines as "safe, effective, client-centered, timely, efficient, and equitable."[40]

For the reasons discussed above, this definition should not include "client-centered" or "equitable."

[37] 134 S. Ct. 2751 (2014).

[38] 86 Fed. Reg. at 19830.

[39] *Id.* at 19817.

[40] *Id.* at 19829.

Proposed requirements conflict with Title X

Additional project requirements. The NPRM complains that the 2019 Rule created burdensome requirements.[41]

But the proposed rule proposes adding a number of new requirements in § 59.5(a)(3), namely that Title X services provided be "client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed" and "ensure[] equitable and quality service delivery consistent with nationally recognized standards of care."[42] Under § 59.4, grant applicants would be required to describe how the proposed project will satisfy the regulatory requirements of Title X.[43]

There is no discussion in the NPRM about the benefit of these additional requirements and how these additional requirements will impact the reporting and compliance burden estimate, or whether it will lead to providers dropping out. These requirements are not mandated by Congress and do not support the purposes of Title X.

They should be rejected.

Information and educational materials. Under proposed addition § 59.6(b)(3)(ii) [sic] of the NPRM, the Advisory Committee shall review the content of Title X informational and educational materials, both print and electronic, to ensure, among other requirements, that it is "inclusive and trauma informed."[44]

The NPRM provides no analysis whether these additional broad requirements will disqualify existing Title X providers or disincentivize potential applicants and providers. The NPRM also does not take into account the additional resources and time an applicant or provider, much less the Advisory Committee, must undergo to certify that all its materials "ensure[] that all people are fully included and can actively participate in and benefit from family planning" and "fully integrat[es] knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[45]

This requirement should be rejected.

Requiring provision of all or most Title X services. The NPRM proposes removing the requirement in § 59.5(a)(1) that each project is "not required to provide every acceptable and effective family planning method or service."[46]

The existing provision helps facilitate participation by organizations that have a conscience objection to certain Title X services but provide excellent service in other Title X areas. No

[41] *See id.* at 19817, 19820.

[42] *Id.* at 19830.

[43] *Id.*

[44] *Id.* at 19831.

[45] *See id.* at 19829–30.

[46] *Id.*

reason is given why every grantee or subrecipient should be required to provide *all* Title X services, so long as the overall Title X project offers a broad range of services.

This change will limit the diversity of partnering service providers who can increase the breadth of affiliated services for clients, and disincentivizes the government from choosing the best qualified applicants for specific services and instead settling for a single sub-par applicant who happens to provide more services.

This provision should be retained.

Assuming statutory compliance by suspect organizations is unwarranted

The proposed rule states,

> "This proposed rule would revise the 2019 Final Rule by readopting the 2000 regulations, with several modifications, and returning the program to the compliance regime as it existed prior to the 2019 rule's implementation."

The proposed rule insists that,

> "our experience suggests the compliance regime as it existed prior to the 2019 Final Rule was effective."

Assertions of compliance and *actual* compliance are not one and the same. Unannounced on-site visits and other enforcement measures should be required to verify separation of Title X program operations from abortion operations.

This is especially needful if organizations receiving Title grants previously have shown a pattern of untrustworthiness, duplicity and/or disregard for the law.

As stewards of taxpayer dollars, the Department must never simply assume that Title X grantees are following the law governing Title X grants. Strict oversight and accountability is required to ensure compliance—most especially when the abortion industry is involved.

Investigative reporting including undercover video provides evidence that abortion businesses such as Planned Parenthood skirt the law, coverup abuse and endanger minors.[47]

[47] "For 12 years, media has ignored Lila Rose's evidence against Planned Parenthood," Live Action, June 24, 2018 https://www.liveaction.org/news/12-years-evidence-planned-parenthood/ accessed May 14, 2021.

The Final Report of the Select Investigative Panel of the [House] Energy & Commerce Committee, December 30, 2016,[48] provides such evidence regarding organizations such as Planned Parenthood that have taken in millions of Title X dollars.

The report, focused on the sale of fetal body parts, found that,

> *"Planned Parenthood affiliates violated the federal guidelines on patient consent (p. 360);*
>
> *"Planned Parenthood abortion clinics appear to have committed systematic violation of HIPAA" (p. 365);*
>
> *"four Planned Parenthood clinics … may have violated federal law, specifically Title 42 U.S.C. §289g-2, which forbids the transfer of fetal tissue for valuable consideration" (p. xxvi); and numerous other findings suggesting a pattern of gross disregard for the law."*

As Congressman Diane Black observed,

> *"Over the last year, the Select Panel's relentless fact-finding investigation has laid bare the grisly reality of an abortion industry that is driven by profit, unconcerned by matters of basic ethics and, too often, noncompliant with the few laws we have to protect the safety of women and their unborn children."*[49]

A report by the *New York Times* focused on the Judiciary Committee's finding that federal agencies had failed to provide oversight and verification:

> *"The Judiciary Committee's report, 'Human Fetal Tissue Research: Context and Controversy,' concluded that the executive branch had for years failed to exercise oversight on the tissue transfer process and created a situation where costs and fees were not properly accounted for. The report recommended that the Justice Department 'fully investigate' the fetal tissue practices of Planned Parenthood, its affiliates, and three companies involved in the sale of the tissue for potential crimes."*[50]

While grant panel reviewers are not made aware of an organization's shortcomings apart from their submitted application, HHS officials who have the ultimate say over Title X grants have a

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[48] https://republicans-energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/Select_Investigative_Panel_Final_Report.pdf accessed April 29, 2021.

[49] https://republicans-energycommerce.house.gov/news/press-release/select-investigative-panel-releases-final-report/ accessed April 29, 2021.

[50] https://www.nytimes.com/2017/12/08/us/politics/planned-parenthood-fetal-tissue-transfers-federal-investigation.html, accessed April 29, 2021.

duty to taxpayers to review and consider evidence regarding a potential grantee's trustworthiness. Relevant evidence from Congressional investigations and justice system findings should be considered in the grant review process by HHS officials.

A past and well-documented history ofuntrustworthiness strongly suggests that outside verification will be required to ensure that legalrequirements are, in fact, being met.

To ensure compliance with the new Title X rule, HHS should employ methods successfully used in the past, including "site visits, conference calls, emails, in-person conversations, official letters of notification, and postings on the websites of its operating divisions. At the time of issuance of an NOA, the relevant grants management and program staff review with the awardee the details of the policiesand regulations that govern the acceptance of the PLGHA conditions. Official acceptance by the awardee of the provision occurs once the awardee draws down funds. Because the majority of these awards are cooperative agreements …, site visits, project oversight, monitoring calls, grant management meetings and other communications with the awardees occur on a frequent basis."[51]

The proposed rule's removal of compliance requirements undermine project transparency and accountability. Examples follow.

Removal of applicant and grantee compliance requirements. The NPRM proposes deleting multiple requirements in the 2019 Rule related to applicants' and providers' compliance:

- *§ 59.7(b), requiring "each applicant to describe its plans for affirmative compliance with each requirement"* [52]*;*
- *§ 59.11, clarifying that "concern with respect to the confidentiality of information, however, may not be used as a rationale for noncompliance with laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, human trafficking, or similar reporting laws"* [53]*;*
- *§ 59.13, relating to assurance of compliance with prohibition on abortion as a method of family planning*[54]*; and*

[51] https://2017-2021.state.gov/protecting-life-in-global-health-assistance-six-month-review/index.html, accessed April 29, 2021.

[52] 84 Fed. Reg. at 7788.

[53] *Id.*

[54] *Id.*

- *§ 59.17(b)(2), relating to maintaining records to demonstrate compliance state notification laws, including the reporting of a minor clints' age.*[55]

No reason is given for deleting these requirements that applicants and providers comply with various aspects of the regulations. These deletions undermine the transparency and accountability of Title X projects and limits HHS' ability to ensure oversight.

These compliance requirements should be retained.

Removal of subrecipient compliance requirements. The NPRM proposed deleting the 2019 Rule's § 59.1 requirement that the regulations apply to subrecipients and that grantees shall require and ensure subrecipients comply with the regulations.[56]

No rationale is given for removing this requirement.

The reporting of subrecipients, partnerships, and oversight plans is necessary to prohibit Title X recipients from ignoring the misuse of those funds by those with whom they work or funneling money to subrecipients who would otherwise be ineligible to receive Title X funds. Further, unlike the 2019 Rule, the NPRM's proposed addition of § 59.5(a)(13) does not specify that the regulations apply to subrecipients.[57]

The removal of an explicit compliance requirement, without at minimum an explanation that subrecipients are assumed to have to comply with all Title X regulations, suggests that such compliance is no longer required. Not having such a requirement opens up the Title X program for abuse and an inability of HHS to ensure proper oversight.

This requirement should be retained.

The NPRM also proposed to remove certain requirements to report information about each subrecipient and agency or individual providing referral services, specifically the name, location, expertise, and services actually provided.[58] The rationale given is that it will "reduce" the reporting burden.[59]

But the NPRM in § 59.5(a)(13) proposes to retain the following reporting requirements: subrecipients and agencies or individuals providing referral services and the services to be provided, the extent of the collaboration, and an explanation "of how the recipient will ensure adequate oversight and accountability for quality and effectiveness of outcomes among subrecipients."[60]

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[55] *Id.* at 7790.

[56] *Id.* at 7786.

[57] 86 Fed. Reg. at 19831.

[58] *See id.* at 19820.

[59] *Id.*

[60] *Id.*

Requiring the name, location, and specific expertise of a subrecipients or referral agency or individual, and the services *actually* provided in addition to the above report requirements is necessary to ensure transparency, compliance, and accountability.

The NPRM does not explain why those specifics were burdensome and the extent to which no longer requiring reporting on such basic information as name, location, and specific expertise, as well as the service provided, would significantly reduce the alleged burden and why such a burden overcomes the benefits of transparency, compliance, and accountability.

These reporting requirements should be retained.

Removal of Family Participation Requirements. Section 1001 of Title X provides:

> *"To the extent practicable, entities which receive grants or contracts under this subsection shall encourage family participation in projects under this subsection."*[61]

As the preamble explains,

> *since FY 1998, Congress has included a rider in HHS's annual appropriations act that provides that "[n]one of the funds appropriated in this Act may be made available to any entity under Title X of the PHS Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services. . . . The same appropriations rider also requires that such an applicant certify to the Secretary that it 'provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities."*[62]

Yet, the NPRM proposes deleting the 2019 Rule requirement in § 59.5(a)(14) that Title X projects:

> *"Encourage family participation in the decision to seek family planning services; and, with respect to each minor patient, ensure that the records maintained document the specific actions taken to encourage such family participation (or the specific reason why such family participation was not encouraged)."*[63]

The proposed definition of "low-income family" likewise deletes the requirement that Title X providers document "specific actions taken by the provider to encourage the minor to involve

[61] 42 U.S.C. 300(a).

[62] 86 Fed. Reg. at 19813.

[63] 84 Fed. Reg. at 7788.

her/his family (including her/his parents or guardian) in her/his decision to seek family planning services," except in cases of abuse or incest.[64]

No reasons are given for these deletions.

This is particularly concerning considering almost 1 in 5 Title X clients are adolescents, and HHS studies confirm the benefits of parent-adolescent communication in the family planning context.[65] Documentation is necessary to confirm compliance and monitor whether the needs of vulnerable minors are met. America's minors deserve no less.

Since these provisions ensure a statutory requirement, have a scientific basis, and benefit minors, they should be retained.

Changes to the list of applicable regulations. The NPRM deletes "45 CFR Part 92—Uniform administrative requirements for grants and cooperative agreements to state and local governments" from its list of regulations that apply to Title X grants in §§ 59.9 and 59.10 of the 2019 Rule.

No explanation is given for this omission or why it is not included in the proposed § 59.12, which includes a table of the applicable regulations.

The NPRM proposes adding 45 CFR 87 ("Equal Treatment of Faith-based Organizations") to the list of regulations that apply to Title X family planning services programs.[66]

This addition is reasonable.

Physically comingling Title X and abortion activities disregards a statutory requirement

Section 1008 of the Title X statute requires that:

> *"none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."*

By contrast, the proposed regulation removes important safeguards included in the 2019 regulation. For example, under Section 59.7, the proposed rule *removes* a requirement from the 2019 final rule that the Secretary ensure "that no Title X funds are used where abortion is a method of family planning." HHS should add similar protocols to the final rule as a minimum

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[64] *Id.* at 7787.

[65] *See, e.g.*, Tanya M. Coakley et al., *Parent-Youth Communication to Reduce At-Risk Sexual Behavior: A Systemic Literature Review*, 27 J. HUM. BEHAV. SOC. ENVIRON. 609 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6726439/; Aletha Y. Akers et al., *Family Discussion About Contraception & Family Planning: A Qualitative Exploration of Black Parent 7 Adolescent Perspectives*, 41 Perspect. Sex Reprod. Health 160 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951274/.

[66] 86 Fed. Reg. at 19820, 19832.

requirement for any grant award, so that grantees satisfy an accountability metric for compliance to the statute.

The NPRM proposed remining the bright line in the 2019 Rule requiring physical and financial separation between Title X services and the provision and promotion of abortion and deleting whole cloth §§ 59.14 to 59.19.

These regulations necessary to ensure that Title X funds are not being used to create infrastructure that supports abortion and should be retained. Without them there is ambiguity and confusion between approved Title X activities and non-Title X activities, making it more difficult, if not impossible, for HHS to ensure compliance.

This is especially true when physical space is shared.

For example, the same staff could provide Title X services in the same location that they later provide non-Title X-funded abortions. At a minimum to avoid confusion, abortion materials may not be displayed in the same space during the provision of Title X services and provider signage and materials should clearly delineate between Title X services and services not permitted with Tile X funds.

Admissions by abortion clinics reinforce the need for separation

The NPRM concludes that there is "no diversion of grant funds that would justify the greatly increased compliance and oversight costs the 2019 rule required." *Id.* at 19816.

But Maine Family Planning (MPF), Maine's sole Title X provider prior to the 2019 Rule, has admitted that it uses Title X funds to directly support its abortion services. When MFP challenged the 2019 Rule in *Family Planning Association of Maine v. U.S. Department of Health and Human Services*, it claimed, in part, that it violates their patients' Fifth Amendment Due Process Clause right to choose an abortion.[67]

In its brief, MPF acknowledged that its clinics providing abortion would close without Title X funding.[68]

By refusing to comply with the Rule and voluntarily foregoing Title X funding, MFP clinics offering abortion services would not have to close *unless* MFP uses Title X funds in some way to support their abortion services.

In a decision dismissing MFP's case, a Main district court acknowledged as much:

[67] Pls.' Mem. in Supp. of Mot. for Prelim. Inj. 31–39.

[68] *See id.* at 1–2 ("[I]f MFP is forced to leave the Title X program, it will have to close more than half of its clinics entirely, causing thousands of women in Maine to lose access to *both* family planning services and abortion services."); *id.* at 35 (indicating that if MFP does not implement the Rule, eleven to fifteen rural clinics offering abortion will close).

> *"The irony of [MFP's] argument, of course, is that it substantiates [the 2019 Rule]'s concern that the Title X program is subsidizing abortion."*[69]

MFP's admission supports the rationale behind the 2019 Rule's separation requirements and shows why the Rule's regulations are necessary and beneficial.

The NPRM cites to the lack of evidence found by "legally required audits, regular site visits, and other oversight of grantees" as a reason for why the change is necessary,[70] but the inability of the "legally required audits, regular site visits, and other oversight of grantees" to flag MFP's use of Title X to support infrastructure for abortion services funds further shows why the physical and financial separation requirements in the 2019 Rule are necessary to ensure compliance with Section 1008.

MFP was not the only challenger to the 2019 Rule that was concerned about its impact on abortion, despite the fact that abortion is statutorily excluded from Title X projects.

For example, the California plaintiffs claimed the Rule "constitutes a significant impediment to low-income Title X patients' access to . . . abortion services."[71] Likewise, the Oregon plaintiffs claimed the Rule's separation requirements "will have consequences on all aspects of reproductive health for low-income clients, from access to contraception and abortion to screening and treatment for sexually transmitted infections."[72] They further stated the Rule's separation requirements "will deprive patients of information about abortion and access to abortion" and "imped[e] or delay[] [patients'] ability to obtain an abortion."[73] And according to the Washington plaintiffs, the Rule's counseling, physical separation, and referral requirements "will impede patients' ability to obtain the [abortion] care they want and need."[74]

Similarly, the dissent in the en banc Ninth Circuit decision upholding the 2019 Rule claimed the 2019 regulations will prevent some "from accessing abortion altogether."[75]

But Title X physical and financial separation requirements should not impact abortion access unless Title X projects and funding were being used in some way to promote, encourage, or facilitate abortion services.

This is not mere fungibility. It is the use of Title X funds to support abortion in violation of the Hyde Amendment.

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[69] *Family Planning Ass'n v. U.S. Dep't of Health & Human Servs.*, No. 1:19-cv-00100-LEW, 17-18 (D. Me. Jun. 9, 2020).

[70] 86 Fed. Reg. at 19816.

[71] Cal.'s Notice of Mot. & Mot. for Prelim. Inj., with Mem. of Points & Auths. at 13, *California v. Azar*, No. 19-1184 (N.D. Cal. Mar. 21, 2019).

[72] Pl. States' Mot. for Prelim. Inj. at 29, *Oregon v. Azar*, No. 19-317 (D. Or. Mar. 21, 2019).

[73] *Id.* at 35.

[74] State of Wash.'s Mot. for Prelim. Inj. at 44, *Washington v. Azar*, No. 19-3040 (E.D. Wash. Mar. 22, 2019).

[75] *California v. Azar*, 950 F.3d 1067, 1109 (9th Cir. 2020) (Paez, J., dissenting).

Training and requirements are essential to ensuring separation

Setting aside whether the physical separation requirements are burdensome, the NPRM does not explain why the financial separation requirements are so onerous that the financial separation requirements in 2019 Rule §§ 59.15 and 59.18 must also be rescinded.

These provisions should be retained and are necessary to ensure program accountability, transparency, and integrity.

Moreover, instructions to grantees should include prohibited activities related to abortion, such as: offering any financial or material support, providing abortion supplies or equipment, making appointments for abortion, delivering drugs that initiate the abortion process, conducting or financing biomedical research on abortion methods, steering patients toward abortion during any counseling, or providing information or materials that are created for the purpose of driving business to abortion providers.

All Title X staff, whether paid or volunteer, should be required to be trained to fully understand the difference between permissible and impermissible Title X activities.

The proposed rule removes the physical separation requirements, but clients cannot be expected to discern what services and what visible materials are paid with Title X funds and which are not. So a minimum requirement for both grantees and subrecipients should require them to make it abundantly clear what is funded with the Title X grant.

The proposed rule creates confusion between approved Title X activities and those that are not Title X activities, making it more difficult to determine whether Title X projects are compliant with the provisions within the statute.

For example, shared physical space makes this ambiguity extremely likely when abortion advertisements or advocacy materials may be on display in the same waiting room used by Title X clients. The same staff could provide Title X services but then later could assist with non-Title X-funded abortion, further adding confusion. Physical separation is the most effective way to ensure a clear separation between compliant and noncompliant Title X activities.

If HHS proves unwilling to require physical separation, grantees and subrecipients at the very least should be required to proactively eliminate any confusion between Title X and abortion services.

For example, providers should guarantee that no abortion-promotion materials are displayed in any space during the provision of Title X services and public-facing Title X staff should be clearly separate from abortion services. Signage should plainly delineate Title X services as well as those that are not included in Title X, taking care to avoid any appearance that Title X services are involved in abortion-advocacy of any kind. Training of staff should be frequent, ensuring accountability of appropriate messaging with a full understanding of what is and what is not permitted with Title X funds.

Title X projects must avoid any appearance that Title X services are involved in abortion-advocacy. Therefore, non-compliant materials and signage should be removed from all public

spaces. Staff should receive training to fully understand what is and what is not permitted with Title X funds.

Training should be annually scheduled as well as individually programed for new hires. Staff should be proficient with a granular understanding of permissible nondirective counseling with sample scripts for added understanding. They should be given examples of do's and don'ts during conversations or counseling with clients, and should practice how to compassionately and legally respond to real-life scenarios that staff members may confront during a session with clients.

HHS must draw a bright line so that all funded projects both understand and implement a line of separation between Title X and abortion services.

Mandatory reporting helps protect victims and prosecute aggressors

The NRPM does well to include the following provision initiated under the 2019 Title X rule, Compliance With Statutory Program Integrity Requirements: Formalizing, as a part of the regulatory standards, the Congressional requirement that,

> *"[n]otwithstanding any other provision of law, no provider of services under Title X of the PHS Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest" [FR, p. 19813].*

Consistent with the 2019 Title X rule, this proposed rule necessarily includes a mandate for the creation of a project-wide compliance plan and annual training of all staff for its implementation. Mandatory reporting is essential for protecting victims and prosecuting aggressors. Concerns about confidentiality of information may not be used as a rationale for noncompliance with laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, and the like.

Neglecting family participation neglects the law and decreases effectiveness

While the proposed rule includes a description of Title X legislative requirements, the proposed rule omits a formalization of most of these requirements, purposefully striking compliance requirements from the 2019 rule and thereby calling into question the seriousness with which HHS will require grantees to abide by these congressional mandates.

HHS should require grantees to incorporate family participation in their project plan, policy, and reports. The Title X statute requires grantees to:

> *"encourage family participation in projects under this subsection."*

Grant applicants should include their plan in their Title X applications. *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm)* included family participation in

its recommendations and research is replete with examples of how including couples in sexual decision-making reduces coercion and improves the prospect ofboth partners following the agreed-upon plan.

HHS can assist by providing science-based materials and training to grantees and subrecipients in order to encourage such communication while ensuring voluntary choices are respected and that there is an equal role in decision-making. Meaningful communication and family/couple participation can improve the effectiveness of the Title X program and should be a significant pillar among best practices implemented.

Neglecting the importance of parental counsel endangers minors

Minors are at increased risk for coercive sexual activity. Studies show that more than one in two reported cases of sexual abuse are among minors and that almost half of all rape occurs before 18 years of age. This abuse often leads to life-long trauma and unhealthy coping mechanisms that can persist for years. Protective factors related to sexual decision-making include frank, honest, and trusting conversations between parents and children.

Not surprisingly, Congress has long included riders to encourage "family participation in the decision of minors to seekfamily planning services" and to provide "counseling to minors on how to resist attempts tocoerce minors into engaging in sexual activities.' However, even if Congress did not have these appropriations riders in place, HHS still has an ethical obligation to mandate that Title X grantees implement a proactive approach for preventing or ending sexual abuse of minors through their daily protocols and procedures.

The 2019 Title X rule required grantees and subrecipients to maintain records on the age of minor clients, the age of their sexual partner(s) where required by State law, and what reports or notifications were made to appropriate State agencies. These requirements should be added to the final rule in order to protect underage victims, end ongoing abuse, and increase the chances that perpetratorsreceive justice.

In addition, years of research should be practicably implemented into Title X projects to make consequential and effective parent/child communication an important part of counseling for minors. The literature builds a strong case for parental involvement and communication which are often among the most compelling protective factors for youth.

The Title X clinician must understand the bench of research behind encouraging youth to bring a caring parent into the conversation. Merely requiring grantees to sign a compliance agreement to the Congressional mandate is insufficient to ensure implementation in a substantive manner.

There is no explanation for removing the requirement to document that specific actions were taken to encourage family participation for minors - or the specific reason why encouraging family participation in general was avoided. In the proposed rule, HHS accurately notes that Congress requires that "[n]one of the funds appropriated in this Act may be made available to any entity under Title X of the PHS Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services." This obligation has been a part of the Title X program since FY 1998, but

until the 2019 final Title X rule, there was little assurance that the mandate was consistently implemented with rigor and effectiveness.

During adolescence, youth are especially vulnerable to sexual activity. Giving parents the tools to have meaningful conversations about sex with their children is critical to their being effectively engaged with their children. Providing opportunities for parents to have these conversations, particularly when their child is contemplating sex or is already sexually initiated is even more critical.

The Title X clinician can provide a compelling reason for youth to bring a caring parent into the conversation. The literature builds a strong case for parental involvement and communication. Parent-child interaction is especially important during crisis moments, such as those that might bring youth to a Title X clinic.

For example, a systematic review of research on parent-youth sexual communication showed that "parents play a pivotal role in reducing at-risk sexual behaviors in adolescents and consequently, in decreased rates of STIs for their youth."[76]

Other studies confirm that parent-adolescent communication helps delay sexual intercourse, reduce sexual behaviors, and increase contraceptive use.[77]

Parental influences can be protective across a variety of domains and are usually among the most compelling protective factors for youth.

Taking a step back now is neither wise nor in the best interest of minors who may visit a Title X clinic as their first independent medical experience, and who are depending upon the Title X clinicians to be transparent, honest, and their advocates for health.

Removing sexual coercion counseling requirements endangers minors

Approximately one in five Title X clients are adolescents, yet the proposed regulation provides no rationale for removing the 2019 final rule's requirement that grantees document that counseling for minors took place on how to resist attempts to coerce them into engaging in sexual activities.

This documentation is needed to confirm compliance and monitor continuous improvement to meeting the critical needs of vulnerable youth.

The 2019 Title X rule required grantees and subrecipients to maintain records on the age of minor clients, the age of their sexual partner(s) where required by State law, and what reports or

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[76] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6726439/ accessed May 13, 2021.

[77] https://www.researchgate.net/publication/45506706_Parental_influences_on_adolescent_decision_making_and_contraceptive_use accessed May 13, 2021.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951274/ accessed May 13, 2021.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6726439/ accessed May 13, 2021.

notifications were made to appropriate State agencies. Such recordkeeping is reasonable and should remain a required minimal point-of-care policy to protect underage victims, stop the abuse and further associated trauma, and set prosecution in motion for perpetrators of sexual abuse.

HHS should follow the science and include metrics for encouraging family communication with minors. The Department should provide training for providers on the best methods to encourage family involvement consistent with minor patient's confidentiality rights, health needs, and best interests. HHS must apply additional priority to this Congressional requirement for the sake of those most vulnerable for premature sexual activity.

Therefore, we strongly urge HHS to follow the science and include metrics for the implementation of this Congressional mandate to encourage parent-child communication. Addressing this requirement simply by compelling grantees to affix an obligatory signature of compliance on a letter does little to ensure implementation in a substantive manner. This evidence-based Congressional directive is intended to improve meaningful and positive results for youth that visit Title X clinics. HHS has the obligation to apply rigor to it for the sake of America's youth.

Adding adoption counseling would assist Title X clients

Giving birth to a child is one option presented in nondirective counseling, and adoption could be a choice within that option. Adoption counseling and referral should be added into the final rule for the Title X Program. Adoption information and referrals fit comfortably into both preconception counseling and post conception options counseling.

Assisting couples who wish to have children is an approved purpose of the Program. Couples who struggle with infertility currently can be given resources or referrals for the management of infertility (including adoption) because the 2019 final rule included this provision.

Women faced with an unplanned pregnancy rarely choose adoption. This is likely because they are rarely presented adoption as a realistic and positive option. Facts confirm that children who are adopted often have lifelong opportunities that would have been impossible before adoption. Statistics also show that more than 90% of adoptees are positive about their own adoption, a positive piece of information that few pregnant women are aware.

Having a solid understanding of patients' options, resources, and referrals can help family planning providers and counselors navigate difficult discussions with clients. When a woman is undecided or ambivalent about pregnancy, the Title X counselor could non-directively ask, "What are your thoughts on adoption?" This question permits the client to learn about an option they may not have considered, but would like to learn more. Clients who are not comfortable with abortion or parenting their child may be open to adoption.

Amending the NRPM to include an adoption provision within preconception care differs from the actual provision of adoption services to an interested family, which is outside of Title X approved services. Similarly, nondirective pregnancy counseling can include counseling on adoption, and corresponding referrals to adoption agencies, without straying into impermissible activities like providing adoption services within the Title X project itself.

Title X has an opportunity to streamline resources through a linkage with Administration for Children and Families Child Welfare Information Gateway – a portal that provides state-specific information and can increase knowledge for both the clinic staff and clients.

Including adoption within the portfolio of Title X is not without precedent. In addition to its inclusion in the 2019 rule, Congress also specified that Title X clinics should be provided training on dispensing adoption information and referrals under the 2000 Infant Adoption Awareness Grant Program.

Adoption counseling and the ability to provide referrals for patients who are interested in exploring this option can be done without compromising other family planning services. Rather, including adoption will expand realistic options for Title X clients and will be a net benefit to many children who can enjoy lifelong benefits from adoption – and for the sake of couples who are longing for children. I urge HHS to make full use of the Title X Program to include adoption counseling and referrals within its appropriate portfolio of options.

Eliminating key grant review criteria weakens evaluation of applicants

The same review criteria weaknesses present in the 2000 regulation persist in this proposed rule. The Department should give more serious consideration to the 2019 final rule scoring criteria, which had a two-fold purpose (1) to increase the rigor of the review process, and (2) to expand services in locations of unmet need. A specific description of how the applicant will guarantee adherence to the Title X statute should undergird every successful application. However, until the 2019 rule, no points were ever ascribed to this priority.
The purpose of a competitive grant program is to attract a large pool of applicants and then to select the highest quality proposals. A competitive grant makes it possible for new organizations to build credibility in their communities and implement new and innovative new models for better service. A competitive grant program should also build responsibility and quality programs because low-performing grantees will presumably be replaced in the next competition.

However, a review of Title X grantees over the program's 50-year history reveals that many of the same grantees have been continuous grantees for *decades*.

In fact, some grantees have received funding since the program's inception. This long-term funding helps grantees understand the Title X program well, makes them skilled at submitting winning proposals, and makes them a fixture in the community.

However, it often means that long-term service gaps remain, implementation innovation can wane, and the organizational business model can overtake a priority on authentic client care.

Therefore, a robust effort to encourage more competition in the Title X program should be a high priority of HHS. This program does not "belong" to any grantee. It belongs to the American people, especially those who are most in need of its services. HHS owes taxpayers and Title X clients a serious priority on returning the Title X program to a truly competitive grant program.

Recruiting new and diverse applicants can energize and renew the 50-year-old program. In addition, adding a diverse network of grantees and subrecipients can expand the client base by

growing service offerings of Title X, while still staying closely aligned to the statutory intent of the program.

Specific scoring criteria that awards points to new, qualified, applicants would help expand the face of the Title X grant recipient network. Then, in order to ensure program quality, new grantees should receive intensive mentorship to understand the Title X program in all its nuances, to increase their speed of implementation and result in the provision of quality service. A truly competitive grant process also provides other advantages. For example, the 2019 final rule included scoring criteria designed to encourage new grant proposals that can meet current unmet service needs.

As acknowledged in the proposed rule,

> *"seven states (CO, DE, KY, ND, NM, NV, TX) experienced a meaningful increase in the number of Title X clinics after the 2019 regulatory change."*

Adding scoring criteria to encourage applicants to reach unserved areas with services historically not available is an underutilized incentive for the Title X program and is likely the only way to remove gaps in service from the Title X coverage map.

Scoring criteria should better measure the quality of both the applicant and the application. As written in the 2000 regulation, the criteria lacks rigor, making it possible for nearly any applicant to score near the top. Adding these recommended criteria to the scoring measures will increase both competition and rigor, while also helping HHS improve the Title X program.

Grantees should be allowed to select sub-recipients

The proposed rule foreshadows a return to hostile restrictions on Title X grantees' ability to select subrecipients of their own choosing.

HHS is signaling a return to a policy similar to the Obama regulation that prohibited states and other grantees from selecting quality subrecipients of their choosing. HHS should be reminded that this regulation was overturned by the Congressional Review Act in 2017, which means that the agency cannot issue another regulation that is "substantially the same."

The proposed rule signals that HHS will again apply chilling restrictions on states and other grantees. Reminiscent of the 11th-hour controls imposed in the waning days of the Obama Administration, these restrictions limit the ability of grantees to select subrecipients of their choosing so long as they are consistent with the Title X statute and meet the specific needs of the grantee's Title X implementation plan. [Page 19817]

If restrictions are adopted similar to those under the Obama Administration, these changes to the Title X Rule will undermine the ability of grantees to construct a seamless plan for implementation of their specific proposal.

States and regions of the United States have differing family planning needs and unique obstacles for meeting those needs. A successful Title X project considers the cultural realities of

the targeted area of service when building the Title X proposal and implementation plan. Allowing grantees the freedom to select subrecipients that are responsive to these unique needs is an important aspect of this cultural sensitivity.

Adopting exclusionary requirements for the selection of subrecipients that stray beyond the statutory requirements of the program will interfere with the sensitive balance needed for successful implantation of the Title X program. Doing so also can jeopardize the ability of the grantee to meet targets for care.

In the NPRM, HHS is critical of state restrictions on the eligibility of "otherwise qualified providers" to partner with the state as subrecipients in its Title X program "based either on the non-Title X activities of the providers or because they are a certain type of provider."[78] This is a thinly veiled reference to state policies that prohibit Title X and other state family planning funding from going to Planned Parenthood or other abortion providers.

HHS invited comments on ways it can "ensure" Title X projects "do not undermine the program's mission by excluding otherwise qualified providers as subrecipients."[79]

HHS should not limit states' ability to choose to not fund abortion providers in its Title X projections, especially because of section 1008's abortion prohibition and federalism concerns. Moreover, HHS already attempted this with a 2016 Title X regulation that limited the ability of States and other Title X grantees to exercise flexibility in choosing their subrecipients.

This regulation, however, was rendered void by a joint resolution of disapproval passed by Congress under the Congressional Review Act and signed by the President.[80] Any attempt by HHS to similarly limit states' ability to choose its subrecipients will be unlawful.[81]

HHS should permit states and other grantees the freedom to select qualified subrecipients of their choosing, to avoid undermining the program's mission and unnecessarily interfering with clients' access to family planning services.

Requiring contraceptive referral drives out faith-based sub-grantees

The Proposed Rule needlessly requires that program participants which offer one or only a few methods of family planning "must be able to provide a referral to the client's method of choice and the referral must not unduly limit the client's access to their method of choice."[82] The referral requirement suggests that program participants may even be mandated to prescribe or provide

[78] 86 Fed. Reg. at 19817.

[79] *Id.*

[80] Joint Resolution Providing for Congressional Disapproval Under Chapter 8 of Title 5, United States Code, of the Final Rule Submitted by Secretary of Health and Human Services Relating to Compliance with Title X Requirements by Project Recipients in Selecting Subrecipients, Public Law 115-23 (Apr. 13, 2017), 131 Stat. 89.

[81] *See* 5 U.S.C. § 801(b)(2).

[82] 86 FR 19830

contraceptives in circumstances where a referral would "unduly limit the client's access to their method of choice."[83]

These mandates unsettle the balance struck by the Protect Life Rule under which single-method NFP providers could serve as subrecipients without being required to support contraceptive methods, so long as the overall project of which they are a part provides a broad range of family planning methods, including contraceptives.[84]

Instead of improving patient choice, this contraceptive referral mandate would drive out of the Title X program many providers of natural family planning (NFP) (and other fertility-awareness based methods), despite the fact these services are explicitly recognized under a 1975 law that amended the Title X statute.[85]

HHS previously recognized that "many couples or families seeking these [NFP] services may prefer specialized, single-method NFP service sites", which for reasons of logistics, personnel, cost, and conscience, may only provide or refer for natural methods of family planning or abstinence.[86] Preventing single-method NFP clinics from serving as sub-recipients will limit patient access to those best equipped to provide NFP services, contrary to the intent of Congress.

Federal law has long protected individuals from being forced to provide or refer for contraceptives against their religious beliefs or moral convictions in other contexts, such as the FEHB program[87] and the PEPFAR program.[88]

The contraceptive referral mandate also fails to include exemptions based on religious beliefs or moral convictions. This violates the Church Amendments, which prohibit HHS from requiring any individual "to perform or assist in the performance of any part of a health service program…. [if it] would be contrary to his religious beliefs or moral convictions".[89]

This requirement also limits the diversity of partnering service providers who can increase the breadth of affiliated services for clients.

For example, a highly rated subrecipient in a given community may have earned significant support and respect for its trauma-informed counseling care for sexually abused youth. As a

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[83] 86 FR 19830

[84] 42 CFR § 59.5(a)(1)

[85] Section 1001(a) of the Public Health Service Act, as added by the *Family Planning and Population Research Act of 1975*, Title II of Public Law 94-63, section 204, 89 Stat. 307 (July 29, 1975)

[86] 83 FR 25516

[87] Consolidated Appropriations Act, 2021, Public Law 116-260, Div. E, sec. 726(c): "In implementing this section, any plan that enters into or renews a contract under this section may not subject any individual to discrimination on the basis that the individual refuses to prescribe or otherwise provide for contraceptives because such activities would be contrary to the individual's religious beliefs or moral convictions."

[88] 22 U.S.C. 7631(d): "An organization… shall not be required, as a condition of receiving such assistance… to endorse, utilize, make a referral to, become integrated with, or otherwise participate in any program or activity to which the organization has a religious or moral objection"

[89] 42 U.S.C. 300a-7

matter of organizational policy and necessary to maintaining their carefully built community standing and coalition of partners, they purposefully avoid referrals for family planning methods.

Requiring them to change their organizational policy may cause them to lose their community standing as a leader in trauma-informed care and could negatively impact the critical assistance they provide to adolescents. They likely would be forced to remove themselves as a subrecipient, compromising services to youth in their community, and leaving a gap in quality service within the Title X project.

One solution would be for grantees to provide the referrals to the broad range of family planning methods and services, rather than placing the onus to do so on the individual subrecipient.

Removing prenatal referrals does a disservice to vulnerable women

On April 13, 2021, President Biden issued a Presidential Proclamation on Black Maternal Health Week which turned a spotlight on the need to address "the crisis of Black maternal mortality and morbidity in this country."

Title X clinics afford a natural opportunity to refer pregnant women to prenatal care since increased awareness about the signs of serious pregnancy complications are critical to the health of both mother and baby. Almost a third of maternal deaths occur prior to birth, with older women or those with preexisting conditions are at greater risk.

However, if physicians identify health conditions early in the pregnancy, these conditions can often be prevented, cured, or managed successfully. Prenatal care is important for the growing fetus.

According to HHS Office of Women's Health,

> *"[b]abies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care."*

Therefore, referring women for prenatal care is a time-sensitive and medically necessary priority which can identify and treat possible medical emergencies. Such referrals should be non-coercive but providing referral information and counsel on vital prenatal care should be a part of pregnant client conversations. Since the need for prenatal care is medically necessary and preexisting to a visit to the Title X clinic, it falls outside of the requirement for nondirective counsel.

Such referral is not post-conception care, since the clinic is not providing the prenatal care or prenatal services. Such referral promotes a continuity of care for clients and is not outside the scope of the project since pregnancy makes such referral medically necessary. This is corroborated by the fact that prenatal care is one of 14 categories of mandatory Medicaid services.

So it is unclear why HHS would remove this requirement under the pretense that this "approach cannot be squared with well-accepted public health principles."

The Title X clinic is well situated to provide such referrals. Since the clinic is often the location where low-income women go for pregnancy testing, clinic staff will likely have the first opportunity to start the process to achieve healthy pregnancy outcomes and/or healthy maternal outcomes. It is a disservice to exclude such referrals for women who are most at risk for poor maternal or pregnancy health outcomes.

HHS should include prenatal referrals as part of the Title X protocols for care and should include this requirement in the final rule.

The NRPM must clearly ban abortion lobbying, education and legal action

The NPRM proposes deleting the 2019 Rule's prohibition in § 59.16, restricting Title X project funds from being used for lobbying, education, and legal action that encourages the use of abortion as a method of family planning.

No reason is given for this change.

Removing these restrictions indicates that Title X funds could be used in such a way to promote abortion. The restrictions on Title X funds in § 59.16 should be retained.

The NPRM ignores the federalism impact

The proposed rule ignores harm to the States. It erases most program integrity requirements implemented in the 2019 rule – similar requirements made by a growing number of states. At least 16 states have enacted program integrity requirements that apply to state funded family planning programs, with some states enacting more than one related requirement. This represents a growing consensus that robust program integrity requirements are necessary to ensure quality and accessible patient care, and the proper administration of taxpayer dollars.

However, HHS failed to perform a federalism impact study to determine how the proposed rule could affect State laws, merely stating that it does not "have any federalism implications." HHS then completely disregards concerns by a sizeable number of states by stating that while some states will not "support the policies contained in this proposed rule," other states will approve of the changes, suggesting this statement is sufficient to proceed.

The Department's nonchalance is a clear indication that the Department is not interested in finding a solution that respects States' sovereignty. The NPRM compels States to adopt policies that conflict with their own laws without pre-emption authority and is Federal overreach.

This conflict can be remedied in the final rule but first necessitates a comprehensive analysis for the federalism implications of the proposed rule.

This analysis should begin with a state-by-state summary of possible concerns and legal conflicts. HHS must resolve conflicts between the proposed rule and the various state laws. In order to ensure the regulation does not run afoul of federalism impacts, HHS should *extend the comment filing deadline another 60 days*, since 30 days is insufficient time to evaluate the full extent of the impacts of the NPRM on affected states.

The NPRM misgauges the impact of the 2019 and proposed rules

HHS requested public comments "that might facilitate refinement of the [financial] analysis prior to regulatory finalization."[90]

The NPRM's analysis of the impact of the 2019 rule and the projected impact of the proposed rule is flawed, for reasons that follow.

The NPRM ignores benefits and assumes harms of 2019 Rule. The NPRM summarily states:

> *"The 2019 Final Rule increased compliance and oversight costs, with no discernible benefit."*[91]

But the NPRM fails to explain how ensuring program integrity and statutory compliance creates "no discernible benefit."

Similarly, there is no particularized analysis of the exact increase of compliance and oversight costs or what requirements in the 2019 Rule specifically created such an allegedly burdensome increase.

The NPRM assumes, without sufficient evidence, that the lack of formal Title X providers and projects means that family planning services are not available to those who seek it and as such there will be a host of negative consequences, such as unintended pregnancies. Yet the NPRM acknowledges that Planned Parenthood continued to provide family planning services—though not officially under the Title X project or funding—and that "a comparison of Planned Parenthood's two most recent annual financial reports [(2018–2019 and 2019–2020)] indicates no subsequent decrease in the number of patients served and an increase, from 9.8 million to 10.4 million, in the number of services provided per annum (pre-pandemic)."[92]

To the extent that there was a gap in services from Planned Parenthood and other providers dropping out mid-year, they were not forced out by HHS. They *chose* their abortion services *over* Title X services, presumably because referring clients for abortion is vital to their bottom line.

Planned Parenthood should not be rewarded for deserting their Title X clients in order to benefit their own political and financial special interests.

NPRM footnote 54 acknowledges that Planned Parenthood used the 2019 Rule as an effective fundraiser, demonstrating that Planned Parenthood does not need Title X taxpayer dollars to provide family planning services.[93]

Shockingly, footnote 54 also states:

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[90] *Id.* at 19826.

[91] *Id.* at 19816.

[92] *Id.* at 19826.

[93] *Id.* at 19826 n.54.

> *"If funds are more efficiently gathered and distributed via a program such as Title X than through such private campaigns, the efficiency would represent a cost savings attributable to the proposed rule."*[94]

This is absurd.

This is not a cost savings that the NPRM can claim as its own; the cost savings would be Planned Parenthood's. Their fundraising was to their own benefit, not clients served in the Title X program.

No evidence is asserted that funds are more efficiently gathered and distributed via the government's Title X program than a private campaign. Indeed, in a private campaign funds are given directly to the organization and cuts out costs associated with applications, review, distribution, compliance, and reporting.

This statement is also very concerning and completely inappropriate, as it prejudges that Planned Parenthood will be awarded Title X grants, indicating that HHS may not be impartial when it comes to evaluating Planned Parenthood applications and that the aim of the NPRM is to fund Planned Parenthood.

The NPRM also assumes that all the current Title X providers will remain in the program, which does not take into account those providers which joined with the advent of the 2019 Rule and may be forced out if the new regulations ignoring conscience rights are adopted.

The NPRM acknowledges that at least seven states had a "meaningful increase" in the number of Title X clinics in their states after the 2019 Rule (CO, DE, KY, ND, NM, NV, TX),[95] but does not explain whether this increase will remain if Title X's regulations are again changed.

The NPRM also mentions that six states lost all Tile X providers when a number dropped out of the program, but there is no analysis of whether individuals in these states are able to attain family planning services outside of the Title X program, such as the case with Planned Parenthood clients.

The regulatory impact analysis (RIA) also assumes that an increased number of grantees and service sites will lead to increased Title X clients served and that the number of clients served from 2022 on will remain constant. But there has been a steady decline in Title X clients served over the last decade, despite increases in grantees, subrecipient, or service sites, as indicated in the table below:

Title X Clients Served Per Year[96]

2009	2010	2011	2012	2013	2014

[94] *Id.*

[95] *Id.* at 19822 n.43.

[96] Office of Population Affairs, HHS, Title X: Family Planning Annual Report: 2019 National Summary A-6 (2020), https://opa.hhs.gov/sites/default/files/2020-09/title-x-fpar-2019-national-summary.pdf. Accessed May 14, 2021.

5,186,267	5,224,862	5,021,711	4,763,797	4,557,824	4,129,283

2015	**2016**	**2017**	**2018**	**2019**	**2020**
4,018,015	4,007,552	4,004,246	3,939,749	3,095,666	1,536,744 (est.)

The vast majority of the decline in clients was under the 2000 regulations that HHS wants to return to. The NPRM provides no explanation for why the number of projected clients in years 2023–2026 will remain at 3,983,849, and not continue the downward trend of the last decade.

The RIA ignores the significant impact of COVID-19. The RIA of the 2019 Rule brushes over the unprecedented impact of COVID-19, its attendant lockdowns and quarantine orders across the country, and the decline in "non-essential" health care services across the board. The RIA merely states that the preliminary figures for FY2020 "likely represents an underestimate for a typical year of the program under the current regulations since services were likely disrupted by the ongoing public health emergency."[97]

Nevertheless, the RIA used the 2020 figure as the low-bound estimate for Title X services under the 2019 Rule.

At the same time that the RIA plans for a "two-year phase-in" for the proposed Rule to achieve the estimated numbers and reach "long-run equilibrium estimates," it limits the 2019 Rule's impact to the partial year in which it went into effect and numerous providers dropped out mid-grant cycle and a year characterized by the COVID pandemic.[98] There are fewer than two years of data for the 2019 Rule and not even a year's worth of data unaffected by COVID.

The NPRM's blatant lack of analysis of the significant impact of COVID on health care services is glaring in light of HHS's recognition of COVID risks and concerns.

For example, on HHS's "find a family planning clinic" website, an alert bar at the top states "please call to ensure your clinic is open" with a link to COVID-19 updates.[99]

Additionally, only a few days before the NPRM was issued, on April 12, 2021, the FDA—over a year after the pandemic started—lifted the requirement that Mifepristone (the abortion pill) be dispensed in-person during the COVID-19 pandemic because it "may present additional COVID-related risks to patients and healthcare personnel."[100]

If such a time-sensitive service poses such risks to patients and healthcare personnel such that it cannot be done in-person, it stands to reason that Title X services, which are less time-sensitive

[97] 86 Fed. Reg. at 19822.

[98] *Id.* at 19822, 19827.

[99] *See Clinic Locator*, HHS Office of Population Affairs, https://opa-fpclinicdb.hhs.gov . Accessed May 14, 2021.

[100] Letter from Janet Woodcock, Acting Comm'r of Food & Drugs, U.S. Food & Drug Admin., to Maureen G. Phipps, Am. Coll. of Obstetricians & Gynecologists, and William Grobman, Society for Maternal-Fetal Med., re In-Person Dispensing Requirement in the Mifepristone REMS Program During the COVID-19 Pandemic (Apr. 12, 2021), *available at* https://www.aclu.org/sites/default/files/field_document/fda_acting_commissioner_letter_to_acog_april_12_2021.pdf. Accessed May 14, 2021.

(though important), are not being conducted in-person to the same extent they otherwise would be due to COVID-related risks and concerns.

HHS should consider the unprecedented and ongoing impact of COVID-19 on the availability of new Title X applicants and providers and the provision of Title X services in 2020 and in the future, and not attribute to the 2019 Rule that which is due to COVID.

The abortion industry does not own Title X

Inexplicably, HHS suggests that a political fundraising campaign by Planned Parenthood is less efficient and less of a federal cost savings than them receiving Title X funding, as they have for decades:

> *"Please see [link 1] and [link 2].*
>
> *"The latter report indicates that Planned Parenthood conducted a major fundraising campaign with the 2019 Title X regulatory changes as its key motivating message. If funds are more efficiently gathered and distributed via a program such as Title X than through such private campaigns, the efficiency would represent a cost savings attributable to the proposed rule" [FR p. 19826].*

Planned Parenthood has no legitimate hold on Title X funds. Taxpayer funding for the Title X program is completely unaffected by the financial fortunes or misfortunes of any private organization.

Inclusion of this example within the regulatory impact analysis, however, points to HHS' misunderstanding of (1) the purpose of Title X funds, (2) thedifference between earmarks and competitive grant programs, and (3) how advocacy organizations effectively use government policies they oppose to energize fundraising campaigns.

As is true for any grantee, Planned Parenthood has an obligation to agree to the terms of the grant or relinquish funding. The abortion-focused organization chose to refuse the Title X funds that could have benefitted clients with non-abortion services and instead launched a campaign to benefit their own financial and political interests.

HHS should not be implying an endorsement of Planned Parenthood's actions, in a proposed rule, in a final rule, in a regulatory impact analysis, or in grant application guidance. Rather than favoring the administration's supporters in the grant-monopolizing abortion industry, HHS instead should prioritize the needy clients who depend on the Title X program for significant portions of their personal health care.

In the January 28, 2021 *Memorandum on Protecting Women's Health at Home and Abroad,* President Biden predicted this Title X proposed rule. In the context of this program and others across the government, the President stated that "[i]t is the policy of my Administration to support women's and girls' sexual and reproductive health and rights [SRHR] in the United States, as well as globally."

"Sexual and reproductive health and rights" is a term of art that by definition includes *abortion* as if it is a universal human right.

Abortion is not a human right. Abortion is, in fact, inhumane.

Further, abortion promotion is prohibited in the Title X Program.

HHS must moderate its abortion advocacy within the Title X program, lest HHS stray into statutorily prohibited activities, as it appears intent on doing through this proposed rule.

Conclusion: Keeping the 2019 rule protects clients and professionals

Rather than restricting competition for grants by giving the abortion industry a virtual monopoly on Title X funds, the Department should instead keep the 2019 rule.

Implementing the valuable and strong reforms in the 2019 rule related to Title X requirements has been an important step in closing the door to past abuses and opening the door to new and more effective Title X partnerships.

Unlike the proposed rule, the 2019 rule unequivocally applies clear federal statutory conscience protections, thereby ensuring a broader pool from which to select grantees. The rule broadens healthcare options and enhanced health outcomes for women. The rule protects the vulnerable including the unborn, minor children and victims of abuse. And the 2019 rule prevents American tax dollars from propping up the abortion industry.

In clear contrast to the proposed rule, the 2019 rule aligns the Title X program with the original intent of Congress and with the values of the American people.

At the very least—the very least—the proposed rule must enforce statutory conscience protections and remove all stated requirements to refer for abortions.

Thank you for your consideration of these views.