NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

May 17, 2021

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

Attn: Title X Rulemaking

The National Association of County and City Health Officials (NACCHO) is pleased to provide comments to the US Department of Health and Human Services' (HHS) notice of proposed rulemaking (NPRM): "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," RIN 0937-AA11.

NACCHO represents the nation's nearly 3,000 local health departments that work every day in their communities to prevent disease, promote wellness, and protect health. They convene community partnerships and facilitate important conversations with diverse stakeholders on how to create the conditions in which all people can be healthy. On behalf of our nation's local health departments, I would like to highlight the importance of a strong Title X program to the health of people and families across the country.

Local health departments ensure access to a broad range of family planning and complete preventive health services through the Title X program. For nearly fifty years, the program has provided these critical services to those who need them most, including people of color, young people, LGBTQ people, immigrants, and those in rural communities who have limited access to health care services. More than half of Title X grantees are local and state health departments. Further, health departments that are not Title X grantees work alongside the funded entities to ensure services such as family planning and STI and HIV testing (and prevention) are available in communities across the country.

The Trump administration made changes to the Title X program that did not allow grantees to fulfill its mission of providing a broad range of family planning and complete preventive health services. NACCHO opposed the 2019 Title X regulations when they were proposed and strongly supports HHS's NPRM revoking the 2019 Title X regulations and reinstating the 2000 regulations with some revisions. Once finalized, the proposed rule will return Title X to its proper focus on "making comprehensive voluntary family planning services readily available to all persons desiring such services."[1] Furthermore, because of the devastating impact of the 2019 Title X regulations on the program's provider network and its patients, NACCHO supports finalization of the proposed rule as quickly as possible.

When the 2019 rule was implemented, grantees immediately began to withdraw from Title X, limiting services in communities across the nation. Overall, as the proposed rule notes, the Title X program lost more than 1,000 health centers, approximately one quarter of all Title X-funded sites in 2019.[2,3] Nearly two years later, six states continue to have no Title X-funded provider network (Hawaii, Maine, Oregon, Utah, Vermont, and Washington)[4] and an additional six states have a very limited Title X-funded network (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York).[5] The significant damage to the Title X provider network resulted in at least 1.5 million patients losing access to Title X-funded services.[6]

As HHS rightly calls out in the proposed rule, federal data shows the rapid and devastating impact of the 2019 rule on access to critical family planning and sexual health services. Title X saw 844,083 fewer patients in 2019 compared to 2018 (3.1 million vs. 3.9 million), a dramatic 21% drop in patients. This decrease meant that providers offered 280,000 fewer cancer screenings, 1.3 million fewer sexually transmitted disease screenings, and 278,000 fewer confidential HIV tests. Additionally, hundreds of thousands of people lost access to contraceptive care due to the rule. The preliminary numbers for 2020 as shared in the proposed rule are even worse –only an estimated 1.5 million people received Title X-supported services in 2020, a loss of 2.5 million people from the network in just two years.[7] In a 2016 study, six in ten women seeking contraceptive services at a Title X-funded health center reported that to be their only source of medical care in the past year.[8] Thus, this kind of precipitous decline in patients receiving services through the Title X program has concerning implications for broader access to care.

Health equity

NACCHO strongly supports the administration's emphasis on health equity in the proposed rule. The statutory requirements that Title X-funded health centers prioritize people with low-incomes, and provide care regardless of ability to pay, ensure that the Title X program is well-positioned to advance health equity for the patients it serves. NACCHO strongly supports the additions the proposed rule makes to the definitions in the Title X regulations, including definitions for health equity and inclusivity. In particular, the transition from using the word "women" to the more inclusive "client" is more reflective of the diverse population of patients served by the Title X program. Gender identity should never be a barrier to receiving the care one needs and all people who are capable of becoming pregnant, including queer, transgender, and nonbinary people, may have a need for family planning care, just as their sexual partners may.

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

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

State Restrictions on Provider Networks

NACCHO urges HHS to ensure that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients. At least 15 states currently have laws on the books that, where funds flow through the state government, could negatively impact the Title X service delivery network. Two additional states have similar bills that are likely to become law this year. Tiering and other prohibitions against family planning providers often exclude key providers to help Title X patients achieve their family planning goals.

The NPRM appropriately recognizes that "state policies restricting eligible subrecipients unnecessarily interfere with beneficiaries' access to the most accessible and qualified providers," and that "denying participation by family planning providers that can provide effective services has resulted in populations in certain geographic areas being left without

Title X providers for an extended period of time."[9] NACCHO strongly agrees with HHS that "state restrictions on subrecipient eligibility unrelated to the ability to deliver Title X services undermine the mission of the program to ensure widely available access to services by the most qualified providers."[10]

As noted in the NPRM, "[P]roviders with a reproductive health focus often provide a broader range of contraceptive methods on-site and therefore may reduce additional barriers to accessing services."[11] To best achieve the program's goals, Title X has historically funded a diverse network of service delivery providers—including county, city, and state health departments, as well as hospitals, family planning councils, Planned Parenthood affiliates, federally qualified health centers, and other private non-profit organizations. These networks vary widely across communities because they are specifically established to provide the most effective care to their specific patient populations. It is therefore imperative that HHS "ensure that Title X projects do not undermine the program's mission by excluding otherwise qualified providers as subrecipients."[12]

Confidentiality

Two interrelated hallmarks of Title X have been the program's historically strong protections for patient confidentiality and its commitment to serving adolescents. Since the 1970s, federal law has required that both adolescents and adults be able to receive confidential family planning services in Title X projects. Research shows these confidentiality protections are one of the reasons individuals choose to seek care at Title X sites.[13]

Family planning services address some of the most sensitive and personal issues in health care and therefore require strong confidentiality protections. Patients seeking family planning services encompass a broad spectrum of patient populations.[14] Certain groups, including adolescents and young adults, and people at risk of domestic or intimate partner violence, have special privacy concerns that require particularly strong protection.[15]

The 2019 Title X rule weakened these protections by requiring providers to encourage family involvement even when it could be harmful; by giving the HHS Secretary oversight authority in the enforcement of complex and nuanced state reporting laws; and by adding new inappropriate reporting and documentation obligations on providers. The NPRM would reinstate the Title X confidentiality regulations in place prior to the 2019 rule[16] while making important improvements. First, the NPRM eliminates the 2019 rule's unnecessary and harmful requirements to take and document specific actions to encourage family involvement in the family planning decision-making of adolescents, without including the statutory limitation "[t]o the extent practicable"[17] and with complete disregard for the expertise, training, and experience Title X providers already use in assisting adolescents to involve their families in decisions about family planning services and other key health care matters when realistic and appropriate.

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

Determinations regarding compliance with state reporting laws properly rest with state authorities. State reporting laws are complex and vary widely from state to state.[18] They seek a nuanced balance between the need to protect those who experience abuse and ensure that law enforcement can bring victimizers to justice with the need to ensure that patients are able to seek critical health care services they might avoid if they do not trust their health care provider. Thus, many state laws include both specific requirements that clearly trigger an obligation to make a report and others that allow for the exercise of discretion by health care professionals.

Third, the NPRM adds important clarification to how Title X-funded entities are to balance client confidentiality with the program's statutory requirement that "no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge."[19]

NACCHO welcomes the NPRM's addition of language codifying a longstanding practice that had been included in the 2014 Title X Program Requirements that reasonable efforts must be made to "collect charges without jeopardizing client confidentiality," along with a new requirement that clients be informed of "any potential for disclosure of their confidential health information to policyholders where the policyholder is someone other than the client."[20] HHS is right to recognize the potential for harm from varied state and local laws regarding the accessibility of client information to insurance policyholders that are not the client. As more and more patients have access to insurance, the potential risks of disclosure of sensitive information have increased. These proposed additions to the Title X regulations will help to ensure that confidentiality remains paramount in Title X.

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

Modernizing Title X regulations

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

However, it is important to note that "consultation by a [health care] provider" is not and should not be limited only to the examples cited by HHS, as these CSPs represent only one facet of health care providers in Title X settings.[21] In 2019, 23% - or more than 1.07 million – of family planning encounters fell under the primary responsibility of other service providers, including registered nurses practicing within a standard scope of practice, licensed practical nurses, health educators, and social workers.[22] These professionals not only account for a substantial number of Title X encounters on their own, but also provide critical support to CSPs in team-based care models typical to modern health care delivery. They are more likely to be Black, Indigenous, and People of Color (BIPOC)—racial/ethnic groups that are both persistently underrepresented in health care professions and more reflective of clients served through the Title X program.[23] NACCHO encourages HHS to elevate the critical role these health care professionals play in the Title X program.

Among enhancements it proposes to the 2000 regulations through the NPRM, HHS also specifically highlights "telemedicine." The importance of telehealth, more broadly, has been growing in recent years and has become particularly clear in the context of the COVID-19 public health emergency. Since spring 2020, use of telehealth modalities has allowed tens – if not hundreds – of thousands of Title X users to remotely access many Title X services without placing themselves at increased risk for potential COVID-19 exposure. For example, health departments in Denver and Washington, DC quickly shifted to telehealth during the pandemic to provide sexual health services for their patients.

The Department's use of the term "telemedicine" in the NPRM instead of "telehealth" is of concern, with "telehealth" referring to a broader scope of remote health care services than telemedicine and includes non-clinical services like

counseling and education. Accordingly, in addition to its change from "physician" to "[health care] provider" in §59.5(b)(1), HHS can further improve the Title X regulations by explicitly naming and defining "telehealth" to clarify that section as follows:

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

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

In addition, NACCHO strongly supports the following specific clarifying changes and urges HHS to finalize them:

- The inclusion of "FDA-approved contraceptive services" and reinstatement of the term "medically approved" to the proposed definition of family planning services;
- The requirement that Title X service sites refer patients out if the site does not offer the contraceptive method of the patient's choice;
- The requirement to provide services "in a manner that is client-centered, culturally and linguistically appropriate, inclusive, and trauma-informed; protects the dignity of the individual; and ensures equitable and quality service delivery consistent with national recognized standards of care;"[24]
- The reinstatement of the requirement to offer nondirective options counseling to pregnant patients on each of the three options, if requested by the patient, including referral upon request.
- The elimination of unnecessary, unworkable physical, systems, and administration separation, contrary to the requirements and realities of modern quality health care.

In conclusion, the 2019 Title X rule severely undermined this bedrock public health program that has provided high quality, affordable family planning and sexual health care to millions for 50 years. NACCHO and local health departments strongly support the revocation of the 2019 rule, and reinstatement of the 2000 regulations with revisions, so that the Title X program can return its focus to its patients and communities. If you require additional information about the issues raised in these comments, please contact Adriane Casalotti, Chief of Government and Public Affairs, at acasalotti@naccho.org.

Sincerely,

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CEO

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

2 NPRM p. 19815.
3 Mia Zolna et al., *Estimating the impact of changes in the Title X network on patient capacity*, Guttmacher Inst., 2 (Feb. 5, 2020), https://www.guttmacher.org/sites/default/files/article_files/estimating_the_impact_of_changes_in_the_title_x_network_on_patient_capacity_2.pdf; *see also Title X Family Planning Directory*, n.5.
4 Zolna et al., n.59, at 2.
5 NPRM p. 19815.
6 *Title X: Key Facts About Title X*, n.5.
7 NPRM p. 19815.
8 Kavanaugh ML, Zolna MR and Burke KL, Use of health insurance among clients seeking contraceptive services at Title X-funded facilities in 2016, *Perspectives on Sexual and Reproductive Health*, 2018, 50(3):101–109.
9 "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021), citing Carter, M.W., Gavin, L., Zapata, L.B., Bornstein, M., Mautone-Smith, N., & Moskosky, S.B. (2016). Four aspects of the scope and quality of family planning services in U.S. publicly funded health centers: Results from a survey of health center administrators. Contraception. doi:10.1016/ j.contraception.2016.04.009.
10 "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021).
11 "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021).
12 "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19817 (April 15, 2021).
13 Frost et al., *Specialized Family Planning Clinics in the United States*.
14 Rachel B. Gold, *A New Frontier in the Era of Health Reform: Protecting Confidentiality for Individuals Insured as Dependents*, 16 GUTTMACHER POLICY REVIEW 2, 2 (2013), https://www.guttmacher.org/pubs/gpr/16/4/gpr160402.pdf.
15 Pamela J. Burke et al., *Sexual and Reproductive Health Care: A Position Paper of the Society for Adolescent Health and Medicine*, 54 J. ADOLESCENT HEALTH 491, 491-496, (2014), https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf; Diane M. Reddy, Raymond Fleming, & Carolyne Swain, *Effect of Mandatory Parental Notification on Adolescent Girls' Use of Sexual Health Care Services*, 288 J. AM. MED. ASS'N 710, 710–714 (2002); Rachel K. Jones et al., *Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception*, 293 J. AM. MED. ASS'N 340, 340–348; Liza Fuentes, Meghan Ingerick, Rachel Jones, & Laura Lindberg, *Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. ADOLESCENT HEALTH 36, 36-43; *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings,* Family Violence Prevention Fund (2004), http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf.
16 Title X's confidentiality requirements are currently largely codified at 42 C.F.R. § 59.11; the NPRM proposes reorganizing the Title X regulations so that the confidentiality section would now be § 59.10.
17 42 U.S.C. § 300.
18 *See, e.g.*, Rebecca Gudeman & Erica Monasterio, *Mandated Child Abuse Reporting Law: Developing and Implementing Policies and Training*, National Center for Youth Law and Family Planning National Training Center for Service Delivery (2014), http://www.cardeaservices.org/documents/resources/Mandated-Child-Abuse-Reporting-Law-GUIDE-20140619.pdf.
19 300a-4
20 "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 Federal Register 19812, 19820 (April 15, 2021).
21 C Fowler, J Gable, B Lasater, and K Asman, *Family Planning Annual Report: 2019 National Summary* (Washington, DC: Office of Population Affairs, 2020).
22 Ibid.
23 E Salsberg, C Richwine, and S Westergaard S, et al, "Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce," *JAMA Netw Open.* 2021;4(3):e213789. doi:10.1001/jamanetworkopen.2021.3789.
24 NPRM, p. 19830