May 17, 2021

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

Attn: Title X Rulemaking

The Association of State and Territorial Health Officials (ASTHO) is pleased to provide comments regarding U.S. 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. ASTHO is the national nonprofit organization representing the public health agencies of the 50 States, the U.S. territories and freely associated states, and the District of Columbia. ASTHO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and ensuring excellence in public health practice. That is the point of view we take in providing our comments.

ASTHO strongly supports HHS’ proposed changes to the 2019 Title X regulations, which would reinstate the 2000 regulations with some revisions. The changes ensure that Title X focuses on “making comprehensive voluntary family planning services readily available to all persons desiring such services.”1 ASTHO affirms that reproductive health services (1) improve birth outcomes for both mothers and infants through preconception, prenatal, and inter-conception care, (2) increase access to education and contraception to enable responsible and respectful sexual activity, and (3) safeguard and promote the public’s health.2 ASTHO also strongly supports access to medically accurate, science-based information and services that are age-appropriate and culturally competent. Further, ASTHO believes in creating conditions for everyone to live in healthy, thriving, prosperous communities free from barriers to realizing full health and wellness.3 Fulfilling this aim requires an explicit focus on addressing structural racism and acknowledging racism and racial discrimination as a public health issue.

As the proposed rule notes, the Title X program lost more than 1,000 health centers after the 2019 rule was implemented in August 2019, representing approximately one quarter of all Title X-funded sites in 2019.4,5 Nearly two years later, six states (Hawaii, Maine, Oregon, Utah, Vermont, and Washington) continue to have no Title X-funded provider network, and an additional six states (Alaska, Connecticut, Massachusetts, Minnesota, New Hampshire, and New York) have a very limited Title X-funded network.6,7 This resulted in at least 1.5 million patients losing access to Title X-funded services.8 Since the 2019 ruling, Office of Population Affairs (OPA) has been unable to find new grantees to fill the gaps the 2019 rule created, including in the six states that lost all Title X-funded services, and has served far fewer clients.1

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1 OPA released two competitive funding opportunity announcements for “areas of high need” on May 29, 2020, intending to provide approximately $18 million through an estimated 10 grants to provide services in areas left without Title X-funded services. (See HHS grants notices PA-FPH-20-001, FY2020 Title X Services Grants: Providing
ASTHO believes that it is critical to give individuals access to timely, quality, affordable health services, including the reproductive healthcare services offered through Title X. As HHS states in the proposed rule, federal data shows the impact of the 2019 rule on access to critical family planning and sexual health services: Title X-funded providers saw 844,083 fewer patients in 2019 than in 2018 (3.1 million vs. 3.9 million). That 21% drop in patients was seen only in effect for less than half of the year. This decrease meant that providers were able to offer 280,000 fewer cancer screenings, 1.3 million fewer sexually transmitted disease screenings, and 278,000 fewer confidential HIV tests. Additionally, hundreds of thousands of people lost access to contraceptive care due to the rule. Preliminary numbers estimate that only 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. In a 2016 study, six in 10 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.

ASTHO supports the revocation of the 2019 rule and reinstatement of the 2000 regulations with revisions. These changes should ensure adequate federal funding and guidance to support client-centered quality, accessible, and effective reproductive health services, including for infrastructure, workforce needs, and flexible policy and funding mechanisms, and allow programs to maintain and sustain existing quality service providers and otherwise address the specific needs of their populations served.

Health equity

ASTHO strongly supports the administration’s emphasis on health equity in the proposed rule, including definitions for health equity and inclusivity. 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. The NPRM’s enhanced health equity provisions will advance Title X’s mission to provide equitable, affordable, client-centered, quality family planning and sexual health services. In particular, the transition from using the word “women” to the more inclusive “client” is more reflective of the diverse population of patients served by the Title X program. Gender identity should never be a barrier to receiving the care one needs, and all people who are capable of becoming pregnant, including queer, transgender, and nonbinary people, may have a need for family planning care, just as their sexual partners may. The proposed rule’s definitions help to illustrate key aspects of quality care, including the importance of client-centeredness; cultural and linguistic appropriateness; and recognition of how trauma affects people. AStHO believes that everyone, regardless of age, geography, disability, race, ethnicity, religion, sex, gender, gender identity, sexual orientation, education, income, country of origin, marital status, and language, should have access to the full range of affordable, evidence-based, medically accurate, age-
and culturally-appropriate, effective reproductive health services, and information, along with the full range of FDA-approved reversible contraceptive drugs and devices. Defining how services should be provided is an important way to move toward a more equitable Title X program.

The COVID-19 pandemic has shown the many inequities in our nation’s healthcare system and highlighted how systemic racism has resulted in pervasive health disparities and disproportionately poor health outcomes for people of color. Black, Indigenous, and people of color (BIPOC) face disproportionately high rates of COVID-19 infections and deaths; these disparities can be attributed to structural racism and longstanding structural inequalities related to the social determinants of health. 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.

With CDC’s recent declaration that racism is a serious threat to public health, ASTHO would like to see systemic racism explicitly included and addressed as part of the expectations related to health equity. Systemic racism has resulted in structural barriers to healthcare 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. Contemporary public health agencies must acknowledge that legacy and the policies that maintain their hierarchical system before they can transform to advance public health’s mission to assure the conditions for everyone to live healthy lives and achieve optimal health. ASTHO encourages HHS to commit to achieving equity by acknowledging historical trauma and the advantages derived from structural racism to different groups of Americans. This history has contributed to a justifiable mistrust of the healthcare system, particularly with respect to family planning. As the administration raises health equity as an important goal of Title X in the proposed rule, ASTHO urges HHS to lead internal organizational change efforts that support racial healing, racial justice, and transformation.

Confidentiality

Title X has long had historically strong protections for patient confidentiality and 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.

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

ASTHO recommends that state and territorial health agencies help lead efforts to inform providers, clients, and educators about state and federal laws and regulations on reproductive health, such as access to confidential services, requirements for medically accurate reproductive health information,
and adolescent access to reproductive health services and mandatory reporting. Privacy and confidentiality are central components of healthcare, with federal and state laws and regulations providing formal protections around personal health information, medical records, and other aspects of health privacy. Adolescents continue to see barriers to accessing reproductive services, particularly when it comes to confidentiality. On a nationwide survey, approximately 70% of youths who had not told a parent about clinic visits said that they would not seek family planning services. Approximately 25% reported that they would have unsafe sex if they could not have confidential services. The ability to confidentially access contraception or other reproductive health services may determine whether an individual decides to access services at all, particularly for adolescents.

The NPRM would reinstate the Title X confidentiality regulations in place prior to the 2019 rule while making important improvements. First, the NPRM eliminates the 2019 rule’s requirements to take and document specific actions to encourage family involvement in the family planning decision-making of adolescents, without including the statutory limitation “to the extent practicable,” 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 healthcare 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 penalties if HHS (not the state) believes a Title X project is out of compliance, the 2019 rule required providers to apply inappropriate screening techniques and overreporting 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. 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 healthcare services they might avoid if they do not trust their healthcare providers. 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 healthcare 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.”

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ii 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.
ASTHO 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.”\textsuperscript{34} 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.

\textit{Purpose of the program/standard of care}

The Title X statute requires Title X projects to “offer a broad range of acceptable and effective family planning methods and services,” and prioritizes a project’s capacity to make rapid and effective use of federal funds for family planning.\textsuperscript{35} The 2019 rule eliminated the term “medically approved” from the longstanding regulatory requirement that projects provide “a broad range of acceptable and effective medically approved family planning methods;” included language that allowed providers who objected to fundamental tenets of the Title X program to participate; and diverged from the Quality Family Planning guidelines, the nationally recognized clinical standards published by OPA and CDC in 2014.\textsuperscript{36} Furthermore, the 2019 rule made changes to pregnancy counseling by Title X providers, which created a system of different standards of quality based on the provider and encouraged withholding medically accurate information, which contradicted central principles of medical ethics.

ASTHO supports access to medically accurate, science-based information, as well as access to medically appropriate and effective reproductive health services.\textsuperscript{37} The 2019 rule allowed for two tiers of providers and individual clinics—those that offer the full range of contraceptive options and those that may only offer one “choice,” which undermined quality and trust with providers. The 2019 rule exacerbated contraceptive health deserts, particularly in rural areas and sites that primarily serve adolescents or other marginalized populations.\textsuperscript{38}

ASTHO supports the proposed rule for reinforcing the core mission of the Title X program and matching patients’ expectations that they will receive high-quality, client-centered care that includes comprehensive, medically accurate counseling and information and referrals for any other services sought.\textsuperscript{39} Specifically, ASTHO strongly supports the following changes and urges the administration to finalize them:\textsuperscript{40}

- Including “FDA-approved contraceptive services” and reinstating the term “medically approved” to the proposed definition of family planning services. ASTHO asserts that individuals accessing reproductive health services have access to the full range of affordable, evidence-based, medically accurate, and effective reproductive health services and information, and the full range of FDA-approved reversible contraceptive drugs and devices. \textsuperscript{41}
The requirement that Title X service sites refer patients out if the site does not offer the contraceptive method of the patient’s choice. ASTHO believes that the family planning visit provides a linkage for individuals to additional service providers to ensure individuals have access to reliable, effective contraception and reproductive health plans that meets their needs and preferences.\(^{42}\) States and territories promote access to high-quality reproductive health services by coordinating efforts with local health departments and other reproductive health/family planning providers; enabling and supporting integrating reproductive health services into primary care settings, including those that do not have Title X funds; and supporting health professionals in their obligation to ensure their patients receive complete and accurate information about their treatment options.

Providing 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.”\(^{43}\) ASTHO believes in providing culturally and linguistically appropriate services and developing a trauma-informed workforce that must acknowledge historical trauma and the advantages derived from structural racism to different groups of Americans.\(^{44,45,46}\)

Reinstating 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. Strong partnerships are essential to successfully implementing family planning programs, particularly considering the budget limitations that many state and territorial health departments must work within. ASTHO recognizes the family planning visit as an opportunity to link individuals to additional service providers, including family practitioners, pediatricians, obstetrician-gynecologists, social workers, mental health providers, lactation consultants, nutritionists, home visitors, and public health workers.\(^{47}\) As a state health agency plans a family planning project, it needs to retain current partners and recruit new partners to align programs, connect with provider champions, and share their expertise. Agencies may partner or collaborate with hundreds of individuals and organizations, from informal referral networks to subgrantees.

Eliminating unnecessary, unworkable physical, systems, and administrative separations that are contrary to the requirements and realities of modern quality healthcare. ASTHO recommends that the federal government should help lead and implement adequate funding to support quality, accessible, and effective reproductive health services, including funding for infrastructure and workforce needs.\(^{48}\)

**Modernizing the Title X regulations**

Changes in the healthcare 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 healthcare providers who are not physicians. The NPRM preamble specifically mentions physician assistants and nurse practitioners as the types of healthcare providers that provide consultation in Title X settings. Nurse practitioners, certified nurse midwives, and physician assistants accounted for 67% of the Title X program’s full-time equivalent (FTE) clinical services providers (CSPs) in 2019; physicians and registered nurses with an expanded scope of practice accounted for 24% and 9% of all CSP FTEs, respectively. ASTHO believes that any healthcare provider permitted to provide this counseling should not be restricted, in any manner or form, from providing
their scope of services. In addition, many state-based clinics are staffed by a wide range of providers. It is burdensome and costly to only authorize doctors when other clinic staff are qualified and routinely counsel patients on all aspects of reproductive health.

However, it is important to note that “consultation by a [healthcare] provider” is not and should not be limited only to the examples cited by HHS, as these CSPs represent only one facet of healthcare providers in Title X settings. 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. 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 healthcare delivery. These providers are more likely to be BIPOC, racial/ethnic groups that are both persistently underrepresented in healthcare professions and more reflective of clients served through the Title X program. ASTHO encourages HHS to elevate the critical role these healthcare professionals play in the Title X program and the importance of recruiting a racially and ethnically diverse workforce reflective of the communities served by the 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. Due to significant flexibilities that occurred as a result of federal policies to address COVID-19, including the Coronavirus Aid, Relief, and Economic Security Act and related CMS guidance, there has been an unprecedented increase in telehealth use during the COVID-19 response. To ensure continuity of care beyond COVID-19, sustaining these flexibilities will be critical and allow for continued access to telehealth for underserved and rural populations. 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. By continuing to invest in telehealth, Title X can increase access to preventive and specialty care, address health disparities affecting priority populations, and save costs. ASTHO recommends leveraging advancements in telehealth by exploring licensing requirements and reimbursement policies that allow maximum use of telehealth.

That said, HHS’ use of the term “telemedicine” in the NPRM instead of “telehealth” is of concern, as “telehealth” refers to a broader scope of remote healthcare services than telemedicine and includes non-clinical services like counseling and education. Accordingly, in addition to its change from “physician” to “[healthcare] 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, continuing supervision, laboratory examination, and contraceptive supplies), in person or via telehealth, including audio-only modalities, regardless of the patient’s or provider’s setting, provide necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.
For 50 years, the Title X family planning program has been a critical underpinning of the public health safety-net infrastructure that serves millions of low-income people each year. ASTHO appreciates the opportunity to comment on the NPRM, “Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services.” If you have any questions or would like additional information, please contact Ellen Pliska, ASTHO’s senior director of family and child health, at epliska@astho.org.

Sincerely,

Michael R. Fraser, PhD MS CAE FCPP
Chief Executive Officer

6 Ibid.
8 National Family Planning and Reproductive Health Association. “Title X: Key Facts About Title X.” Available at https://www.nationalfamilyplanning.org/title-x_title-x-key-facts.
12 ASTHO. “Access to Reproductive Health Services Policy Statement.” Available at https://www.astho.org/About/Policy-and-Position-Statements/Reproductive-Health-Services/.. 
13 Ibid.
14 Ibid.
15 Ibid.


29 ASTHO. “State Efforts to Protect Confidentiality for Insured Individuals Accessing Contraception and Other Sensitive Healthcare Services.” Available at: https://www.astho.org/MCH/State-Efforts-to-Protect-Confidentiality-for-Insured-Individuals-Accessing-Contraception/.


40 Ibid.

41 Ibid.

42 Ibid.


48 Ibid.

49 Ibid.


51 Ibid.


