UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PLANNED PARENTHOOD OF WISCONSIN, INC., PLANNED PARENTHOOD ASSOCIATION OF UTAH, PLANNED PARENTHOOD OF GREATER OHIO and NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION,

Plaintiffs,

v.

ALEX M. AZAR II, in his official capacity as United States Secretary of Health and Human Services, and VALERIE HUBER, in her official capacity as Acting Deputy Assistant Secretary for the Office of Population Affairs,

Defendants.

Case No. 1:18-cv-1035-TNM (con)

DECLARATION OF CLARE M. COLEMAN

Clare M. Coleman declares and states the following:

1. I am the President and CEO of the National Family Planning & Reproductive Health Association ("NFPRHA"), a Plaintiff in this action. I submit this declaration in support of Plaintiffs' motion for preliminary injunctive relief barring the use of the Funding Opportunity Announcement Number PA-FPH-18-001 ("2018 FOA") and the criteria contained therein for the Department of Health and Human Services ("HHS")'s review of applications and awarding of fiscal year 2018 family planning services grants under the authority of Title X of the Public Health Services Act.

2. In the 2018 FOA, Defendants fundamentally alter the grant decision-making criteria that are mandated by the Title X statute and regulations and that have governed the

program's grant-making for over 45 years. In so doing, they introduce new program requirements for grants that both conflict with the Title X statute and regulations and undermine Title X's effectiveness. They steer this essential, federally-funded health care network far off course, harming Title X grantees, their health care provider networks, and the millions of individuals with few financial resources who depend on Title X-funded family planning care.

3. Unless Defendants are enjoined from using the 2018 FOA by this Court, NFPRHA's members and the millions of patients they serve each year will suffer irreparable harm. NFPRHA seeks injunctive relief to preserve the integrity of the Title X program; enable its members to continue in their roles as Title X grantees; preserve its members' high quality, voluntary, comprehensive, client-centered family planning projects; avoid the diversion of Title X resources toward priorities that do not belong in Title X projects; and ensure that those who depend on this important safety net-program are not deprived of the critical health services that Title X was created by Congress to provide.

NFPRHA and Its Membership

4. NFPRHA is a national, nonprofit membership organization established to ensure access to voluntary, comprehensive, and culturally sensitive family planning and sexual health care services, and to ensure reproductive freedom for all. NFPRHA represents more than 850 health care organizations and individuals, primarily health care professionals or practitioners, in all 50 states, the District of Columbia and the territories. NFPRHA's organizational members include state, county, and local health departments; private, nonprofit family planning organizations (including Planned Parenthood affiliates and many others); family planning councils; hospital-based clinics; and Federally Qualified Health Centers ("FQHCs").

5. Of particular relevance here, NFPRHA represents 66 Title X grantees, which constitute 84% of all grantees. Altogether, NFPRHA's grantee members operate or fund a network of more than 3,500 health centers that provide high-quality family planning and other preventive health services to more than 3.7 million low-income, uninsured, or underinsured individuals each year, or roughly 93% of all patients served in Title X-funded health centers.

6. NFPRHA grantee members are composed of 35 state, local, county, or territorial health departments – or 81% of all the Title X grantee health departments – and 31 nonprofit or non-health department members – or 86% of all the nonprofit or non-health department Title X grantees. NFPRHA has at least one grantee member in 46 states, the District of Columbia, and two territories. NFPRHA brings this suit on behalf of our members.

7. NFPRHA is the lead national advocacy organization for the Title X family planning program, and believes that Title X projects are a critical part of the public health safety-net infrastructure. NFPRHA advocates preserving and strengthening these federally funded projects to ensure that the millions of women and men who rely on the networks of providers participating in Title X can continue to access high-quality family planning methods and services there.

8. I have led NFPRHA for more than eight years. Prior to assuming NFPRHA's leadership, I was President and CEO of Planned Parenthood Mid-Hudson Valley, a Title X provider that included 11 health centers in a four-county area. At Planned Parenthood Mid-Hudson Valley, I directed a 110-person staff, the majority of whom were dedicated to providing clinical services, and oversaw the organization's $9 million operating budget.

9. My work experience also includes significant time as a senior staff person on Capitol Hill, with an emphasis on health care and appropriations-related efforts, and as a

legislative representative for Planned Parenthood Federation of America. Throughout my career, I have focused on reproductive health care, including a long-standing emphasis on family planning policy and service provision.

10. As discussed below, from 2010 to 2014 the Centers for Disease Control and Prevention ("CDC") and HHS's Office of Population Affairs ("OPA"), the HHS office that is responsible for Title X family planning, developed a joint publication on how to provide quality family planning services, now referred to as "the QFP". In developing their new national standards for family planning care, CDC and OPA worked with various panels of outside experts.

11. I was appointed by the Acting Director of OPA and served as a member of the Expert Working Group that advised the CDC and OPA throughout their development of the QFP. The Expert Working Group advised on the structure and content of the QFP recommendations and helped make those recommendations more feasible and relevant to the needs of the field.

12. Through my professional experience, my interactions with NFPRHA members and with OPA and other federal agencies, my related work with Congress, and my review of literature and historical material, I am well-versed in the history of Title X, all aspects of Title X programs, including best practices for providing family planning services, and the process of Title X grant-making, and am regarded as an expert in the field.

The History and Purpose of Title X

13. Title X became law in the "Family Planning Services and Population Research Act of 1970." The same 1970 act created OPA.

14. In 1960, the Food and Drug Administration had approved the first oral contraceptive pill for use by prescription. The cost of "the Pill" was high. Not only did it require a doctor's visit and prescription, but Enovid, the initial manufacturer, had a monopoly. Shortly after its release, an annual supply of Enovid cost the equivalent of about $760 in 2010 dollars. The other most effective contraceptive method at the time, the copper intra-uterine device ("IUD"), similarly required physician visits and a significant financial investment.

15. In the 1960s, many women, especially low-income women, had more children than they desired. Research established that it was inequitable access to contraceptives that made low-income women less able to match their actual childbearing with their desired family size.

16. In a Special Message to Congress on the Problems of Population Growth on July 18, 1969, President Richard M. Nixon called on Congress to "establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them." President Nixon pressed Congress to address the fact that "most of an estimated five million low income women of childbearing age in this country do not now have adequate access to family planning assistance, even though their wishes concerning family size are usually the same as those of parents of higher income groups." He also called for "additional research on birth control methods of all types[.]" Providing assistance to low-income women who cannot afford the cost of modern family planning tools, Nixon urged, is something the federal government has "the capacity to do." He stressed that "no American woman should be denied access to family planning assistance because of her economic condition."[1]

[1] President Richard Nixon, *271 – Special Message to the Congress on Problems of Population Growth* (July 18, 1969), available at http://www.presidency.ucsb.edu/ws/?pid=2132.

17. With bipartisan support (the bill passed unanimously in the Senate), Congress responded by enacting Title X.[2] Title X was at inception, and remains, the only dedicated source of federal funding for family planning services in the United States.

18. Family planning as referenced in Title X meant, first and foremost, access to clinical care – including biomedical supplies like the Pill and consultation with clinical professionals – and was intended to make modern methods of contraception available to all, especially low-income women. One reflection of this intent is Title X's reference to those it intends to serve as "patients." 42 U.S.C. § 300(b).

19. From the outset, the hallmarks of the Title X program have been voluntariness, responsiveness to the desires of the patient, comprehensive access to contraceptive methods, especially the currently most effective ones, confidentiality, and an effort to equalize the ability of all women to space child-bearing and prevent unintended pregnancies.

20. While the new contraceptives and their cost were the impetus behind and focus at the time of Title X's initial passage, in 1975 Congress amended the statute to also explicitly include the option of natural family planning in the array of methods offered by Title X programs. Likewise, Title X was amended in 1978 to explicitly cover adolescent patients and to include infertility services.

21. Since 1970, Title X has built and sustained a national network of family planning health centers, delivered high-quality family planning in a cost-effective manner, and enabled millions to prevent unintended pregnancies, instead enabling individuals to plan for the children they desire.

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[2] *See generally* Bailey, M.J., *Reexamining the Impact of Family Planning Programs on US Fertility: Evidence from the War on Poverty and the Early Years of Title X*, 4 Am. Econ. J.: Applied Econ. 62, 66 (2012), https://www.aeaweb.org/articles?id=10.1257/app.4.2.62.

22. In 2015 alone, for example, services provided by health centers that received Title X funding helped women avert an estimated 822,300 unintended pregnancies, thus preventing 387,200 unplanned births and 277,800 abortions. Without the services provided by Title X–funded sites, the U.S. unintended pregnancy rate would have been 31% higher and the rate among teens would have been 44% higher.[3]

23. Further, in 2016, Title X helped fund: 5.1 million tests for sexually transmitted infections ("STIs"), including 1.2 million tests for human immunodeficiency virus ("HIV"); almost 1 million clinical breast exams; and approximately 700,000 Pap tests.[4] These services have important impacts for the patients and on public health overall. For example, Title X health centers reduce chlamydia infections through screenings and early treatment, so fewer individuals are then subject to the effects of an untreated chlamydia infection, such as infertility. In doing so, Title X sites are more likely than non-Title X providers (both public and private) to follow chlamydia screening guidelines.[5]

24. In 2016, 2.8 million patients left Title X health centers utilizing medically safe forms of contraception approved by the U.S. Food and Drug Administration. 2016 FPAR at ES-2. Notably, Title X sites are more likely to offer forms of long-acting reversible contraceptives ("LARCs") – like IUDs and contraceptive implants – onsite, and to provide better access to

[3] Frost, et al., *Publically Funded Contraceptive Services at U.S. Clinics, 2015*, Guttmacher Institute (2017), https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.
[4] Office of Population Affairs, Title X Family Planning Annual Report, 2016 National Summary at ES-3 (August 2017), https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf.
[5] Chow, et al., *Comparison of adherence to chlamydia screening guidelines among Title X providers and non-Title X providers in the California Family Planning, Access, Care, and Treatment Program*, J. Women's Health (Aug. 2012), https://www.ncbi.nlm.nih.gov/pubmed/22694761.

contraceptive care generally, than non-Title X providers.[6] This is critical because, as reflected in HHS's own publications, IUDS and implants, together with sterilization, are the most effective methods of contraception. 2016 FPAR at C-5. Without Title X services, many patients would go without these essential services, screenings, and tests.

25. The CDC named family planning one of the most important achievements in public health in the 20th century, noting that the "hallmark of family planning has been the ability to achieve desired birth spacing and family size… Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic role of women…. Modern contraception and reproductive health-care systems that became available later in the century further improved couples' ability to plan their families. Publicly supported family planning services prevent an estimated 1.3 million unintended pregnancies annually."[7] Title X also saves the public millions of dollars in health care costs.[8]

The Structure and Scope of Title X Service Provision

26. Section 1001 of the statute provides for the funding of competitive grants to public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects, 42 U.S.C. § 300, and those projects are Title X's means of service provision to individuals. The FOA that is the subject of this lawsuit governs the process for

[6] Zolna & Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute (2016), http://www.guttmacher.org/report/publicly-funded-family-planning-clinic-survey-2015.
[7] CDC, *Achievements in Public Health, 1990-1999: Family Planning*, 48(47) Morbidity and Mortality Weekly Report 1073-80 (December 3, 1999), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847a1.htm.
[8] *See* Frost, et al., *Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program*, 92 The Milbank Q. 667, 703 (2014), https://www.guttmacher.org/sites/default/files/article_files/frost_et_al-2014-milbank_quarterly.pdf.

awarding those competitive services grants and the means of deciding which entities receive funding to provide services.

27. Within each project funded by Title X, there are typically three levels: the grantee, sub-recipients, and individual service sites. In some states, the state health department is the sole grantee; other states have a non-profit organization as the sole grantee; and in other states there may be multiple Title X grantees. Some grantees handle only overall program direction, funding, administration, and oversight, and the sub-recipients include all of the service sites. In other instances, the grantee itself operates direct service sites and may or may not also have sub-recipients who operate additional sites. NFPRHA's membership includes grantees that fall into each of these categories.

28. Title X grantees must closely track and report data on their service provision each year, for preparation of OPA's Family Planning Annual Report ("FPAR"). In 2016, the last year for which FPAR data is available, the Title X program awarded 91 grants (48 of which went to state or other public health departments and 43 of which went to private non-profit agencies). Some grantees were awarded multiple grants, for different geographic areas. The grants together funded a network of 1,117 sub-recipients and nearly 3,900 service delivery sites. Grantees are required to conduct oversight of all of the sub-recipients and service sites in their program.

29. As the 2016 FPAR describes, Title X "is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families." 2016 FPAR (published by OPA in August 2017) at ES-1. The 2016 FPAR goes on to summarize:

> In addition to offering a broad range of effective and acceptable contraceptive methods on a voluntary and confidential basis, Title X-funded service sites provide contraceptive education and counseling; breast and cervical cancer screening; sexually transmitted disease (STD) and human immunodeficiency

> virus (HIV) testing, referral, and prevention education; and pregnancy diagnosis and counseling.

2016 FPAR at ES-1. The report also notes that "Title X providers continue to make important gains in delivering high-quality, evidence-based contraceptive and related preventive care to a vulnerable population. While declining revenue over time has resulted in fewer funded health centers and users, trends in the use of most and moderately effective contraceptive methods, as well as cervical cancer screening and chlamydia testing, demonstrate the program's continued dedication to delivering services that meet the highest national standards." 2016 FPAR at ES-3 to -4.

30. Title X grantees track and the FPAR uses as its primary metric the "family planning encounter," which is a confidential and documented "face-to-face contact between an individual and a family planning provider that includes the delivery of family planning and related preventive health services to avoid unintended pregnancies or achieve intended pregnancies." 2016 FPAR at ES-1 to -2. Many program clients may have multiple encounters over the course of a year.

31. In 2016, Title X programs served 4,007,552 clients. Women made up 89% of those served, men 11%. Title X programs serve patients without regard to age or marital status. In 2016, approximately 92% of program users were adults; 9% were 18 or 19 years of age, 48% were between 20 and 29, 34% were 30 or older. Title X programs serve a racially and ethnically diverse population, including a disproportionately high percentage of black and Latina clients. According to the 2016 FPAR, 54% of program users identified as white, 21% as black or African-American, 32% identified as Hispanic or Latina, 3% as Asian, and 1% as either Native Hawaiian or Other Pacific Islander or American Indian or Alaska Native. Thirteen percent of 2016 users reported having limited English proficiency. 2016 FPAR at 11-12, 24.

32. Consistent with Title X's purpose, providers in a Title X project must give priority in the provision of services to persons with limited incomes and in fact, Title X clients are overwhelmingly poor or low-income. In 2016, 88% of clients had incomes at or below 250% of the federal poverty level and 64% had incomes at or below poverty the poverty level. 2016 FPAR at A-16 (Exhibit A-7a). In 2016, the federal poverty level for a single person was $11,880 and $24,300 for a family of four.[9] As required by Title X regulation, clients with incomes below the federal poverty line do not pay anything for the services or supplies they receive from a Title X provider. For clients with incomes not below the federal poverty line but not more than 250% of that level, Title X providers use a schedule of discounts to the reasonable cost of providing services or supplies.

33. In 2016, 80% of all female users adopted or continued use of a contraceptive method at their last Title X health center encounter. HHS categorizes contraceptive methods as most, moderately, or less effective. According to the 2016 FPAR; 62% of Title X users adopted or continued use of a most or moderately effective method. Fewer than 0.5% of users were using natural family planning or fertility awareness methods, which HHS categorizes as less effective methods. Nine percent exited their encounter with no method because they were pregnant or seeking pregnancy; another 5% exited with no method for other reasons. Three percent of female users reported they were abstinent. 2016 FPAR at A-21.

34. Section 1008 of Title X requires that "[n]one of the funds appropriated … shall be used in programs where abortion is a method of family planning." 42 U.S.C. § 300a-6. This requirement governs all grants and is included in all sub-recipient agreements. This prohibition has been in place, unchanged, since the inception of Title X in 1970. If a Title X grantee or sub-

[9] HHS, Office of the Assistant Secretary for Planning and Evaluation, *HHS Poverty Guidelines*, https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references.

recipient provides abortions, the Title X-supported activities must be separate and distinguishable from abortion activities.

35. Pregnancy testing, however, is a Title X service and a client who receives a positive pregnancy test at a Title X site is entitled to receive nondirective counseling on, and referral for, all of her legal options, including prenatal care, adoption, and abortion upon her request.

36. In 74% of client encounters, a highly trained medical professional is involved: either a physician (22%), an advanced practice clinician (i.e., physician assistant, nurse practitioner, or certified nurse midwife, 71%), or a registered nurse with an advanced scope of practice license (7%). In the other 26% of individual visits, other trained health care staff, such as nurses, nurse assistants, health educators, social workers or clinic assistants, handle the care, which could include routine laboratory tests, some aspects of individualized client counseling and education, referrals or follow-up services. 2016 FPAR at 51 (Ex. 30).

37. These are all one-on-one, confidential encounters, as in other medical settings. In fact, the Title X regulations have always contained an explicit, stringent confidentiality requirement to protect clients in this highly personal context.

Clinical Standards and Program Requirements

38. Because Title X aims to best advance equal and effective access to family planning methods and services, OPA has periodically adopted and revised clinical standards and other program guidance. These have governed grant applicants and grantees to help ensure that Title X programs are providing evidence-based clinical care consistent with current nationally recognized standards, and are consistently and effectively accomplishing the purpose of Title X.

39. In 2009, in a memorandum distributed to Title X grantees, OPA acknowledged that its directives had fallen behind then-currently recognized national standards and it triggered an extensive process to update its program guidance.

40. This process culminated in April 2014 with the publication of two documents that currently comprise OPA's Title X program guidance and that govern current Title X grants: (1) OPA's *Program Requirements for Title X Funded Family Planning Projects* ("Title X Program Requirements"), and (2) the QFP – the joint CDC and OPA publication on clinical standards for providing quality family planning services. The QFP describes national clinical guidance for any family planning provider, whether funded by Title X or not. OPA has explicitly incorporated the QFP into its current directions for and monitoring of Title X programs. Program Requirements at 5-6. [10]

41. The Program Requirements describe the purpose of Title X as I have above: "[t]o assist individuals in determining the number and spacing of their children through the provision of affordable, voluntary family planning services." Program Requirements at 5. The OPA summary in that document continues as follows:

> The Title X Family Planning Program is the only Federal program dedicated solely to the provision of family planning and related preventive health services. The program is designed to provide contraceptive supplies and information to all who want and need them, with priority given to persons from low-income families. All Title X-funded projects are required to offer a broad range of acceptable and effective medically (U.S. Food and Drug Administration (FDA)) approved contraceptive methods and related services on a voluntary and confidential basis. Title X services include the delivery of related preventive health services, including patient education and counseling; cervical and breast cancer screening; sexually transmitted disease (STD) and human immunodeficiency virus (HIV) prevention education, testing, and referral; and pregnancy diagnosis and counseling. By law, Title X funds may not be used in programs where abortion is a method of family planning.

[10] OPA, *Program Requirements for Title X Funded Family Planning Projects* at 5-6 (April 2014), https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf.

Program Requirements at 5. The Program Requirements then describe in detail, over approximately 15 pages, OPA's regulatory requirements for Title X projects ("as set out in the Title X statute and implementing regulations") – in order to, in conjunction with the QFP, "assist current and prospective grantees in understanding and implementing the family planning services grants program" and "form the basis for monitoring projects under" the program. Program Requirements at 5-6.

42. The QFP set new national clinical standards for family planning services, after a lengthy process involving dozens of technical experts and the Expert Working Group of which I was a part. It drew on the CDC's "long-standing history of developing evidence-based recommendations for clinical care" and the fact that "OPA's Title X Family Planning Program has served as the national leader in direct family planning service delivery" since 1970. QFP at 2. [11]

43. The QFP's recommendations "outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services." QFP at 1. These recommendations, for example, are used by medical directors, including those who oversee Title X projects, "to write clinical protocols that describe how care should be provided." QFP at 3.

44. As described in the QFP, its central premise "is that improving the quality of family planning services will lead to improved reproductive health outcomes." QFP at 2. Chief among the essential attributes of quality care (listed directly after safety and effectiveness) is a

[11] CDC & OPA, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs* ("the QFP"), 63:4 Morbidity & Mortality Weekly Report at 2 (April 25, 2014), available at https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

client-centered approach. This means starting from and respecting the client's reason for seeking family planning care. QFP at 2, 4. Individual "client values guide all clinical decisions." QFP at 4. The "primary purpose for visiting the service site must be respected." QFP at 2. The QFP also prioritizes effectiveness and, for example, "support[s] offering a full range of Food and Drug Administration (FDA)-approved contraceptive methods as well as counseling that highlights the effectiveness of contraceptive methods" so that "clients can make a selection based on their individual needs and preferences." QFP at 2. The QFP further emphasizes equitable, evidence-based care consistent with current professional knowledge, so that family planning care does not vary in quality because of the personal characteristics of clients. QFP at 4.

45. The QFP underscores the importance of providing confidential services to all patients. QFP at 2. That is consistent with the explicit Title X regulations that protect the confidentiality of all individuals receiving services, regardless of age, marital status or other characteristics.

Title X Services Funding and Grant-Making

46. The Title X family planning program, including services projects, are funded annually through HHS appropriations. The recently-passed Fiscal Year 2018 omnibus appropriations legislation provides $286,479,000 for Title X funding.

47. This is the same amount appropriated for each year from 2015 to 2017. The largest appropriation to Title X was in Fiscal Year 2010, at over $317 million. After that year, sequential cuts in funding followed.

48. To fully meet the needs of women for subsidized family planning care, the program would today require in excess of $700 million annually, assuming the Affordable Care

Act ("ACA") stays in place. Without the ACA, the need would be even greater. In 2001, Title X satisfied 28% of the need for publicly funded contraceptive services and supplies; by 2015 that number had shrunk to approximately 20%.[12]

49. Under the Title X regulations, no grant may be made for 100% of the project's estimated costs. Thus, each Title X services project must raise additional money to fund its operations.

50. The Title X grants subsidize the project's operation, from staff salaries and training, to equipment, overhead, and administrative expenses, to laboratory tests, contraceptive supplies, and other materials. Although the structure of Title X necessitates additional funding to support the project, providers must follow the Title X requirements as to how they spend all of their project dollars. Title X providers are also required to bill all third parties (whether government or commercial) that are authorized or legally obligated to pay for any clients' services (including clients with incomes below the federal poverty line) and make reasonable efforts to collect charges from such third-party payers without jeopardizing client confidentiality.

51. Title X projects are substantial undertakings: with each project grantee typically responsible for millions of project dollars (often with multiple sub-recipients and dozens of service sites) to provide specialized care, and each project subject to elaborate regulatory, compliance and reporting requirements. The recruitment, vetting, training, and coordination with sub-recipients are especially intense tasks as a project's network of providers is first established. Likewise, special budgeting, billing and other administrative processes must be put in place to comply with Title X requirements. Thus, the initial establishment of a Title X

[12] Frost, et al., *Contraceptive Needs and Services, 2014 Update,* Guttmacher Institute (Sept. 2016), available at https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

project's service network, clinical protocols, and administrative processes typically takes many months to accomplish.

52. Over time, the Title X primary grantees and sub-recipients have been relatively stable, and many now have deep expertise and decades of experience in providing family planning methods and services to their primarily low-income patients. They also typically offer night and weekend hours, and have shaped their projects to best meet local needs. Many service sites are specialized family planning centers, whether run by non-profit providers or within government health departments, with all clinicians spending full-time on family planning care. Their specialization and expertise have benefited patients in essential ways: Specialized providers are significantly more likely to provide the full range of FDA-approved contraceptives including IUDs and contraceptive implants, onsite.[13] Those contraceptive methods – LARCs or long-acting reversible contraceptives – are by far the most effective contraceptive methods.[14] In addition, many patients prefer accessing care through the specialized Title X providers.[15]

53. Compared with non-Title X family planning providers, Title X sites provide higher quality care and are better able to help clients start and effectively use their chosen method of family planning.[16] A joint HHS and CDC study showed that Title X centers

[13] *See, e.g.*, Bocanegra, et al., *Onsite Provision of Specialized Contraceptive Services: Does Title X Funding Enhance Access?*, J. Women's Health (May 2014), *abstract available at* https://www.liebertpub.com/doi/full/10.1089/jwh.2013.4511; *see also* Frost, et al., *Publicly Funded Family Planning Clinics in 2015, supra*.

[14] CDC Fact Sheet, *Effectiveness of Family Planning Methods*, https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/pdf/Contraceptive_methods_508.pdf.

[15] Frost, et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 *Women's Health Issues* 519, 525 (2012), https://doi.org/10.1016/j.whi.2012.09.002.

[16] *See, e.g.*, Hasstedt, *Why We Cannot Afford to Undercut the Title X National Family Planning Program*, 20 Guttmacher Policy Review 20, 21-22 (May 17, 2017); Hasstedt, *Understanding Planned Parenthood's Critical Role in the Nation's Family Planning Safety Net*, 20 Guttmacher

consistently outperform other non-Title X publicly funded providers, such as most FQHCs, in their compliance with best practices for family planning care.[17]

54. OPA has most commonly made Title X project grants for three years, with annual progress reports, updated work plans, and budget submissions required each year in order to continue the grant for the three-year period. OPA initiates the grant-making process by issuing a funding opportunity announcement ("FOA"). Title X project grants are competitive grants, and the competitive grant FOA specifies the regions, states or territories for which applications are being solicited. In the past, FOA has staggered the years in which Title X grants related to particular states or territories are subject to competition – i.e., initial grant-making rather than year two or later of an awarded grant – and thus has not had the entire country competing all at once, at least for quite some time.

55. The FOA tells grantees and prospective grantees, in precise detail, the requirements for any proposed Title X project and for the application describing that proposed project. Each FOA includes a program description, which historically (through 2017) has referenced the full set of OPA governing authorities and made clear that: "All activities funded under this announcement must be consistent with the Title X statute, regulations and legislative mandates, and are expected to be in compliance with the Program Guidelines and Policy Notices." 2017 FOA at 8.[18]

Policy Review 12, 12-13 (2017), https://www.guttmacher.org/gpr/2017/01/understanding-planned-parenthoods-critical-role-nations-family-planning-safety-net.

[17] Carter, et al., *Four aspects of the scope and quality of family planning services in U.S. health centers: Results from a survey of health center administrators*, 94 J. Contraception 340 (2016), *abstract available at* http://dx.doi.org/10.1016/j.contraception.2016.04.009.

[18] 2017 FOA available at https://www.hhs.gov/opa/sites/default/files/FY-17-Title-X-FOA-New-Competitions.pdf.

56. The FOA also specifies the criteria and process that OPA will use to award the grants. Since 1971, the regulations have specified the following seven criteria:

> (1) The number of patients, and, in particular, the number of low-income patients to be served;
> (2) The extent to which family planning services are needed locally;
> (3) The relative need of the applicant;
> (4) The capacity of the applicant to make rapid and effective use of the federal assistance;
> (5) The adequacy of the applicant's facilities and staff;
> (6) The relative availability of non-federal resources within the community to be served and the degree to which those resources are committed to the project; and
> (7) The degree to which the project plan adequately provides for the requirements set forth in these [Title X] regulations.

42 C.F.R. § 59.7. The yearly FOAs have occasionally altered a word or added an explanatory phrase, but have never deviated from these same seven criteria.

57. In recent years, OPA has often included in the competitive FOAs designated point allocations for each of the seven criteria, to further specify the relative weight that each criterion is given in the grant award decision-making process, with the points adding up to 100. From 2001 through 2017, the seven criteria have been given 10 to 20 points each (with no single criterion receiving more than 20), except that the relative need of the applicant has been given only 5 points in recent years.

58. HHS's agency-wide review process requires that a competitive FOA fully set forth the criteria for reviewing, scoring and awarding grant applications. Merits review panels are given the FOA and required to use only the specified or referenced criteria and descriptions of the program therein to assess the applications. Thus, as reflected by past practice and my discussions with HHS personnel, review panels are not provided with any documents not referenced in the FOA, and therefore do not see, for example, any answers to FAQs provided to grant applicants during the application process. The review panels score and rank the

applications based on the FOA's criteria. Likewise, final decision-making by the designated HHS officials must occur as specified in the FOA, and be limited by the review criteria and the proposed projects' geographic distribution.

59. In addition to the decision-making criteria for Title X services grants, competitive FOAs for Title X have often included a number of "program priorities" and/or "key issues" that articulate HHS's or OPA's topical concerns in a particular year. These have functioned as "add on" ideas or matters of emphasis to be considered by the applicant and to serve as goals for further project development, but they have never previously been a part of the application scoring, added any new grant decision-making criteria, or been designated as additional requirements for Title X projects.

The Altered and Uncertain Timing of Fiscal Year 2018 Grant-making

60. By 2017, all competitive Title X services grants had started on either April 1 or July 1 of a given year. The FOA for Title X competitions, which most recently determined 3-year grant cycles, would come out several months before those dates.

61. In July 2017, however, all competitive awards – as well as all continuing awards from previous competitions on the July cycle – were issued only for a one-year period, to end on June 30, 2018. All grants that had started on an April 1 date and had project periods not scheduled to end on March 31, 2018, received a notice in 2017 from HHS stating that their grants too would nonetheless end on March 31, 2018, and that they would be receiving revised notices of award that reflected that change.

62. When grantees inquired about these unexpected changes to the award periods and the shortening of already-awarded grants, OPA referred to changes in priorities and the

convenience of the government. Grantees were told to anticipate a new FOA in September or October 2017 that would reflect the changed approach.

63. That new FOA was delayed and not released until February 2018. Because it takes months to coordinate the content of and prepare a Title X services grant application, and then takes months for the merits review by scoring panels and OPA final decision-making, this meant that new awards could not possibly be awarded by April 1 or July 1, 2018.

64. Instead, OPA has notified current grantees whose previous awards ended in March 2018 or will end in June 2018 that continuation grants (known as "cost extensions") are available to continue their funding until new award decisions are made and the grant period for new Fiscal Year 2018 awards begins. The grantees whose awards ended in March are now operating under such cost extensions.

65. On February 23, 2018, OPA released the 2018 FOA. Applications are due on May 24, 2018. The FOA gives the estimated start date for grants awarded under it as September 1, 2018. The FOA states that HHS "seeks to award funds as much in advance of the anticipated project state date … as practicable, with a goal of 10-15 days. Note that this is an estimated start date and award announcements may be made at a later date and with a later project period start time." 2018 FOA at 47.

66. Once applications are filed electronically and then transferred from the grant application platform to HHS, they are first reviewed by the agency for any disqualifying characteristics. Then HHS convenes the review panels charged with scoring the applications.

67. According to the FOA, all award decisions under it "are final and you may not appeal." 2018 FOA at 45.

The Changes Wrought by the 2018 FOA

68. The 2018 FOA directs funding away from Title X's purpose of providing access to modern, high-quality family planning clinical care, including contraceptives, regardless of a patient's means and responsive to a patient's desires, and instead requires an emphasis within Title X projects on changing a client's behaviors or stressing a particular model for their lives. The FOA's directive, value-based messages and new required activities are inconsistent with the Title X statute, regulations, and current program requirements, extend the program well beyond "services necessary to aid individuals to determine freely the number and spacing of their children," and diminish the central role of clinical care. The 2018 FOA's terms and required bases for decision-making highjack funds and program efforts that should instead go to proper Title X family planning health care and related activities, open these grants to new types of competitors using impermissible criteria, and thereby misdirect grant decision-making to the detriment of NFPRHA member grantees and the clients with low income who most need these services.

69. Strikingly, the 2018 FOA nowhere uses the word contraceptive or contraception at any point in its 60 pages.

70. Similarly, the 2018 FOA nowhere mentions the QFP or requires compliance with its clinical standards of care for quality family planning programs. Likewise, the 2018 FOA nowhere mentions OPA's own Program Requirements and Policy Notices, or otherwise tells prospective grantees that their programs must follow those.

71. Instead, the 2018 FOA encourages applications for projects that use methods that are "historically underrepresented in the Title X program." 2018 FOA at 7. Because Title X providers have been in the forefront of offering all methods of family planning, including the

most effective and up-to-date ones, for ultimate choice by patients, this preference for "underrepresented" methods represents a step backward from current clinical standards and patient wishes. The FOA also repeatedly reiterates the need to include natural family planning methods, also known as fertility awareness methods, which are already part of Title X programs, but are one of the least effective methods (according to HHS) and chosen by less than 0.5% of users. 2016 FPAR at A-21. Thus, despite the fact that the regulations require projects to offer a broad range of "acceptable and effective medically approved family planning methods and services," the 2018 FOA names only natural family planning, one of the least effective and acceptable methods (as demonstrated by its low demand), and ignores the regulations' specific requirements that Title X projects, for example, "provide for the effective use of contraceptive devices and practices" by their patients. 42 C.F.R. § 59.5(a)(1), (b)(1).

72. The 2018 FOA also now adds an eighth criterion to the seven that have governed since 1971, and gives the new eighth criterion the highest weight in scoring applications – 25%. 2018 FOA at 43-45.

73. Critically, the eighth criterion is the "degree to which the project plan adequately provides for the effective and efficient implementation of requirements set forth in the priorities and key issues" of the FOA. 2018 FOA at 44. Those priorities and key issues and their now-25% of the points that must be used to determine grants redirect Title X projects and resources *away* from up-to-date, comprehensive clinical family planning care driven by individual patients' requests and desires, and *toward* projects that instead require providers to articulate certain values and that assure that any care is "contextualized" within a model that promotes optimal life outcomes, as determined by OPA, not the patient.

74. This is a one-size-fits-all approach that asks Title X projects to stress marriage and abstinence as the choice until then. Relatedly, the eighth criterion, with its incorporated priorities and key issues, also scores "cooperation with" faith-based and other community organizations for the first time in determining Title X grants.

75. Rather than starting from and responding to the individual patient's life circumstances, reasons for the visit, and request for care as the QFP requires, the 25% eighth criterion requires, among other things, that Title X programs place a "meaningful emphasis" on directive messages from the provider about "healthy decision-making," committed, healthy marriages and the benefits, for clients of all ages, of "avoiding sexual risk or returning to a sexually risk-free status[.]" 2018 FOA at 10-11. Title X providers are told to "prioritize optimal health and life outcomes" and to "contextualize Title X services[.]" 2018 FOA at 10.

76. These terms and phrases may seem generic, but they are in fact the buzzwords of abstinence-only-until-marriage approaches to sex education in schools, now sometimes called "sexual risk avoidance."[19] Abstinence-only and "sexual risk avoidance" are described by their advocates as the means of achieving "optimal health" by delaying sexual activity until a faithful marriage. As the advocacy organization Ascend (formerly known as the National Abstinence Education Association) describes it, the sexual risk avoidance sex education that it advocates helps youth achieve "optimal health" and empowers them to make the "healthiest choices." Ascend, *Sexual Risk Avoidance Works* 3 (2016), https://weascend.org/wp-content/uploads/2017/10/sraworksweb.pdf. Ascend has taken the position that the benefits of

[19] *See, e.g.*, Boyer, *New Name, Same Harm: Rebranding of Federal Abstinence-Only Programs*, The Guttmacher Institute (Feb. 18, 2018), https://www.guttmacher.org/gpr/2018/02/new-name-same-harm-rebranding-federal-abstinence-only-programs.

"sexual delay (preferably until marriage)" are "benefits that contraception can never duplicate." *Id.*

77. According to Ascend, the sexual risk avoidance approach "includes a cessation intervention approach" for those who are sexually active, offering the "encouragement and skills to return to an optimally healthy lifestyle free from all sexual risk." *Id.* at 7. The sexual risk avoidance "approach is holistic, linking and contextualizing the value of avoiding sex" with other components of life, including by providing "information on the non-physical consequences" that can accompany sex and on "the practical skills associated with healthy decision-making, and … healthy relationships." *Id.* The 2018 FOA requires a "meaningful emphasis" on this abstinence-only approach not only when communicating with adolescents, but within each Title X project for clients of *all ages*. 2018 FOA at 11 (Key Issue 5); *see also* 2018 FOA at 5-8, 9-10 (Priorities 1 & 2).

78. The eighth criterion also requires "activities for adolescents that do not normalize sexual risk behaviors" (by which it means any sex) and requires other activities for all clients that "promote positive family relationships." 2018 FOA at 10-11.

79. Each of these mandates is highly problematic for NFPRHA's members. The new priorities require Title X providers to pursue messages endorsed by OPA, rather than, again, responding to the client's reasons for the visit, their personal circumstances, and their own values. They direct Title X providers to pursue an overall "holistic vision of health" devised for clients by OPA, while making so-called "core family planning services" only a minimal part of Title X projects. 2018 FOA at 9.

80. Not only does the changed approach required by the FOA prioritize information and services that will be ineffective at meeting important health goals of Title X patients – only a

tiny percentage of whom say that they are abstinent – but by pushing messages that are at odds with their life circumstances and values, providers risk alienating patients from the critical, indeed sometimes life-saving, clinical family planning and related preventive services that Title X health centers offer.

81. The 2018 FOA accomplishes its changes to application scoring and the nature of Title X projects by mandating these criteria in merits review scoring and ultimate grant decisions:

> a. The number of patients, and, in particular, the number of low-income patients to be served (10 points);
> b. The extent to which the applicant's family planning services are needed locally (10 points);
> c. The relative need of the applicant (15 points);
> d. The capacity of the applicant to make rapid and effective use of the Federal assistance (10 points);
> e. The adequacy of the applicant's facilities and staff, demonstrating that the staff are adequately trained to carry out the program requirements, as well as the priorities and key issues outlined in this announcement. For applicants that will not provide all services directly, the extent to which the applicant has documented the process and selection criteria it will use for providing an opportunity to receive subawards to qualified entities eligible to receive federal funds in providing services throughout the service area to meet the needs of project beneficiaries. (10 points);
> f. The relative availability of non-federal resources within the community to be served and the degree to which those resources are committed to the project (10 points);
> g. The degree to which the project plan adequately provides for the requirements set forth in the Title X regulations, subpart A (10 points); and
> h. The degree to which the project plan adequately provides for the effective and efficient implementation of requirements set forth in the priorities and key issues outlined on pages 9-11 of this funding announcement (25 points).

2018 FOA at 43-44.

82. In the 2018 FOA, the annual priorities and key issues are transformed from "add on," if-possible elements in an FOA, which before have reflected ever-changing aspirational goals and have never been a part of application scoring, to "requirements." 2018 FOA at 44.

Those requirements must be effectively and efficiently implemented, and have become the most important components of each application, allotted 25% of all points. 2018 FOA at 44. In addition, the 2018 FOA also adds the priorities and key issues into criterion (e), worth another 10 points, and increases the need of the grant *applicant* (not its potential patients) to the second-highest point value, 15 points. In so doing, the 2018 FOA significantly alters the nature of requested Title X project applications, and the overall constellation of grants and grant recipients that will result, if the FOA is allowed to govern.

83. The 2018 FOA diminishes the role of contraception methods and services and does not require compliance with QFP clinical standards of care, while prioritizing certain types of grant applicants and grant content that are not focused on aiding "individuals to determine freely the number and spacing of their children" – and that would in many instances undermine patients' dignity, contrary to the Title X regulations.

84. For example, the 2018 FOA requires evidence that clinicians will attempt to use "counseling techniques that encourage family participation for *all clients*, including the involvement of parents, spouses or [other] family where practicable," 2018 FOA at 22 (emphasis added), though at the same time recognizing that this may not be in the best interest of the client; under the QFP, such counseling techniques should not be used for "all clients." If a clinician, following the scored priorities and key issues, attempts to promote "positive family relationships" when those are not a possibility, or emphasizes the benefits of returning to a sexually risk-free status to a single adult who wishes to stay sexually active, or to an unmarried couple that wishes to continue to have sex, such actions fail to respect the dignity of patients and their freedom to make their own choices and violate basic tenets of good medical care.

85. Moreover, requiring a sexually active, unmarried patient who is seeking a contraceptive device to first sit through counseling on the benefits of abstaining from sexual activity unless and until she gets married, before she can obtain the contraception she came to the health center for, likewise runs counter to the national standards and accepted practice. In addition, it runs directly counter to Title X regulations that require the provision of services "without subjecting individuals to any coercion to . . . employ . . . any particular methods of family planning" and that "[a]cceptance of services must be solely on a voluntary basis and may not be made a pre-requisite to . . . receipt of, any other service." 42 C.F.R. § 59.5.

86. Despite the 2018 FOA's remarks that grants under it will promote the purposes of section 1001 of Title X, its substance cuts strongly in the other direction.

87. For example, this FOA's required scoring gives more points to the "relative need of the [grant] applicant" (15 points) (as well as to the new eighth criterion) than it does to the extent to which family planning services are needed locally (10 points). Likewise, the need of the grant applicant gets more points than either its capacity to make "rapid and effective use of the Federal assistance (10 points)" or the "degree to which the project plan adequately provides for the requirements set forth in the Title X regulations, subpart A (10 points)." 2018 FOA at 43-44.

88. Take for example a grant application from a nonprofit organization with a directive mission to stress sexually-risk-free status, emphasize the commitment needed for healthy marriages, not normalize extra-marital or adolescent sexual behavior, and contextualize care to advance the organization's views as to optimal outcomes for an individual's physical, emotional, and social health (25 points), and with staff already trained and facilities already designed to serve that mission (10 points), but with no funding for or experience with family

planning work at present, and thus great need to expand its own resources (15 points). Such an applicant, under this 2018 FOA, would have a considerable advantage over established, specialized family planning clinical providers who can provide rapid and effective use of the Federal assistance (10 points), have the commitment of non-federal resources (10 points), and fully provide for the requirements set forth in the Title X regulations (10 points).

89. In addition, the 2018 FOA, unlike previous FOAs, repeatedly references that a project can include not just the grantee and formal sub-recipients, but also "documented partners," and that OPA's review will use all of those entities to determine whether a project provides the area to be served "with a variety and breadth of effective family planning methods …." 2018 FOA at 45. Similarly, the 2018 FOA indicates that "signed referral agreements" could be used to provide "all required clinical services," 2018 FOA at 23, rather than grantees and/or sub-recipients directly providing clinical services on site at their own facilities.

90. All of these changes mean that a grant program designed to directly provide low-income individuals with access to the same clinical family planning methods and services – especially biomedical contraception and other medical advances – that those with more resources can readily access on their own could instead, for the first time, fund instead a primarily education-focused project to emphasize OPA's newly-stated behavioral values, with clinical services available only tangentially or only through referral to an outside provider.

The Irreparable Harms If this FOA Is Allowed to Govern Grant-making

91. If the 2018 FOA is allowed to govern OPA application review and grant decision-making, as it purports to do, the FOA will fundamentally shift the Title X program as a whole away from its intended purpose of providing voluntary access to the quality, clinical family planning care necessary to aid low-income patients and to give them the same options as others.

It will shortchange the low-income women, men and adolescents that Title X is designed to serve in ways that cannot be undone.

92. NFPRHA members are now working hard to take steps that in their judgment will put them in the best position to maintain their status as grantees or sub-recipients and to win grant funding from the Fiscal Year 2018 appropriations, because they want to continue to serve their clients. For current grantees, that means preparing the most competitive application they can under the 2018 FOA, whether by adding or subtracting sub-recipients or referral relationships, instituting new training or protocols, or taking other steps that attempt to at least partially meet OPA's changed direction and new requirements that shift resources away from clinical family planning care (while also highlighting the current grantees' ongoing strengths). These changes caused by the 2018 FOA will of necessity govern their projects under it, if funded. 2018 FOA at 48.

93. If it were not for the 2018 FOA, many NFPRHA members would be making different decisions about their future plans for their Title X projects. Right now they face a Hobson's choice. In order to get the funding they need to allow them and their networks to continue providing Title X care to patients, they must shift resources away from providing high-quality, clinical care that is responsive to patients' needs, including access to effective forms of contraception, toward developing and implementing programs that may respond to patients' needs with information that is out of touch with patients' lives, ineffective in helping them achieve their reproductive plans, and not designed to foster patients' continuing participation in Title X services. As a result of the 2018 FOA, NFPRHA members are being forced to make some decisions regarding sub-recipients, other partners, programs, staffing, and services that are geared toward meeting the FOA's requirements rather than what they know, based on their

experience and expertise, would allow them to most effectively respond to the needs of the patients they serve.

94. Yet if they do not do so, they run an even higher risk of losing funding to inexperienced entities that will provide care that is less effective and less appropriate for the patients who rely on Title X-funded sites for their care. For example, the 2018 FOA opens the door to grant applicants that do not provide any clinical care and will not do so within a project's sub-recipients, instead providing only referrals to medical providers. It opens the door to applicants who may provide some minimal clinical care or prescription writing within their project sites, but who plan to spend a majority of funds on ideological, judgmental education efforts, such as advocating that clients refrain from all sex outside of marriage, rather than providing clients access to methods of family planning that are acceptable and effective for them.

95. NFPRHA's members and other current grantees should not have to compete for an ongoing role in the Title X program on these terms. Existing grantees are being asked to either significantly alter their programs to attempt to secure future Title X funding and then to operate under that result, or face the very real risk of being denied some or all of their requested Title X funds.

96. NFPRHA members are each trying to cope with these impermissible new application review criteria and the new requirements for Title X projects that the criteria incorporate, and making a range of decisions in how to do so, but with no way to avoid the 2018 FOA's impact. Most are making some changes, ranging from small to large, in their networks of sub-recipients, their referral partners and/or their programming, that they would not otherwise make in their own best judgment about how to provide Title X care and to pursue their organizational mission, were it not for the new 2018 FOA application review criteria. At the

same time, despite this diversion of resources and these new FOA-imposed priorities that both conflict with Title X's purpose and threaten NFPRHA members' continued participation in the program, NFPRHA's members are working hard to continue their long-standing, effective approaches. Because NFPRHA members will not compromise central aspects of their Title X work, our members are greatly disadvantaged under these new criteria. In a program where stability in the network typically allows grantees to use federal funds most rapidly and effectively, NFPRHA members and other existing grantees now face the substantial risk of an end to their participation in this sole dedicated federal program to provide family planning services as a result of the impermissible 2018 FOA standards.

97. If the 2018 FOA criteria and specified grant-making process are allowed to remain in place, and regardless of which applicants might win awards, this FOA's provisions will have the overall effect of moving funds and time from Title X projects' work in offering comprehensive access to family planning methods and services to instead expend those Title X funds for directive social messages about broader topics, reflecting required OPA values and imposing those values on all clients, regardless of their own preferences. Among NFPRHA's members – the long-standing backbone and large majority of providers in the Title X program – a large number are at risk of losing most or all Title X funds and all are, under the terms of the 2018 FOA, being told to change the direction of their programming in order to attempt to remain in the Title X network.

98. In fact, based on the advantages that the 2018 FOA gives to applicants who are not specialized family planning service providers and the other aspects of its new scoring scheme, I have no doubt that some NFPRHA members will face severe reductions in their Title X grant funding or lose their role in Title X care entirely if the 2018 FOA is allowed to govern

decision-making. Any such cut in Title X funds will have a direct impact on NFPRHA members' functions: There will be cuts in health centers' hours, staff layoffs, and, in some cases, health centers will be closed. As a result of these reductions, fewer patients will receive much-needed contraceptive and preventive services, as NFPRHA members are often low-income patients' only option. Once cuts and closures occur, rebuilding takes years, if it can happen at all. NFPRHA members cannot just rehire experienced staff who were laid off, rebuild relationships with patients who they were unable to serve, restart programing and reproductive health care services that were eliminated, and reopen health centers – even if the 2018 FOA were found unlawful after the grant awards have been made.

99. Moreover, new grantees will not be able to fill the need for services created by NFPRHA members' forced service reductions. To the extent that use of the 2018 FOA results in replacing established family planning providers from the Title X network with entities that have little experience providing this care, it will cause substantial gaps in the provision of family planning services for a number of reasons. As discussed above, there is good reason to believe that allowing grants to be awarded under the 2018 FOA will result in the inclusion of entities that do not focus on clinical services and will provide family planning services only tangentially. But even if all the awards went to new entities sincerely attempting to build a new reproductive health care network to serve family planning patients, there would still be significant problems: Entities are expected to have their projects up and running within days after learning they have been awarded the grant. It is virtually impossible for new grantees without systems in place to immediately provide care for the thousands of patients in their area who rely on the Title X program.

100. The 2018 FOA invites this crisis by de-emphasizing applicants' ability to rapidly make use of the funds while giving a boost to applicants that are not experienced in providing family planning services, that instead focus on primary care, and that have advocacy priorities. Additionally, new grantees need time to establish themselves in communities, where patients are familiar with and accustomed to obtaining care at the existing service sites that have been in communities for significant periods of time. While it is, of course, true that some grantees leave the network, and others join over time, I cannot recall a time when the entire national network was competing for grants at the same time, as is the case now. As a result of the impermissible changes to the 2018 FOA that are likely to cause a significant shift in the grantee landscape, the gaps in service are likely to be massive and will impact those least able to find alternative care.

101. If not enjoined, the 2018 FOA will not only harm many NFPRHA member entities directly, but will disrupt access to preventive care for many thousands of individuals who benefit from Title X funding by accessing Title X-supported sites operated by NFPRHA members. Once the specialized family planning providers close or cut vital services, many patients will be left without access, because new Title X grantees will be unable to rapidly or effectively replace the reproductive health care that the patients have come to rely on– with terrible results. Patients will lose access to the "broad range of effective and acceptable medically approved contraceptive methods" that NFPRHA members specialize in providing, and will have to utilize less effective methods.

102. As noted above, NFPRHA members' and other current Title X projects are more likely to have IUDs and other long-acting reversible contraceptive methods available onsite, which are more effective methods, but also more expensive. A reduction in Title X services would put such methods out of reach for the low-income patients who are Title X's priority.

Patients will also lose access to the panoply of other family planning-related services offered so effectively by existing Title X health centers, including screenings for breast and cervical cancer, STI and HIV testing, and pregnancy diagnosis. Without access to reliable contraceptives and these additional family planning-related services, individuals will experience higher rates unintended pregnancies, infertility, STIs and HIV, and will be subject to the very type of vulnerabilities that Title X has always sought to ameliorate.

103. These effects will fall hardest on low-income people, people of color, and young people. Closures and reductions in services will also have a greater impact on rural areas, where Title X health centers are often the only reproductive healthcare provider available for low-income individuals in those areas.

104. The Title X program has been a public health safety-net success for decades. NFPRHA member grantees have been an essential part of that success. If the 2018 FOA is allowed to govern grant awards it would cause irreparable damage to NFPRHA's members and the Title X program as a whole. Moreover, by cutting off access to essential care and experienced health care professionals, it would have devastating consequences for the health and lives of those Title X was designed to serve and their family planning objectives.

For all these reasons, NFPRHA and I support the motion for injunctive relief.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 8th day of May 2018.

Clare M. Coleman