

FAMILY PLANNING *Matters*

National Family Planning & Reproductive Health Association

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Sticking Together: The Family Planning Network in the Face of Adversity

By: *Burke Hays*

Even passive followers of the news have undoubtedly noticed the unusual amount of scrutiny directed at Planned Parenthood by Congress over the past year. A new wave of attention began in July 2015 when the Center for Medical Progress, a sham organization, released a series of misleading and highly edited undercover videos that suggested Planned Parenthood was in the business of selling fetal tissue for profit. Many media outlets and lawmakers quickly renounced the videos as little more than a blatant attempt to sully the good name of a respected and trusted health care provider. Nonetheless, the videos set off a political firestorm that consumed much of Congress' work over the following months.

Many of the bills that came in the aftermath of the videos obliquely targeted Planned Parenthood, yet others took direct aim. Representative David Jolly's (R-FL) bill (HR 3301), for example, would have barred Planned Parenthood from receiving any federal money, while others such as Representative Diane Black's (R-TN) legislation (HR 3134) sought to prohibit Planned Parenthood from accessing Title X funds while the US Government Accountability Office conducted a two-year investigation of the organization's health care practices. Neither of the bills, nor other similarly deleterious legislation attacking Planned Parenthood, advanced beyond the House. Nevertheless, Republican leaders in both chambers continued to hold a series of special committee hearings throughout the summer and fall that intended to mischaracterize Planned Parenthood's use of federal funds and promote demagoguery about services provided at its health care centers.

Senate Democrats served as a much-needed backstop to actions in Congress by threatening to filibuster any bill that placed women's access to reproductive health care services in jeopardy. However, their ability to do so ended in the fall when congressional Republicans stopped using the traditional legislative process and instead began

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utilizing a powerful budget maneuver, known as reconciliation, to attack Planned Parenthood. The Senate rules for reconciliation are different than those for other legislative measures: passage only requires 51 votes rather than 60, the standard threshold for a filibuster-proof majority. Congressional Republicans were therefore able to pass HR 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, in both chambers. The bill not only would have excluded Planned Parenthood from Medicaid for one year, it would have also redirected funding by providing an additional \$235 million to federally qualified health centers (FQHC) under the Section 330 program during the same one-year period. The \$235 million reflects multi-year federal savings that the Congressional Budget Office reported would be achieved by banning Planned Parenthood from participating in Medicaid for one year. The bill also repealed major pieces of the Affordable Care Act (ACA), and eliminated the Prevention and Public Health Fund. In early January, Congress sent the legislation to the White House, and President Obama promptly vetoed it.

It has been an exceptionally tough several years for the entire publicly funded family planning network. Planned Parenthood receives much of the public and political hostility because they are family planning's "name brand." However, examination of the nature of those attacks reveals they are really intended to undermine the entirety of the provider network, not just Planned Parenthood. Case in point: In June 2015, the House Appropriations Labor, Health and Human Services, Education, and Related Agencies Subcommittee completely eliminated funding for the Title X program in its annual spending bill. Republican members supporting program elimination claimed that Planned Parenthood health centers use Title X as fungible dollars to pad budgets and free up funds for so-called controversial operations such as abortion care and sexual health education. Had Planned Parenthood been their sole target, appropriators could have simply prohibited Planned Parenthood from receiving Title X funds while allowing other reproductive health providers to access the program. Instead, their willingness to completely eliminate the program is a strong indication that the true aim of many members of Congress is to systematically dismantle the entirety of the publicly funded family planning network.

On the state level, there is similar evidence that conservative lawmakers have set their sights beyond defunding Planned Parenthood. In 2011, the Texas legislature cut state family planning funds by two-thirds, slashing the budget from \$111 million to \$37.9 million.¹ Much of the argument for doing so centered on the role of Planned Parenthood as part of the

family planning network in Texas and need to exclude it and other abortion providers from accessing state funds. Legislators agreed that the small amount of remaining for family planning services would be distributed on a three-level tiering system that first prioritized funding for health departments, then FQHCs, and finally standalone family planning health centers.

In the end, cutting state funds and excluding abortion providers such as Planned Parenthood left the remaining family planning health centers with less money and more patients to serve.

At the same time, the state began excluding abortion providers, including Planned Parenthood, from receiving funds through its Women's Health Program, the state's Medicaid family planning expansion. The state even went so far as to exclude providers that were part of a practice where another physician performed abortions, even though those health centers did not offer the procedure. Texas' abortion exclusions were a violation of federal law, and the restrictions ultimately ended the state-federal partnership that provided family planning services through the Medicaid waiver. Nevertheless, the state opted to administer a Women's Health Program using only state dollars so it could continue excluding abortion providers. Although abortion providers represented just 2% of the total Women's Health Program provider network, they provided health care to half of the women covered by the Medicaid family planning waiver. In the end, cutting state funds and excluding abortion providers such as Planned Parenthood left the remaining family planning health centers with less money and more patients to serve. The resulting strain forced many centers to close their doors, stranding millions of women and men without access to family planning and sexual health care services²—likely Texas conservative lawmakers' true intent. Since then, several other states have followed Texas' example by enacting similar "tiering" laws and abortion provider exclusions, and each have had a similarly devastating effect on the entirety of the publicly funded family planning network in those states.

Whether lawmakers' true intent is to bring down the entire publicly funded family planning network or dismantle Planned Parenthood may be insignificant. The fact is, their concerted attempts exclude Planned Parenthood *are* compromising publicly funded family planning. Each attack on Planned Parenthood disrupts an essential component of the network: the ability of communities to design a provider network that meets the unique

¹ Leighton Ku, Lara Cartwright-Smith, Jessica Sharac, Erika Steinmetz, Julie Lewis, Peter Shin, Deteriorating Access to Women's Health in Texas: Potential Effects of the Women's Health Program Affiliate Rule (Washington, DC: Geiger Gibson RCHN Community Health Foundation Research Collaborative Report, The George Washington University, October 2012) available at <http://www.rchnfoundation.org/wp-content/uploads/2013/02/Texas-WHP-study-FINALFINAL-pdf-10.10.12.pdf>.

² *Ibid.*

needs of their communities. That disruption is an attack on the public's health.

Ejecting a trusted, high-quality family planning provider from the network puts undue financial pressure on the network and hinders providers' capacity to care for patients. When a health center is forced to close its doors, the Title X grantee must begin a long and arduous process of recruiting and training a new provider. The time, money, and other resources devoted to that process could easily be used by an existing member of the network to provide needed health services. Moreover, after the grantee identifies a replacement provider, it can often take several years before that provider is able to build the same volume of patients as the previous provider. If a community cannot identify a provider willing to fill the gaps left after abortion providers are excluded, patients are often shuffled to nearby centers that are likely already close to capacity. Health centers that remain would likely be limited in their ability to serve patients due to limited resources and increased patient demand, creating an untenable situation for the network where its continued viability and quality of care comes into question.

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It is clear that an attack on Planned Parenthood is an attack on the entire publicly funded family planning network. Our obligation as a network is to stick together in times of crisis and to recognize that public health is a matter of public policy—reproductive health most of all. We are obligated to be involved in that process to the extent that our positions allow. For some, that may mean educating the community about the role family planning access plays in keeping families healthy and happy. Others may have the ability to take an active role advocating in the halls of Congress or the state legislature. Regardless, all members of the publicly funded family planning network must hold the line and together push forward to ensure robust reproductive health services for the millions of women and men who would otherwise go without care.

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The Final Year of the Obama Administration: Regulatory Opportunities

By: Mindy McGrath

Introduction

There are roughly 11 months remaining in the Obama administration with countless regulations outstanding. As with previous administrations, the coming months will see a flurry of regulations and sub-regulatory guidance released, some final and others proposed. There are several regulations that have already been proposed and still need to be finalized, but there are also areas where additional regulation could be proposed and finalized in 2016. There will likely not be enough time to finalize all of the outstanding regulations, so continued advocacy could help ensure those that are finalized are as advantageous as possible for the publicly funded family planning network. NFPRHA sees the administration's desire to "clear the decks" as a strategic opportunity to better position the network of safety-net family planning providers for the future. The following article will review the regulations that are expected and have the potential to benefit safety-net family planning health centers, as well as other areas where NFPRHA is advocating for new regulations to be considered.

Outstanding Regulations

There are several outstanding regulations of interest to safety-net family planning health centers that have been proposed by the Obama administration, and NFPRHA has commented on each of these proposed regulations; NFPRHA continues to urge the administration to finalize the regulations and use those final rules as opportunities to bolster safety-net family planning.

2017 Benefit and Payment Parameters for Health Insurance Marketplaces

In November 2015, the US Department of Health and Human Services (HHS) issued a notice of proposed rulemaking (NPRM) for its annual Affordable Care Act (ACA) marketplace regulation. Qualified health plans (plans offered through the health insurance marketplaces) must be certified by HHS prior to the open enrollment period, so this NPRM would affect plans in the 2017 plan year. The 2017 benefit and payment parameters NPRM addressed a broad range of marketplace-related issues. NFPRHA's comments on the NPRM, submitted on December 21, 2015, urged HHS to:

- establish network adequacy standards that ensure enrollees have timely access to family planning and sexual health services;
- modify the notification requirements regarding a discontinued provider in order to better protect patient confidentiality;

- maintain the current policy that multiple providers at one location count as a single essential community provider for the purposes of meeting the percentage threshold;
- give preference to safety-net providers in the navigator funding review process, given the increased emphasis on targeting underserved and/or vulnerable populations; and,
- collect reporting data from certified application counselor organizations on a quarterly, rather than a monthly, basis.

The 2017 benefit and payment parameters final rule is expected sometime in late February or early March 2016. Since this is an annual rule required for continued functioning of the marketplaces, it is highly unlikely that HHS would delay release of the final rule.

Non-Discrimination in Health Programs (Section 1557 of the Affordable Care Act)

In September 2015, HHS released the NPRM implementing Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in any federally supported health program, any health program administered by a federal agency, or any health insurance marketplace. NFPRHA was pleased to see HHS had interpreted Section 1557 rather broadly, including defining sex discrimination to include discrimination on the basis of "pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity." NFPRHA submitted comments on November 9, 2015, which included the following requests:

- provide clear guidance as to the reach of the sex discrimination prohibition;
- include providers in the types of individuals protected from discrimination;
- avoid creating exceptions from the prohibition on sex discrimination; and,
- make clear that discrimination on the basis of sex includes discrimination on the basis of sexual orientation.

The rule's associational discrimination guarantee is particularly important in protecting the ability of family planning providers to participate in federally supported or administered health programs when such providers are otherwise eligible and qualified. Because the provision of sex-specific women's health services establishes a provider's association with a potential or existing female patient population, the adverse treatment of

family planning based on the provision of sex-specific services should amount to impermissible associational discrimination based on sex. NFPRHA continues to urge HHS to finalize the Section 1557 regulations and use them as an opportunity to specifically ban provider discrimination in any health program or activity supported with federal funds. Doing so would further reinforce existing law that prevent states from barring abortion providers from participating in the Medicaid program and ensure that patients continue to have access to their provider of choice when seeking family planning and reproductive health services.

Medicaid Managed Care

In June 2015, the Centers for Medicare and Medicaid Services (CMS) issued an NPRM on modernizing the regulations that govern Medicaid managed care. NFPRHA submitted comments on July 24, 2015, which urged CMS to take the following actions:

- clarify the policies, processes, and oversight necessary for effective utilization of Medicaid's freedom of choice protections for family planning;
- explicitly clarify that utilization controls and medical necessity criteria may not be imposed on family planning methods or services;
- strengthen network adequacy requirements to ensure enrollees have timely access to family planning and reproductive health services and providers;
- ensure direct access to family planning services and providers;
- strengthen protections for enrollee confidentiality, particularly as it relates to family planning and other sensitive services;
- strengthen provider non-discrimination protections;
- clarify and strengthen states' responsibility for ensuring enrollees have access to the full range of family planning and reproductive health information, services, referrals, and providers;
- monitor and address problems with access to family planning and reproductive health providers and services; and,
- ensure safety-net providers are able to best leverage 340B-priced drugs within Medicaid managed care.

Ensuring this regulation is finalized before the end of the administration is of high importance for NFPRHA, given Medicaid's critical importance to safety-net family planning and the increasing prevalence of managed care for Medicaid beneficiaries.

340B Drug Pricing Program Omnibus Guidance

In August 2015, the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs released long-awaited guidance covering most facets of the 340B drug pricing program, including the patient definition, registration, termination, audits, and contract pharmacy arrangements. The guidance was issued as proposed and HRSA accepted

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comments. NFPRHA submitted comments on several different issues, but of primary concern and importance were the proposed changes to the patient definition.

It is unclear if this proposed guidance will ever be finalized. HRSA has been engaged in legal battles for the past few years over whether they even have the statutory authority to write regulations for the 340B program, and experienced another setback over the summer. It is possible it will choose not to finalize this guidance to avoid further legal challenges.

New Opportunities

Modernization of the Title X Regulations

While the ACA has accelerated changes in health care delivery and financing over the last 15 years, the regulatory framework of Title X has been untouched over that same period. The Office of Population Affairs (OPA), which oversees Title X, has advanced many opportunities for change through sub-regulatory channels. Specifically, over the first six years of the Obama administration, OPA has partnered with the Centers for Disease Control and Prevention (CDC) to achieve publication of the first-ever nationally recognized clinical standards related to family planning care; produced the first revision of Title X program requirements since 2001; and re-designed the national research and training structure authorized under 42 U.S.C. 300 *et seq.*

In its annual release of program priorities and funding opportunity announcements for Title X grants, OPA has shifted to emphasizing aspects of health care delivery that align with the ACA. One of the 2015 priorities centers on requiring grantees to demonstrate that its network ensure sustainability of family planning and reproductive health services throughout the proposed service area. Grantees and/or subrecipients should address this priority by including certified electronic health record (EHR) systems and other health information technology systems that are interoperable; establishing contracts with third party payers and facilitating enrollment of patients into insurance and Medicaid; and finally, improving access to primary care services onsite or establishing formal linkages with primary care providers. In each instance of modernization, there have been changes that would be beneficial but can't be achieved without regulatory updates.

Updating the Title X regulation is imperative to protecting the integrity of the program and would allow the provider network to make the necessary service delivery and operational changes that conform to the new world that the ACA envisions. The more advocates can do to strengthen the program at the regulatory level, the greater capacity the program will have to fulfill its mission in years to come.

Inclusion of Provider Non-Discrimination Language

Currently, there are no protections for providers in Title X like those that exist in Medicaid where beneficiaries have the ability to select the provider of their choice. To buttress against ideological opponents, including hostile legislatures, Title X regulations should be updated with explicit language regarding provider non-discrimination.

Sub-regulatory attempts to protect providers have been exhausted, and in fact, in the most recent FOA release October 23, 2015, the language was weakened for discussing "extent to which applicants are inclusive" to "documenting the process." Litigation as a pathway is becoming increasingly difficult because of *Armstrong v. Exceptional Child*; not to mention the expense of litigation. Federal funding for Title X has declined by \$31 million over the last six years, and state funds have shrunk as well. Most recent federal data show a loss of 1.1 million patients in the Title X network between 2010 and 2014. The network does not have sufficient resources for service delivery let alone litigation.

Reinforcing Confidentiality Protections

A hallmark of the Title X program is its confidentiality protection for patients. However, while these protections exist in sub-regulatory guidance, they are absent from the actual Title X regulation. It is important to codify the existing confidentiality language in an updated Title X regulation.

Conclusion

The end of any presidential administration is marked by a multitude of outstanding regulations. Despite the heightened activity, there is rarely enough time to complete the process for all regulations. This reality offers NFPRHA the challenge of communicating its priorities with the administration and advocating for regulations that are the most advantageous for the safety-net family planning network. NFPRHA is committed to doing that work and will continue to seek out all opportunities for regulatory action throughout the remainder of the Obama administration.

The Supreme Court and Reproductive Rights in 2016

By: Robin Summers

The US Supreme Court is poised to make at least two significant rulings in 2016 on reproductive rights. The Court will revisit the issue of the Affordable Care Act's (ACA) contraceptive coverage requirement, this time in seven challenges brought by religiously affiliated nonprofit organizations. And in what could be its most significant abortion ruling in nearly 25 years, the Court will consider what constitutes an "undue burden" on a woman's right to choose to have an abortion.

Contraceptive Coverage *Zubik v. Burwell*

Oral Argument Scheduled for March 23, 2016

The ACA requires insurance plans—including those sponsored by an employer—to provide all FDA-approved contraceptive methods without copays or other cost-sharing. Certain religious institutions were exempted from the contraceptive coverage requirement. Religiously affiliated nonprofits were not exempted, but were given an accommodation by the Obama administration that allows them to opt out of directly arranging or paying for contraceptive coverage if they sign a form certifying that such coverage violates their religious beliefs. In such cases, the insurance plan or third-party administrator (TPA) must offer the coverage directly to enrollees without cost-sharing.

More than 100 lawsuits challenging the contraceptive coverage requirement were filed in federal court.¹ These legal challenges fell into two primary lines of cases: those brought by for-profit corporations and those brought by nonprofit organizations. In June 2014, the for-profit line of cases culminated in the Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.*,² which held that under the Religious Freedom Restoration Act (RFRA),³ closely held for-profit corporations do not have to comply with the contraceptive coverage requirement. Much of the Court's reasoning turned on its assessment that the religious nonprofit accommodation was a less restrictive means of ensuring contraceptive access. Although the Court's majority was careful to say that it was not ruling on whether the accommodation complies with RFRA, it wrote, "At a minimum, however, it does not impinge on the plaintiffs' religious belief that providing

insurance coverage for the contraceptives at issue here violates their religion, and it serves [the Department of Health and Human Services' (HHS)] stated interests equally well."

However, just days after the *Hobby Lobby* ruling was announced, the Supreme Court issued an injunction preventing the Obama administration from requiring Wheaton College to comply with the accommodation. The Court noted that the lower courts were divided on the accommodation's requirement that nonprofits sign the certification form, and that this kind of division is "traditional ground" for the Supreme Court. In the Court's view, its order would not prevent Wheaton College's employees and students from getting their contraceptives covered by the insurer, rather the government could rely on Wheaton College's religious objection to require the insurer to provide the coverage.

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In August 2014, the Obama administration issued new rule-making to a) expand the accommodation to certain closely held for-profit corporations, in light of *Hobby Lobby*, and b) to revise the accommodation to create an alternate way for eligible organizations to avail themselves of the accommodation, in light of the Court's injunction for Wheaton College. Rather than submitting the certification form, under the revised accommodation, objecting nonprofits can notify HHS in writing of their religious objection to contraceptive coverage. HHS will then notify the insurance plan (or the Department of Labor will notify the TPA) that the nonprofit objects to providing the coverage and that the insurer or TPA is responsible for providing enrollees separate no-cost coverage for contraceptive services.

1 National Women's Law Center, Status of the Lawsuits Challenging the Affordable Care Act's Birth Control Coverage Benefit, October 27, 2015, <http://nwl.org/resources/status-lawsuits-challenging-affordable-care-acts-birth-control-coverage-benefit/>.

2 *Burwell v. Hobby Lobby Stores, Inc.*, 573 US __ (2014), http://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf.

3 42 U.S.C. §§ 2000bb to 2000bb-4.

The Case

Despite the revised accommodation process, the nonprofits have pressed ahead with their lawsuits, arguing that the accommodation imposes a substantial burden on their religion in violation of RFRA. The nonprofits contend that the act of opting out triggers the insurer or TPA to provide contraceptive coverage to the nonprofits' employees, and the nonprofits are therefore being forced to facilitate contraceptive coverage against their beliefs. Noncompliance with the contraceptive coverage requirement would result in financial penalties, and thus the nonprofits are being "force[d] ... to choose between violating their religious beliefs or else incurring massive penalties."⁴

As of November 2015, eight circuit courts of appeals had considered and ruled on religious nonprofit challenges; all of those decisions came after the Supreme Court's *Hobby Lobby* ruling. Seven of the appellate courts ruled against the nonprofits on the grounds that the accommodation is not a substantial burden on the nonprofits' religious beliefs—the first step of a multi-tiered analysis under RFRA. However, on September 17, 2015, the US Court of Appeals for the Eighth Circuit decided in favor of the nonprofits in *Sharpe Holdings, Inc. v. US Department of Health and Human Services*, ruling that compelling the nonprofits' participation in the accommodation constitutes a substantial burden on the nonprofits' religious beliefs, and that while the government has a compelling interest in providing access to contraceptives without cost-sharing, the accommodation process was not the least restrictive means of achieving that interest.⁵

The contrary rulings between the Eighth Circuit and other circuit courts, known as a "circuit split," increased the likelihood that the Supreme Court would take up one or more of the cases. On November 6, 2015, the Court announced it would take up seven cases originating out of four different circuits.⁶ The Court intends to consolidate the cases, which currently carry the name of the first case filed at the Court, *Zubik v. Burwell*—for oral argument, though details are still being worked out. Oral argument is expected on March 23, 2016.

In *Zubik*, the Court will rule on whether the accommodation violates RFRA.⁷ The Court will assess whether the government (by enforcing the accommodation) substantially burdens the nonprofits' exercise of religion.⁸ If the Court finds that the government is imposing a substantial burden, the Court will assess whether the burden 1) furthers a compelling governmental interest; and 2) is the least restrictive means of furthering that interest.⁹

For the nonprofits to succeed on their substantial burden argument, they would theoretically have to convince the Court that it is the nonprofits' act of opting out that helps facilitate employee coverage, and not, in fact, the ACA itself. Several circuit courts have expressly rejected the nonprofits' argument, finding that federal law, not the act of opting out, entitles the employees to receive contraceptive coverage. However, it is possible the Court will circumvent the issue and instead focus its substantial burden inquiry. In *Hobby Lobby*, the Court refused to assess the validity of the for-profit corporations' religious beliefs, writing that the question of "whether the religious belief asserted in a RFRA case is reasonable" is a "question that the federal courts have no business addressing." Indeed, in holding that the accommodation constituted a substantial burden in *Sharpe Holdings*, the Eighth Circuit wrote, "The question here is not whether [the nonprofits] have correctly interpreted the law, but whether they have a sincere religious belief that their participation in the accommodation process makes them morally and spiritually complicit in providing abortifacient coverage." Thus, the Court may conclude in *Zubik* that the accommodation constitutes a substantial burden simply because the nonprofits say it does.

Should the Court find a substantial burden exists, and assuming it finds contraceptive coverage without cost-sharing to be a compelling governmental interest, the Court will once again turn to the question of least restrictive means, which was the deciding question in *Hobby Lobby*. The Court concluded in *Hobby Lobby* that the contraceptive coverage requirement was not the least restrictive means, in part because the government could simply "assume the cost" of providing the contraception, but in larger part because the accommodation provided a readily available, less restrictive alternative. But the Court's subsequent grant of an injunction to Wheaton College only a few days after *Hobby Lobby* puts into question whether the Court considers the accommodation the least restrictive means, or whether it will determine that there are other, less restrictive means.

4 Petition for a Writ of Certiorari, *Zubik v. Burwell*, <http://www.scotusblog.com/wp-content/uploads/2015/11/Zubik-v.-Burwell-Cert-Petition.pdf>.

5 United States Court of Appeals for the Eighth Circuit, Case No. 14-1507, September 17, 2015, <http://www.scotusblog.com/wp-content/uploads/2015/09/ACA-8th-CA-ruling-on-mandate-Sharpe-Holdings.pdf>.

6 *Zubik v. Burwell* (Third Circuit); *Priests for Life, Inc. v. Department of Health and Human Services* (DC Circuit); *Roman Catholic Archbishop of Washington v. Burwell* (DC Circuit); *East Texas Baptist University v. Burwell* (Fifth Circuit); *Little Sisters of the Poor Home for the Aged v. Burwell* (Tenth Circuit); *Southern Nazarene University v. Burwell* (Tenth Circuit); and *Geneva College v. Burwell* (Third Circuit).

7 The Court also agreed to hear a second question in the *Little Sisters of the Poor* case, as to whether *Little Sisters* has to obey the requirement even though its health insurer would not take part because it has an exempt "church plan."

8 42 U.S.C. § 2000bb-1.

9 *Ibid.*

In *Zubik*, NFPRHA will once again be working to clarify misrepresentations about what Title X is, how it works, and why Title X and other safety-net programs cannot be conflated with the private insurance market.

The nonprofits have doubled down on the least restrictive means argument in *Zubik*, arguing that the government could “accomplish its goals through existing programs, such as the insurance exchanges established under the ACA, the Title X family planning program, the Medicaid program, or other forms of tax subsidies.”¹⁰ One of the nonprofits’ briefs even goes on to argue that despite Title X’s statutory requirement prioritizing low-income people, HHS could simply issue a regulation essentially redefining “low income” to include women who can’t get the contraceptive coverage to which they are legally entitled because of their employer’s religious objection.¹¹

During *Hobby Lobby*, NFPRHA worked with the National Health Law Program to incorporate language into its amicus brief¹² refuting claims that safety-net programs, such as Title X, are alternative, less restrictive means for the government to use in achieving its objectives. Justice Ruth Bader Ginsburg quoted some of this language in her *Hobby Lobby* dissent, highlighting one of NFPRHA’s principle arguments, “Safety net programs like Title X are not designed to absorb the unmet needs of ... insured individuals.”¹³ In *Zubik*, NFPRHA will once again be working to clarify misrepresentations about what Title X is, how it works, and why Title X and other safety-net programs cannot be conflated with the private insurance market.

Abortion and the Undue Burden Standard *Whole Woman’s Health v. Cole*

Oral Argument Scheduled for March 2, 2016

In 2013, Texas passed HB 2, a law that contained a number of abortion restrictions, including a provision requiring that health centers that provide abortion services meet the same building standards as ambulatory surgical centers, and another requiring physicians working in those health centers have admitting privileges at a local hospital no more than thirty miles away.¹⁴

The Center for Reproductive Rights (CRR) filed suit on behalf of a group of women’s health care providers, challenging the ambulatory surgical center and admitting privileges requirements of the law. A federal district court blocked enforcement of both provisions in August 2014.¹⁵ The district court found that both requirements imposed an undue burden on women’s access to abortion.¹⁶ The case moved to the US Court of Appeals for the Fifth Circuit, which twice issued rulings that would allow portions of the law to be in effect while the case moved forward.¹⁷ The Supreme Court, however, twice intervened—in October 2014, and again in June 2015—to prohibit enforcement of the ambulatory surgical center requirement across Texas, and to block the admitting privileges requirement from being enforced against specific plaintiffs’ health centers.¹⁸ As of October 2015, the number of abortion providers in Texas dropped to 19, compared with the more than 40 health centers open before HB 2.¹⁹ CRR estimates that if the law were to fully go into effect, it would force the closure of all but nine or ten health centers that provide abortions in the state.²⁰

The Case

CRR appealed the Fifth Circuit ruling to the Supreme Court, and on November 13, 2015, the Court granted the petitioners’ request to hear *Whole Woman’s Health v. Cole*. The case is likely to have significant ramifications, as a number of states in recent years have passed similar targeted regulation of abortion providers (TRAP) laws, as well as other restrictions on abortion access designed to interfere with, and in some cases outright eliminate, women’s access to abortion.

10 Brief of Petitioners in Nos. 14-1418, 14-1453 & 14-1505, *Zubik v. Burwell*, <http://www.scotusblog.com/wp-content/uploads/2016/01/Jones-Day-SCOTUS-Brief.pdf>.

11 *Ibid.*

12 Brief of National Health Law Program, et al., as Amici Curiae in Support of the Government, *Burwell v. Hobby Lobby, Inc.*, http://www.healthlaw.org/publications/browse-all-publications/nelp-supreme-court-amicus-brief-in-sebelius-v-hobby-lobby#.Vp_kC_krIU.

13 *Burwell v. Hobby Lobby Stores, Inc.*, 573 US _ (2014) (Ruth Bader Ginsburg, dissenting), http://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf.

14 Center for Reproductive Rights, *Whole Women’s Health v. Cole* (web page), <http://www.reproductiverights.org/case/whole-womans-health-v-cole>.

15 *Ibid.*

16 *Ibid.*

17 *Ibid.*

18 *Ibid.*

19 *Ibid.*

20 *Ibid.*

Casey's undue burden standard is rooted in the Fourteenth Amendment's Due Process Clause protection of fundamental liberties, but Casey also recognized this liberty interest is linked to the Constitution's protections of equality, noting, "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."

The Supreme Court's last major ruling on abortion was in 2007 (*Gonzales v. Carhart*, upholding the "Partial-Birth Abortion Ban Act"), but *Whole Woman's Health* could be more significant because it is specifically focused on the undue burden²¹ standard set forth in the Court's 1992 ruling in *Planned Parenthood v. Casey*.

The Court ruled that while the state can enact regulations to "further the health or safety of a woman seeking an abortion," just as a state can do with any medical procedure, it cannot impose "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion."²² The Court wrote, "An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability" (emphasis added).²³

There are a number of questions that may play into the Court's inquiry into whether HB 2 is an undue burden, and therefore unconstitutional. The Fifth Circuit held that the provisions at issue do not constitute an undue burden, in large part because it determined that the undue burden standard does not require, or even allow, an examination of the extent to which an abortion restriction furthers a valid state interest.²⁴ The question of whether HB 2 furthers a valid state interest, and whether the Fifth Circuit should have allowed an inquiry into that question, is a key issue for the Supreme Court to consider, particularly in the context of the impact HB 2 will have and is already having on abortion access. As petitioners argue in their brief to the Court, "whether an obstacle is substantial depends in part on the strength of a state's interest in imposing it."²⁵

Additionally, the Court may look to its own recent precedents to examine the intersection of the Constitution's protections of liberty and equality. Casey's undue burden standard is rooted in the Fourteenth Amendment's Due Process Clause protection of fundamental liberties, but Casey also recognized this liberty interest is linked to the Constitution's protections of equality, noting, "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."²⁶ The linkages between the Due Process and the Equal Protection Clauses of the Fourteenth Amendment have been clarified further in recent years, most notably in cases dealing with LGBTQ rights, culminating in the Supreme Court's landmark 2015 ruling in *Obergefell v. Hodges*: "The Due Process Clause and the Equal Protection Clause are connected in a profound way. Rights implicit in liberty and rights secured by equal protection may rest on different precepts and are not always coextensive, yet each may be instructive as to the meaning and reach of the other."²⁷ In *Whole Woman's Health*, the Supreme Court may examine this intersectionality further as it assesses whether HB 2 constitutes an undue burden.²⁸

Conclusion

Decisions in both *Zubik* and *Whole Woman's Health* are expected at the end of the Court's current term in June. In the coming months, NFPRHA will continue to provide information and analysis of these and other cases important to its members.

21 This is a different standard than the substantial burden standard in *Zubik*.

22 *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

23 *Ibid*.

24 Petition for Writ of Certiorari, *Whole Woman's Health v. Cole*, <http://www.scotusblog.com/wp-content/uploads/2015/09/2015-09-02-Cert-Petition.pdf>.

25 Brief for Petitioners, *Whole Woman's Health v. Cole*, <http://www.scotusblog.com/wp-content/uploads/2016/01/15-274-ts.pdf>. This idea is measuring the state's interest is inherent in *Casey*, in which the Court wrote, "Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." See *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

26 *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

27 *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).

28 NFPRHA is a signatory to an amicus brief filed by the National Women's Law Center that highlights the linkages between liberty and equality. The brief argues that restrictions like HB 2 "deny the equal dignity guaranteed to women under the Fourteenth Amendment by unduly burdening a woman's constitutional right to decide whether to carry a pregnancy to term. Such laws violate women's constitutionally-protected liberty to make intimate, personal decisions and impose substantial costs on women, depriving them of the ability to participate in society on equal terms." Brief of Amici Curiae National Women's Law Center and 47 Additional Organizations, *Whole Woman's Health v. Cole*, http://nwlc.org/wp-content/uploads/2016/01/RRH_Whole-Womens-Health-Amicus-Brief_1.4.16.pdf.

Success with Quality Recognition

By: *Melissa Kleder*

The provision of high-quality care has been a core tenant of the Title X family planning program since its inception. The Providing Quality Family Planning (QFP) recommendations, released in April 2014, further emphasizes the importance and benefits of providing quality family planning and reproductive health services, noting that “by improving the quality of care, family planning outcomes, such as reduced rates of unintended pregnancy, improved patient experiences, and reduced costs, are more likely to be achieved.”¹ Furthermore, as payers shift from fee-for-service toward quality-based payments and more patients gain access to insurance and a wider provider network, quality measurement and improvement become even more central to a health center’s sustainability.

It is important for a health center to select a specific method by which to assess and improve quality that best fits its infrastructure. One option is to utilize a quality designation, such as the recognition programs offered through the National Committee for Quality Assurance (NCQA), as a guideline for quality improvement through data collection and monitoring. In addition to providing a structure for quality-related activities, these designations provide third-party validation of a practice’s quality standards, thereby increasing a health center’s credibility and recognition among patients, partners, and payers.

Patient-centered medical home (PCMH) recognition is likely the most well-known quality designation. NCQA is one entity that offers recognition for PCMH, which has become widely used by primary care practices to enhance care coordination and communication. Using its PCMH program as the model, NCQA has developed two additional programs to include other provider types in the medical field²:

- In 2013, the patient-centered specialty practice (PCSP) recognition program was created to help practices that offer specialty care effectively partner with primary care.
- Released in 2015, patient-centered connected care (PCCC) is the newest recognition designed to support practices that provide episodic care, like urgent care, school-based health centers (SBHC), and retail clinics, coordinate with primary care.

1 Centers for Disease Control and Prevention. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs—United States, 2014. *MMWR* 2014;63(Suppl; April 25, 2014): 21.

2 The “medical neighborhood” is defined by the Patient-Centered Primary Care Collaborative as a clinical-community partnership that includes the medical and social supports necessary to enhance health, with the PCMH serving as the patient’s primary “hub” and coordinator of health care delivery. <https://www.pccc.org/content/medical-neighborhood>

The Providing Quality Family Planning (QFP) recommendations, released in April 2014, further emphasizes the importance and benefits of providing quality sexual and reproductive health services, noting that “by improving the quality of care, family planning outcomes, such as reduced rates of unintended pregnancy, improved patient experiences, and reduced costs, are more likely to be achieved.”

To be eligible for PCMH, a practice must provide comprehensive primary care services to at least 75% of its patients. As a result, fewer NFPRHA members are eligible for PCMH recognition; however, when PCSP was released, NFPRHA saw an opportunity for its members to be recognized for their work to provide high-quality, patient-centered care. To put this theory to the test, NFPRHA sponsored a one-year Leadership Learning Collaborative (LLC) in 2013.

The learning collaborative brought together teams of staff from four organizations to learn, share, and practice problem solving and strategic thinking with the real-time problems they faced when pursuing NCQA recognition. LLC focused on three areas:

1. leadership development, focused on building leadership skills within their organization to gain support of staff and boards;
2. education about key health care reform issues that may impact participants’ organizations; and
3. development and implementation of practical projects, i.e. applying for recognition, aimed to build participants’ organizational capacity to succeed in an evolving health care environment.

In order to achieve recognition, health centers must demonstrate high-quality, patient-centered, coordinated care per a set of Standards and Guidelines. Each Standard contains Elements and Factors that are assigned a numerical value used to evaluate the application. Elements deemed to be of particular importance are must-pass, which means a health center must score at least 50% on those Elements to receive recognition. There are

three levels of quality recognition — Level 3 being the highest level. Recognition is granted at the individual health center level and lasts for three years.

Three of the four LLC participants have successfully applied for and received NCQA recognition (the application for the fourth organization is pending).

MIC Women's Health Services (MIC) is a part of Public Health Solutions, a large nonprofit and Title X grantee with health centers located across the state of New York that oversees direct service programs serving nearly 80,000 women and men every year. MIC operates two health centers that provide family planning and reproductive health care to 4,500 women and men. MIC received PCSP Level 2 recognition at its Brooklyn location in March 2015.

Maine Family Planning (MFP) is the sole Title X grantee in Maine and directly operates 18 of its own health centers and six SBHCs. Statewide, the agency sees nearly 30,000 women and teens across 45 health centers. While MFP's leadership initially considered PCSP, the organization ultimately sought PCMH recognition. In 2013, MFP integrated primary care services into one of its rural family planning sites and believed PCMH recognition would bolster its reputation in a new, broader service arena. The Belfast site received PCMH Level 3 recognition in May 2015.

Public Health Seattle/King County's (PHSKC) Family Planning Program provides innovative community-based health education and operates seven comprehensive family planning clinics in public health centers located throughout King County in Washington state. These centers serve approximately 12,000 patients annually. PHSKC received PCSP Level 3 recognition in August 2015.

Adagio Health is a nonprofit community-based organization headquartered in Pittsburgh, Pennsylvania, and is a Title X grantee that supports family planning services in 23 counties across western Pennsylvania. Adagio Health directly administers 18 health centers and is seeking a multi-site PCSP recognition. The multi-site application is available to practices with three or more locations that share an electronic health record system and standardized policies and procedures across all sites. The multi-site application allows select Elements to apply to multiple sites; however, recognition is achieved at the individual health center level and each site must submit an individual application as well. The organization has one year to submit individual site applications after receiving a score on its corporate application. Adagio Health's individual site applications are pending.

NFPRHA plans to engage LLC participants over time to fully assess benefits of the PCSP program, and some initial outcomes and experiences of early adopters have already been reported.

- New ways of organizing work to meet the PCSP standards resulted in greater efficiency with work flows, increased collaboration among care teams, and improved patient care.
- Research shows practices that have attained PCMH recognition have experienced higher reimbursement rates, and the number of states with private and public payer PCMH initiatives increased from 18 in 2009 to 44 in 2013.³ The PCSP program is designed to achieve similar results and is anticipated to be increasingly used by health plans to drive referrals to preferred sites of care and make care coordination payments available to specialists.
- Close coordination among providers is a high priority, and LLC participants reported that PCSP offers a platform that will help them develop or enhance relationships with external primary care and specialty providers.
- The NCQA recognition process increased overall readiness for other transformative care delivery and/or new payment models. PCSP is an opportunity for family planning health centers to be at the forefront of the innovations taking place in health care and position themselves as leaders in care transformation.
- Staff learned new ways to more effectively coordinate patient care, work in teams, and coordinate and track care over time with primary care and other specialty care colleagues. Through these new processes and trainings, staff have the opportunity to build valuable professional skills.

NCQA is scheduled to release a revision of the PCSP standards this year. NFPRHA commented on the proposed changes and believes the new Standards will ease some of the challenges family planning providers face seeking recognition. In particular, changes to requirements for incoming referral agreements are expected to be particularly helpful.

NFPRHA strongly encourages its members to seek quality designations. To support these efforts, it has developed *A Framework for Quality Improvement: Family Planning and Patient-Centered Specialty Practice Toolkit*, which features checklists, guides, and sample documentation to assist family planning organizations to assess readiness and apply for the NCQA's PCSP recognition. In addition, NFPRHA staff can offer expertise and technical assistance with the requirements, application process, and documentation of the NCQA PCMH and PCSP Recognition program. To learn more about NCQA recognition or how NFPRHA can support your organization, please contact Melissa Kleider at mkleider@nfprha.org.

³ Edwards, S. T., A. Bitton, J. Hong, and B. E. Landon. "Patient-Centered Medical Home Initiatives Expanded In 2009-13: Providers, Patients, And Payment Incentives Increased." *Health Affairs*, 2014, 1823-831.

Member Spotlight: Planned Parenthood of Wisconsin

By: Liz Rich

Wisconsin has long been recognized as a state with a robust publicly funded family planning network that includes a number of high-quality agencies across the state. Nearly two dozen of those agencies are supported by the Title X grant, which has been held by Planned Parenthood of Wisconsin (PPWI) for three and a half decades; the majority are united through the state's maternal and child health efforts. Despite significant support from communities and recognition that these specialized family planning health centers are essential access points for residents, Governor Scott Walker of Wisconsin has directed his ire at family planning and taken a number of steps to restrict reproductive health and access to affordable health care to women and men across the state since coming into office in 2011.

In 2011, Medicaid eligibility was rolled back in the state from 250% of the federal poverty level (FPL) to 100%, which pushed out 92,000 people from the program, and in the same year, Walker declined to expand Medicaid under the Affordable Care Act (ACA). These individuals had the option to purchase health insurance through the marketplace, and many who were previously enrolled in Medicaid already paid small monthly premiums but still lost their coverage with no guarantee that they would pay the same amount for coverage purchased on the marketplace.¹

In addition to changes to Medicaid, Walker signed into law a 20-week abortion ban in 2015, which did not include exceptions for rape victims or fetal anomalies.² In 2011, he signed a budget into law eliminating state family planning funding to Planned Parenthood of Wisconsin (PPWI)³ and declined renewing a contract with PPWI to provide cancer screenings.⁴ The 2011 state budget also prohibited the provision of

In 2011, [Walker] signed a budget into law eliminating state family planning funding to Planned Parenthood of Wisconsin (PPWI) and declined renewing a contract with PPWI to provide cancer screenings.

abortion care at the University of Wisconsin hospital.⁵ Later that year, the state passed legislation prohibiting coverage of abortions in health plans sold in the health insurance marketplace.⁶ In 2013, legislation was enacted requiring abortion providers have hospital admitting privileges. As of November 2015, the law has been blocked from going into effect.⁷ In 2012, Walker also signed into law legislation repealing Wisconsin's comprehensive sexuality education policy, which had required sexuality education taught in schools to be age-appropriate, medically accurate, and comprehensive. The legislation passed required emphasis of abstinence as the "only reliable way to prevent pregnancy and sexually transmitted infections."⁸ More recently, the governor said that he would sign legislation that would limit only family planning and STD clinics to receiving Medicaid reimbursements for 340B-priced drugs at the actual acquisition cost should the legislature not complete its action to do so. This effort is in spite of the noted congressional intent that the 340B program serve as a revenue source for safety-net programs and that a number of safety-net providers bill above acquisition cost to have the ability to

1 Phil Galewitz, "Amid Health Law Expansion, Some States Trim Medicaid Rolls," *Kaiser Health News*, August 18, 2013, accessed January 5, 2016, <http://khn.org/news/medicaid-cuts-in-four-states/>.

Erin Toner, "Scott Walker's Medicaid Maneuver," *Kaiser Health News*, November 19, 2013, accessed January 5, 2016, <http://khn.org/news/wisconsin-governor-scott-walker-embraces-parts-of-obamacare/>.

2 Laura Bassett, "Scott Walker Signs 20-Week Abortion Ban Into Law," *Huffington Post*, July 20, 2015, http://www.huffingtonpost.com/entry/scott-walker-abortion-ban_55ad0c69e4b065dfe89ec3d8.

3 Laura Bassett, "Wisconsin Set To Defund Planned Parenthood, Slash Family Planning," *Huffington Post*, August 21, 2011, accessed January 5, 2016, http://www.huffingtonpost.com/2011/06/21/wisconsin-fourth-state-to-defund-planned-parenthood_n_881504.html.

4 Laura Bassett, "Scott Walker Cuts Cancer Screenings for Uninsured Women, Offers No Alternatives," *Huffington Post*, accessed January 5, 2016, http://www.huffingtonpost.com/2011/12/20/scott-walker-cuts-cancer_n_1161496.html.

5 Patrick Marley and Jason Stein, "Walker signs budget bill, vetoes just 50 items," *Milwaukee-Wisconsin Journal Sentinel*, accessed January 5, 2016, <http://www.jsonline.com/news/statepolitics/124563073.html>.

6 "Health Reform and Abortion Coverage in the Insurance Exchanges," National Conference of State Legislatures, accessed January 6, 2016, <http://www.ncsl.org/research/health/health-reform-and-abortion-coverage.aspx>.

7 Patrick Marley, "Judges: Wisconsin abortion admitting privileges law unconstitutional," *Milwaukee-Wisconsin Journal Sentinel*, accessed January 6, 2016, <http://www.jsonline.com/news/statepolitics/wisconsin-abortion-admitting-privileges-law-unconstitutional-court-affirms-b99621967z1-353085451.html>.

8 Leigh Owens, "Wisconsin Republicans Pass Abortion, Abstinence-Only Sex Education Bills," *Huffington Post*, accessed January 20, 2016, http://www.huffingtonpost.com/2012/03/14/wisconsin-abortion-sex-education-bills-pass_n_1345873.html.

Since its founding in 1935, Planned Parenthood of Wisconsin has grown into the largest reproductive health care provider in Wisconsin, providing services to 61,000 women and men at 22 health centers across Wisconsin.

reinvest those resources in service delivery. Despite continued attacks on the network, PPWI has worked alongside the expansive network of non-Title X family planning providers across the state in their steadfast, collective commitment to providing high-quality care to those in need.

Since its founding in 1935, Planned Parenthood of Wisconsin has grown into the largest reproductive health care provider in Wisconsin, providing services to 61,000 women and men at 22 health centers across Wisconsin. These health centers provide essential health care services, including contraception, annual wellness exams, breast and cervical cancer screenings, comprehensive sexuality education, colposcopy services, HPV education, screening, and vaccinations. The affiliate also provides referrals for prenatal care and mammograms and offers abortion care in three of its health centers. More than half of PPWI's patients report Planned Parenthood health center is their primary health care provider.

In addition to providing reproductive and sexual health services, PPWI has undertaken innovative programs to reach patients and provide services and education. For example, PPWI established a text messaging system that allows teens to access confidential sexuality education and get questions answered by a trained professional.

PPWI is also the sole Title X grantee for the state of Wisconsin, supporting services at both its own centers and two other sub-recipient health care providers that deliver care through 18 health centers. The organization has held the grant for more than 35 years and annually serves 50,000 patients through Title X, 66% of which had incomes at or below 100% of the FPL (an annual income of \$11,770 for an individual in 2015). In fact, only 6% of the program's patients had incomes above 250% of the FPL. In addition to serving patients with Title X funds, PPWI is reimbursed by Medicaid and private insurance, and is also funded with private donations, local government grants, and foundation grants. Wisconsin also has a state plan amendment that expands Medicaid coverage of family planning services for women and men with incomes up to 306% of the FPL. The affiliate previously received state funding for reproductive health care that, as mentioned earlier, ended in 2011.

In addition to providing reproductive and sexual health services, PPWI has undertaken innovative programs to reach patients and provide services and education. For example, PPWI established a text messaging system that allows teens to access confidential sexuality education and get questions answered by a trained professional. The affiliate supports a *Promotores de Salud* (Community Health Workers) program for many years in the state, which looks to reach low-income and underserved Latino/Hispanic populations and to provide those communities with prevention efforts and increased access to health insurance and to health education. Following the program's success, it is now expanding to include a comprehensive sexuality education component.

Recognizing the universal hardship agencies have faced resulting from budget cuts and political attacks, PPWI also collaborates closely to advance a unified advocacy agenda. The institution holds a seat on the Wisconsin Family Planning & Reproductive Health Association board. Through these efforts, PPWI stands shoulder to shoulder with other family planning agencies to combat harmful policies and fight for access for the more than 336,000 Wisconsin women in need of affordable family planning services.⁹ PPWI, which is proud to be celebrating its 80th anniversary, has withstood challenges and will continue providing high-quality, confidential care, regardless of the political obstacles created by their opponents.

⁹ Guttmacher Institute, *Contraceptive Needs and Services*, 2010, accessed 2016, <http://www.guttmacher.org/pubs/win/2010/WIN-2010-Wisconsin.pdf>.



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