

National
Family Planning
& Reproductive Health Association

October 26, 2017

Office of the Assistance Secretary for Planning and Evaluation
Strategic Planning Team
Department of Health and Human Services
200 Independence Ave. SW
Room 415F
Washington, DC 20201

VIA ELECTRONIC MAIL – HHSPlan@hhs.gov

Attn: Strategic Plan Comments

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments on the US Department of Health and Human Services' (HHS) draft strategic plan.

NFPRHA is a national membership organization representing the nation's publicly funded family planning providers, including nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private nonprofit organizations.

We have organized our comments by thematic area and then provided specific edits on objectives and strategies. The main areas we address are the strategic plan's implications for family planning and sexual health, health equity, and the LGBTQ population. We also provide additional general comments.

I. Development of Strategic Plan

The Government Performance and Results Act (GPRA) Modernization Act of 2010 (P.L. 111-352) requires agencies to develop a performance plan that expresses performance goals for each strategic objective "in an objective, quantifiable, and measurable form" unless otherwise authorized by the Office of Management and Budget.¹ Performance goals must include "clearly defined milestones."² The

¹ 31 U.S.C. § 1115(b)(2), § 1115(c).

² 31 U.S.C. § 1115(b)(5)(B).

performance plan must also establish a balanced set of performance indicators to be used in measuring or assessing progress toward each performance goal, including, as appropriate, customer service, efficiency, output, and outcome indicators,” and “provide a basis for comparing actual program results with the established performance goals.”³ Unfortunately, much of HHS’ plan fails to contain performance indicators and instead moves to further ideological goals – such as focusing on life beginning at conception rather than birth – instead of focusing on the requirements for a strategic plan.

Furthermore, HHS has omitted “a description of how the goals and objectives incorporate views and suggestions obtained through congressional consultations.”⁴ When developing a strategic plan, HHS “shall consult periodically with the Congress, including majority and minority views from the appropriate authorizing, appropriations, and oversight committees, and shall solicit and consider the views and suggestions of those entities potentially affected by or interested in such a plan.”⁵ Congress also has the ability “to establish, amend, suspend, or annul a goal of the Federal Government or an agency.”⁶ The current strategic plan cannot be considered compliant unless and until HHS consults with the appropriate members of Congress, and a public comment period is insufficient to meet these requirements.

II. Implications for Family Planning and Sexual Health

We support HHS programs and initiatives that serve and protect all individuals across the lifespan. Public health programs and policies must be based on research, evidence, and medical and health-related facts, and must be responsive to individual patient and consumer needs and wishes. However, we note that religion and conscience are not limited to those who support the idea of life beginning at conception. In fact, the vast majority of patients have religious and conscience needs and wishes that are not served using that limited framework. In order to fulfill the person-centered strategy laid out by HHS, consumers require medically accurate, evidence-based, unbiased comprehensive health care information and services so that they can use their own decision making capacity to choose health care services that comport with their individual morality and circumstances. This means that the full range of family planning and sexual health services, including hormonal contraception, sterilization, and pregnancy termination, must be available to all who desire those services in accordance with their own individual beliefs.

High-quality, comprehensive sexuality education provides science-based, medically accurate and complete, and age-, developmentally, and culturally appropriate sexual health information to address the physical, mental, emotional and social dimensions of human sexuality for all young people. Taught by trained educators sequentially throughout students’ school years, comprehensive sexuality education includes information and skill development related to a range of topics addressing human development,

³ 31 U.S.C. § 1115(b)(6)–(7).

⁴ 5 U.S.C. § 306(a)(5).

⁵ 5 U.S.C. § 306(d).

⁶ Pub. L. 111–352, §15, Jan. 4, 2011, 124 Stat. 3883.

relationships, personal skills, sexual behaviors (including abstinence), sexual health, and society and culture.⁷

While to date there is no dedicated federal funding stream for sexuality education, let alone comprehensive sexuality education, evidence-based programs—such as those currently supported at the federal level—that incorporate elements of comprehensive sexuality education have been shown to improve academic success; prevent child sexual abuse, dating violence, and bullying; help young people develop healthier relationships; delay sexual initiation; reduce unintended pregnancy, HIV, and other STDs; and reduce sexual health disparities among LGBTQ young people.⁸ Decades of research on sexual health education programs that include information on condoms and contraception—in addition to abstinence—has shown that they effectively delay sexual activity as well as increase condom and other contraceptive use when young people do become sexually active.⁹ The strategic plan does not reflect this reality; while thin on additional substance as to how the strategy will be implemented, we are concerned by the Administration’s promotion of principles and programs that have been shown to be ineffective at their primary goal of promoting abstinence until marriage, fail to meet the needs of marginalized young people, and often perpetuate stigma and shame for LGBTQ young people, sexually active youth, survivors of sexual assault, young parents, and adolescents of varying abilities.¹⁰

We are also deeply concerned that HHS is inserting concepts such as “the unborn” and life “from conception” into its strategic plan. These concepts run contrary to medical and health-related evidence and standards of care, and instead reflect a religious point of view that has no role in advancing and protecting the public health of a diverse population. Elevating a fertilized egg to equal status with a person is contrary to US law and establishes a policy framework that would undermine the ability of women and others to make the best decisions for themselves and their families, including decisions impacting their health and well-being, and their ability to participate in public life.¹¹ Such policies will impede the ability of HHS to cultivate and inform best practices for women’s health, and in turn, interfere with the ability of providers, particularly those who offer family planning and sexual health services, to provide quality care to their patients.

Second, one of the basic functions of government is to ensure the health and well-being of its population. Privileging embryos and fetuses over people threatens the capability of HHS to fulfill this function, and would deprive women of health care benefits that medical and health care experts

⁷ Future of Sex Education (FoSE). National Sexuality Education Standards. 2012. Journal of School Health; SIECUS. Guidelines for Comprehensive Sexuality Education. 2004.

⁸ FoSE. Building a Foundation for Sexual Health is a K–12 Endeavor: Evidence Underpinning the National Sexuality Education Standards. Nov 2016

⁹ Manlove J, et al. Patterns of Contraceptive Use Within Teenagers’ First Sexual Relationship. Perspectives on Sexual and Reproductive Health. 2003, 35(6):246–255

¹⁰ JAH/SAHM Article

¹¹ Roe v. Wade, 410 U.S. 113, 153 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992).

recognize as critical to ensuring women’s health and well-being.¹² Elevating the status of a fetus over the health needs of pregnant women would result in poorer maternal health and poorer birth outcomes.¹³ Moreover, adopting policies that give health rights to fetuses would also undermine a woman’s constitutional right to access abortion care, and interferes with the patient-provider relationship by limiting the information, counseling, referral and provision of abortion services that a woman can receive, despite the fact that these are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. The language is overly broad, confusing, and subject to misuse and abuse by creating a federal health care framework that invites HHS to refuse to participate in the orderly delivery of evidence-based health care services.

Third, the language is contrary to both the Establishment Clause and the Free Exercise Clause of the US Constitution. The idea that “life begins at conception” is not an evidence-based theory. Free speech and religious liberty are concepts that cannot be limited to one specific view; those who do not believe that life begins at conception are entitled to the same free exercise of religion, and any language to the contrary is decidedly discriminatory. The decision to obtain any health service, including family planning and sexual health care, should remain with the individual.

Here are some additional comments related to these issues:

- We agree with HHS’ affirmation of the importance of consumer choice and empowerment, but note that consumer choice and empowerment must be driven by fully informed, patient-centered decision making.
- We oppose all efforts to limit the provision of health information, including but not limited to when it concerns the full range of contraceptive options including sterilization, abortion, and LGBTQ-inclusive sexual health information.
- We appreciate HHS’ desire to strengthen and expand the health care workforce. However, federal law provides ample protections and religious exemptions, such as the Church Amendments, for health care entities and individuals who object to providing certain services based on their religious beliefs. The strategic plan cites no evidence that further protections are needed, and we note that additional provisions to shield these providers from delivering evidence-based, quality medical and health-related services that meet the standard of care would be unnecessary and restrictive.
- We strongly support expanding resources, supports, and information for adolescents so that they can make the best decisions for their health and well-being. However, programs and information supported under this strategic plan must include age, developmentally and culturally appropriate, medically accurate, evidence-based family planning and sexual health information

¹² American College of Obstetricians and Gynecologists, Committee Opinion: Increasing Access to Abortion (2014), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20171019T1538434634>.

¹³ Center for Reproductive Rights and Ibis Reproductive Health, Evaluating Priorities: Measuring Women’s and Children’s Health and Well-being Against Abortion Restrictions in the States (2017), <https://ibisreproductivehealth.org/sites/default/files/files/publications/Evaluating%20Priorities%20August%202017.pdf>.

to ensure that adolescents have the tools they need to make informed and healthy decisions throughout their lives.

- We support comprehensive family planning and sexual health counseling and services from LGBTQ-competent providers, and discourage use of faith-based partners that shame LGBTQ individuals and communities based on specific ideological beliefs.
- We recommend considering the importance of family planning and sexual health in relation to preventing interpersonal violence and promoting healthy relationships.

III. Implications for Health Equity

HHS must continue to undertake activities to identify and address health disparities with the ultimate goal of eliminating them. In activities spanning the Office for Civil Rights, Office of Minority Health, Office of Women's Health as well as the Centers for Medicare & Medicaid Services, all of HHS' endeavors must ensure that disparities are not heightened but are prevented. We appreciate recognition of the need to address disparities within the strategic plan but believe that HHS must strengthen these sections to ensure all individuals can achieve their health equity.

Further, the strategic plan should ensure that all of HHS' activities are undertaken in a culturally competent manner. Providing culturally competent services is critical to ensure that services are client/patient centered and are appropriate for not just the particular program at issue but also for the clients/enrollees served. We urge HHS to include more specific and measurable goals and strategies to address cultural competency in a holistic manner including race, ethnicity, language, immigration status, age, disability, sex, gender identity, and sexual orientation.

Here are some additional comments related to these issues:

- We support HHS' recognition of the need for health literacy tools. We suggest HHS specifically recognize the need to provide culturally competent tools such that all individuals, regardless of their background, can benefit from these tools.
- We recommend additional requirements to specifically address collecting, analyzing and applying *demographic* data.
- We appreciate HHS' mention of the need to reduce disparities. We believe this includes not merely racial and ethnic health disparities but also disparities based on language, age, sex, sexual orientation, gender identity, and disability. We recommend HHS include a broad definition of health care disparities in its strategic plan.
- We note that alternative payment models must not be implemented in such a way that they create incentives to skimp on needed care or avoid costlier patients. Furthermore, we recommend that if HHS uses financial incentives, those incentives should be focused on improving outcomes and not to reducing costs.
- We appreciate the recognition of the need to provide programs that improve the quality of care and increase access. To that end, we recommend that such programs be developed and implemented in a culturally competent manner.

- We strongly support the inclusion of the strategy “Reduce disparities in quality and safety” as it is critical to ensure that our health care system is accessible to all individuals, regardless of race, ethnicity, language, immigration status, sex, gender identity, sexual orientation, age, and/or disability.
- We are concerned that the plan fails to mention other federal civil rights laws and Executive Orders which are relevant to providing health care options that are responsive to consumer demands. These include Executive Order 13166, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act (ACA). All of these laws must be fully implemented and enforced by HHS to ensure that HHS’ programs and activities, and those it supports with federal funds, are responsive to consumer demands.
- We do not agree with HHS’ statement that removing barriers to and promoting participation in HHS programs by persons and organizations with religious beliefs or moral convictions is a solution to assisting targeted populations. Rather, HHS should remain neutral in its funding and activities to ensure that individuals do not feel proselytized by providers or receive access to a limited scope of services due the moral or religious nature of an organization.
- We appreciate the role HHS has in preparing for and responding to public health emergencies. We believe that much of this work, especially in the provision of tools to states and providing public health communications must be done in a culturally competent manner.
- We support the recognition of the need to improve collaboration with State, Local, Tribal and Territorial (SLTT) partners. We recommend that these strategies also specifically recognize the need to provide information in a culturally competent manner.
- We support the objective to optimize information technology investments to improve process efficiency and believe HHS should ensure that efforts to identify and address health care disparities are sufficiently recognized through information technology investments.

IV. Implications for LGBTQ Individuals

LGBTQ people are considered a vulnerable population as it concerns their health. LGBTQ people face higher rates of HIV/AIDS, depression, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder. Transgender people in particular are at higher risk for a range of poor health outcomes. For example, the 2015 US Transgender Survey, a national study of nearly 28,000 transgender adults, found that respondents were nearly five times more likely to be living with HIV than the general population, with even higher rates for some populations: for example, nearly one in five (19%) Black transgender women living with HIV, more than 63 times the rate in the general population. Transgender respondents were nearly eight times more like than the general population to be living with serious psychological distress based on the Kessler 6 scale, with higher rates correlating with experiences of discrimination, violence, and rejection. The medical community and scientific research has repeatedly demonstrated that the poor health outcomes that LGBTQ people face are not associated with any inherent pathology, but rather high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. Recognizing these disparities and the impact they have on LGBTQ people, improving the health,

safety, and well-being of LGBTQ people was made a goal of Healthy People 2020. LGBTQ people were also included in several other health objectives including mental health and mental illness, tobacco use, usual source of care, and health insurance coverage, and the National Institute of Health (NIH) formally designated sexual and gender minorities as a health disparity population in 2011 for NIH research.¹⁴

A major factor in these health disparities is the discrimination that LGBTQ people face when trying to access health care. While the ACA has significantly increased the percentage of LGBTQ people with insurance and has helped prohibit discrimination against LGBTQ people in coverage and care, LGBTQ people are still more likely than non-LGBTQ people to lack insurance and LGBTQ people still face discrimination.^[4] A recent survey by found that transgender respondents were over 5 times more likely to avoid medical offices just to avoid the risk of experiencing discrimination than their cisgender counterparts.^[5] Additionally, the 2015 U.S. Transgender Survey found that, just in the past year, 33% of those who saw a health care provider face some form of mistreatment or discrimination because of being transgender, such as being refused care, harassed, or physically or sexually assaulted, and 23% avoided seeing a provider when needed due to fear of discrimination. We expect HHS to continue serving LGBTQ people and believe the strategic plan is an ideal opportunity for HHS to show that it plans to engage in targeted efforts to ensure that vulnerable populations like LGBTQ communities get the health care they need.

As a population that experiences the significant disparities related to health care access, essential services, and economic security described above, LGBTQ people should be specifically mentioned in relevant portions of the strategic plan. In previous strategic plans, HHS included explicit references to the LGBTQ population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals. We recommend that the needs of the LGBTQ population be explicitly mentioned in some of the following key goals:

- Collect additional data, identify barriers to access, facilitate consumer engagement, and promote evidence-based practices to improve access to physical and behavioral health services
- Measure and report on health care quality and disparities at the national, state, local, and individual provider level to facilitate improvement in the health care system
- Identify individuals and populations at risk for limited health care access and assist them to access health services, including prevention, screening, linkages to care, clinical treatment, and relevant support services, including through mobilization of faith-based and community organizations
- Health promotion and wellness strategies supported by HHS are often focused on specific populations at risk for poorer health outcomes, such as older adults, people with disabilities, racial and ethnic minorities, American Indian and Alaska Native populations, people with low socioeconomic status, children, and people with limited English proficiency

¹⁴ Kellan Baker, "Open Doors for All" (Washington: Center for American Progress, 2015), available at <https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/112169/open-doors-for-all/>.

- Produce and promote patient-centered health care delivery methods and interventions that improve care quality, promote health care access, reduce disparities, and address social determinants of health among populations at risk for poor health outcomes
- Support research to identify, implement, and evaluate interventions to reduce health disparities and improve the health of populations at risk for poor health outcomes

We recommend HHS revisit the strategic plan taking into consideration the large body of research demonstrating the need for specific and competent inclusion of LGBTQ people in all aspects of efforts to improve the health of Americans.

V. Additional Comments

We believe HHS' strategic plan must specifically mention and address HHS' legal responsibility to uphold the laws of the United States, including the ACA and Medicaid. Without robust continued implementation of the ACA and adherence to Medicaid's governing statute and regulations, many of the goals and strategies outlined in this plan will be unobtainable. Further, we appreciate the recognition that consumers and enrollees should have choice, but that choice must come with sufficient knowledge and information to make informed choices. The recent actions by the Administration to cut funding for navigators and open enrollment outreach are contrary to the stated ability to provide consumers with choices that they can understand. Navigators, in particular, play a critical role in informing consumers about their eligibility for health insurance, helping them enroll, explaining how to use health insurance, and connecting them with health care.

We thus suggest adding a new "strategy" bullet that would read as follows:

Implement and enforce the Affordable Care Act

- *Ensure sufficient resources to maintain and improve [healthcare.gov](https://www.healthcare.gov) and its Call Center.*
- *Provide sufficient financial support to FFM navigators to ensure they can operate in all counties in all FFM states and throughout the entire calendar year.*
- *Conduct outreach activities commensurate with the need to educate and inform individuals about the marketplaces, public health insurance programs (including Medicaid, CHIP, and Medicare), their health insurance options, and how to enroll.*
- *Ensure compliance with all statutory and regulatory requirements regarding the ACA and Medicaid.*

VII. Conclusion

NFPRHA appreciates the opportunity to comment on HHS' draft strategic plan. If you require additional information about the issues raised in this letter, please contact Robin Summers at rsummers@nfprha.org or 202-552-0150.

Sincerely,

A handwritten signature in cursive script that reads "Clare M. Coleman". The signature is written in a dark ink and is positioned above the printed name.

Clare Coleman
President & CEO