Bill as Introduced

HB 228-FN – AS INTRODUCED

2011 SESSION

11-0007
01/10

HOUSE BILL *228-FN*

AN ACT prohibiting the department of health and human services from entering into a contract with Planned Parenthood Federation of America, Inc. or any organization that provides abortion services and prohibiting the use of public funds or insurance for abortion services.

SPONSORS: Rep. Willette, Hills 6; Rep. Kappler, Rock 2; Rep. Bates, Rock 4; Rep. Cebrowski, Hills 18; Rep. Groen, Straf 1; Rep. J. Richardson, Merr 8

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill prohibits the department of health and human services from entering into a contract with Planned Parenthood Federation of America, Inc. or any organization that provides abortion services and prohibits the use of public funds or insurance for abortion services.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 228-FN – AS INTRODUCED

11-0007
01/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT prohibiting the department of health and human services from entering into a contract with Planned Parenthood Federation of America, Inc. or any organization that provides abortion services and prohibiting the use of public funds or insurance for abortion services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraph; Certain Contracts Prohibited. Amend RSA 126-A:3 by inserting after paragraph VIII the following new paragraph:

IX. Notwithstanding any provision of law to the contrary, the department shall not enter into a contract with Planned Parenthood Federation of America, Inc. or any other organization that provides abortion services.

2 New Subdivision; Use of Public Funds or Insurance for Abortion Prohibited; Exception. Amend RSA 132 by inserting after section 31 the following new subdivision:

Use of Public Funds or Insurance for Abortion Prohibited

132:32 Use of Public Funds or Insurance for Abortion Prohibited; Exception.

I. Notwithstanding any provision of law to the contrary, no public funds or tax moneys of this state or any political subdivision of this state or any federal funds passing through the state treasury or the treasury of any political subdivision of this state shall be expended for payment to any person or entity for the performance of any abortion unless an abortion is necessary to save the life of the woman having the abortion.

II. Notwithstanding any other provision of law, public moneys or tax moneys of this state or any political subdivision of this state shall not be expended directly or indirectly to pay the costs, premiums, or charges associated with a health insurance policy, contract, or plan that provides coverage, benefits, or services related to the performance of any abortion unless an abortion is necessary to either:

(a) Save the life of the woman having the abortion; or

(b) Avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.

III. This section does not prohibit the state from complying with the requirements of federal law relative to Title XIX and Title XXI of the Social Security Act.

3 Effective Date. This act shall take effect 60 days after its passage.

LBAO
11-0007
Revised 02/14/11

HB 228 FISCAL NOTE

AN ACT prohibiting the department of health and human services from entering into a contract with Planned Parenthood Federation of America, Inc. or any organization that provides abortion services and prohibiting the use of public funds or insurance for abortion services.

FISCAL IMPACT:

The Departments of Health and Human Services and Administrative Services state this bill will have an indeterminable fiscal impact on state, county and local revenue and expenditures in FY 2012 and in each year thereafter.

METHODOLOGY:

The Department of Health and Human Services states this bill prevents the Department from contracting with Planned Parenthood of Northern New England. The Department stated the current contract with Planned Parenthood is in the amount $794,370 of which $428,960 is federal Title X funds and $365,410 is state general funds. Under the contract, Planned Parenthood provides family planning services, reproductive healthcare, HIV testing, STD testing and treatment, and health education. The Department states federal law prohibits these funds from being used to fund abortions. The Department assumes that, without this contract, the federal funds would be returned to the federal government and the general funds would be returned to the general fund.

The Department of Administrative Services states this bill prohibits public funding of health plans that provide coverage for abortions. The Department indicated that there could be a conflict between the proposed law and state employee collective bargaining agreements containing provisions to continue existing coverage. The Department assumes, if the State health benefit plan discontinued providing coverage for abortions, there would be a reduction in expenditures associated with that medical procedure. In addition, the Department assumes there would be an increase expenditures associated with pre-natal care, delivery and continued coverage for dependents to age 26.

HB 228-FN – AS AMENDED BY THE HOUSE

18Jan2012... 0237h

2011 SESSION

11-0007
01/10

HOUSE BILL *228-FN*

AN ACT prohibiting the use of public funds for abortion services.

SPONSORS: Rep. Willette, Hills 6; Rep. Kappler, Rock 2; Rep. Bates, Rock 4; Rep. Cebrowski, Hills 18; Rep. Groen, Straf 1; Rep. J. Richardson, Merr 8

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill clarifies public funding of abortions.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT prohibiting the use of public funds for abortion services.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Chapter; Whole Woman's Health Funding Priorities Act. Amend RSA by inserting after chapter 126-U the following new chapter:

CHAPTER 126-V

WHOLE WOMAN'S HEALTH FUNDING PRIORITIES ACT

126-V:1 Legislative Findings and Purpose.

I. Limited federal and state public funding exists for family planning and preventive health services for women generally, and for maternal and fetal patients in particular. Fiscal constraints mandate that the state allocate available funding efficiently. The principal means by which the state may fulfill its duty to manage these funds is to ensure that funds are distributed by priority to the most efficient point-of-service health care providers. The general court finds that public and private providers of primary and preventive care utilize public funds more effectively than providers of health care services that are specialized to particular medical services or discrete patient populations. Consequently, it is the intention of the general court through this act and any rules and policies adopted under this act to prioritize the distribution and utilization of public funds for family planning, reproductive health care, and maternal/fetal care to such public and private primary and preventive care providers.

II. Prioritization of public health care funding to primary and preventive care also reflects sound health care policy. Individuals who have a primary care clinician are more likely to access health care services, leading to more favorable long-term outcomes. Health care costs are lowered when primary and preventive care is provided by such primary care clinicians in a setting that addresses the whole person by emphasizing counseling, screening, and early detection of leading causes of morbidity and mortality including diabetes, hypertension, obesity, cardiovascular and renal diseases, and asthma. Indirect costs such as lost worker productivity and employer health care costs are also reduced. Most importantly, individual citizens will lead longer, healthier, and happier lives as a result of having less fragmented health care.

III. It is also the public policy of this state to ensure delivery of comprehensive preconception and prenatal care for maternal and fetal patients in order to reduce maternal and fetal morbidity and mortality. The United States Centers for Disease Control and Prevention states, "Comprehensive preconception and prenatal care includes encouraging women to stop smoking, refrain from using alcohol and other drugs, eat a healthy diet, take folic acid supplements, maintain

a healthy weight, control high blood pressure and diabetes, and reduce exposure to workplace and environmental hazards. In addition, screening and providing services to prevent intimate partner violence and infections (*e.g.*, HIV, STI and viral hepatitis) help to improve the health of the mother and the baby." Delivery of these critical services is best accomplished through a single point-of-service provider such as a primary care provider, and directed by a primary care clinician who has knowledge of the patient's medical history and personal, familial, and environmental health factors. The utilization of public funding to maximize effective delivery of holistic prenatal and maternal health care conflicts with medical intervention models that emphasize the provision of services to discrete patient sub-populations, including women of child-bearing age, to address discrete patient conditions, or provide particular therapies.

IV. The general court also declares that it shall be the policy of this state that federal public funds shall not be provided for the direct or indirect costs, including, but not limited to, administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utilities of non-federally qualified abortions, abortion referral, or abortion counseling, and these activities shall not be subsidized, either directly or indirectly, by federal public funds.

126-V:2 Definitions. In this chapter:

I. "Abortion" means the act of using or prescribing any instrument, medicine, drug, or any other substance, device, or means with the intent to terminate the clinically diagnosable pregnancy of a woman with the knowledge that the termination by those means will with reasonable likelihood cause the death of the unborn child. Such use, prescription, or means is not an abortion if done with the intent to:

(a) Save the life or preserve the health of the unborn child;

(b) Remove a dead unborn child cause by spontaneous abortion; or

(c) Remove an ectopic pregnancy.

II. "Department" means the department of health and human services.

III. "Federally qualified abortion" means an abortion qualified for federal reimbursement under the Medicaid program, 42 U.S.C.A. section 1396 et seq., and as amended hereafter.

IV. "Federally qualified health center" means a health care provider that is eligible for federal funding under 42 U.S.C. section 1396d(1)(2)(B).

V. "Hospital" means a primary or tertiary care facility licensed pursuant to RSA 151.

VI. "Public funds" means state funds from whatever source, including without limitation state general revenue funds, state special account and limited purpose grants and/or loans, and federal funds provided under Title X of the Public Health Service Act (42 U.S.C. section 300 et seq.) and Title V (42 U.S.C. section 701 et seq.), Title XIX (42 U.S.C. section 1396 et seq.) and Title XX (42 U.S.C. section 1397 et seq.) of the Social Security Act.

VII. "Rural health clinic" means a health care provider that is eligible for federal funding under 42 U.S.C. section 1395x(aa)(2).

126-V:3 Prioritization of Public Funds to Health Care Entities. Subject to any applicable requirements of federal statutes, rules, regulations, or guidelines:

I. Any expenditures or grants of public funds for family planning services by the state made by the department shall be made in the following order of priority to:

(a) Public entities;

(b) Non-public hospitals and federally qualified health centers;

(c) Rural health clinics; and

(d) Non-public health providers that have as their primary purpose the provision of the primary health care services enumerated in 42 U.S.C. section 254b(a)(1).

II. The department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed.

126-V:4 Enforcement.

I. The attorney general shall have authority to bring an action in law or equity to enforce the provisions of this chapter, and relief shall be available in appropriate circumstances including recoupment and declaratory and injunctive relief, including without limitation suspension or disbarment.

II. Any entity eligible for the receipt of public funds, as defined in RSA 126-V:2, VI, shall possess standing to bring any action that the attorney general has authority to bring pursuant to the provisions of this section, provided, however, that an expenditure or grant of public funds made in violation of this chapter has resulted in the reduction of public funds available to it, and that any award of monetary relief shall be made to an appropriate public officer for deposit into one or more accounts maintained by the state for public funds enumerated in RSA 126-V:3.

III. In an action brought pursuant to this section, a prevailing plaintiff shall be entitled to an award of reasonable attorneys' fees and costs.

126-V:5 Right of Intervention. The general court, by joint resolution, may appoint one or more of its members to intervene as a matter of right in any case in which the constitutionality of this law is challenged.

126-V:6 Severability. If any provisions of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

126-V:7 Effect on Appropriations. Any appropriation of public funds made by the department in violation of the provisions of this chapter shall be null and void, and the funds allocated pursuant to such appropriations shall be reallocated to eligible entities.

2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
11-0007
Revised 02/14/11

HB 228 FISCAL NOTE

AN ACT prohibiting the use of public funds for abortion services.

FISCAL IMPACT:

The Departments of Health and Human Services and Administrative Services state this bill will have an indeterminable fiscal impact on state, county and local revenue and expenditures in FY 2012 and in each year thereafter.

METHODOLOGY:

The Department of Health and Human Services states this bill prevents the Department from contracting with Planned Parenthood of Northern New England. The Department stated the current contract with Planned Parenthood is in the amount $794,370 of which $428,960 is federal Title X funds and $365,410 is state general funds. Under the contract, Planned Parenthood provides family planning services, reproductive healthcare, HIV testing, STD testing and treatment, and health education. The Department states federal law prohibits these funds from being used to fund abortions. The Department assumes that, without this contract, the federal funds would be returned to the federal government and the general funds would be returned to the general fund.

The Department of Administrative Services states this bill prohibits public funding of health plans that provide coverage for abortions. The Department indicated that there could be a conflict between the proposed law and state employee collective bargaining agreements containing provisions to continue existing coverage. The Department assumes, if the State health benefit plan discontinued providing coverage for abortions, there would be a reduction in expenditures associated with that medical procedure. In addition, the Department assumes there would be an increase expenditures associated with pre-natal care, delivery and continued coverage for dependents to age 26.

LBAO
11-0007
Amended 03/20/12

HB 228 FISCAL NOTE

AN ACT prohibiting the use of public funds for abortion services.

FISCAL IMPACT:

The Department of Health and Human Services states this bill, **as amended by the House (Amendment #2012-0237h)**, will have an indeterminable fiscal impact on state, county and local revenues and expenditures.

METHODOLOGY:

The Department of Health and Human Services states this bill will prohibit the Department from entering into a contract with any provider who performs non-federally qualified abortions. The Department indicates it has Medicaid provider agreements with the 26 acute care hospitals in the state and 25 of the hospitals provide non-federally qualified abortion services. The Department makes the following assumptions concerning the fiscal impact on the Medicaid program:

- If hospitals continued to offer non-federally qualified abortion services the Department would have to terminate their Medicaid provider agreements;
- A reduction in the number of hospitals providing services to Medicaid enrollees could result in violation of 42 USC 1396a(a)(30)(A), which requires state Medicaid programs to ensure access to services for Medicaid enrollees equal to the access enjoyed by individuals who are commercially insured;
- Federal Medicaid law, 42 USC 1396a(a)(23) mandates that Medicaid enrollees may obtain care from any willing provider. By excluding providers from the state Medicaid network, based on the range of services offered, would violate the federal provision;
- Violation of the federal Medicaid requirements would force the Centers for Medicare and Medicaid Services to impose financial and or other sanctions against the state including withholding some, or all, of the federal match for the Medicaid program; and
- The total federal Medicaid match is approximately $700 million.

In Fiscal Year 2012, the Department will receive $818,263 of federal Title X family planning funds. Of this amount, $514,827 is combined with $410,079 in state general funds to fund contracts that serve approximately 10,000 individuals through 10 agencies. Services include comprehensive reproductive health care, breast and cervical caner screening, HIV testing, STI testing and treatment, and health education. The agencies are listed in the following table:

Agency	Title X Federal Funds	General Funds
Ammonoosuc CHC	$45,057	$35,890
Belknap-Merrimack CAP	$98,947	$78,815
Child Health Services	$27,040	$21,538
Concord Hospital	$55,958	$44,573
Coos County CHC	$32,540	$25,919
Goodwin CHC	$68,293	$54,398
Indian Steam HC	$13,979	$11,135
Lamprey HC	$97,715	$77,884
Weeks CHC	$28,043	$22,337
White Mountain HC	$47,255	$37,640
Total	**$514,827**	**$410,129**

The remaining $303,436 of federal funds covers administration of the program including two full-time state employees.

The Department assumes one of the agencies would not be funded based on the priorities established in proposed RSA 126-V:3 and the funds allocated to that contract would be reallocated to a provider that satisfies the priorities or be allocated among the remaining providers above. The Department states federal Title X guidelines require that pregnant women be offered the opportunity to receive information and counseling on prenatal care and delivery, infant care, foster care or adoption, and pregnancy termination. The Department assumes the agencies would no longer provide counseling or referral for pregnancy termination, the program would not comply with the Title X requirement, and the federal funds would no longer be available. In addition, the Department assumes the general funds would be returned to the state, and family planning services would discontinue.

The fiscal impact on local and county revenue and expenditures cannot be determined, but there will be an impact as a result of the costs associated with the decrease in reproductive healthcare.

Amendments

Sen. Lambert, Dist. 13
Sen. DeBlois, Dist. 18
Sen. Groen, Dist. 6
April 18, 2012
2012-1727s
01/04

If this amendment is adopted by the Committee, please deliver to the House Clerk (Room 317) or Senate Clerk (Senate Chamber), the 2 originals and 2 copies.

Amendment to HB 228-FN

Amend RSA 126-V:1 as inserted by section 1 of the bill by replacing it with the following:

126-V:1 Legislative Findings and Purpose. The general court declares that it shall be the policy of this state that federal public funds shall not be provided for the direct or indirect costs, including, but not limited to, administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utilities of non-federally qualified abortions. These activities shall not be subsidized, either directly or indirectly, by federal public funds.

Amend RSA 126-V:3, II as inserted by section 1 of the bill by replacing it with the following:

II. The department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed; provided that this paragraph shall not apply to any hospital.

Amend RSA 126-V:4, II as inserted by section 1 of the bill by replacing it with the following:

II. Any entity eligible for the receipt of public funds shall possess standing to bring any action that the attorney general has authority to bring pursuant to the provisions of this section, provided, however, that an expenditure or grant of public funds made in violation of this chapter has resulted in the reduction of public funds available to it, and that any award of monetary relief shall be made to an appropriate public officer for deposit into one or more accounts maintained by the state for public funds enumerated in RSA 126-V:3.

Amend the bill by replacing section 2 with the following:

2 Effective Date. This act shall take effect 180 days after its passage.

Sen. Lambert, Dist. 13
Sen. DeBlois, Dist. 18
Sen. Groen, Dist. 6
April 18, 2012
2012-1727s
01/04

Amendment to HB 228-FN

Amend RSA 126-V:1 as inserted by section 1 of the bill by replacing it with the following:

126-V:1 Legislative Findings and Purpose. The general court declares that it shall be the policy of this state that federal public funds shall not be provided for the direct or indirect costs, including, but not limited to, administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utilities of non-federally qualified abortions. These activities shall not be subsidized, either directly or indirectly, by federal public funds.

Amend RSA 126-V:3, II as inserted by section 1 of the bill by replacing it with the following:

II. The department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed; provided that this paragraph shall not apply to any hospital.

Amend RSA 126-V:4, II as inserted by section 1 of the bill by replacing it with the following:

II. Any entity eligible for the receipt of public funds shall possess standing to bring any action that the attorney general has authority to bring pursuant to the provisions of this section, provided, however, that an expenditure or grant of public funds made in violation of this chapter has resulted in the reduction of public funds available to it, and that any award of monetary relief shall be made to an appropriate public officer for deposit into one or more accounts maintained by the state for public funds enumerated in RSA 126-V:3.

Amend the bill by replacing section 2 with the following:

2 Effective Date. This act shall take effect 180 days after its passage.

Sen. Lambert, Dist. 13
Sen. DeBlois, Dist. 18
Sen. Groen, Dist. 6
April 18, 2012
2012-1727s
01/04

Amendment to HB 228-FN

Amend RSA 126-V:1 as inserted by section 1 of the bill by replacing it with the following:

126-V:1 Legislative Findings and Purpose. The general court declares that it shall be the policy of this state that federal public funds shall not be provided for the direct or indirect costs, including, but not limited to, administrative costs or expenses, overhead, employee salaries, rent, and telephone and other utilities of non-federally qualified abortions. These activities shall not be subsidized, either directly or indirectly, by federal public funds.

Amend RSA 126-V:3, II as inserted by section 1 of the bill by replacing it with the following:

II. The department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed; provided that this paragraph shall not apply to any hospital.

Amend RSA 126-V:4, II as inserted by section 1 of the bill by replacing it with the following:

II. Any entity eligible for the receipt of public funds shall possess standing to bring any action that the attorney general has authority to bring pursuant to the provisions of this section, provided, however, that an expenditure or grant of public funds made in violation of this chapter has resulted in the reduction of public funds available to it, and that any award of monetary relief shall be made to an appropriate public officer for deposit into one or more accounts maintained by the state for public funds enumerated in RSA 126-V:3.

Amend the bill by replacing section 2 with the following:

2 Effective Date. This act shall take effect 180 days after its passage.

Committee Minutes

Printed: 03/14/2012 at 9:32 am

SENATE CALENDAR NOTICE
HEALTH AND HUMAN SERVICES

Senator Jeb Bradley Chairman
Senator Tom De Blois V Chairman
Senator Molly Kelly
Senator Gary Lambert
Senator Andy Sanborn

For Use by Senate Clerk's Office ONLY
☐ Bill Status
☐ Docket
☐ Calendar
Proof: ☐ Calendar ☐ Bill Status

Date: March 14, 2012

HEARINGS

Thursday **4/5/2012**

(Name of Committee)	(Place)	(Time)
HEALTH AND HUMAN SERVICES	SH 100	1:00 PM

EXECUTIVE SESSION MAY FOLLOW

1:00 PM HB228-FN (New Title) prohibiting the use of public funds for abortion services.

Sponsors:
HB228-FN
Rep. Robert Willette
Rep. Warren Groen
Rep. Lawrence Kappler
Rep. Jon Richardson
Rep. David Bates
Rep. John Cebrowski

Robyn Dangora 271-4154

Sen. Jeb Bradley
Chairman

Health and Human Services Committee

Hearing Report

TO: Members of the Senate

FROM: Robyn Dangora, Legislative Aide

RE: Hearing report on HB 228-FN – **(New Title) prohibiting the use of public funds for abortion services.**

HEARING DATE: April 5, 2012

MEMBERS OF THE COMMITTEE PRESENT: Sen. Bradley, Sen. De Blois, Sen. Kelly, Sen. Lambert, Sen. Sanborn

MEMBERS OF THE COMMITTEE ABSENT: None

Sponsor(s): Rep. Willette, Hills 6; Rep. Kappler, Rock 2; Rep. Bates, Rock 4; Rep. Cebrowski, Hills 18; Rep. Groen, Straf 1; Rep. J. Richardson, Merr 8

What the bill does: This bill clarifies public funding of abortions.

Who testified in support: U.S. Congresswoman M. Musgrave, Susan B. Anthony List; Rep. Groen, Straf 1; Rep. Baldasaro, Rock 3; Rep. Willette, Hills 6; Rep. Souca, Hills 11; Sen. Groen, Dist 6; Julie Laughner; Ellen Kolb, Cornerstone; Kurt Wuelper, NH Right to Life; Steve Aden, NH Right to Life; Joan Espiñola, Michael Tierney; Darlene Pawlik; Dan Farrelly; Charlie Siggins; Ada Voissem; Veronica Molloy
**To see the full list of those who signed in to support the bill, please see the permanent record*

Who testified in opposition: Rep. Millham, Belk 5; Rep. Bouchard, Merr 11; Rep. Fredette, Hills 1; Vanessa Santarelli, Bi-State Primary Care Assoc.; Dr. Barry Smith, NH Medical Society; Kate Frey and Lisabritt Solsky, Dept. Health & Human Services; Dr. James Squires; Heather Lavoie, Geneia/ Planned Parenthood of Northern New England; Jen Castle, Jen Frizzelle, and Maribeth Quinn, Planned Parenthood of Northern New England; Rabbi Robin Nafshi, Faith Coalition; Susan Scheffer; Dr. Julia Burdick; Leslie Melby, NH Hospital Assoc.; Claire Ebel, NH Civil Liberties Union; Helen Shotanus, Marie Malroy
**To see the full list of those who signed in to oppose the bill, please see the permanent record*

Summary of testimony received:
Hearing opened at 1:01 PM

Summary of Testimony Received in Support (See committee file for all submissions)

•This bill does not prevent women from having an abortion or businesses from performing abortions. It says the government will not fund any of the overhead related to abortions directly or indirectly.

•There are limited funds available for family planning and the goal of the bill is to use taxpayers' money allocated to women's healthcare in the most the efficient way for the most holistic approach to family planning. HB 228 focuses the funds and will lead to an upgrade in service through prioritization.

•This bill is based on a similar bill from TX based on bifurcation that was taken to court and upheld three times. In TX if a family planning organization wants funding, it has to separate its abortion services completely from its other programs.

•The U.S. Supreme Court case Russ v. Sullivan stated that the decision not to fund abortion related activities does not deny any right to engage in abortion related activities.

• Section 126-V: 3 states the bill is to be interpreted "subject to any applicable requirements of federal statutes, rules, regulations, or guidelines" so it will not affect Title X or Medicaid.

•Providers will not lose Medicaid dollars as long as they separate their services. Planned Parenthood has fungible money so they do not receive federal or state funds for direct abortion services but there is no way to ensure state dollars that are spent on indirectly funding abortion or the state funds free up other money to be spent on abortion.

•Abortion is not a healthcare procedure. Taxpayer money should not be used complicity involved in this. Abortions do not help the health of mother or child and may lead to psychological issues or pre-term births in the future for the mother.

•Planned Parenthood is the country's largest abortion provider, providing 27% of the abortions over the past 3 years adding up to over a million in that time, which is not "rare". Planned Parenthood of Northern New England carried out 3,185 abortions in 2005 and nationally 91% of pregnant women who go to Planned Parenthood receive an abortion.

•Separating the federal funds from buildings were abortions are performed is a good check on Planned Parenthood. Planned Parenthood has been proven to have defrauded the government and waste taxpayers' money all over the country. They have been charged with overbilling the states of WA, TX, CA, NJ, and NY. They have been charged with falsifying documents to cover up things such as rape, sex trafficking, and minors receiving abortions without parental consent in KS, VA, and OH and former employees from MA, SD, TX, CA, and IA has testified to similar cover ups. Planned Parenthood is a non-profit that made over $300Million in the past 5 years.

•The Medicaid Act allows states broad discretion for qualifying entities, there was a similar conclusion from U.S. Supreme Court case Planned Parenthood v. Casey.

Summary of Testimony Received in Opposition (See committee file for all submissions)

- The language in the bill says no state funds will be used for costs "directly or indirectly" relating to abortion, so hospitals where counseling or referrals for abortion are made may also lose federal funds and Medicaid patients, according to section 126-V:1, IV. Such counseling is protected under Title X.
- The language of the original bill named Planned Parenthood and this bill is aimed at trying to defund Planned Parenthood.
- The Center for Medicare & Medicaid Services (CMS) sent TX a letter stating that their law violated federal law and risks losing their federal women health waiver. In the worst case scenario, if NH loses our federal match for Medicaid of $700Million, that would end the program and end the Medical Home.
- Medicaid will have to unenroll all hospitals performing abortions, which could be traumatic for the program and its enrollees. If hospitals decide to keep Medicaid patients then we may see more underground, unsafe illegal abortions.
- CMS finds this bill in violation of the provision ensuring adequate access to care to all Medicaid enrollees and the any willing provider provision.
- There are safeguards in place to ensure state funds do not go toward abortion services. Planned Parenthood and similar providers are audited every third year. They fill out extensive Title X paperwork. Title X provides necessary healthcare for the needs of low-income women and receives no federal dollars for abortion services and the 2012-2013 budget prohibits state dollars for abortion services. Title X providers must offer counseling and referrals for abortions to those who request them.
- No state or federal funds are used for abortions. There is no proof of misdeeds by Planned Parenthood. They have always passed audits.
- Federal law prohibits states from discriminating against Medicaid providers solely on their scope of services.
- Healthcare should be preventive and Planned Parenthood provides preventive care for women between the ages of 18-40 years old. In Northern New England 3-5% of those services are abortions (1,194 in 2011) and others are screenings for chronic diseases, preventive care, and serve as primary care physicians for 6 out of 10 patients.
- This is an anti-abortion and anti-women bill that tries to make it harder to receive an abortion in New Hampshire, even though they are legal under the law. Abortions are part of comprehensive healthcare.
- This bill is a religious imposition on women. Some religions counsel that abortion is right in some instances and some people are not religious. This bill does not permit religious freedom.
- If passed this would raise healthcare costs, at least to start because it takes effect 60 days after passage which is not enough time to build any new facilities and would therefore create a large number of uninsured patients. This would lead companies to raise premiums on the insured to pay for this.
- This bill will disproportionately affect low-income women who receive their family planning at clinics and Planned Parenthood and other Medicaid providers. In 2011, 47% of Medicaid visits were for primary care services.

•Similar laws in KS, IN, and NC have recently been struck down as unconstitutional.

There was Conflicting Testimony Concerning:

1. Number of abortion providers in NH:

•Rep. Groen testified that a 2010 report from the Guttmacher Institute sited 11 providers in the state: 6 Planned Parenthood facilities, 2 free standing clinics, and the others are likely hospitals. Therefore this will not have the effect promoted on hospitals – if abortions account for a fraction of a percent of their revenues, then it should not change their business model of accepting Medicaid funds in favor of that tiny percent.

•DHHS testified that of the 26 hospitals in NH, only 2 definitely do not perform abortions. The two Catholic hospitals mentioned are both in the southern tier of the state. DHHS has reason to believe most of the other 22 hospitals perform abortions outside the narrow definition permitted under Medicaid, but the data is not requested by the state so it is not collected. Others testified that on the seacoast, hospitals providing abortions include Exeter Hospital, Portsmouth Hospital, Dover Hospital, and Frisbie Hospital.

•DHHS said Guttmacher use different definitions of an abortion provider.

2. Indirect Funding/Legislative Intent:

•Steven Aden of NH Right to Life said that funds to facilities offering counseling and referrals for abortions would not be prohibited because language in the preamble of the bill (Finding and Purpose) is not legally binding (referring to section 126-V:1, IV). Enforceable laws begin at section 126-V: 3 and does not prohibit counseling and referral.

•Attorney Michael Tierney said that because section 1 stated that this bill deals strictly with family planning grants and contracts, so as long as abortion providers have separate books for abortion and non-abortion services so state funds can be proven as spent on non-abortion related services.

•Unlike Mr. Tierney, Claire Ebel of the NH Civil Liberties Union believes section 126-V: 3 II. stand alone and is not limited by section 1; therefore, any facility that allocates any money toward abortion services would be defunded entirely under HB 228.

•Co-sponsor, Rep. Groen stated the legislative intent is bifurcation. In Texas, hospitals have bifurcated and removed abortion services from healthcare facilities and continued to take Title X money.

Hearing closed at 4:49 PM

Funding: The Department of Health and Human Services states this bill, as amended by the House (Amendment #2012-0237h), will have an indeterminable fiscal impact on state, county and local revenues and expenditures.

Action: Pending

rmd
[file: HB 228-FN report]
Date: 4/9/12

Speakers

(1)

SPEAKING IN OPPOSITION

Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing	Oppose	Speaking? Yes	Speaking? No
Vanessa Santarelli	Bi-State Primary Care Assoc. (Community Health Ctrs)	☑	☑	☐
Barry Smith, MD	NH Medical Society	☒	☒	☐
~~Norman Tregenza~~	~~Barr... NH~~	☐	☐	☒
Rep. Alida Millham	Belknap Dist #5	☑	☑	☐
		☐	☐	☐
Rep. Candace Bouchard	Concord / Merrimack Dist. 11	☒	☒	☐
~~Charlie Siggins~~	~~MHTF~~	☐	☐	☐
Kate Frey / Lisabritt Solsky	DHHS	☑	☑	☐
Heather Lavoie	~~General~~ NNEPP	☑	☑	☐
James Soyres	Self	☐	☑	☐
Jen Castle / Jen Frizzell	PPNNE	☐	☐	☐
Rabbi Robin Nafshi	Faith Coalition	☐	☐	☐
Susan Scheffer	Concord resident, Mom.	☑	☑	☐
Julia Burdick MD	employed by Dartmouth	☑	☑	☐

Rep Bob Fredette

SPEAKING IN OPPOSITION
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	**Representing**	Oppose	Speaking?	Yes	No
~~Lucy Hodder, Esq~~	~~PPNNE~~	~~[x]~~	~~Speaking?~~	~~[ ]~~	~~[x]~~
Maribeth Quinn	PP NNE	[x]	Speaking?	[x]	[ ]
Leslie Melby	NH Hospital Association	[ ]	Speaking?	[x]	[ ]
Claira Ebel	NHCLU	[x]	Speaking?	[x]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]
		[ ]	Speaking?	[ ]	[ ]

SPEAKING IN SUPPORT
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing				
Joan Espinola	Self	Support ☒	Speaking?	Yes ☒	No ☐
Dan Ferrelly	self	Support ☒	Speaking?	Yes ☒	No ☐
Charlie Siggins	Self	Support ☒	Speaking?	Yes ☒	No ☐
Rep Al Baldasaro	Rockingham - District 3	Support ☒	Speaking?	Yes ☒	No ☐
		Support ☐	Speaking?	Yes ☐	No ☐
Michael Tierney	self	Support ☒	Speaking?	Yes ☒	No ☐
Steven H. Arden	NH Right to Life	Support ☑	Speaking?	Yes ☒	No ☐
Marilyn Musgrave	SBA List	Support ☒	Speaking?	Yes ☒	No ☐
REP. WARREN CLOEN	SELF	Support ☒	Speaking?	Yes ☒	No ☐
Julie Laughner	self	Support ☒	Speaking?	Yes ☒	No ☐
Ellen Kolb	CORNERSTONE	Support ☒	Speaking?	Yes ☒	No ☐
KURT WUEHPER	N.H. Right to Life	Support ☑	Speaking?	Yes ☑	No ☐
R.F. Willette	SPONSER	Support ☒	Speaking?	Yes ☒	No ☐
Rep. Kathleen Souza	Hills. # 11	Support ☑	Speaking?	Yes ☒	No ☐

(2)

SPEAKING IN SUPPORT
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing		
Darlene Pawlik	myself	Support ☑	Speaking? Yes ☑ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐
		Support ☐	Speaking? Yes ☐ No ☐

SPEAKING IN SUPPORT

Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing	Support	Speaking?	Yes	No
Ava Voissem	self women of the College of St. Mary Magdalen	☒	Speaking?	☒	☐
Fenton Groen	Senate Dist 6	☒	Speaking?	☒	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐
		☐	Speaking?	☐	☐

(1)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing	Support	Oppose
Sen Luther	District 12	☑	☐
Rep Edith "Dee" Hogan	District 25	☑	☐
REP. MOE VILLENEUVE	DIST. #18	☑	☐
Rep. Don LeBrun	Dist #26 Nashua.	☑	☐
REP. L. MIKE KAPPLER	ROCK 2	☑	☐
Rep Jerry Borgevin	Hillsborough 17	☑	☐
Linda Tuomsky	Self	☒	☐
Lindsey Allen	NHDP	☐	☒
Janet Monahan	NH Medical Society	☐	☒
DAVID CHAMBERLAIN	Pro-Life/God	☑	☐
Linda Gould (Linda Stone)	Self / NHRTL	■	☐
Tara Bishop	self	☑	☐
Elizabeth Jacobs		☑	☐
Natasha Moore		☑	☐

(2)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing	Support	Oppose
Stephanie Manners	Self	☑	☐
Norman Tregenza	Carroll II	☒	☐
Rep CARL SEIDEL	Hills 20	☒	☐
Ava Voissem	self	☒	☐
[illegible]	Self	☑	☐
Frances Vall	self	☑	☐
Veronica Miller	Self	☒	☐
DAN HOGAN	Self	☒	☐
GEORGE HARNE	Self	☑	☐
Sheila F. Ross	Self	☑	☐
Nicki MONROE	Self	☒	☐
Raffaela Lenus	self	☑	☐
Charles Lenus	Self	☒	☐
Billy Cody	SBA List	☑	☐

(3)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing	Support	Oppose
Felix Miller	Myself	☒	☐
Therese Saunders	Myself	☒	☐
[illegible]	Nottingham NH	☒	☐
Samantha Zabrykevitz	Myself	☒	☐
[illegible]	Myself	☒	☐
Jonathan Camara	myself	☒	☐
Daniel Walker	Self	☒	☐
Freda Muldoon	myself	☒	☐
Susan Clifton	myself	☒	☐
Marie Malloy	NHPHA	☐	☒
Beth Boucher	NHPHA	☐	☒
Rep. Jeanine Notter	Hills 19	☒	☐
Rep. Timothy Horrigan	Strafford 7	☐	☒
Rachel Laughner		☒	☐

(4)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing		
Rep. Linette Peterson	Hills Dist. 19	Support ☒	Oppose ☐
Mary Rauh	New Castle	Support ☐	Oppose ☑
Sara Crane	NARAL Pro-Choice NH	Support ☐	Oppose ☒
Helen Schotanus	Grantham	Support ☐	Oppose ☒
Kevin	NH Right to Life	Support ☒	Oppose ☐
Jessica Clark	America Votes	Support ☐	Oppose ☒
Christina D'Allesandro	Self	Support ☐	Oppose ☒
Abby Blum	Self	Support ☐	Oppose ☒
Rep Twombly	Hills Dist 23	Support ☒	Oppose ☐
Sen. Sylvia Larsen	Dist. 16	Support ☐	Oppose ☑
Mrs Karen Cate	Our common good under God	Support ☑	Oppose ☐
Rep. David Bates	Rockingham 4	Support ☒	Oppose ☐
Donna Andronico	self	Support ☑	Oppose ☐
Gina Andronico	self	Support ☑	Oppose ☐

(5)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing		
James R. Finn	RHRTL / RofC	Support ☑	Oppose ☐
John Dillon		Support ☑	Oppose ☐
Molly Strempfer		Support ☐	Oppose ☒
Mari Thibodeau		Support ☑	Oppose ☐
Loretta Choiniere		Support ☑	Oppose ☐
Joelle Choiniere		Support ☑	Oppose ☐
Marielle Choiniere		Support ☑	Oppose ☐
Ben. Thibodeau		Support ☑	Oppose ☐
James Thibodeau		Support ☑	Oppose ☐
Charles Venus		Support ☑	Oppose ☐
Rachelle Choiniere		Support ☑	Oppose ☐
Alex Rohan		Support ☑	Oppose ☐
Nate Thibodeau		Support ☑	Oppose ☐
Chantal Choiniere		Support ☑	Oppose ☐

(6)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing		
Suzi Rohm		Support ☑	Oppose ☐
Lois Bates	self	Support ☒	Oppose ☐
Veronica Molloy	SELF	Support ☒	Oppose ☐
Susan Arnold	Board mem, NARAL PC NH	Support ☐	Oppose ☒
Amanda Merrill	Dist. #21	Support ☐	Oppose ☒
Pamela Walsh	Concord, NH self	Support ☐	Oppose ☒
Heather Krans	self	Support ☐	Oppose ☒
Robert Stein	Self	Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐

(7)

THOSE **NOT** WISHING TO SPEAK
Senate Health and Human Services Committee: Sign-In Sheet

Date: April 5, 2012 Time: 1:00 p.m. SH 100 Public Hearing on HB 228-FN

HB 228-FN **(New Title) prohibiting the use of public funds for abortion services.**

Name	Representing		
Rep Tara Sad	Cheshire 2	Support ☐	Oppose ☒
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐
		Support ☐	Oppose ☐

Testimony

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUN 0 1 2011

Patricia Casanova, Director
Office of Medicaid Policy and Planning
MS 07, 402 W. Washington Street, Room W382
Indianapolis, IN 46204-2739

Dear Ms. Casanova:

I am responding to your request to approve the State of Indiana's Medicaid State plan amendment (SPA) 11-011, received by the Centers for Medicare & Medicaid Services (CMS) on May 15, 2011. In this amendment, Indiana proposes to prohibit the State Medicaid agency from entering into a contract or grant with providers that perform abortions or maintain or operate facilities where abortions are performed, except for hospitals or ambulatory surgical centers. For the reason set forth below, I am unable to approve SPA 11-011 as submitted, because it does not comply with the requirements of section 1902(a)(23) of the Social Security Act (the Act).

Section 1902(a)(23)(A) of the Act provides that beneficiaries may obtain covered services from any qualified provider that undertakes to provide such services. This SPA would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons not related to their qualifications to provide such services. As you know, federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (such as in cases of rape or incest). At the same time, Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a provider's scope of practice. Such a restriction would have a particular effect on beneficiaries' ability to access family planning providers, who are subject to additional protections under section 1902(a)(23)(B) of the Act. These protections also apply in managed care delivery systems. Therefore, we cannot determine that the proposed amendment complies with section 1902(a)(23) of the Act.

For this reason, and after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15(c), I am unable to approve this SPA. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of receipt of this letter in accordance with the procedures set forth at 42 CFR 430.18. Your request for reconsideration may be sent to Ms. Cynthia Hentz, Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP and Survey & Certification, 7500 Security Boulevard, Mail Stop S2-01-01, Baltimore, MD 21244-1850.

We assume this decision is not unexpected. As the Indiana Legislative Services Agency indicated in its April 19, 2011 fiscal impact statement, "While States are permitted to waive a recipient's freedom of choice of a provider to implement managed care, restricting freedom of choice with respect to providers of family planning services is prohibited."

If you have any questions or wish to discuss this determination further, please contact Ms. Verlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Centers for Medicare & Medicaid Services, 233 N. Michigan Avenue, Suite 600, Chicago, Illinois, 60601.

Sincerely,

Donald M. Berwick, M.D.
Administrator

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857

FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

April 2, 2012

APR 04 2012

The Honorable Jeb Bradley, Chairman
Senate Health and Human Services Committee
Legislative Office Building, Room 102
33 North State Street
Concord, NH 03301

Re: HB 228 – (New Title) Prohibiting the use of public funds for abortion service.

Dear Chairman Bradley:

I am writing to you in regard to HB 228, prohibiting the direct and indirect use of public funds for abortion services, which would re-align New Hampshire's health care service delivery system and negatively impact its citizens, in particular women, children and families. If enacted, community based health care providers and the majority of New Hampshire's hospitals would be unable to accept Medicaid, and Federal Title X Family Planning funds, thus significantly straining the safety net of health care providers available for families within the State. The proposed policy in HB 228 is not based on proven evidence-based public health and Medicaid policy and practice. It is also in clear violation of federal law. For those reasons, the New Hampshire Department of Health and Human Services ("Department") strongly opposes this legislation.

To provide some context and to demonstrate the negative impact that would result from passage of HB 228, as amended and passed by the New Hampshire House of Representatives, the following is an overview of the negative and, perhaps, unintended policy and fiscal implications within the legislation.

OVERVIEW OF NEGATIVE AND UNINTENDED CONSEQUENCES

Implications to Medicaid, Title XIX

First, the proposed new RSA 126-V:3, paragraph II, states that "***[t]he department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed.***" (Emphasis added.)

The Department has Medicaid provider agreements with 26 acute care hospitals in New Hampshire, and upon information and belief, all but one of which provide "non federally qualified abortion" services. While Medicaid is only permitted to reimburse for federally qualified abortion services, this bill would prohibit the contracts for all other services to continue. Consequently, if these 25 hospitals continued to offer this service, the Department would have to withdraw these provider agreements and disenroll 25 of the 26 acute care hospitals in the State.

This would result in only one hospital in the southern-tier of the State with a remaining contract with the Medicaid program and all 120,000 Medicaid enrollees would have only one hospital at which to seek inpatient and certain outpatient care. Such a restriction is a violation of 42 USC §1396a(a)(30)(A), which requires that state Medicaid programs ensure equal access to services for Medicaid enrollees as are accessible to the commercially insured population. New Hampshire's Medicaid Program would be unable to comply with this mandate with only one acute care hospital. Noncompliance with federal Medicaid mandates places the New Hampshire Medicaid program, and its 120,000 enrollees, in great jeopardy.

Federal Medicaid law also prohibits states from excluding providers from participation in the network based on the range of services they provide because 42 USC §1396a(a)(23) mandates that Medicaid enrollees may obtain care from "any willing provider." A recent informational bulletin issued by the Center for Medicaid and Medicare Services makes this abundantly clear, http://www.cms.gov/CMCSBulletins/downloads/6-1-11-Info-Bulletin.pdf. Such a clear and unambiguous violation of the access and any willing provider mandates is expected to force CMS to impose very serious financial or other sanctions against the State including, but not limited to, withholding some or all of the federal match for the State Medicaid program, totaling approximately $700 million.[1]

Implications to Family Planning Services, Title X

Second, the proposed new RSA 126-V:1, paragraph IV, states in relevant part that "...it shall be the policy of this state that federal public funds shall not be provided for the direct or indirect costs, ...of non-federally qualified ***abortions, abortion referral, or abortion counseling, and these activities shall not be subsidized, either directly or indirectly, by federal public funds.***" (Emphasis added.)

It is already the case that no federal or state general funds under Title X are to be used to pay for abortions. However, Title X funded agencies *are required to provide referral* and basic information *if requested* by the client. This amendment, as written, would place the 10 agencies across the State that receive Title X funds in non-compliance with federal regulations. Without the support of Title X funds, access to all reproductive health care services would be limited in New Hampshire. Without the support of Title X funds, nearly 10,000 women would lose access to reproductive health care services, and for many of whom, this is the only source of health care service they may receive.

Third, RSA 126-V:3 requires the prioritization of expenditures or grants of public funds for family planning services, subject to any applicable requirements of federal statutes, rules, regulations, or guidelines. New Hampshire's health care safety net, including providers of Title X services, consists of an array of private, nonprofit community health centers, some of which are Federally Qualified Community Health Centers. The priority organization to expend funds, within the amendment, to is "public entities" but this term is not defined. Are "public entities" different than community health centers and how would the Department do this type of prioritization? It is unclear how this prioritization would be managed within the State's current competitive bid process.

---

[1] On March 15, 2012, in a letter from Cindy Mann, Director of the Centers for Medicare & Medicaid Services, the US Department of Health and Human Services announced that it will cut off all Medicaid funding for family planning to the state of Texas following the state's decision to implement a new law that excludes Planned Parenthood from the state's Medicaid Women's Health Program.

Implications to Health Care Delivery Infrastructure

Fourth, in the proposed new RSA 126-V:1, paragraph I, found in HB 228, it states in its legislative findings and purposes that "[t]he general court finds that public and private providers of primary and preventive care utilize public funds more effectively than providers of health care services that are specialized to particular medical services or discrete patient populations..." and "...it is the intention of the general court through this act and any rules and policies adopted under this act to ***prioritize the distribution and utilization of public funds for family planning, reproductive health care, and maternal/fetal care to such public and private primary and preventive care providers***." (Emphasis added.)

While the Department strongly supports a network of private, nonprofit community health centers, this is an extremely broad statement of legislative intent with far-reaching implications. The language suggests that specialists such as OB/GYN's, pediatricians, maternal-fetal medicine physicians, neonatologists and other specialists are less effective than family practice clinicians. The Department promotes evidence-based policies with referral and access to appropriate health care. An unintended consequence of this language would be that women with, or who may have the potential for, a high-risk pregnancy would not have access to life-saving specialty care for herself or her baby.

The Department questions how this prioritization of distribution and utilization would take place, especially, in terms of Medicaid dollars. Would high-risk neonatal patients need to get care from their primary care physician as opposed to a neonatologist? Would a pregnant woman with diabetes be prohibited from seeing an endocrinologist? HB 228 leaves countless unanswered questions with significant fiscal and policy implications.

Administrative Implications

Fifth, as to a technical problem highlighted by the legislative findings and purposes section of the legislation that references "rules and policies," HB 228 fails to provide the Department with rulemaking authority to implement the provisions of the proposed new RSA Chapter 126-V.

Finally, the 60-day effective date, upon passage, is problematic in terms of the provision of all family planning, reproductive health and maternal-fetal care for Medicaid and Title X clients, and would cause extreme hardship for currently funded agencies.

CONCLUSION

In closing, the ideological policies within this legislation tear apart the strength of the safety net in New Hampshire, forcing health care providers to choose between federal funding to see their most vulnerable patients and the ability to perform their full scope of medical practice and referral. Equally as harmful, at a minimum, HB 228 places hospitals in the position of choosing to provide the full spectrum of healthcare services that patients need causing disenrollment from the Medicaid program potentially resulting in significant disruption to the acute care system and sacrificing some or all of the approximately $700 million in federal dollars that support our State Medicaid program to pay for the healthcare needs of needy children, disabled and elders.

Thus, given the serious policy and fiscal implication of HB 228, if enacted into law, the Department is respectfully requesting that HB 228 be found inexpedient to legislate.

Thank you for the opportunity to comment on HB 228.

Sincerely,

Nicholas A. Toumpas
Commissioner

Enclosure

cc: His Excellency, Governor John H. Lynch
The Honorable Senate President Peter Bragdon
The Honorable Speaker of the House of Representative William L. O'Brien
The Honorable Members of the Senate Health and Human Services Committee
The Honorable Senator Chuck W. Morse, Chairman, Senate Finance Committee
The Honorable Kenneth L. Weyler, Chairman, House Finance Committee
The Honorable Representative Robert F. Willette

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

March 15, 2012

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
P.O. Box 13247
Austin, TX 78711

Dear Mr. Millwee:

I am writing in regard to Texas' section 1115 Medicaid Family Planning Demonstration, entitled "Women's Health Program" (WHP). As you know, together with the State, we have been committed to the success of this critical coverage program since its inception in 2006. WHP has been essential to ensuring that women in Texas have access to important preventive care services. It has been our hope that we can continue to support WHP through a renewal of the program, which serves over 130,000 women. In December 2011, CMS granted Texas a temporary extension of the Demonstration until March 31, 2012, to allow the State additional time to consider a renewal request, while maintaining coverage for women enrolled in WHP.

Texas has elected to move forward with a State rule that restricts freedom of choice of health care providers for women enrolled in WHP effective March 14, 2012. Consistent with longstanding statutory provisions that assure free choice of family planning providers, the Demonstration does not provide the State the authority to impose such a limitation, and we advised the State in our December 12, 2011 letter that we had concluded that such authority would not be granted. We very much regret the State's decision to implement this rule, which will prevent women enrolled in the program from receiving services from the trusted health care providers they have chosen and relied upon for their care. Last year, nearly half of all the services under WHP were provided by clinics that are likely to be excluded from the program under the new rule.

In light of Texas' actions, CMS is not in a position to extend or renew the current Demonstration, except for purposes of phasing out the Demonstration. Given the important role that this Demonstration plays for the women of Texas, CMS is prepared to allow a two-stage phase-out period. This will help to minimize any disruption in coverage for women enrolled in the program. During the first three months, the State would take all necessary steps associated with preparing for termination of the Demonstration, including identifying women who may be eligible for Medicaid under another eligibility category and preparing notices to enrollees and providers. It should also establish a referral process for women whose providers have been dropped from the program, to the extent that other providers are available to serve them. This first stage of the phase out would also permit a transfer of the program, with a more limited set of providers, to a fully State-funded program, consistent with Governor Perry's March 8, 2012

letter. If at any time during the three-month period the State were to confirm that it is ready to begin operating a fully State-funded program, CMS would terminate the WHP Demonstration, allowing the State to assume all responsibility for the program. If Texas were not to establish a State-funded program within this three-month period, the State would begin the second stage of the phase out, which would extend for six months. During this period, the State would stop new enrollment, provide enrollees clear notice of the termination of the WHP program, offer assistance to enrollees in transitioning to other sources of needed services if available, and ensure that ongoing courses of treatment will continue as necessary to stabilize and protect patient health and safety.

We request that the State submit a Demonstration phase-out plan for CMS approval, as described above and consistent with the Special Terms and Conditions (STCs) that govern this Demonstration. Please submit the proposed phase-out plan to CMS no later than April 16, 2012. It is important to note that, until a phase-out plan is approved by CMS or until you receive further notice from CMS, the State should not make any eligibility changes to its program or issue notifications to enrollees or applicants regarding planned changes. Your Project Officer for this Demonstration, Jennifer Sheer, may be reached at 410-786-1769 or by e-mail at Jennifer.Sheer@cms.hhs.gov, and is ready to assist the State with phase-out plan development.

CMS regrets the State's decision to move forward with this restriction on women's choice of health care providers, but we remain committed to working with Texas on this or future Family Planning Demonstration proposals that do not impermissibly limit enrollees' choice of providers. Please feel free to contact me at 202-205-5682 if you have any questions or wish to discuss this issue further.

Sincerely,

Cindy Mann
Director

cc: Victoria Wachino, CMCS
Jennifer Ryan, CMCS
Bill Brooks, Region VI ARA

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857

XXXXXXXX XXXXXXXXX FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

April 4, 2012

Senator Jeb Bradley, Chairman
Senate Health and Human Services Committee
Legislative Office Building, Room 102
33 North State Street
Concord, NH 03301

Re: Title X Federal Regulations and Guidance on Financial Separation of Funding.

Dear Chairman Bradley:

I am writing to you as a follow up to the Department's letter dated April 2, 2012 regarding the related policy and fiscal implications to HB 228. As you have requested, this response outlines the required audit controls to ensure that there is no co-mingling of Title X Family Planning Services funds with abortion services.

As stated in the letter of April 2, no federal or state general funds under Title X are to be used to pay for abortions. Law and contractual provisions safeguard this mandate and there are three levels of controls, at the federal, state, and agency levels, as described below.

FEDERAL SAFEGUARDS:
Federal law and regulations prohibit the use of Title X funding for abortion services. Section 1008 of the Title X statute, 42 U.S.C. §300a–6, states that ***"[n]one of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."*** (Emphasis added.)

- Federal controls consist of regular site visits to grantees, like the State of New Hampshire.
- Site visits occur about every 3 years and include visits to several sub-grantee sites.
- A site visit audit tool includes specific criteria relating to the abortion prohibition. The federal review team consists of the federal project officer and expert financial, administrative, and clinic services consultants.
- Financial consultants review charges to assure that no prohibited activities have been charged to grant funds and that the appropriate separation of staff, facility, and supplies between the Title X Program and prohibited or unauthorized services, including abortion, has been maintained.

STATE SAFEGUARDS:
- At the state-level, sub-grantees are held to their contractual obligations in Exhibit A, Scope of Services.
- The Family Planning Exhibit A requires compliance with all relevant state and federal laws and adherence to the Office of Population Affairs' Program Guidelines for Project

Grants for Family Planning Services, which can be found at the following website: http://www.hhs.gov/opa/pdfs/2001-ofp-guidelinescomplete.pdf.

- Two type of compliance audits are conducted by the Department:
  - Full programmatic audits occur every 3 years and use the federal site visit tool to assure consistency with federal requirements. Clinical record reviews are held annually; and
  - The Department's Internal Audit Unit schedules and performs audits every 3 years.

AGENCY SAFEGUARDS:

- Agencies have internal controls, policies, and procedures in place to ensure that costs are appropriately charged.

Additionally, for your information and use, I am enclosing a copy of the Federal Register, Title X regulation notice, published by the US Department of Health and Human Services, Office of Public Health and Science, Provision of Abortion-Related Services in Family Planning Services Projects, dated July 3, 2000, which also can be found at the following website: http://www.hhs.gov/opa/pdfs/provision-of-abortion-related-services.pdf.

Specifically, in section 4 of this regulation notice titled, "Separation," it states in relevant part that ***"[n]on-Title X abortion activities must be separate and distinct from Title X project activities. Where a grantee conducts abortion activities that are not part of the Title X project and would not be permissible if they were, the grantee must ensure that the Title X-supported project is separate and distinguishable from those other activities."*** (Emphasis added.)

The regulation notice goes on to detail the requirements regarding the appropriate separation of staff, facility, and supplies between the Title X Program and prohibited or unauthorized services. In closing, please let me know if you any questions or need any additional information related to this matter.

Sincerely,

Nicholas A. Toumpas
Commissioner

Enclosure

cc: Honorable Governor John H. Lynch
Honorable Senate President Peter Bragdon
Honorable Speaker of the House of Representative William L. O'Brien
Honorable Members of the Senate Health and Human Services Committee
Honorable Senator Chuck W. Morse, Chairman, Senate Finance Committee
Honorable Kenneth L. Weyler, Chairman, House Finance Committee
Honorable Representative Robert F. Willette

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Public Health and Science

Provision of Abortion-Related Services in Family Planning Services Projects

AGENCY: Office of Population Affairs, OPHS, DHHS.

ACTION: Notice.

SUMMARY: This notice informs the public of the interpretations relating to the statutory requirement that no funds appropriated under Title X of the Public Health Service Act be used in programs in which abortion is a method of family planning.

FOR FURTHER INFORMATION CONTACT: Samuel S. Taylor, Office of Population Affairs, (301) 594–4001.

SUPPLEMENTARY INFORMATION: On February 5, 1993, the Department of Health and Human Services published in the **Federal Register** a notice of proposed rulemaking that proposed to revise the regulations at 42 CFR Part 59, Subpart A. Subpart A of Part 59 sets forth the program requirements applicable to grantees under section 1001 of the Public Health Service (PHS) Act, 42 U.S.C. 300, *et seq.* The notice of proposed rulemaking proposed to revise that subpart by readopting the program regulations as they existed prior to February 2, 1988. This action would have the effect of revoking the regulations published on February 2, 1988, commonly known as the "Gag Rule," which set forth standards for the compliance by such grantees with section 1008 of that Act, 42 U.S.C. 300a–6.

The February 5, 1993 notice of proposed rulemaking also proposed to reinstitute the pre-1988 policies and interpretations regarding compliance with section 1008. 58 FR 7464. As explained in the notice of proposed rulemaking, those policies and interpretations derived from previous opinions of the Department concerning section 1008. To promote more useful public comment in the rulemaking process, the Department subsequently made available a more detailed summary of the policies and interpretations and reopened the public comment period. 58 FR 34042 (June 23, 1993).

A number of public comments on the prior policies and interpretations were obtained during the reopened comment period, and the public comments received during both comment periods were generally focused on the prior policies and interpretations rather than on the proposed regulatory language. The Department has changed one paragraph of the regulations and has modified its prior interpretations in several particulars based in part on the public comment received. These modifications, and the grounds therefor, are described in the preamble to the final rules published on this date in the rules section of the **Federal Register.** The interpretations, as so modified, are set out in the summary statement below. The summary below is also reorganized from the summary statement made available for public comment, for purposes of clarification.

Accordingly, to provide guidance to grantees in order to promote uniform administration of the program and facilitate grantee compliance with the interpretations that are being reinstituted in conjunction with the final regulations adopted on this date, provided below is a summary of the program regulatory requirements and interpretations that relate to section 1008 of the PHS Act.

Program Policies Regarding the Title X National Family Planning Program and the Section 1008 Abortion Prohibition

Section 1008 of the Title X statute, 42 U.S.C. 300a–6, states: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." This prohibition applies not only to the performance of abortion by a Title X project, but also to the conduct of certain abortion-related activities by the project. However, the prohibition does not apply to all the activities of a Title X grantee, but only to those within the Title X project. This statement summarizes the Department requirements and interpretations in existence prior to the imposition of the 1988 "Gag Rule" with regard to implementation of section 1008, as modified following the rulemaking of 1993.

1. General Principles

In general, section 1008 prohibits Title X programs from engaging in activities which promote or encourage abortion as a method of family planning. However, section 1008 does not prohibit the funding under Title X of activities which have only a possibility of encouraging or promoting abortion; rather, a more direct nexus is required. The general test is whether the immediate effect of the activity in question is to promote or encourage the use of abortion as a method of family planning. If the immediate effect of the activity in question is essentially neutral, then it is not prohibited by the statute. Thus, a Title X project may not provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating abortion within Title X program activities, or failing to preserve sufficient separation between Title X program activities and abortion-related activities.

2. Abortion Counseling and Referral

Under 42 CFR 59.5(a)(5), a Title X project must:

Not provide abortion as a method of family planning. A project must:

(i) Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral on request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

However, there are limitations on what abortion counseling and referral is permissable under the statute. A Title X project may not provide pregnancy options counseling which promotes abortion or encourages persons to obtain abortion, although the project may provide patients with complete factual information about all medical options and the accompanying risks and benefits. While a Title X project may provide a referral for abortion, which may include providing a patient with the name, address, telephone number, and other relevant factual information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider, the project may not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient. Where a referral to another provider who might perform an abortion is medically indicated because of the patient's condition or the condition of the fetus (such as where the woman's life would be endangered), such a referral by a Title X project is not prohibited by section 1008 and is required by 42 CFR 59.5(b)(1). The limitations on referrals do not apply in cases in which a referral is made for medical indications.

3. Advocacy Activities

A Title X project may not promote or encourage the use of abortion as a method of family planning through advocacy activities such as providing speakers to debate in opposition to anti-abortion speakers, bringing legal action to liberalize statutes relating to abortion, or producing and/or showing films that encourage or promote a favorable attitude toward abortion as a method of family planning. Films that present only neutral, factual information about abortion are permissible. A Title X project may be a dues paying participant in a national abortion advocacy organization, so long as there are other legitimate program-related reasons for the affiliation (such as access to certain information or data useful to the Title X project). A Title X project may also discuss abortion as an available alternative when a family planning method fails in a discussion of relative risks of various methods of contraception.

4. Separation

Non-Title X abortion activities must be separate and distinct from Title X project activities. Where a grantee conducts abortion activities that are not part of the Title X project and would not be permissible if they were, the grantee must ensure that the Title X-supported project is separate and distinguishable from those other activities. What must be looked at is whether the abortion element in a program of family planning services is so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost.

The Title X project is the set of activities the grantee agreed to perform in the relevant grant documents as a condition of receiving Title X funds. A grant applicant may include both project and nonproject activities in its grant application, and, so long as these are properly distinguished from each other and prohibited activities are not reflected in the amount of the total approved budget, no problem is created. Separation of Title X from abortion activities does not require separate grantees or even a separate health facility, but separate bookkeeping entries alone will not satisfy the spirit of the law. Mere technical allocation of funds, attributing federal dollars to non-abortion activities, is not a legally supportable avoidance of section 1008.

Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities: (a) A common waiting room is permissible, as long as the costs properly pro-rated; (b) common staff is permissible, so long as salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project; (c) a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, as long as the abortion activities are sufficiently separate from the Title X project; and (d) maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated.

Whether a violation of section 1008 has occurred is determined by whether the prohibited activity is part of the funded project, not by whether it has been paid for by federal or non-federal funds. A grantee may demonstrate that prohibited abortion-related activities are not part of the Title X project by various means, including counseling and service protocols, intake and referral procedures, material review procedures, and other administrative procedures.

Dated: June 28, 2000.

Samuel S. Taylor,

Acting Director, Office of Population Affairs.

[FR Doc. 00–16759 Filed 6–30–00; 8:45 am]

BILLING CODE 4160–17–M

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857

603-271-4680 FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

APR 13 2012

April 11, 2012

The Honorable Jeb Bradley, Chairman
Senate Health and Human Services Committee
Legislative Office Building, Room 102
33 North State Street
Concord, NH 03301

Re: Direct and Indirect Costs as they relate to Title X Federal Regulations and Guidance.

Dear Chairman Bradley:

I am writing to you as a follow up to questions regarding direct and indirect costs as they relate to Title X funding and abortion services. In the Department's letter dated April 4, 2012, we included the Federal Register, Title X regulation notice, Provision of Abortion-Related Services in Family Planning Services Projects: http://www.hhs.gov/opa/pdfs/provision-of-abortion-related-services.pdf .

As stated in the letter and regulations, no Title X funds can be used in programs where abortion is a method of family planning and that prohibited activities and expenses such as abortion services must be separate and distinct from Title X activities. The regulation also clarifies the requirements regarding the appropriate separation of indirect costs such as staff, facility and supplies between the Title X family planning services and prohibited or unauthorized services.

Under section 4, Separation, the regulation states; "*Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities:*

(a) common waiting room is permissible, ***as long as the costs are properly pro-rated;***
(b) common staff is permissible, so long as salaries ***are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project;***
(c) a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, ***as long as the abortion activities are sufficiently separate from the Title X project;*** *and*
(d) Maintenance of a single file system for abortion and family planning patients is permissible, ***so long as costs are properly allocated.*** *"* (Emphasis added.)

In summary, under federal regulations no funds can be used for abortion services. Activities and costs must be appropriately separated and financially pro-rated between Title X allowed activities and prohibited activities, such as abortion. There have never been any findings regarding a violation of this requirement in state and federal audits of past and present Title X contractors.

In closing, please let me know if you have any questions or need any additional information related to this matter.

Sincerely,

Nicholas A. Toumpas
Commissioner

Enclosure

cc: The Honorable Governor John H. Lynch
The Honorable Senate President Peter Bragdon
The Honorable Speaker of the House of Representative William L. O'Brien
The Honorable Members of the Senate Health and Human Services Committee
The Honorable Senator Chuck W. Morse, Chairman, Senate Finance Committee
The Honorable Kenneth L. Weyler, Chairman, House Finance Committee
The Honorable Representative Robert F. Willette

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Public Health and Science

Provision of Abortion-Related Services in Family Planning Services Projects

AGENCY: Office of Population Affairs, OPHS, DHHS.

ACTION: Notice.

SUMMARY: This notice informs the public of the interpretations relating to the statutory requirement that no funds appropriated under Title X of the Public Health Service Act be used in programs in which abortion is a method of family planning.

FOR FURTHER INFORMATION CONTACT: Samuel S. Taylor, Office of Population Affairs, (301) 594–4001.

SUPPLEMENTARY INFORMATION: On February 5, 1993, the Department of Health and Human Services published in the **Federal Register** a notice of proposed rulemaking that proposed to revise the regulations at 42 CFR Part 59, Subpart A. Subpart A of Part 59 sets forth the program requirements applicable to grantees under section 1001 of the Public Health Service (PHS) Act, 42 U.S.C. 300, *et seq.* The notice of proposed rulemaking proposed to revise that subpart by readopting the program regulations as they existed prior to February 2, 1988. This action would have the effect of revoking the regulations published on February 2, 1988, commonly known as the "Gag Rule," which set forth standards for the compliance by such grantees with section 1008 of that Act, 42 U.S.C. 300a–6.

The February 5, 1993 notice of proposed rulemaking also proposed to reinstitute the pre-1988 policies and interpretations regarding compliance with section 1008. 58 FR 7464. As explained in the notice of proposed rulemaking, those policies and interpretations derived from previous opinions of the Department concerning section 1008. To promote more useful public comment in the rulemaking process, the Department subsequently made available a more detailed summary of the policies and interpretations and reopened the public comment period. 58 FR 34042 (June 23, 1993).

A number of public comments on the prior policies and interpretations were obtained during the reopened comment period, and the public comments received during both comment periods were generally focused on the prior policies and interpretations rather than on the proposed regulatory language. The Department has changed one paragraph of the regulations and has modified its prior interpretations in several particulars based in part on the public comment received. These modifications, and the grounds therefor, are described in the preamble to the final rules published on this date in the rules section of the **Federal Register**. The interpretations, as so modified, are set out in the summary statement below. The summary below is also reorganized from the summary statement made available for public comment, for purposes of clarification.

Accordingly, to provide guidance to grantees in order to promote uniform administration of the program and facilitate grantee compliance with the interpretations that are being reinstituted in conjunction with the final regulations adopted on this date, provided below is a summary of the program regulatory requirements and interpretations that relate to section 1008 of the PHS Act.

Program Policies Regarding the Title X National Family Planning Program and the Section 1008 Abortion Prohibition

Section 1008 of the Title X statute, 42 U.S.C. 300a–6, states: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." This prohibition applies not only to the performance of abortion by a Title X project, but also to the conduct of certain abortion-related activities by the project. However, the prohibition does not apply to all the activities of a Title X grantee, but only to those within the Title X project. This statement summarizes the Department requirements and interpretations in existence prior to the imposition of the 1988 "Gag Rule" with regard to implementation of section 1008, as modified following the rulemaking of 1993.

1. General Principles

In general, section 1008 prohibits Title X programs from engaging in activities which promote or encourage abortion as a method of family planning. However, section 1008 does not prohibit the funding under Title X of activities which have only a possibility of encouraging or promoting abortion; rather, a more direct nexus is required. The general test is whether the immediate effect of the activity in question is to promote or encourage the use of abortion as a method of family planning. If the immediate effect of the activity in question is essentially neutral, then it is not prohibited by the statute. Thus, a Title X project may not provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating abortion within Title X program activities, or failing to preserve sufficient separation between Title X program activities and abortion-related activities.

2. Abortion Counseling and Referral

Under 42 CFR 59.5(a)(5), a Title X project must:

Not provide abortion as a method of family planning. A project must:

(i) Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral on request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

However, there are limitations on what abortion counseling and referral is permissable under the statute. A Title X project may not provide pregnancy options counseling which promotes abortion or encourages persons to obtain abortion, although the project may provide patients with complete factual information about all medical options and the accompanying risks and benefits. While a Title X project may provide a referral for abortion, which may include providing a patient with the name, address, telephone number, and other relevant factual information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider, the project may not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient. Where a referral to another provider who might perform an abortion is medically indicated because of the patient's condition or the condition of the fetus (such as where the woman's life would be endangered), such a referral by a Title X project is not prohibited by section 1008 and is required by 42 CFR 59.5(b)(1). The limitations on referrals do not apply in cases in which a referral is made for medical indications.

3. Advocacy Activities

A Title X project may not promote or encourage the use of abortion as a method of family planning through advocacy activities such as providing speakers to debate in opposition to anti-abortion speakers, bringing legal action to liberalize statutes relating to abortion, or producing and/or showing films that encourage or promote a favorable attitude toward abortion as a method of family planning. Films that present only neutral, factual information about abortion are permissible. A Title X project may be a dues paying participant in a national abortion advocacy organization, so long as there are other legitimate program-related reasons for the affiliation (such as access to certain information or data useful to the Title X project). A Title X project may also discuss abortion as an available alternative when a family planning method fails in a discussion of relative risks of various methods of contraception.

4. Separation

Non-Title X abortion activities must be separate and distinct from Title X project activities. Where a grantee conducts abortion activities that are not part of the Title X project and would not be permissible if they were, the grantee must ensure that the Title X-supported project is separate and distinguishable from those other activities. What must be looked at is whether the abortion element in a program of family planning services is so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost.

The Title X project is the set of activities the grantee agreed to perform in the relevant grant documents as a condition of receiving Title X funds. A grant applicant may include both project and nonproject activities in its grant application, and, so long as these are properly distinguished from each other and prohibited activities are not reflected in the amount of the total approved budget, no problem is created. Separation of Title X from abortion activities does not require separate grantees or even a separate health facility, but separate bookkeeping entries alone will not satisfy the spirit of the law. Mere technical allocation of funds, attributing federal dollars to non-abortion activities, is not a legally supportable avoidance of section 1008.

Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities: (a) A common waiting room is permissible, as long as the costs properly pro-rated; (b) common staff is permissible, so long as salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project; (c) a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, as long as the abortion activities are sufficiently separate from the Title X project; and (d) maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated.

Whether a violation of section 1008 has occurred is determined by whether the prohibited activity is part of the funded project, not by whether it has been paid for by federal or non-federal funds. A grantee may demonstrate that prohibited abortion-related activities are not part of the Title X project by various means, including counseling and service protocols, intake and referral procedures, material review procedures, and other administrative procedures.

Dated: June 28, 2000.

Samuel S. Taylor,

Acting Director, Office of Population Affairs.

[FR Doc. 00–16759 Filed 6–30–00; 8:45 am]

BILLING CODE 4160–17–M

State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-4501 FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964
New Number: 603-271-9200

NICHOLAS A. TOUMPAS
COMMISSIONER

April 17, 2012

The Honorable Jeb Bradley, Chairman
Senate Health and Human Services Committee
Legislative Office Building, Room 102
33 North State Street
Concord, NH 03301

APR 18 2012

RE: HB 228 proposed amendment

Dear Chairman Bradley:

Thank you for the opportunity to review and comment on the proposed amendment to HB 228, which would limit the prohibition of contracting by excluding hospitals. While this mitigates the Medicaid concerns the Department raised at the public hearing and in prior communications, it does not eliminate the concern.

Recall that federal Medicaid law requires states to 1) assure adequate access to covered services to all Medicaid enrollees (see 42 USC §1396a(a)(30)(A)); and 2) contract with 'any willing provider' to deliver those services to Medicaid enrollees (see 42 USC §1396a(a)(23)). The similar legislation that passed in Texas was determined by the federal Centers for Medicaid and Medicare Services to violate the 'any willing provider' requirement because that legislation effectively mandated that Texas disenroll Planned Parenthood. As a result, Texas has lost many millions of dollars in federal matching funds for their women's healthcare waiver and future punitive action cannot be ruled out at this time. The proposed amendment to HB 228 would effectively require New Hampshire Medicaid to disenroll all Planned Parenthood sites, as well as several other free standing women's health clinics. We worry that the bill continues to violate the 'any willing provider' requirement. Additionally, in some communities, these sites represent the primary source of access to healthcare for low-income women. For this reason, we continue to be concerned that disenrolling these sites will impede access to necessary healthcare services. So while the exclusion of hospital-based contracts does mitigate the access concerns, those concerns are not eliminated and the bill still presents a concern regarding any willing provider.

Legislation in Kansas proposed a similar type of prioritization for public healthcare funds as HB 228 and placed providers of abortion services at the very bottom of the priority list. Kansas is presently being sued over this provision.

Legislation in Indiana mirrors the contract prohibition language of HB 228 and has resulted in issuance of preliminary injunctive relief to prevent enforcement of the law.

While the final resolution of the litigation and CMS activity is not concluded in Texas, Indiana and Kansas, it is fair to say that these states are expending valuable human and financial resources to defend laws similar to HB 228. Our Department has several, important and high profile initiatives that require the full attention of our staff. We can ill afford a diversion of staff to defending the possible

passage of HB 228. Similarly, our state Medicaid program is embracing innovations that could be severely curtailed or compromised by HB 228 with a net negative result to all those that rely on publicly funded healthcare in New Hampshire.

The attached memorandum expounds on these points and is offered for your further consideration. For the reasons contained in the memorandum, as well as in this letter, we urge you to find HB 228 inexpedient to legislate.

If you have any questions about this letter or its attachment, please feel free to contact Lisabritt Solsky at 271-9408.

Sincerely,

Nicholas A. Toumpas
Commissioner

ENCLOSURE

cc: His Excellency, Governor John H. Lynch
The Honorable Senate President Peter Bragdon
The Honorable Speaker of the House of Representative William L. O'Brien
The Honorable Members of the Senate Health and Human Services Committee
The Honorable Senator Chuck W. Morse, Chairman, Senate Finance Committee
The Honorable Kenneth L. Weyler, Chairman, House Finance Committee
The Honorable Representative Robert F. Willette

SIMILARITIES BETWEEN NH'S HB228 AND RECENT LEGISLATION IN THE STATES OF IN, TX AND KS REGARDING THE FUNDING OF FAMILY PLANNING

INDIANA

Overview:

In May of 2011, Indiana Governor Mitch Daniels signed HEA 1210 into law, becoming the third state to make it illegal to contract with any health provider, other than a hospital, that performs abortion as part of its health care services.[1]

HEA 1210 adds a new section to IC 5-22-17-5.5 to the Indiana Code that states that "an agency of the state may not enter into a contract with or make a grant to any entity that performs abortions or maintains or operates a facility where abortions are performed, except hospital or ambulatory surgical centers licensed by the sate, that involves the expenditure of state funds or federal funds administered by the state." The complete text of this section of the legislation can be found at Appendix A.

On June 24, 2011, U.S. District Judge Tanya Walton Pratt issued a preliminary injunction to block the provisions in the new law that cut Medicaid funding to Planned Parenthood. Judge Pratt stated that the law conflicts with federal Medicaid statutes saying, "States do not have carte blanche to expel otherwise competent Medicaid providers". The state has agreed to comply with the injunction, but has asked a federal appeals court to lift Judge Pratt's order, saying that the issue should be decided by Medicaid officials and not the courts. A federal appeals court heard argument from the State on October 20, 2011. The injunction will remain in effect while the appeal is pending and until a decision is made in the case.

CMS Response:

Implementation of HEA 1210 require the State of Indiana to seek an amendment to their Medicaid State Plan allowing the state's Medicaid agency to be prohibited from contracting with abortion providers. CMS denied the state's request citing that the amendment "would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons not related to their qualifications to provide such services". In a letter to the Indiana's Medicaid director, Medicaid Administrator, Donald Berwick, informed the state that such restrictions were illegal.

---

[1] Indiana's legislation follows that of Texas, which passed "Rider 8" in 2003, and Missouri, with passage of similar legislation in 1999. Both pieces of legislation disqualified abortion providers from family planning funds. In both cases, the courts found that it was impermissible and unconstitutional to wholly exclude abortion providers from eligibility for family planning funds on the basis that they provided abortion services. However, the Texas court did allow that organizations like Planned Parenthood, could continue to receive funding if they created a separate affiliate for the provision of abortion services. See PP of Houston & Se. Tex. v. Sanchez, 403 F 3e 324,338 (5th Cir. 2005) and PP of Mid-Mo. & E. Kan., Inc. v. Dempsey, 167 F. 3d 458 (8th Cir. 1999)

In his letter, Berwick informed the state that federal law requires Medicaid beneficiaries to be able to obtain services from any qualified provider. As such, "Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a providers scope of practice...Such a restriction would have a particular effect on beneficiaries' ability to access family planning providers...While states are permitted to waive a recipients' freedom of choice of a provider to implement managed care, restricting freedom of choice with respect to providers of family planning services is prohibited." The text of this letter can be found in Appendix B.

In addition to Berwick's letter, CMCS Director, Cindy Mann, posted an Informational Bulletin in response to recent inquires as to whether States may exclude certain providers from participating in Medicaid based on their scope of practices. The letter emphasized that states may bar providers from participating in Medicaid in certain circumstances, such as if a provider is committing fraud or criminal acts, but "States are not, however, permitted to exclude providers from the program solely on the basis of the range of medical services they provide. Under federal law Medicaid beneficiaries may obtain medical services 'from any institution, agency, community pharmacy, or person, qualified to perform the service or services required...who undertakes to provide him such services. (Section 1902(a)(23) of Title XIX of the Social Security Act (the Act))' This provision is often referred to as the 'any willing provider' or 'free choice of provider' provision." Relevant text from this letter can be found in Appendix B.

Indiana could lose some or all of its federal Medicaid money if the state persists in violation federal Medicaid law. The State has filed an administrative appeal of the decision to deny its Medicaid plan amendment, and requested a rehearing of the ruling. On December 15, 2011, a panel of hearings officers at the CMS regional office in Chicago took the oral arguments under advisement and will issue a ruling at a later date.

Similarities to HB228:

Like Indiana's HEA 1210 legislation, New Hampshire's HB228 restricts the state from contracting with or making a grant to "any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed" with the exception of hospitals. Unlike Indiana, New Hampshire's legislation also prioritizes the types of organizations that may be funded. See Table 1 for a direct comparison of the language used by HB223 and HEA12107.

TEXAS

Overview:

In July of 2011, Texas Governor Rick Perry signed SB7 into law. The law blocks funding to clinics affiliated with abortion providers.

Section 1.19 of SB7 amends Chapter 531 of the Government Code by adding a new section 531.0025, which establishes an "order of priority" for the distribution of funds to providers of family planning. It also amends Section 32.024 of the Human Resources Code to prohibit the state from contracting with "entities that perform or promote elective abortions or *affiliate with entities that perform or promote elective abortions*" on behalf of the Texas Women's Health Program (TWHP)[2]. Full text of the rule can be found Appendix A.

In April of 2012, eight Planned Parenthood organizations filed suit against the State saying that the new law violates their constitutional rights to freedom of speech and association. The group argues that the 1st and 14th Amendments of the Constitution prevent states from punishing groups for their political views of associations by excluding them from programs in which they are otherwise qualified to participate. Planned Parenthood is asking the federal court in Austin to prohibit the state from enforcing the law before a April 30th deadline, when the law will cut off their funding. State leaders contend that the state should be allowed to set funding rules, including deciding which health providers are eligible.

CMS Response:

On March 15th of 2012. CMS announced that it has denied an extension of the state's family planning waiver citing that the new law, which bars Medicaid funds to providers like Planned Parenthood, violates federal Medicaid laws and the waiver agreement by restricting which clinics could receive funding. In a conference call with reporters, Cindy Mann, Director of CMS, stated, "Patients, not state government officials, are able to choose the doctor and health care providers that are best for them and their families." Mann also said that federal funding would be phasing out gradually "to minimize any disruption in coverage for women enrolled in the program."

The Texas Attorney General filed a lawsuit against CMS challenging the administration's decision and demanding that it restore its funding for the Women's Health program. The suit claims that states have the right, under federal law, to determine qualified providers in the program. The suit also argues that the federal government's decision "violates the Constitution...by seeking to commandeer and coerce the state's lawmaking process in awarding taxpayer subsidies to elective abortion providers."

Texas Governor Rick Perry has vowed to identify state funding to continue services provided by the TWHP.

Similarities to HB228:

Like the Texas SB7 legislation, HB228 prioritizes public funding for family planning services and restricts the state from contracting with or making a grant to "any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed." Texas goes even further by including

[2] TWHP is a Medicaid demonstration waiver program that provides preventative health care to Texas women including screenings for breast and cervical cancer, diabetes and hypertension, among other services.

organizations *affiliated with abortion providers*. See Table 1 for a direct comparison of the language used by HB223 and SB7.

KANSAS

Kansas' budget bill, HB 2014, took effect on July 1, 2011. Section 107(l) of this bill shifts funds away from private entities like Planned Parenthood and places them at the bottom of the eligibility list behind public entities, hospitals and federally qualified health centers (FQHC's). [3]

Planned Parenthood of Kansas and Mid-Missouri (PPKM) filed a lawsuit seeking to prevent the enforcement of this new law. PPKM argued that the statute violated the Supremacy Clause, in that it conflicted with federal law under Title X, and that the statue violate its First Amendment rights.

On August 1, 2011, Planned Parenthood received a preliminary injunction against these cuts. District Judge J. Thomas Marten ruled the law was likely unconstitutional because it conflicted with Federal law governing Title X and was enacted for unconstitutional purposes. The state was ordered to continue funding Planned Parenthood until a final decision is reached in the suit. On August 30th, the Court affirmed its earlier ruling that the state maintain Title X funding to PPKM.

Similarities to HB228:

Like the Kansas legislation (HB2014), New Hampshire's HB228 restricts the availability of family planning funds to non-public providers by placing them last on the order of funding priorities. Although the language in HB2014 is more direct, both pieces of legislation prohibit the use of funds to organizations, like Planned Parenthood, that limited their scope of services to family planning and do not offer the full range of health care services. Unlike HB228, the legislation proposed by Kansas does not include any other restrictions specific to entities that provide abortion services. See Table 1 for a direct comparison of the language used by HB223 and HB2014.

[3] Section 57 is similarly worded for remainder of state fiscal year ending June 30, 2011

TABLE 1 - Comparison of Legislative Language

	NH's HB228	IN's HEA 1210	TX's SB7	KS's HB 2014
Restrictions by Order of Priority	Any expenditures or grants of public funds for family planning services by the state made by the department shall be made in the following order of priority to: (a) Public entities; (b) Non-public hospitals and federally qualified health centers; (c) Rural health clinics; and (d) Non-public health providers that have as their primary purpose the provision of the primary health care services enumerated in 42 U.S.C. section 254b(a)(1).	N/A	Notwithstanding any other law, money appropriated to the Department of State Health Services for the purpose of providing family planning services must be awarded: (1) to eligible entities in the following order of descending priority: (A) public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers; (B) nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services; and (C) nonpublic entities that provide family planning services but do not provide comprehensive primary and preventive care services; or (2) as otherwise directed by the legislature...	...any expenditures or grants of money by the department of health and environment—division of health for family planning services financed in whole or in part from federal title X moneys shall be made subject to the following two priorities: First priority to public entities (state, county, local health departments and health clinics) and, if any moneys remain, then, Second priority to non-public entities which are hospitals or federally qualified health centers that provide comprehensive primary and preventative care in addition to family planning services.
Restrictions Directed At Abortion Providers	The department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed, provided, however, that this provision shall not apply to any Hospital, as that term is defined in Sec. 126-V:2(V) above	An agency of the state may not: (1) enter into a contract with; or (2) make a grant to; any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.	The department shall ensure that money spent for purposes of the demonstration project for women's health care services under former Section 32.0248, Human Resources Code, or a similar successor program is not used to perform or promote elective abortions, or to contract with entities that perform or promote elective abortions *or affiliate with entities that perform or promote elective abortions.*	N/A

VK 4/15/12

APPENDIX A
PERTINANT TEXT OF LEGISLATION REGARDING ABORTION FUNDING

NEW HAMPSHIRE'S HB228 (Floor Amendment)

126-V:3 Prioritization of Public Funds to Health Care Entities. Subject to any applicable requirements of federal statutes, rules, regulations, or guidelines:

I. Any expenditures or grants of public funds for family planning services by the state made by the department shall be made in the following order of priority to:

(a) Public entities;

(b) Non-public hospitals and federally qualified health centers;

(c) Rural health clinics; and

(d) Non-public health providers that have as their primary purpose the provision of the primary health care services enumerated in 42 U.S.C. section 254b(a)(1).

II. The department shall not enter into a contract with, or make a grant to, any entity that performs non-federally qualified abortions or maintains or operates a facility where non-federally qualified abortions are performed, provided, however, that this provision shall not apply to any Hospital, as that term is defined in Sec. 126-V:2(V) above

INDIANA'S HEA 1210

SECTION 1. IC 5-22-17-5.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5.5.

(a) This section does not apply to hospitals licensed under IC 16-21-2 or ambulatory surgical centers licensed under IC 16-21-2.

(b) An agency of the state may not:
(1) enter into a contract with; or
(2) make a grant to;
any entity that performs abortions or maintains or operates a facility where abortions are performed that involves the expenditure of state funds or federal funds administered by the state.

(c) Any appropriation by the state:
(1) in a budget bill;
(2) under IC 5-19-1-3.5; or
(3) in any other law of the state;
to pay for a contract with or grant made to any entity that performs abortions or maintains or operates a facility where abortions are performed is canceled, and the money appropriated is not available for payment of any contract with or grant made to

the entity that performs abortions or maintains or operates a facility where abortions are performed.

(d) For any contract with or grant made to an entity that performs abortions or maintains or operates a facility where abortions are performed covered under subsection (b), the budget agency shall make a determination that funds are not available, and the contract or grant shall be terminated under section 5 of this chapter.

TEXAS' SB7 (enrolled version)

SECTION 1.19. (a) Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.0025 to read as follows:

Sec. 531.0025. RESTRICTIONS ON AWARDS TO FAMILY PLANNING SERVICE PROVIDERS.

(a) Notwithstanding any other law, money appropriated to the Department of State Health Services for the purpose of providing family planning services must be awarded:
  (1) to eligible entities in the following order of descending priority:
    (A) public entities that provide family planning services, including state, county, and local community health clinics and federally qualified health centers;
    (B) nonpublic entities that provide comprehensive primary and preventive care services in addition to family planning services; and
    (C) nonpublic entities that provide family planning services but do not provide comprehensive primary and preventive care services; or
  (2) as otherwise directed by the legislature in the General Appropriations Act.

(b) Notwithstanding Subsection (a), the Department of State Health Services shall, in compliance with federal law, ensure distribution of funds for family planning services in a manner that does not severely limit or eliminate access to those services in any region of the state.

(b) Section 32.024, Human Resources Code, is amended by adding Subsection (c-1) to read as follows:

(c-1) The department shall ensure that money spent for purposes of the demonstration project for women's health care services under former Section 32.0248, Human Resources Code, or a similar successor program is not used to perform or promote elective abortions, or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions.

KANSAS' HB 2014

Sec. 57. (a) During the fiscal year ending June 30, 2011, subject to any applicable requirements of federal statutes, rules, regulations or guidelines, any expenditures or grants of money by any state agency for family planning services financed in whole or in part from federal title X moneys shall be made subject to the following two priorities: First priority to public entities (state, county, local health departments and health clinics) and if any moneys remain then; second priority to non-public

entities which are hospitals or federally qualified health centers that provide comprehensive primary and preventative care in addition to family planning services.

(b) As used in this section ''hospitals'' shall have the same meaning as defined in K.S.A. 65-425, and amendments thereto, and ''federally qualified health center'' shall have the same meaning as defined in K.S.A. 65-1669, and amendments thereto.

Sec 107(l) During the fiscal year ending June 30, 2012, subject to any applicable requirements of federal statutes, rules, regulations or guidelines, any expenditures or grants of money by the department of health and environment—division of health for family planning services financed in whole or in part from federal title X moneys shall be made subject to the following two priorities: First priority to public entities (state, county, local health departments and health clinics) and, if any moneys remain, then, Second priority to non-public entities which are hospitals or federally qualified health centers that provide comprehensive primary and preventative care in addition to family planning services:
Provided, That, as used in this subsection ''hospitals'' shall have the same meaning as defined in K.S.A. 65-425, and amendments thereto, and ''federally qualified health center'' shall have the same meaning as defined in K.S.A. 65-1669, and amendments thereto.

APPENDIX B - CMS LETTERS

Text of the June 1, 2011 letter from Donald M. Berwick, M.D. Administrator to Indiana Medicaid Director, Patricia Casanova

Dear Ms. Casanova:

I am responding to your request to approve the State of Indiana's Medicaid State plan amendment (SPA) 11-0 11 , received by the Centers for Medicare & Medicaid Services (CMS) on May 15,2011. In this amendment, Indiana proposes to prohibit the State Medicaid agency from entering into a contract or grant with providers that perform abortions or maintain or operate facilities where abortions are performed, except for hospitals or ambulatory surgical centers. For the reason set forth below, I am unable to approve SPA 11-011 as submitted, because it does not comply with the requirements of section 1902(a)(23) of the Social Security Act (the Act). Section 1902(a)(23)(A) of the Act provides that beneficiaries may obtain covered services from any qualified provider that undertakes to provide such services. This SPA would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons not related to their qualifications to provide such services. As you know, federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (such as in cases of rape or incest). At the same time, Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a provider's scope of practice. Such a restriction would have a particular effect on beneficiaries' ability to access family planning providers, who are subject to additional protections under section 1902(a)(23)(B) of the Act. These protections also apply in managed care delivery systems. Therefore, we cannot determine that the proposed amendment complies with section 1902(a)(23) of the Act.

For this reason, and after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15(c), I am unable to approve this SPA. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of receipt of this letter in accordance with the procedures set forth at 42 CFR 430.18. Your request for reconsideration may be sent to Ms. Cynthia Hentz, Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP and Survey & Certification, 7500 Security Boulevard, Mail Stop S2-01-01 , Baltimore, MD 21244-1850.

We assume this decision is not unexpected. As the Indiana Legislative Services Agency indicated in its April 19,2011 fiscal impact statement, "While States are permitted to waive a recipient's freedom of choice of a provider to implement managed care, restricting freedom of choice with respect to providers of family planning services is prohibited."

If you have any questions or wish to discuss this determination further, please contact Ms. Yerlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Centers for Medicare & Medicaid Services, 233 N. Michigan A venue, Suite 600, Chicago, Illinois, 60601.

Sincerely,

Donald M. Berwick, M.D. Administrator

Relevant excerpt from the June 1, 2011 Informational Bulletin from CMCS Director, Cindy Mann

Medicaid Requirement of Freedom of Choice

We have received some inquiries as to whether States may exclude certain providers from participating in Medicaid based on their scope of practice, as well as a proposed state plan amendment presenting the same question, and we thought a review of longstanding federal law would be helpful to States.

States have authority to exclude providers from participating in Medicaid under certain circumstances, and indeed in some situations federal law requires exclusion. States are required, for example, to exclude providers that commit fraud or certain criminal acts. States are not, however, permitted to exclude providers from the program solely on the basis of the range of medical services they provide. Under federal law Medicaid beneficiaries may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." (Section 1902(a)(23) of Title XIX of the Social Security Act (the Act)) This provision is often referred to as the "any willing provider" or "free choice of provider" provision.

Federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (in cases of rape, incest, or when the life of the woman would be in danger). At the same time, Medicaid programs may not exclude qualified health care providers—whether an individual provider, a physician group, an outpatient clinic, or a hospital—from providing services under the program because they separately provide abortion services (not funded by federal Medicaid dollars, consistent with the federal prohibition) as part of their scope of practice.

If you have any questions about this provision of the law, please contact Dr. Gerald Zelinger at gerald.zelinger@cms.hhs.gov

DHHS

NH Department of Health and Human Services
Division of Public Health Services - Maternal and Child Health Section

Exhibit A

Scope of Services
Family Planning Program SFY 2012 & 2013

CONTRACT PERIOD: July 1, 2011 or date of G&C approval, whichever is later, through June 30, 2013.

The Contractor shall provide family planning services as specified below.

I. General Provisions

A) Eligibility and Income Determination

Family Planning (FP) services will be provided to individuals of childbearing ages in New Hampshire (NH) who request such services. Preference will be given to clients who live within the Contractor's service area. Special emphasis will be placed on serving adolescents and individuals in low-income families (defined as $\leq$ **250%** of the U.S. Department of Health & Human Services "Poverty Guidelines").

1. The Contractor shall implement, and post in a public and conspicuous location, a sliding fee payment schedule for low-income clients. As an alternative, the Contractor may post, in a public and conspicuous location, a notice to clients that a sliding fee scale is available and that no client will be denied services for inability to pay. The sliding fee scale must be updated annually based on USDHHS Poverty guidelines as published in the Federal Register.

2. The Contractor must inform clients of Medicaid and Healthy Kids eligibility requirements and assist in the application process.

3. Per Title X Federal Program Guidelines for Project Grants for Family Planning Services (January 2001) Gross Family Income is defined as the total gross income of all members of a family. Family, for the purpose of application of these guidelines, is defined as a social unit composed of one person, or two or more persons living together, as a household. Eligibility for minors who receive confidential services must be based on the income of the minor.

4. Per Region I Family Planning Office guidance, if a client's income cannot be determined for the initial visit, the client is considered to be unable to pay and must be placed in Category I. On return visits, if income can be determined, the fee category may be changed although the client's inability to pay cannot be a barrier to services.

5. The Contractor shall bill all third party payment sources (including private insurance and Medicaid) prior to spending the family planning contract funds EXCEPT when such billing presents a barrier to confidential services.

B) Numbers Served

The FP Program will provide comprehensive reproductive health care to include age-appropriate clients, anticipatory guidance, education, assessment, counseling on preconception health care (reproductive life plan) and referrals for nutrition services, substance abuse, domestic violence, sexual assault and other health related issues.

C) Culturally and Linguistically Appropriate Standards of Care

The Department of Health and Human Services (DHHS) recognizes that culture and language have considerable impact on how consumers access and respond to public health services. Culturally and linguistically diverse populations experience barriers in efforts to access health services. To ensure equal access to quality health services, the Division of Public Health Services (DPHS) expects that Contractors shall provide culturally and linguistically appropriate services according to the following guidelines:

1. Assess the ethnic/cultural needs, resources and assets of their community.

2. Promote the knowledge and skills necessary for staff to work effectively with consumers with respect to their culturally and linguistically diverse environment.

3. When feasible and appropriate, provide clients of limited English proficiency (LEP) with interpreter services. Persons of LEP are defined as those who do not speak English as their primary language and whose skills in listening to, speaking, or reading English are such that they are unable to adequately understand and participate in the care or in the services provided to them without language assistance.

4. Offer consumers a forum through which clients have the opportunity to provide feedback to providers and organizations regarding cultural and linguistic issues that may deserve response.

5. The Contractor shall maintain a program policy that sets forth compliance with Title VI, Language Efficiency and Proficiency. The policy shall describe the way in which the items listed above were addressed and shall indicate the circumstances in which interpretation services are provided and the method of providing service (e.g. trained interpreter, staff person who speaks the language of the client, language line).

D) State and Federal Laws

The Contractor is responsible for compliance with all relevant state and Federal laws. Special attention is called to the following statutory responsibilities:

1. The Contractor shall report all cases of communicable diseases according to New Hampshire RSA 141-C and He-P 301 as most currently amended (1/05).

2. Persons employed by the Contractor shall comply with the reporting requirements of New Hampshire RSA 169:C, Child Protection Act; RSA 161:F46, Protective Services to Adults and RSA 631:6, Assault and Related Offences.

3. Contractor shall ensure that clients served will receive up-to-date recommended immunizations either on site or by referral to a primary care provider in accordance with

RSA 141-C and the most current Immunization Rules promulgated.

E) Relevant Policies and Guidelines

Contractors operate, at minimum, in accordance with the following:

1. The (Federal) Office of Population Affairs, Office of Family Planning, *Program Guidelines for Project Grants for Family Planning Services*, dated January 2001, and subsequent amendments, program instructions and clarifications.

2. National program priorities established by the Office of Population Affairs.

3. The most current New Hampshire Guidelines for Family Planning Clinical Services (NH Guidelines) and any revisions to these guidelines.

4. The Contractor must submit to MCHS the completed face sheet to the NH Guidelines with the signature of the agency medical director and all medical providers who will provide family planning services. New providers are required to add their signatures to this document.

5. The Contractor shall design and implement systems of governance, administration, financial management, information management, and clinical services which are adequate to assure the provision of contracted services and to meet the data and reporting requirements. These systems shall meet the most current minimum standards described in at least one of the following: Health Resources and Services Administration (HRSA) Office of Performance review protocols, Joint Commission on Accreditation of Health Care Organizations (JCAHO), Community Health Accreditation Program (CHAP) or Accreditation Association for Ambulatory Healthcare (AAA).

F) Publications Funded Under Contract (Standard Language)

1. The DPHS and/or its funders will retain COPYRIGHT ownership for any and all original materials produced with DPHS contract funding, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports.

2. All documents (written, video, audio) produced, reproduced, downloaded from a web source or purchased under the contract shall have prior approval from DPHS before printing, production, distribution, or use. In the case of Family Planning Programs, all such documents are subject to review by the information and education review committee.

3. The Contractor shall credit DPHS on all materials produced under this contract following the instructions outlined in Exhibit C (14)

G) Subcontractors

1. If any service required by this exhibit is provided, in whole or in part, by a subcontracted agency or provider, the Division of Public Health Services (DPHS), Maternal and Child Health Section (MCHS) must be notified in writing prior to initiation of the subcontract.

2. In addition, the original DPHS Contractor will remain liable for all requirements included in this exhibit and carried out by subcontractors.

II. Minimal Standards of Core Services

A. Service Requirements

1. Clinical Services

In addition to following the federal and state guidelines outlined above, clinical services will be guided by the protocol and practice guidelines established by the Contractor and will be supervised by a medical director qualified to oversee obstetric and gynecological care.

2. HIV Counseling and Testing

HIV counseling and testing provided by family planning Contractors must conform to CDC's *Fundamentals of HIV Prevention Counseling* and staff providing this counseling must be trained in this counseling model.

3. Health Education Materials

Health education materials are to be reviewed according to Federal Program Guidelines for Project Grants for Family Planning Services (reference section 6.8) and the NH State Family Planning Program's Information and Education Policy on the review, approval, and distribution of family planning materials. Delegate agencies may be asked to work with the State in identifying consumer volunteers to review educational materials in order to provide consumer input. Any and all materials an agency develops for marketing or patient education must be submitted, in its final draft form, for approval before printing or duplicating it in quantity.

4. Sterilization Services

Those Contractors providing sterilization services will adhere to all federal sterilization requirements as outlined in the Federal Program Guideline's Attachment C, *Sterilization of Persons in Federally Assisted Family Planning Projects* and subsequent revisions or amendments related to this federal requirement.

5. Transitional Assistance for Needy Families (TANF) and Title X FP Collaborative

The TANF and Title X Collaborative will conduct statewide activities to support knowledge of and access to FP services by populations in need, with a particular emphasis on Medicaid-eligible women and adolescents at risk for pregnancy. The Contractor shall produce a plan that documents a promotional & partnership building strategy and marketing/outreach campaign that includes identification of the target population, details, activities and projects for reaching the target population and specifies evaluation measures. The NH FP & Contractors will review the plan on an on-going basis to monitor progress towards outcomes and overall project goals.

6. Research

Contractors considering clinical or sociological research using clients as subjects must adhere to the legal requirements governing human subjects research. Contractors must

inform the Division of Public Health Services, Maternal and Child Health Section prior to initiating any research related to this contract.

7. **School-based Education Programs**

Contractors must enter into a written agreement with any school where the Contractor will implement sexuality education programs for students under the age of 18. The agreement must be signed by the school principal/or designee and must include a statement that information was provided to parents which offered the opportunity for the parents to opt their child out of any program to which the parent objects.

B) Staffing Provisions

1. **Staff Training and Qualifications**

Documentation will be available to show that all staff members employed in the Family Planning program has adequate training to fulfill their activities. Staff performing clinical functions will have NH licensing that is required for their responsibilities. Each agency will employ appropriate credentialing procedures to assure that clinical staffs have appropriate education and experience for their responsibilities.

2. **Medical Director Participation**

Each agency will have the services of a medical director who has special training and/or experience in family planning services. For each Contractor, the medical director and the clinical staff shall participate in the development and approval of specific guidelines for medical care that meet or exceed these minimal standards. In addition, the medical director shall participate in QI activities and be available to other staff for consultation.

3. **Community Education & Partnership Development**

The Contractor will designate one staff member or committee responsible for the coordination and development of a community education and outreach plan, to include partnership development so as to increase utilization of family planning services. A community education & outreach report will be required, as well as any supporting documentation that supports the development of partnerships with key community stakeholders.

4. **Staffing Changes**

New Hires

The Contractor shall notify the Maternal and Child Health Section (MCHS) in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. A resume of the employee shall accompany this notification.

Vacancies

The Contractor must notify MCHS in writing of key positions (agency executive director, agency fiscal director, medical director, site manager, community educator, teen clinic coordinator, TANF coordinator) vacant for more than three months. This may be done

through a budget revision. In addition, MCHS must be notified in writing if at any time any site funded under this agreement does not have adequate clinical and administrative staffing to perform all required services for more than one month.

C) Coordination of Services

1. The Contractor will be responsible to ensure that other providers in the designated service area, particularly those who serve low income individuals and adolescents, are aware of the availability and scope of their family planning services, including awareness of the availability of confidential services and of a sliding fee scale. The Contractor shall coordinate, where possible, with other service providers in the community. At a minimum, such collaboration shall include interagency referrals.

2. As appropriate, agencies should participate in community needs assessments, public health performance assessments and the development of regional public health improvement plans within their Public Health Networks. Network staff should also be engaged, as appropriate, to enhance the implementation of community-based public health prevention initiatives, emergency planning or emergency relief efforts being implemented by the agency.

3. As part of the Family Planning Workplan process, each Contractor will make plan explicitly identifying community services providers who will be contacted for face-to-face meetings intended to build partnerships, increase coordination and referrals with other providers.

D) Meetings and Trainings

The Contractor will be responsible to send staff to meetings and training required by the family planning program, including but not limited to: medical director's meetings, family planning director's meetings, community educator/clinic coordinators meetings, data training and review meetings -and family planning orientation.

III. Quality or Performance Improvement (QI/PI)

A) Workplans

1. Performance Workplans must be submitted and are used to monitor achievement of standard measures of performance of the services provided under this contract. Said workplan is incorporated herein by reference.

2. Performance Workplans and Workplan Outcome Reports will be completed according to the schedule and instructions provided by MCHS. The workplans are a key component of the DPHS and MCHS performance based contracting system and of this contract.

3. The Contractor shall incorporate required and developmental performance measures, defined by the MCHS into the agency's QI/PI plan. Reports on Workplan Progress/Outcomes shall detail the QI/PI plans and activities that monitor and evaluate the agency's progress toward performance measure targets. If the Contractor's performance is above the defined target, an explanation must be provided to identify what action steps were successful. If the Contractor's performance is below the defined target, an explanation must be provided of why and what action steps will be taken to improve performance.

4. The Contractor shall comply with minor modifications and/or additions to the workplan and annual report format as requested by MCHS. MCHS will provide the Contractor with reasonable notice of such changes.

B) Data and reporting requirements

In addition to Performance Workplans and Outcome Reports, the Contractor shall submit to MCHS the following data used to monitor program performance:

1. In years when contracts or amendments are not required, the DPHS Budget Form, Budget Justification, Sources of Revenue and Program Staff list forms must be completed according to the relevant instructions and submitted as requested by DPHS.

2. The Sources of Revenue report must be resubmitted at any point when changes in revenue threaten the ability of the agency to carry out the planned program.

3. Completed UDS tables reflecting program performance in the previous calendar as requested by DPHS.

4. A copy of the Contractor's updated Sliding Fee Scale including the amounts(s) of any client fees and the schedule of discounts must be submitted by March 31st of each year. The Contractor's sliding fee scale must be updated annually based on the USDHHD Poverty guidelines as published in the Federal Register.

5. An annual summary of patient satisfaction results obtained during the prior contract year and of the method by which the results were obtained must be submitted with annual Workplan Outcome/Progress report.

6. Following the instructions provided in the Family Planning Annual Report Manual, a Family Planning Encounter Record (FPER) must be submitted by the 10th of the month, following the delivery of service for each client visit provided in the family planning program. This record must be submitted in compliance with the Region I Title X Family Planning Data System Instruction Manual relevant to the submission method being used and any other state specific instructions provide by the family planning program.

7. By February 1st of each program year, submit data required for submission of the federal Family Planning Annual Report.

8. As requested by the family planning program, submit costing reports using a methodology approved by the Family Planning Program.

9. Comply with all Family Planning Program and STD/HIV Prevention Bureau requirements for reporting chlamydia testing.

C) On-site reviews

1. The Contractor shall allow a team or person authorized by the MCHS to periodically review the Contractor's systems of governance, administration, data collection and submission, clinical services management, financial management and design and delivery of educational services to assure systems are adequate to provide the contracted services.

2. Reviews shall include client record reviews to measure compliance with this exhibit.

3. The Contractor shall make corrective actions as advised by the review team if contracted services are not found to be provided in accordance with this exhibit.

4. On-site reviews may be waived or abbreviated at the discretion of MCHS, upon submission of satisfactory reports of reviews such as Health Services Resources Administration (HRSA): Office of Performance Review (OPR), or reviews from nationally accreditation organizations such as the Joint Commission for the Accreditation of Health Care Organizations (JCAHO), the Community Health Accreditation Program (CHAP) or the Accreditation Association for Ambulatory Healthcare (AAA). Abbreviated reviews will focus on any deficiencies found in previous reviews, issues of compliance with this exhibit, and actions to strengthen performance as outlined in the agency Performance Workplan.

Implications to Family Planning Services, Title X

Title X, Family Planning Program Facts:

- Title X is a federal program administered by the US Office of Population Affairs (OPA) for over 40 years to provide access to reproductive health care and birth control methods for women in need.
- The Division of Public Health Services (DPHS) contracts with 10 agencies to provide Title X family planning services to approximately 10,000 individuals a year. The majority served is low-income adults. The screening and care provided by Title X agencies are often the only healthcare services that some clients receive.
- Among the important health services covered by these contracts are health examinations; screenings for cancer; screenings for sexually transmitted diseases; reproductive health education including healthy relationships and abstinence education; to provide knowledge and access to safe and effective contraception at low or no cost for low-income individuals; and health counseling that promotes healthy, planned pregnancies which lead to having a healthy infant.
- As part of the standard of practice for provision of birth control methods, prevention and cancer screenings, examinations and health education are also offered through Title X. **Abortion services are specifically excluded, as abortion is not considered a method of birth control.**

In HB 228 as amended by the House, the proposed new RSA 126-V:1, paragraph IV, states in part that "...it shall be the policy of this state that federal public funds shall not be provided for the direct or indirect costs, ...of non-federally qualified ***abortions, abortion referral, or abortion counseling, and these activities shall not be subsidized, either directly or indirectly, by federal public funds***."

No federal or state general funds under Title X are used to pay for abortions. Law and contractual provisions safeguard this mandate and there are three levels of controls, at the federal, state, and agency levels.

FEDERAL SAFEGUARDS:

Federal law and regulations prohibit the use of Title X funding for abortion services. Section 1008 of the Title X statute, 42 U.S.C. §300a–6, states that ***"none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."***

- Federal controls consist of regular site visits to grantees, like the State of New Hampshire.
- Site visits occur about every 3 years and include visits to several sub-grantee sites.
- A site visit audit tool includes specific criteria relating to the abortion prohibition. The federal review team consists of the federal project officer and expert financial, administrative, and clinic services consultants.
- Financial consultants review charges to assure that no prohibited activities have been charged to grant funds and that the appropriate separation of staff, facility, and supplies between the Title X Program and prohibited or unauthorized services, including abortion, has been maintained.

Also specifically, the regulation is section 4 "Separation," which states that ***"non-Title X abortion activities must be separate and distinct from Title X project activities. Where a grantee conducts abortion activities that are not part of the Title X project and would not be permissible if they were, the grantee must ensure that the Title X-supported project is separate and distinguishable from those other activities."***

The regulation notice goes on to detail the requirements regarding the appropriate separation of staff, facility, and supplies between the Title X Program and prohibited or unauthorized services. In closing, please let me know if you any questions or need any additional information related to this matter.

STATE SAFEGUARDS:

- At the state-level, sub-grantees are held to their contractual obligations in Exhibit A, Scope of Services.
- The Family Planning Exhibit A requires compliance with all relevant state and federal laws and adherence to the Office of Population Affairs' Program Guidelines for Project Grants for Family Planning Services, which can be found at the following website: http://www.hhs.gov/opa/pdfs/2001-ofp-guidelinescomplete.pdf.
- Two type of compliance audits are conducted by the Department:
  - Full programmatic audits occur every 3 years and use the federal site visit tool to assure consistency with federal requirements. Clinical record reviews are held annually; and
  - The Department's Internal Audit Unit schedules and performs audits every 3 years.
- In addition to these state safeguards, HB2 of the SFY 12-13 budget states that the funding of abortions are prohibited. "Notwithstanding any provision of law to the contrary, the appropriation in accounting unit 05-95-90-902010-5530, family planning program, and any other funds shall not be used for evaluation, assessment, consultation about, preparation for, or provision of an abortion."

AGENCY SAFEGUARDS:

- Agencies have internal controls, policies, and procedures in place to ensure that costs are appropriately charged.

However while not funds are used for abortion, Title X funded agencies *are required to provide referral* and basic information *if requested* by the client. Under Section 8.6 Pregnancy Diagnosis and Counseling Guidelines for Project Grants for Family Planning Services,

Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and
- Pregnancy termination.

If HB 228 were to pass as written, the 10 agencies across the state that receive Title X funds would be in non-compliance with federal regulations. Without the support of Title X funds, nearly 10,000 women would lose access to reproductive health care services, and for many of whom, this is the only source of health care service they may receive.

Implications to Health Care Delivery Infrastructure; Focus on Prioritization of Funding

RSA 126-V:3 requires the prioritization of expenditures or grants of public funds for family planning services, subject to any applicable requirements of federal statutes, rules, regulations, or guidelines. New Hampshire's health care safety net, including providers of Title X services, consists of an array of private, nonprofit community health centers, some of which are Federally Qualified Community Health Centers. The priority organization to expend funds, within the amendment, to is "public entities" but this term is not defined. Are "public entities" different than community health centers and how would the Department do this type of prioritization? It is unclear how this prioritization would be managed within the State's current competitive bid process.

RSA 126-V:1, paragraph I, found in HB 228 states that "the general court finds that public and private providers of primary and preventive care utilize public funds more effectively than providers of health care services that are specialized to particular medical services or discrete patient populations..." and "...it is the intention of the general court through this act and any rules and policies adopted under this act to ***prioritize the distribution and utilization of public funds for family planning, reproductive health care, and maternal/fetal care to such public and private primary and preventive care providers***."

While the Department strongly supports a network of private, nonprofit community health centers, this is an extremely broad statement of legislative intent with far-reaching implications. The language suggests that specialists such as OB/GYN's, pediatricians, maternal-fetal medicine physicians, neonatologists, and other specialists are less effective than family practice clinicians. The Department promotes evidence-based policies with referral and access to appropriate health care. An unintended consequence of this language would be that women with, or who may have the potential for, a high-risk pregnancy would not have access to life-saving specialty care for herself or her baby.

The Department questions how this prioritization of distribution and utilization would take place, especially, in terms of Medicaid dollars. Would high-risk neonatal patients need to get care from their primary care physician as opposed to a neonatologist? Would a pregnant woman with diabetes be prohibited from seeing an endocrinologist? HB 228 leaves countless unanswered questions with significant fiscal and policy implications.

Administrative Implications

Also as to a technical problem highlighted by the legislative findings and purposes section of the legislation that references "rules and policies," HB 228 fails to provide the Department with rulemaking authority to implement the provisions of the proposed new RSA Chapter 126-V.

Finally, the 60 day effective date, upon passage, is problematic in terms of the provision of all family planning, reproductive health, and maternal-fetal care for Medicaid and Title X clients, and would cause extreme hardship for currently funded agencies.

In closing, the ideological policies within this legislation tear apart the strength of the safety net in New Hampshire, forcing health care providers to choose between federal funding to see their most vulnerable patients and the ability to perform their full scope of medical practice and referral. Equally as harmful, at a minimum, HB 228 places hospitals in the position of choosing to provide the full spectrum of healthcare services that patients need causing disenrollment from the Medicaid program potentially resulting in significant disruption to the acute care system and sacrificing some or all of the approximately $700 million in federal dollars that support our state Medicaid program to pay for the healthcare needs of needy children, disabled, and elders.

Program Guidelines For Project Grants For Family Planning Services

United States Department of Health and Human Services
Office of Public Health and Science
Office of Population Affairs
Office of Family Planning
4350 East West Highway, Suite 200
Bethesda, Maryland 20814

January 2001

Table of Contents

Attachments

Resource Documents

PART I

1.0 Introduction to the Program Guidelines

This document, *Program Guidelines for Project Grants for Family Planning Services (*Guidelines), has been developed by the Office of Population Affairs (OPA), U.S. Department of Health and Human Services (DHHS), to assist current and prospective grantees in understanding and utilizing the family planning services grants program authorized by Title X of the Public Health Service Act, 42 U.S.C. 300, et seq. The Office of Population Affairs also provides more detailed guidance, updated clinical information and clarification of specific program issues in the form of periodic Program Instructions to the Regional Offices.

This document is organized into two parts. Part I (sections 1-6) covers project management and administration, including the grant application and award process. Part II (sections 7-11) covers client services and clinic management.

Reference is made throughout the document to specific sections of the Title X law and implementing regulations, which are contained in *Attachments A and B,* respectively. (Reference to specific sections of the regulations will appear in brackets, e.g., [45 CFR Part 74, Subpart C].) Federal sterilization regulations are contained in *Attachment C.* The DHHS regional offices are listed in *Attachment D.* Selected other materials that provide additional guidance in specific areas are classified as *Resource Documents.*

1.1 DEFINITIONS

Throughout this document, the word "must" indicates *mandatory* program policy. "Should" indicates *recommended* program policy relating to components of family planning and project management that the project is urged to utilize in order to fulfill the intent of Title X. The words "can" and "may" indicate suggestions for consideration by individual projects.

The "grantee" is the entity that receives a Federal grant and assumes legal and financial responsibility and accountability for the awarded funds and for the performance of the activities approved for funding. The "project" consists of those activities described in the grant application and supported under the approved budget. "Delegate/contract agencies" are those entities that provide family planning services with Title X funds under a negotiated, written agreement with a grantee. "Service sites" are those locations where services actually are provided by the grantee or delegate/contract agency.

2.0 The Law, Regulations, and Guidelines

To enable persons who want to obtain family planning care to have access to such services, Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572), which added Title X, "Population Research and Voluntary Family Planning Programs" to the Public Health Service Act. Section 1001 of the Act (as amended) authorizes grants "to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)" (*see Attachment A*). The mission of Title X is to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children.

The regulations governing Title X [42 CFR Part 59, Subpart A] set out the requirements of the Secretary, Department of Health and Human Services, for the provision of family planning services funded under Title X and implement the statute as authorized under Section 1001 of the Public Health Service Act. Prospective applicants and grantees should refer to the regulations (*see Attachment B*). This document, *Program Guidelines for Project Grants for Family Planning Services*, interprets the law and regulations in operational terms and provides a general orientation to the Federal perspective on family planning.

3.0 The Application Process

3.1 ELIGIBILITY

Any public or nonprofit private entity located in a state (which, by definition, includes the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the U.S. Virgin Islands, American Samoa, the U.S. Outlying Islands [Midway, Wake, et al.], the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) is eligible to apply for a Title X family planning services project grant [59.2, 59.3].

To promote the purposes of Section 1001 of the Act in the most cost effective and efficient manner, grants will be made to public and non-profit private entities to foster projects most responsive to local needs. A non-profit private agency, institution, or organization must furnish evidence of its non-profit status in accordance with instructions accompanying the project grant application form. Under the law, grants cannot be made to entities that propose to offer only a single method or an unduly limited number of family planning methods. A facility or entity offering a single method can receive assistance under Title X by participating as a delegate/contract agency in an approvable project that offers a broad range of acceptable and effective medically approved family planning methods and services [59.5(a)(1)].

3.2 NEEDS ASSESSMENT

An assessment of the need for family planning services must be conducted prior to applying for a competitive grant award. The needs assessment documents the need for family planning services for persons in the service area and should include:

- Description of the geographic area including a discussion of potential geographic, topographic, and other related barriers to service;

- Demographic description of the service area including objective data pertaining to individuals in need of family planning services, maternal and infant morbidity/mortality rates, birth rates and rates of unintended pregnancies by age groups, poverty status of the populations to be served, cultural and linguistic barriers to services, etc.;

- Description of existing services and need for additional family planning services to meet community/cultural needs;

- Need indicators that include rates of STDs and HIV prevalence (including perinatal infection rates) in the grantee area;

- Identification and descriptions of linkages with other resources related to reproductive health; and

- Identification and discussion of high priority populations and target areas.

Grantees should perform periodic reassessment of service needs. Competitive grant applications must include a full and updated needs assessment.

3.3 THE APPLICATION

The Department of Health and Human Services' Office of Population Affairs administers the Title X Family Planning Program through the DHHS Regional Offices. An annual announcement of the availability of Title X service grant funds sets forth specific application requirements and evaluation criteria. Applications must be submitted to the Office of Grants Management for Family Planning Services on the form required by the Department. The application forms are available from the Office of Grants Management for Family Planning Services. Assistance regarding programmatic aspects of proposal preparation is available from the Regional Office. For assistance with administrative and budgeting aspects of proposal preparation, contact the Office of Grants Management for Family Planning Services.

Unless otherwise instructed, applicants are to respond to the standard instructions contained in the application kit and to the PHS supplemental instructions. An application must contain:

- a needs assessment
- a narrative description of the project and the manner in which the applicant intends to conduct it in order to carry out the requirements of the law and regulations;
- a budget that includes an estimate of project income and costs, with justification for the amount of grant funds requested [59.4(c)(2)] and which is consistent with the terms of Section 1006 of the Act, as implemented by regulation [59.7(b)];
- a description of the standards and qualifications that will be required for all personnel and facilities to be used by the project;
- project objectives that are specific, realistic, and measurable; and
- other pertinent information as required [59.4(c)(4)].

The application must address all points contained in section 59.7(a) of the regulations, which are the criteria DHHS Regional Offices will use to decide which family planning projects to fund and in what amount. The application shall not include activities that cannot be funded under Title X, such as abortion, fundraising, or lobbying activities.

3.4 PROJECT REQUIREMENTS

Projects must adhere to:

- Section 59.5 and all other applicable provisions of the regulations, which list the requirements to be met by each project supported by Title X.
- The applicable requirements of these *Program Guidelines for Project Grants for Family Planning Services.*
- Other Federal regulations which apply to grants made under Title X [59.10]. For assistance in identifying other relevant regulations, contact the Regional Office.

3.5 NOTICE OF GRANT AWARD

The notice of grant award will inform the grantee how long DHHS intends to support the project without requiring it to recompete for funds [59.8]. This period of funding is called the "project period." The project will be funded in increments called "budget periods." The budget period is normally twelve months, although shorter or longer budget periods may be established for compelling administrative or programmatic reasons.

4.0 Grant Administration

All grantees must comply with the applicable legislative, regulatory and administrative requirements described in the *Public Health Service Grants Policy Statement*. A copy of the *Public Health Service Grants Policy Statement* may be obtained from the Office of Grants Management for Family Planning Services.

5.0 Legal Issues

5.1 VOLUNTARY PARTICIPATION

Use by any individual of project services must be solely on a voluntary basis. Individuals must not be subjected to coercion to receive services or to use or not to use any particular method of family planning. Acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other service or assistance from or participation in any other programs of the applicant [59.5(a)(2)].

Project personnel must be informed that they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure.

5.2 CONFIDENTIALITY

Every project must assure client confidentiality and provide safeguards for individuals against the invasion of personal privacy, as required by the Privacy Act. No information obtained by the project staff about individuals receiving services may be disclosed without the individual's written consent, except as required by law or as necessary to provide services to the individual, with appropriate safeguards for confidentiality. Information may otherwise be disclosed only in summary, statistical, or other form that does not identify the individual [59.11].

5.3 CONFLICT OF INTEREST

Grantees must establish policies to prevent employees, consultants, or members of governing or advisory bodies from using their positions for purposes of private gain for themselves or for others.

5.4 LIABILITY COVERAGE

Grantees and/or delegates/contractors should ensure the existence of adequate liability coverage for all segments of the project funded under the grant, including all individuals providing services. Governing boards should obtain liability coverage for their members.

5.5 HUMAN SUBJECTS CLEARANCE (RESEARCH)

Grantees considering clinical or sociological research using Title X clients as subjects must adhere to the legal requirements governing human subjects research at 45 CFR Part 46, as applicable. A copy of these regulations may be obtained from the Regional Office. Grantees must advise the Regional Office in writing of research projects involving Title X clients or resources in any segment of the project.

6.0 Project Management

6.1 STRUCTURE OF THE GRANTEE

Family planning services under Title X grant authority may be offered by grantees directly and/or by delegate/contract agencies operating under the umbrella of the grantee. However, the grantee is responsible for the quality, cost, accessibility, acceptability, reporting, and performance of the grant-funded activities provided by delegate/contract agencies. Grantees must therefore have a negotiated, written agreement with each delegate/contract agency and establish written standards and guidelines for all delegated project activities consistent with the appropriate section(s) of the *Program Guidelines for Project Grants for Family Planning Services,* as well as other applicable requirements such as Subpart C of 45 CFR Part 74, or Subpart C of 45 CFR Part 92. If a delegate/contract agency wishes to subcontract any of its responsibilities or services, a written negotiated agreement that is consistent with Title X requirements and approved by the grantee must be maintained by the delegate/contractor. Delegate/contract agencies should be invited to participate in the establishment of grantee standards and guidelines.

6.2 PLANNING AND EVALUATION

All projects receiving Title X funds must provide services of high quality and be competently and efficiently administered. To meet these requirements, each competitive application must include a plan which identifies overall goals and specific measurable objectives for the project period. The objectives may be directed to all clients or to specific groups of clients and must be consistent with Title X objectives. The plan must include an evaluation component that addresses and defines indicators by which the project intends to evaluate itself.

6.3 FINANCIAL MANAGEMENT

Grantees must maintain a financial management system that meets the standards specified in Subpart C of 45 CFR Part 74 or Subpart C of 45 CFR Part 92, as applicable, as well as any other requirements imposed by the Notice of Grant Award, and which complies with Federal standards to safeguard the use of funds. Documentation and records of all income and expenditures must be maintained as required.

! Charges, Billing, and Collections

A grantee is responsible for the implementation of policies and procedures for charging, billing, and collecting funds for the services provided by the project. The policies and procedures should be approved by the governing authority or board of the grantee and the Regional Office.

Clients must not be denied project services or be subjected to any variation in quality of services because of the inability to pay. Billing and collection procedures must have the following characteristics:

(1) Charges must be based on a cost analysis of all services provided by the project. At the time of services, clients who are responsible for paying any fee for their services must be given bills directly. In cases where a third party is responsible, bills must be submitted to that party.

(2) A schedule of discounts must be developed and implemented with sufficient proportional increments so that inability to pay is never a barrier to service. A schedule of discounts is required for individuals with family incomes between 101% and 250% of the Federal poverty level. Fees must be waived for individuals with family incomes above this amount who, as determined by the service site project director, are unable, for good cause, to pay for family planning services.

(3) Clients whose documented income is at or below 100% of the Federal poverty

level must not be charged, although projects must bill all third parties authorized or legally obligated to pay for services.

(4) Individual eligibility for a discount must be documented in the client's financial record.

(5) Bills to third parties must show total charges without applying any discount.

(6) Where reimbursement is available from Title XIX or Title XX of the Social Security Act, a written agreement with the Title XIX or the Title XX state agency at either the grantee level or delegate/contract agency level is required.

(7) Bills to clients must show total charges less any allowable discounts.

(8) Eligibility for discounts for minors who receive confidential services must be based on the income of the minor.

(9) Reasonable efforts to collect charges without jeopardizing client confidentiality must be made.

(10) A method for the "aging" of outstanding accounts must be established.

(11) Voluntary donations from clients are permissible. However, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. Donations from clients do not waive the billing/charging requirements set out above.

(12) Client income should be re-evaluated at least annually.

Effective financial management will assure the short and long term viability of the project, including the efficient use of grant funds. Technical assistance in achieving this objective is available from the Regional Office. Title X projects offering services that are not required by the statute, regulations or these Guidelines should whenever possible seek other sources of funding for such services before applying Title X funds to those activities.

! Financial Audit

Audits of grantees and delegate/contract agencies must be conducted in accordance with the provisions of 45 CFR Part 74, Subpart C, and 45 CFR Part 92, Subpart C, as applicable. The audits must be conducted by auditors meeting established criteria for qualifications and independence.

6.4 FACILITIES AND ACCESSIBILITY OF SERVICES

Facilities in which project services are provided should be geographically accessible to the population served and should be available at times convenient to those seeking services, i.e., they should have evening and/or weekend hours in addition to daytime hours. The facilities should be adequate to provide the necessary services and should be designed to ensure comfort and privacy for clients and to expedite the work of the staff. Facilities must meet applicable standards established by the Federal, state and local governments (e.g., local fire, building and licensing codes).

Projects must comply with 45 CFR Part 84, which prohibits discrimination on the basis of handicap in Federally assisted programs and activities, and which requires, among other things, that recipients of Federal funds operate their Federally assisted programs so that, when viewed in their entirety, they are readily accessible to people with disabilities. A copy of Part 84 may be obtained from the Regional office. Projects must also comply with any applicable provisions of the Americans With Disabilities Act (Public Law 101-336).

Emergency situations may occur at any time. All projects must therefore have written plans and procedures for the management of emergencies.

6.5 PERSONNEL

Grantees and delegate/contract agencies are reminded of their obligation to establish and maintain personnel policies that comply with applicable Federal and state requirements, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, and Title I of the Americans With Disabilities Act. These policies should include, but need not be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits, and grievance procedures. Project staff should be broadly representative of all significant elements of the population to be served by the project, and should be sensitive to and able to deal effectively with the cultural and other characteristics of the client population [59.5 (b)(10)].

Grantees must also ensure that:

- Projects are administered by a qualified project director;
- The clinical care component of the project operates under the responsibility of a medical director who is a licensed and qualified physician with special training or experience in family planning;
- Protocols exist that provide all project personnel with guidelines for client care;

- Personnel records are kept confidential;

- Licenses of applicants for positions requiring licensure are verified prior to employment and that there is documentation that licenses are kept current.

6.6 TRAINING AND TECHNICAL ASSISTANCE

Projects must provide for the orientation and in-service training of all project personnel, including the staffs of delegate agencies and service sites. All project personnel should participate in continuing education related to their activities. Documentation of continuing education should be maintained and used in evaluating the scope and effectiveness of the staff training program.

Training through regional training centers is available to all projects under the Title X program. In addition to training, grantees may receive technical assistance for specific project activities. Technical assistance is provided by contract from the OPA and administered through the Regional Office. Information on training and technical assistance is available from the Regional Office.

6.7 REPORTING REQUIREMENTS

Grantees must:

(1) comply with the financial and other reporting requirements of 45 CFR Part 74 or 45 CFR Part 92, as applicable; and

(2) comply with other reporting requirements as required by DHHS.

6.8 REVIEW AND APPROVAL OF INFORMATIONAL AND EDUCATIONAL MATERIALS

An advisory committee of five to nine members (the size of the committee can differ from these limits with written documentation and approval from the Regional Office) who are broadly representative of the community must review and approve all informational and educational (I&E) materials developed or made available under the project prior to their distribution to assure that the materials are suitable for the population and community for which they are intended and to assure their consistency with the purposes of Title X. Oversight responsibility for the I&E committee(s) rests with the grantee. The grantee may delegate the I & E operations for the review and approval of materials to delegate/contract agencies.

The I&E committee(s) must:

- Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;
- Consider the standards of the population or community to be served with respect to such materials;
- Review the content of the material to assure that the information is factually correct;
- Determine whether the material is suitable for the population or community to which it is to be made available; and
- Establish a written record of its determinations [59.6].

The committee(s) may delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate project staff. However, final approval of the I& E material rests with the committee(s).

6.9 COMMUNITY PARTICIPATION, EDUCATION, AND PROJECT PROMOTION

Boards and advisory committees for family planning services should be broadly representative of the population served.

! Community Participation

Title X grantees and delegate/contract agencies must provide an opportunity for participation in the development, implementation, and evaluation of the project (1) by persons broadly representative of all significant elements of the population to be served, and (2) by persons in the community knowledgeable about the community's needs for family planning services [59.5(b)(10)].

The I& E advisory committee may serve the community participation function if it meets the above requirements, or a separate group may be identified. In either case, the grantee project plan must include a plan for community participation. The community participation committee must meet annually or more often as appropriate.

! Community Education

Each family planning project must provide for community education programs [59.5(b)(3)]. This should be based on an assessment of the needs of the community and should contain an implementation and evaluation strategy.

Community education should serve to enhance community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial.

! Project Promotion

To facilitate community awareness of and access to family planning services, projects must establish and implement planned activities whereby their services are made known to the community [59.5(b)(3)]. Projects should review a range of strategies and assess the availability of existing resources and materials. Promotion activities should be reviewed annually and be responsive to the changing needs of the community. For more information, contact the Regional Offices.

6.10 PUBLICATIONS AND COPYRIGHT

Unless otherwise stipulated, publications resulting from activities conducted under the grant need not be submitted to DHHS for prior approval. The word "publication" is defined to include computer software. Grantees should ensure that publications developed under Title X do not contain information which is contrary to program requirements or to accepted clinical practice. Federal grant support must be acknowledged in any publication. Except as otherwise provided in the conditions of the grant award, the author is free to arrange for copyright without DHHS approval of publications, films, or similar materials developed from work supported by DHHS. Restrictions on motion picture film production are outlined in the *Public Health Service Grants Policy Statement*. Any such copyrighted materials shall be subject to a royalty-free, non-exclusive, and irrevocable right of the Government to reproduce, publish, or otherwise use such materials for Federal purposes and to authorize others to do so [45 CFR 74.36][45 CFR 92.34].

6.11 INVENTIONS OR DISCOVERIES

Family planning projects must comply with Government-wide regulations, 37 CFR Part 401, which apply to the rights to inventions made under government grants, contracts and cooperative agreements.

PART II

7.0 Client Services

Projects funded under Title X must provide clinical, informational, educational, social and referral services relating to family planning to clients who want such services. All projects must offer a broad range of acceptable and effective medically approved family planning methods and services either on-site or by referral [59.5(a)(1)]. Projects should make available to clients all methods of contraception approved by the Federal Food and Drug Administration.

Part II of this document has been developed to assist grantees in determining those services which will be provided to fulfill the mission of Title X.

- Projects must provide services stipulated in the law or regulations, or which are required by these Guidelines for the provision of high quality family planning services.

- Projects may also provide those services that are intended to promote the reproductive and general health care of the family planning client population.

7.1 SERVICE PLANS AND PROTOCOLS

The service plan is the component of the grantee's project plan, as set forth in the competitive application, which identifies those services to be provided to clients under Title X by the project. As part of the project plan, all grantees must assure that delegate/contractors have written clinical protocols and plans for client education, approved by the grantee and signed by the service site Medical Director, which outline procedures for the provision of each service offered and which are in accordance with state laws. Clinical protocols must be consistent with the requirements of these Guidelines.

Under exceptional circumstances, a waiver from a particular requirement may be obtained from the Regional Office upon written request from a grantee. In submitting a request for an exception, the grantee must provide epidemiologic, clinical, and other supportive data to justify the request and the duration of the waiver.

7.2 PROCEDURAL OUTLINE

The services provided to family planning clients, and the sequence in which they are provided, will depend upon the type of visit and the nature of the service requested. However, the following components must be offered to and documented on all clients at the initial visit:

Education

- Presentation of relevant information and educational materials, based upon client needs and knowledge;

Counseling

- Interactive process in which a client is assisted in making an informed choice;

Informed Consent

- Explanation of all procedures and obtaining a general consent covering examination and treatment and, where applicable, a method specific informed consent form;

History

- Obtaining of a personal and family medical and social history;

Examination

- Performance of a physical examination and any necessary clinical procedures, as indicated;

Laboratory Testing

- Performance of routine and other indicated laboratory tests;

Follow-up & Referrals

- Planned mechanism for client follow-up;
- Performance of any necessary clinical procedures;
- Provision of medications and/or supplies as needed; and
- Provision of referrals as needed.

Return visits, with the exception of routine supply visits, should include an assessment of the client's health status, current complaints, and evaluation of birth control method, as well as an opportunity to change methods. The following components must be offered to and documented on all clients at the return visit:

History

- Updating a personal and family medical and social history;

Examination

- Performance of a physical examination and any necessary clinical procedures, as indicated;

Laboratory Testing

- Performance of routine and other indicated laboratory tests;

Follow-up & Referrals

- Planned mechanism for client follow-up;
- Performance of any necessary clinical procedures;
- Provision of medications and/or supplies as needed; and
- Provision of referrals as needed.

7.3 EMERGENCIES

Emergency situations involving clients and/or staff may occur at any time. All projects must therefore have written plans for the management of on-site medical emergencies. At a minimum, written protocols must address vaso-vagal reactions, anaphylaxis, syncope, cardiac arrest, shock, hemorrhage, and respiratory difficulties. Protocols must also be in place for emergencies requiring transport, after-hours management of contraceptive emergencies, and clinic emergencies. All project staff must be familiar with these plans. Appropriate training, including training in CPR, should be available to staff.

7.4 REFERRALS AND FOLLOW-UP

Grantees must assure that delegate/contract agencies provide all family planning services listed in Section 8.0 under "Required Services," either on-site or by referral. When required services are to be provided by referral, the grantee must establish formal arrangements with a referral agency for the provision of services and reimbursement of costs, as appropriate.

Agencies must have written policies/procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These policies must be sensitive to clients' concerns for confidentiality and privacy.

For services determined to be necessary but which are beyond the scope of the project, clients must be referred to other providers for care. When a client is referred for non-family planning or emergency clinical care, agencies must:

- Make arrangements for the provision of pertinent client information to the referral provider. Agencies must obtain client's consent to such arrangements, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality;

- Advise client on their responsibility in complying with the referral; and

- Counsel client on the importance of such referral and the agreed upon method of follow-up.

Efforts may be made to aid the client in identifying potential resources for reimbursement of the referral provider, but projects are not responsible for the cost of this care. Agencies must maintain a current list of health care providers, local health and human services departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs to be used for referral purposes. Whenever possible, clients should be given a choice of providers from which to select.

8.0 Required Services

The services contained in this section must be provided by all projects funded under Title X.

The client's written informed voluntary consent to receive services must be obtained prior to the client receiving any clinical services. In addition, if a client chooses a prescription method of contraception, a method-specific consent form must be obtained and updated routinely at subsequent visits to reflect current information about that method.

8.1 CLIENT EDUCATION

Grantees and/or delegate/contract agencies must have written plans for client education that include goals and content outlines to ensure consistency and accuracy of information provided. Client education must be documented in the client record. The education provided should be appropriate to the client's age, level of knowledge, language, and socio-cultural background and be presented in an unbiased manner. A mechanism to determine that the information provided has been understood should be established.

Education services must provide clients with the information needed to:

- Make informed decisions about family planning;
- Use specific methods of contraception and identify adverse effects;
- Perform breast/testicular self examination;
- Reduce risk of transmission of sexually transmitted diseases and Human Immunodeficiency Virus (HIV);
- Understand the range of available services and the purpose and sequence of clinic procedures; and
- Understand the importance of recommended screening tests and other procedures involved in the family planning visit.

Clients should be offered information about basic female and male reproductive anatomy and physiology, and the value of fertility regulation in maintaining individual and family health. Additional education should include information on reproductive health and health promotion/disease prevention, including nutrition, exercise, smoking cessation, alcohol and drug abuse, domestic violence and sexual abuse.

! Method-Specific Informed Consent

Written informed consent, specific to the contraceptive method, must be signed before a prescription contraceptive method is provided. Prior to implementation, informed consent forms should be approved by the service site Medical Director.

The consent forms must be written in a language understood by the client or translated and witnessed by an interpreter. To provide informed consent for contraception, the client must receive information on the benefits and risks, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the contraceptive method chosen. Specific education and consent forms for the contraceptive method provided must be part of

the project's service plan.

The signed informed consent form must be a part of the client's record. All consent forms should contain a statement that the client has been counseled, provided with the appropriate informational material, and understands the content of both. The method-specific consent form should be renewed and updated when there is a major change in the client's health status or a change to a different prescriptive contraceptive method.

Federal sterilization regulations [42 CFR Part 50, Subpart B], which address informed consent requirements, must be complied with when a sterilization procedure is performed or arranged for by the project (see Attachment C).

8.2 COUNSELING

The primary purpose of counseling in the family planning setting is to assist clients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods and services. The counseling process is designed to help clients resolve uncertainty, ambivalence, and anxiety about reproductive issues and to enhance their capacity to arrive at a decision that reflects their considered self-interest.

The counseling process involves mutual sharing of information. Persons who provide counseling should be knowledgeable, objective, nonjudgmental, sensitive to the rights and differences of clients as individuals, culturally aware and able to create an environment in which the client feels comfortable discussing personal information. The counselor must be sufficiently knowledgeable to provide accurate information regarding the benefits and risk, safety, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the various contraceptive methods. Additionally, the counselor should be knowledgeable about the other services offered by the agency. Documentation of counseling must be included in the client's record.

! Method Counseling

Method counseling refers to an individualized dialogue with a client that covers the following:

- Results of physical exam and lab studies;
- Effective use of contraceptive methods, including natural family planning (NFP), and the benefit and efficacy of the methods;
- Possible side effects/complications;
- How to discontinue the method selected and information regarding back-up

method use, including the use of certain oral contraceptives as post-coital emergency contraception;

- Planned return schedule;
- Emergency 24-hour telephone number;
- Location where emergency services can be obtained; and
- Appropriate referral for additional services as needed.

! Sexually Transmitted Disease (STD) and HIV Counseling

All clients must receive thorough and accurate counseling on STDs and HIV. STD/HIV counseling refers to an individualized dialogue with a client in which there is discussion of personal risks for STDs/HIV, and the steps to be taken by the individual to reduce risk, if necessary. Persons found to have behaviors which currently put them at risk for STD/HIV must be given advice regarding risk reduction and must be advised whether clinical evaluation is indicated. All projects must offer, at a minimum, education about HIV infection and AIDS, information on risks and infection prevention, and referral services. On an optional basis, clinics may also provide HIV risk assessment, counseling and testing by specially trained staff. When the project does not offer these optional services, the project must provide the client with a list of health care providers who can provide these services.

8.3 HISTORY, PHYSICAL ASSESSMENT, AND LABORATORY TESTING

! History

At the initial comprehensive clinical visit, a complete medical history must be obtained on all female and male clients. Pertinent history must be updated at subsequent clinical visits. The comprehensive medical history must address at least the following areas:

- Significant illnesses; hospitalizations; surgery; blood transfusion or exposure to blood products; and chronic or acute medical conditions;
- Allergies;
- Current use of prescription and over-the-counter medications;
- Extent of use of tobacco, alcohol, and other drugs;

- Immunization and Rubella status;
- Review of systems;
- Pertinent history of immediate family members; and
- Partner history
  - injectable drug use
  - multiple partners
  - risk history for STDs and HIV
  - bisexuality.

Histories of reproductive function in female clients must include at least the following:

- Contraceptive use past and current (including adverse effects);
- Menstrual history;
- Sexual history;
- Obstetrical history;
- Gynecological conditions;
- Sexually transmitted diseases, including HBV;
- HIV;
- Pap smear history (date of last Pap, any abnormal Pap, treatment); and
- In utero exposure to diethylstilbestrol (DES).

Histories of reproductive function in male clients must include at least the following:

- Sexual history;
- Sexually transmitted diseases (including HBV);

- HIV; and
- Urological conditions.

! Physical Assessment (female)

For many clients, family planning programs are their only continuing source of health information and clinical care. Therefore, an initial complete physical examination, including height and weight, examination of the thyroid, heart, lungs, extremities, breasts, abdomen, pelvis, and rectum, should be performed.

While most client services will necessarily relate to fertility regulation, family planning clinics must provide and encourage clients to use health maintenance screening procedures, initially and as indicated. Clinics must provide and stress the importance of the following to all clients:

- Blood pressure evaluation;
- Breast exam;
- Pelvic examination which includes vulvar evaluation and bimanual exam;
- Pap smear;
- Colo-rectal cancer screening in individuals over 40; and
- STD and HIVscreening, as indicated.

Following counseling about the importance of the above preventive services, if a client chooses to decline or defer a service, this should be documented in their record. Counseling must include information about the possible health risks associated with declining or delaying preventive screening tests or procedures.

All physical examination and laboratory test requirements stipulated in the prescribing information for specific methods of contraception must be followed. Physical examination and related prevention services should not be deferred beyond 3 months after the initial visit, and in no case may be deferred beyond 6 months, unless if in the clinician's judgment there is a compelling reason for extending the deferral. All deferrals, including the reason(s) for deferral, must be documented in the client record. Project protocols should be developed accordingly.

! Physical Assessment (male)

Family planning clinics also may be an important source of reproductive health care for male clients. Physical examination should be made available to male clients, including height and weight, examination of the thyroid, heart, lungs, breasts, abdomen, extremities, genitals and rectum. Examination should also include palpation of the prostate, as appropriate, and instructions in self-examination of the testes. Clinics should stress the importance of the following to male clients:

- Blood pressure evaluation;
- Colo-rectal cancer screening in individuals over 40; and
- STD and HIVscreening, as indicated.

! Laboratory Testing

Specific laboratory tests are required for the provision of specific methods of contraception. Laboratory tests can also be important indicators of client health status and useful for diagnostic purposes. Pregnancy testing must be provided onsite. The following laboratory procedures must be provided to clients if required in the provision of a contraceptive method, and may be provided for the maintenance of health status and/or diagnostic purposes, either on-site or by referral:

- Anemia assessment
- Gonorrhea and chlamydia test
- Vaginal wetmount
- Diabetes testing
- Cholesterol and lipids
- Hepatitis B testing
- Syphilis serology (VDRL, RPR)
- Rubella titer
- Urinalysis

- HIV testing

• Notification of Abnormal Lab Results

A procedure which addresses client confidentiality must be established to allow for client notification and adequate follow-up of abnormal laboratory results.

• Other Laboratory Services or Procedures

Other procedures and lab tests may be indicated for some clients and may be provided on-site or by referral.

! Revisits

Revisit schedules must be individualized based upon the client's need for education, counseling, and clinical care beyond that provided at the initial and annual visit.

Clients selecting hormonal contraceptives, intrauterine devices (IUDs), cervical caps, or diaphragms for the first time should be scheduled for a revisit as appropriate after initiation of the method to reinforce its proper use, to check for possible side effects, and to provide additional information or clarification. A new or established client who chooses to continue a method already in use need not return for this early revisit unless a need for reevaluation is determined on the basis of the findings at the initial visit.

8.4 FERTILITY REGULATION

! Reversible Contraception

Currently, the reversible methods of contraception include barrier methods (female and male), IUDs, fertility awareness methods, natural family planning, and hormonal methods (injectables, implants, orals). Certain oral contraceptive regimens have been found by the Federal Food and Drug Administration to be safe and effective for use as postcoital emergency contraception when initiated within 72 hours after unprotected intercourse. More than one method of contraception can be used simultaneously by a client and may be particularly indicated to minimize the risks of STDs/HIV and pregnancy. Consistent and correct use of condoms should be encouraged for all persons at risk for STDs/HIV.

! Permanent Contraception

The counseling and consent process must assure that the client's decision to undergo sterilization is completely voluntary and made with full knowledge of the permanence, risks, and benefits associated with female and male sterilization procedures. Federal sterilization regulations, which address informed consent requirements, must be complied with when a sterilization procedure is performed or arranged for by the project (see Attachment C).

8.5 INFERTILITY SERVICES

Grantees must make basic infertility services available to women and men desiring such services. Infertility services are categorized as follows:

- *Level I* Includes initial infertility interview, education, physical examination, counseling, and appropriate referral.
- *Level II* Includes such testing as semen analysis, assessment of ovulatory function and postcoital testing.
- *Level III* More sophisticated and complex than Level I and Level II services.

Grantees must provide Level I infertility services as a minimum. Level II infertility services may be offered in projects with clinicians who have special training in infertility. Level III services are considered to be beyond the scope of Title X program.

8.6 PREGNANCY DIAGNOSIS AND COUNSELING

Projects must provide pregnancy diagnosis and counseling to all clients in need of this service. Pregnancy testing is one of the most common reasons for a first visit to the family planning facility. It is therefore important to use this occasion as an entry point for providing education and counseling about family planning.

Pregnancy cannot be accurately diagnosed and staged through laboratory testing alone. Pregnancy diagnosis consists of a history, pregnancy test, and physical assessment, including pelvic examination. Projects should have available a pregnancy test of high sensitivity. If the medical examination cannot be performed in conjunction with the laboratory testing, the client must be counseled as to the importance of receiving a physical assessment as soon as possible, preferably within 15 days. This can be done on-site, by a provider selected by the client, or by a provider to which the client has been referred by the project. For those clients with positive pregnancy test results who elect to continue the pregnancy, referral for early initiation of prenatal care should be made. Clients planning to carry their pregnancies

to term should be given information about good health practices during early pregnancy, especially those which serve to protect the fetus during the first three months (e.g., good nutrition, avoidance of smoking, drugs, and exposure to x-rays). For clients with a negative pregnancy diagnosis, the cause of delayed menses should be investigated. If ectopic pregnancy is suspected, the client must be referred for immediate diagnosis and therapy.

Projects must offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and
- Pregnancy termination.

If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling [59.5(a)(5)].

Clients who are found not to be pregnant should be given information about the availability of contraceptive and infertility services, as appropriate.

8.7 ADOLESCENT SERVICES

Adolescent clients require skilled counseling and age-appropriate information. Appointments should be available to them for counseling and clinical services as soon as possible.

Adolescents seeking contraceptive services must be informed about all methods of contraception. Abstinence as well as contraceptive and safer sex practice options to reduce risks for STD/HIV and pregnancy must be discussed with all adolescents. It is important not to assume that adolescents are sexually active simply because they have come for family planning services. As the contraceptive needs of adolescents frequently change, counseling should prepare them to use a variety of methods effectively.

Adolescents must be assured that the counseling sessions are confidential and, if follow-up is necessary, every attempt will be made to assure the privacy of the individual. However, counselors should encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on resisting attempts to coerce minors into engaging in sexual activities. Title X projects may not require written consent of parents or guardians for the provision of services to minors. Nor can the project notify parents or guardians before or after a minor has requested and received Title X family planning services.

8.8 IDENTIFICATION OF ESTROGEN-EXPOSED OFFSPRING

The children of women who received DES or similar hormones during pregnancy may have abnormalities of their reproductive systems or other fertility related risks. As part of the medical history, clients born between 1940 and 1970 should be asked if their mothers took estrogens during pregnancy. Clients prenatally exposed to exogenous estrogens should receive information/education and special screening either on-site or by referral.

9.0 Related Services

The following related health services, which can improve quality of care, may be offered if skilled personnel and equipment are available.

9.1 GYNECOLOGIC SERVICES

Family planning programs should provide for the diagnosis and treatment of minor gynecologic problems so as to avoid fragmentation or lack of health care for clients with these conditions. Problems such as vaginitis or urinary tract infection may be amenable to on-the-spot diagnosis and treatment, following microscopic examination of vaginal secretions or urine. More complex procedures, such as colposcopy, may be offered, provided that clinicians performing these services have specialized training.

9.2 SEXUALLY TRANSMITTED DISEASES (STD) AND HIV/AIDS

The increasing incidence and prevalence of STDs, particularly among adolescents, requires that family planning projects increase their efforts to provide education and information about the more common STDs and HIV/AIDS. Projects should make available detection and treatment of the more common STDs. At-risk clients should be urged to undergo examination and treatment as indicated, either directly or by referral. When treatment is provided on-site, appropriate follow-up measures must be undertaken.

Gonorrhea and chlamydia tests must be available for clients requesting IUD insertion. Tests for gonorrhea, syphilis, chlamydia and HIV should be provided as indicated by client request or evidence of increased risk for infection.

Grantees and/or delegate contract agencies must comply with state and local STD reporting requirements.

9.3 SPECIAL COUNSELING

Clients should be offered appropriate counseling and referral as indicated regarding future planned pregnancies, management of a current pregnancy, and other individual concerns (e.g., substance use and abuse, sexual abuse, domestic violence, genetic issues, nutrition, sexual concerns, etc.) as indicated. Preconceptional counseling should be provided if the client's history indicates a desired pregnancy in the future.

9.4 GENETIC INFORMATION AND REFERRAL

Basic information regarding genetic conditions should be offered to family planning clients who request or are in need of such services. Extensive genetic counseling and evaluation is beyond the scope of the Title X program. Referral systems should be in place for those who require further genetic counseling and evaluation

9.5 HEALTH PROMOTION/DISEASE PREVENTION

Family planning programs should, whenever possible, provide or coordinate access to services intended to promote health and prevent disease. Programs are encouraged to assess the health problems prevalent in the populations they serve and to develop strategies to address them.

9.6 POSTPARTUM CARE

Family planning programs may provide postpartum care in collaboration with local agencies or institutions which provide prenatal and/or intrapartum care. If a family planning program undertakes responsibility for postpartum care, such care should be directed toward assessment of the woman's physical health, initiation of contraception if desired, and counseling and education related to parenting, breast feeding, infant care, and family adjustment.

10.0 Clinic Management

10.1 EQUIPMENT AND SUPPLIES

Equipment and supplies must be appropriate to the type of care offered by the project. Projects are expected to follow applicable Federal and state regulations regarding infection control.

10.2 PHARMACEUTICALS

Agencies must be operated in accordance with Federal and state laws relating to security and record keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals must be conducted in accordance with state pharmacy laws and professional practice regulations.

It is essential that each facility maintain an adequate supply and variety of drugs and devices to effectively manage the contraceptive needs of its clients. Projects should also ensure access to other drugs or devices that are necessary for the provision of other medical services included within the scope of the Title X project.

10.3 MEDICAL RECORDS

Projects must establish a medical record for every client who obtains clinical services. These records must be maintained in accordance with accepted medical standards and State laws with regard to record retention. Records must be:

- Complete, legible and accurate, including documentation of telephone encounters of a clinical nature;
- Signed by the clinician and other appropriately trained health professionals making entries, including name, title and date;
- Readily accessible;
- Systematically organized to facilitate prompt retrieval and compilation of information;
- Confidential;
- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use; and
- Available upon request to the client.

! Content of the Client Record

The client's medical record must contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results. The required content of the medical record includes:

- Personal data;
- Medical history, physical exam, laboratory test orders, results, and follow-up;
- Treatment and special instructions;
- Scheduled revisits;
- Informed consents;
- Refusal of services; and
- Allergies and untoward reactions to drug(s) recorded in a prominent and specific location.

The record must also contain reports of clinical findings, diagnostic and therapeutic orders, and documentation of continuing care, referral, and follow-up. The record must allow for entries by counseling and social service staff. Projects should maintain a problem list at the front of each chart listing identified problems to facilitate continuing evaluation and follow-up. Client financial information should be kept separate from the client medical record. If included in the medical record, client financial information should not be a barrier to client services.

! Confidentiality and Release of Records

A confidentiality assurance statement must appear in the client's record. The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality [59.11]. HIV information should be handled according to law, and kept separate whenever possible. When information is requested, agencies should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form which does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care.

10.4 QUALITY ASSURANCE AND AUDIT

A quality assurance system must be in place that provides for ongoing evaluation of project personnel and services. The quality assurance system should include:

- An established set of clinical, administrative and programmatic standards by which conformity would be maintained;
- A tracking system to identify clients in need of follow-up and/or continuing care;
- Ongoing medical audits to determine conformity with agency protocols;
- Peer review procedures to evaluate individual clinician performance, to provide feedback to providers, and to initiate corrective action when deficiencies are noted;
- Periodic review of medical protocols to insure maintenance of current standards of care;
- A process to elicit consumer feedback; and
- Ongoing and systematic documentation of quality assurance activities.

Title X Family Planning Services
Program Review Tool: FINANCIAL Section

U.S. Department of Health & Human Services
Office of Population Affairs

FINANCIAL MANAGEMENT: The Grantee/sub-recipient[1] maintains a financial management system consistent with Title X and Federal grant requirements.

The Financial Section of the Program Review is based on the following Title X and other Federal grant requirements:

- Title X Legislation and Title X Implementing Regulations, 42 CFR Part 59
- Program Guidelines for Family Planning Project Grants for Family Planning Services, 2001
- OPA Program Instructions: 11-01; 08-01; 05-03; 05-02; 97-1
- Federal Register Notice, Provision of Abortion Related Services in Family Planning Projects (65 Fed. Reg. 41281)
- HHS Grant Policy Statement 2007
- Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education., Hospitals, Other Nonprofit Organizations, and Commercial Organizations, 45 CFR Part 74
- Uniform Administrative Requirements for Grants and Cooperative Agreement to State, Local and Tribal Governments, 45 CFR Part 92
- Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations, OMB Circular A-110
- Cost Principles for State, Local and Indian Tribal Governments, 2 CFR Part 225, OMB Circular A-87
- Cost Principles for Non-Profit Organizations, 2 CFR Part 230, OMB Circular A-122
- Federal Register Notices related to Veterans Health Care Act of 1992, Title VI -- Drug Pricing Agreements SEC. 601, 602 Treatment of Prescription Drugs Procured by Department of Veterans Affairs or Purchased by Certain Clinics and Hospitals, 340B
- Generally Accepted Government Audit Standards (GASAS)
- Audits of States, Local Governments, and Non-Profit Organizations, OMB Circular A-133
- Appropriate State Not for Profit Corporations Act
- Organization's Articles of Incorporation and By-Laws
- Generally Accepted Internal Control Procedures

[1] Flow-down of Requirements under Sub-awards and Contracts under HHS Grants: The terms and conditions in the HHS Grants Policy Statement apply directly to the recipient of HHS funds. The recipient is accountable for the performance of the project, program or activity; the appropriate expenditure of funds under the award; and all other obligations of the recipient, as cited in the Notice of Grant Award. In general, the requirements that apply to the recipient, including public policy requirements, also apply to sub-recipients and contractors under grants, unless an exception is specified. *(HHS Grant Policy Statement, January 1, 2007)*

An appropriate financial management system includes compliance with the criteria listed in this section of the Program Review tool. Program Review consultants may review the documents listed below (for the current budget year and past two budget years) to aid in assessing compliance:	
Budgetary Control Procedures	▪ Notice of Grant Awards ▪ SF424A, Title X program budgets (including Program Income), and budget expenditure reports ▪ Budget revisions ▪ Indirect Cost Rate Agreement or Allocation Plan for Administrative Costs ▪ Staff Time and Effort documentation and payroll records ▪ Federal PMS Cash Transaction Reports ▪ Board finance committee meeting minutes ▪ Sub-recipient agency expenditure reports
Accounting Systems and Reports	▪ Accounting/Internal Control policies and procedures and accounting system documentation (Fiscal Policy Manual) ▪ Independent Audit Reports for grantee and sub-recipients ▪ Financial Status Reports ▪ General ledger reports and financial statements ▪ Payment Management System records ▪ Internal control documents
Charges, Billing and Collection Policies and Procedures	▪ Grantee/sub-recipient policies and procedures for Charges, Income Verification, Billing & Collection ▪ Client Visit Records ▪ Grantee and sub-recipient: Cost Analyses; Schedule of Discounts; Charges for Services and Supplies; Client Billing/Receipt Statements; Bills to Third Parties ▪ Grantee Fiscal Management Auditing/Review tool

Procurement/Purchasing Procedures and Property Management	▪ Grantee and sub-recipient polices and procedures for procurement of services, equipment and supplies ▪ Sub-recipient agency contracts, sub-recipient allocation formula, sub-recipient funding allocation or schedule and performance data (FPAR) ▪ Sub-recipient agency fiscal monitoring instruments and reports ▪ Inventory system records related to supplies, medications and equipment purchased with Title X funds ▪ Grantee and sub-recipient records of physical inventory for equipment and supplies
Fiscal Monitoring Information	▪ Grantee policies/procedures/schedules/reports and/or tools for fiscal monitoring of sub-recipient agencies

Title X Family Planning Services
Program Review Tool: FINANCIAL Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
1. Budgetary control procedures meet Title X and Federal grant requirements				*Write/Type Comments in the space below*
a) Grantee uses a budget to control its fiscal operations *(45 CFR 74.21; 45 CFR 92.20)*	M			
b) There is a separate budget applicable to Title X project *(45 CFR 74.21; 45 CFR 92.20)*	M			
c) The governing authority approves the grantee budgets *(Appropriate State Not for Profit Corporations Act; Organization's Articles of Incorporation and By-Laws)*	S			
d) The Grantee operating budget for the Title X project is consistent with the approved budget *(45 CFR 74.21; 45 CFR 92.20)*	M			
e) The Chief Financial Officer or designee monitors the approved Title X budget expenditures *(45 CFR 74.21; 45 CFR 92.20)*	M			
f) The Grantee requests a budget revision when required, including: (1) Change in Project scope or objective (2) Change in key personnel, and (3) When sub-awarding or contracting work not approved in NGA *(45 CFR 74.25; 45 CFR 92.30)*	M			
g) The grantee has appropriate cost centers to track and validate costs applicable to any NGA special conditions and/or special projects (i.e., HIV, project service expansion, etc.) *(45 CFR 74.21; 45 CFR 92.20)*	M			
h) There is no evidence of Grantee or sub-recipient financial support of non-Title X activities using Title X funds *(Title X Statute, Section 1008; 65 Fed. Reg. 41281)*	M			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
i) The allocation of Administrative expense is direct or indirect *(2 CFR 225 Apps. C & E; 2 CFR 230 App. A).*				
(1) If the Grantee claims indirect costs:				
(a) Grantee has a Federally approved negotiated indirect rate (IDC) agreement for Administrative expenses (i) Is the IDC rate applied to salaries? (ii) Is the IDC rate applied to total direct costs? (iii) Is there another application of the IDC rate? Specify **OR**	O			
(b) Grantee has an accepted Administrative cost allocation plan with HHS or other cognizant Federal agency in order to claim indirect costs *(2 CFR 225 Apps. C & E; 2 CFR 230 App. A)*	O			
Note: If grantee does not use an IDC rate, inquire, review and document the allocation method used for charging administrative costs, if applicable *(2 CFR 225 Apps. C & E; 2 CFR 230 App. A)*	M			
j) Proper documentation of all income and expenditures is maintained *(45 CFR 74.21; 45 CFR 92.20)*	M			
k) Program income earned during the project period is used to further the objectives of the program *(45 CFR 74.24; 45 CFR 92.25)*	M			
l) Charges of salaries/wages to the award are reflective of Title X activities. Time and effort documentation assures proper validation *(2 CFR 225 App. B.8 h.; 2 CFR 230 App. B.8 m.)*	M			
m) Charges to the award, including staff time and effort documentation, reconcile to PMS Transaction Reports and/or to the reconciliation of Federal draw-down actions *(45 CFR 74. 21; 45 CFR 92.20)*	M			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
2. Accounting Systems and Reports are consistent with Title X and Federal grant requirements				*Write/Type Comments in the space below*
a) **Grantee fiscal oversight and audits**				
(1) Grantee and sub-recipient agencies have written accounting policies and procedures for determining reasonableness, allocability and allowablility of costs in accordance with Federal cost principles *(45 CFR 74.21; 45 CFR 92.20)*	**M**			
(2) Grantee monitors sub-recipient agencies as necessary to ensure Federal compliance with laws and regulations, and grant provisions *(45 CFR 74.51; 45 CFR 92.40; OMB A-133-400(d))*	**M**			
(3) Audits of Grantees/sub-recipients are conducted in accordance with provisions of OMB Circular A-133 *(OMB A-133;45 CFR 74.26; 45 CFR 92.26)*	**M**			
(a) Grantee secures independent audits from its sub-recipients, including management letter annually *(OMB A-133, 320(e) and 400(d))*	**M**			
(b) Auditors meet established criteria for qualifications and independent audits *(GAGAS standards and OMB A-133, 305)*	**M**			
(c) Financial records must be available for review or audit by appropriate officials of the Federal agency *(OMB A-133; 45 CFR 74.53; 45 CFR 92.42)*	**M**			
b) **Maintenance of internal controls** Internal controls over Federal programs are maintained that provide reasonable assurance that the Grantee is managing the Federal award in compliance with applicable laws and regulations *(OMB A-133, 300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(1) Separation of duties No one person has complete control over more than one key function or activity *(e.g., authorizing, approving, certifying, disbursing, receiving, or reconciling)* *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			
(2) Authorization and approval Transactions are properly authorized and consistent with Federal requirements *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			
(3) Custodial and security arrangements Responsibility for physical security/custody of assets is separated from record keeping/accounting for those assets *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			
(a) Unauthorized access to assets and accounting records is prevented				
c) **Review and reconciliation** Systems are in place that allow for proper review and reconciliation of grant funds				
(1) Accounting records and documents are examined by employees who have sufficient understanding of the accounting and financial system to verify that recorded transactions actually took place and were made in accordance with policy and procedures *(OMB A-133,300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**S**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(2) Grantee accounting records and documentation are compared with accounting system reports and financial statements to verify their reasonableness, accuracy, and completeness *(OMB A-133,300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**S**			
(3) Control principles are applied to all departmental operations (i.e., payroll; purchasing approval, receiving, and disbursement approval; equipment and supplies inventories; cash receipts; petty cash and change funds; billing; and accounts receivable) *(OMB A-133,300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			
(4) Methods of drawing funds from the Federal Payment Management System and reconciliation of actual Title X expenditures comply with Federal requirements *(45 CFR 74.21; 45 CFR 92.20)*	**M**			
(5) Grantee reconciles Title X cash receipts/collections to accounting system on either a daily or monthly basis *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**S**			
d) **Fiscal reports**				
(1) Grantee submitted the Financial Status Report (SF-269) for the last budget period on time (90 days after budget period ended) *(45 CFR 74.52; 45 CFR 92.41)*	**M**			
(2) The Financial Status Report (SF-269) was completed in accordance with OGM guidelines and requirements *(45 CFR 74.52; 45 CFR 92.41)*	**M**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
3. Charges, billing, and collection procedures meet Title X and Federal grant requirements *(42 CFR 59.2,59.5 (6)-(9); Title X Guidelines: Section 6.3; OPA Program Instructions 08-01 and 97-1)*				*Write/Type Comments in the space below*
a) Grantee is responsible for implementation of policies and procedures for charging, income verification, billing, and collecting funds for services provided by the project *(Title X Guidelines: Section 6.3)*	**M**			
(1) Policies and procedures are approved by the Grantee's governing authority/board and Regional Office *(Title X Guidelines: Section 6.3)*	**S**			
(2) The manner in which the above policies/procedures are implemented ensures that priority for services is to persons from low-income families and ensures that the inability to pay is not a barrier to the receipt of services *(45 CFR 59.5 (a) (6-8); OPA 08-01; OPA 97-1)*	**M**			
b) Charges, billing and collection system has the following characteristics:				
Charges				
(1) Charges are based on a cost analysis *(42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3)*	**M**			
(2) A schedule of discounts *(SOD)* has been developed and properly implemented *(42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3)*. This includes:	**M**			
(a) Eligibility for discounts is documented in client's financial record *(Title X Guidelines: Section 6.3)*	**M**			
(b) SOD has sufficient proportional increments to ensure income is not a barrier to service *(Title X Guidelines: Section 6.3)*	**M**			
(c) SOD is used for family incomes between 101–250% of FPL *(42 CFR 59.5(a)(8))*	**M**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(d) Eligibility for discounts for minors who receive confidential services is based on the income of the minor *(42 CFR 59.2 – Definitions; OPA 97-1)*	M			
(3) Grantee ensures that there is a mechanism is in place throughout the Title X project for waiving fees of individuals who, for good cause, are unable to pay but do not qualify for the SOD *(42 CFR 59.2 – Definitions; Guidelines: Section 6.3)*	M			
(4) Clients at or below 100% of FPL are not charged for Title X services *(Title X Statute, Section 1006; 42 CFR 59.5(a)(7))*	M			
(5) Client income is re-evaluated annually *(Title X Guidelines: Section 6.3)*	S			
(6) There is no evidence clients are denied services or are subjected to variation in quality of services because of the inability to pay *(Guidelines: Section 6.3)*	M			
Billing *(42 CFR 59.5 (a) (9) Title X Guidelines: Section 6.3)*				
(1) At the time of services, clients responsible for paying are given bills directly	M			
(a) Bills to clients show the total charges, as well as any allowable discounts	M			
(b) Where a third party is responsible, bills are be submitted to that party	M			
(c) Third parties authorized or legally obligated to pay for clients at or below 100% FPL are properly billed	M			
(d) Third party bills show total charges without any discounts	M			
(e) Bills to third parties show total charges without applying any discount unless there is a contracted reimbursement rate that must be billed per the third party agreement	M			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(2) When reimbursement from Title XIX or Title XX of Social Security Act is available, a written agreement at either the Grantee level or sub-recipient level is required *(42 CFR 59.5 (a) (9))*	**M**			
Collections *(Title X Guidelines: Section 6.3)*				
(1) Reasonable efforts to collect charges without jeopardizing client confidentiality are made	**M**			
(2) A method for "aging" outstanding accounts has been established	**M**			
(3) There is no evidence that clients are pressured to make donations	**M**			
(a) Donations are not a prerequisite for provision of any service or supply	**M**			
(b) Billing requirements set out above are not waived because of client donations	**M**			
(4) Projects offering services not required by Title X should seek other funding for such services before applying Title X funds to those activities	**S**			

Title X Family Planning Services
Program Review Tool: FINANCIAL Section

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
4. Procurement /Inventory Control/Property Management meet Title X and Federal grant requirements.				*Write/Type Comments in the space below*
a) Grantee and sub-recipient agencies have written procurement policies and procedures for procurement of supplies, equipment and other services *(45 CFR 74.44; 45 CFR 92.36)*	**M**			
b) All procurement transactions conducted (including those for sub-recipient services) provide for practical, open and free competition (Competitive process is used for purchasing) *(45 CFR 74.43; 45 CFR 92.36 (12) (C); 42 CFR 59.5)*	**M**			
c) Grantee and sub-recipient agencies maintain records that detail the history of a procurement *(45 CFR 74.21 & 74.41; 45 CFR 92.20 & 92.36 (b) (9); Accepted Internal Control Procedures)*	**S**			
d) Grantee has proper segregation between requisition, procuring, receiving and payment functions *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			
e) Grantee/sub-recipient have inventory system to control purchase, use, reordering of medications and supplies *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures; State Pharmacy Regulations)*	**M**			
f) Grantee has adequate safeguards for assuring that supplies purchased through the Federal Drug Pricing Program (340B) are provided only to clients served in the Title X project *(Veterans Health Care Act of 1992)*	**M**			
g) Grantee has established controls over access to medications and supplies *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			

Title X Family Planning Services
Program Review Tool: FINANCIAL Section

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
4. Procurement /Inventory Control/Property Management meet Title X and Federal grant requirements.				*Write/Type Comments in the space below*
h) Grantee periodically confirms inventory with actual inventory counts and provides credit/debit adjustment to Title X charges to reflect actual costs *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**M**			
i) Grantee evaluates contractor performance and documents if contractors have met the terms, conditions and specifications of the contract *(45 CFR 74.47; 45 CFR 92.36)*	**M**			
j) Grantee maintains a property management system (Fixed Assets) *(45 CFR 74.34; 45 CFR 92.32)*	**M**			
k) Property management system includes: asset description, ID number, acquisition date, current location and Federal share of the asset *(45 CFR 74.34; 45 CFR 92.32)*	**M**			
(1) Grantee performs a physical inventory of equipment at least once every 2 years (Records shall be investigated to determine the cause of any differences). *(45 CFR 74.34; 45 CFR 92.32)*	**M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

ADMINISTRATION: The Grantee/sub-recipient maintains administrative systems and processes consistent with Title X and other Federal grant requirements.

The Administrative Section of the Program Review is based on the following Title X and other Federal grant requirements:

- Title X Legislation and Title X Implementing Regulations, 42 CFR Part 59
- Program Guidelines for Family Planning Project Grants for Family Planning Services, 2001
- OPA Program Instructions: 11-01; 09-09; 08-01; 06-01; 99-1; 98-1
- Federal Register Notice, Provision of Abortion Related Services in Family Planning Projects (65 Fed. Reg. 41281)
- Trafficking Victims Protection Act of 2000 (Pub. L. No. 106-386), as amended, and 18 U.S.C. 1591
- Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education., Hospitals, Other Nonprofit Organizations, and Commercial Organizations, 45 CFR Part 74
- Uniform Administrative Requirements for Grants and Cooperative Agreement to State, Local and Tribal Governments, 45 CFR Part 92
- HHS Grants Policy Statement
- The Privacy Act of 1974 5 U.S.C § 552a
- Basic HHS Policy for the Protection of Human Subjects, 45 CFR Part 46
- Title VI, Civil Rights Act, 1964 and Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
- Office of Civil Rights Nondiscrimination on Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance, 45 CFR Part 84
- Occupational Safety and Health Administration Standards, 29 CFR 1910 Subpart E Exit routes, Emergency Action Plans and Fire Plans and Subpart H Hazardous Waste Operations and Emergency Response
- Rehabilitation Act of 1974, Section 504
- Title I Americans with Disabilities Act
- Age Discrimination Act of 1975
- Title IX of the Education Amendments of 1972
- HHS OASH Grant Application
- OPA/OFP Guidelines for Title X Grant Application Preparation
- Family Planning Annual Report -Forms and Instructions
- Appropriate State Not for Profit Corporations Act

Appropriate administrative policies and practices include compliance with the criteria listed in this section of the Program Review tool. Program Review consultants may review the documents listed below to aid in assessing compliance:

- Organizational chart(s)
- Job descriptions – medical director, clinicians and key staff members
- Administrative/clinical policies and procedures
- Personnel policies
- Copies of 3-5 sub-recipient agency agreements
- Grantee policies/procedures/schedules/reports and/or tools for monitoring of sub-recipient agencies
- Program Progress Reports and Work Plans for the current year and past two years
- Current Title X Program Evaluation Plan
- Service site information (such as locations and hours of operations)
- Administrative/management policies and procedures
- Emergency/disaster plans
- LEP related policies and procedures
- Family Planning Annual Report for the past three calendar years
- Grantee policies for compliance with State reporting laws
- Articles of Incorporation, By-laws, current year Board of Directors membership list, Board orientation process, Board meeting minutes, as appropriate
- Policies and procedures for meeting Privacy and HIPAA Regulations
- Insurance policy documents
- Approval documentation for Family Planning research

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
A. Voluntary Participation				
1. Grantee/sub-recipient meets Title X regulations for client voluntary participation				*Write/Type Comments in the Space Below*
a) Grantee/sub-recipient Title X services are provided solely on a voluntary basis *(Title X Statute, Sections 1001 & 1007; 42 CFR 59.5 (a) (2); Title X Guidelines: Section 5.1)*	**M**			
b) There is no indication that clients are subject to coercion in use of any particular method of family planning *(42 CFR 59.5 (a) (2); Title X Guidelines: Section 5.1)*	**M**			
c) Client's acceptance of a family planning service is not a prerequisite to eligibility or receipt of any other service offered by the Grantee/sub-recipient *(Title X Statute, Section 1007; 42 CFR 59.5 (a) (2); Title X Guidelines: Section 5.1)*	**M**			
d) Project personnel must be informed that they may be subject to prosecution if they coerce or they try to coerce any person to under go abortion or sterilization procedures *(42 CFR 59.5 (2) footnote 1; Title X Guidelines: Section 5.1)*	**M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance	C	NC	Comments/Documentation/Explanation
B. Confidentiality			
1. Grantee/sub-recipient meets confidentiality requirements of Title X. *(42 CFR 59.11; Title X Guidelines as listed below)* • Staff disclosures *(Tile X Guidelines: 5.2)* • Client billing *(Title X Guideline: Section 6.3)* • Client privacy and the facility *(Title x Guidelines: Section 6.4)* • Employee records *(Tile X Guidelines: Section 6.5)* • Referrals and follow-up results *(Title X Guidelines: Section 7.4)* • Reporting abnormal test results *(Title X Guidelines: Section 8.3)* • Adolescent Services *(Title X Guidelines: Section 8.7)* • Medical records *(Title X Guidelines: Section 10.3)*			*Write/Type Comments in the space below*
a) Policies are in place regarding agency's compliance with the Privacy Act **M** b) No information obtained by staff is disclosed without written consent, except as required by law **M** c) Grantee/sub-recipient ensures that summary, statistical, or other forms of information disclosed, without a client's consent, does not allow individual clients to be identified **M** d) Grantee/sub-recipient provides required Family Planning data elements such that client confidentiality is protected **M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
C. Conflict of Interest				*Write/Type Comments in the space below*
Grantee/sub-recipient has established policies to prevent employees, consultants, or members of governing/advisory bodies from using their positions for private gain as required by Title X *(45 CFR 74.42; 45 CFR 92.36; HHS Grants Policy Statement II-7; Title X Guidelines: Section 5.3)*	**M**			
D. Liability Coverage				
1. Title X recommendations for liability coverage are met by the Grantee *(Title X Guidelines: Section 5.4)*				*Write/Type Comments in the space below*
a) Grantee/sub-recipient ensures adequate liability coverage for all segments of the project funded by the grant	**S**			
b) Governing board has obtained liability coverage for its members	**S**			
E. Human Subjects Clearance (Research)				
1. Grantee/sub-recipient complies with Federal regulations regarding the use of Title X clients in research				*Write/Type Comments in the space below*
a) Grantee/sub-recipient has advised the Regional Office in writing of research projects involving Title X clients *(HHS Grant Policy Statement; Title X Guidelines: Section 5.5)*	**M**			
b) Grantee/sub-recipient acknowledges adherence to *45 CFR Part 46* and its requirements	**M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
F. Prohibition of Abortion				
1. Grantee/sub-recipient is in full compliance with the Title X Statute, Section 1008 prohibiting abortion as a method of family planning *(Title X Statute, Section 1008; 42 CFR 59.5 (a) (5); Grant Policy Statement, II-22; Title X Guidelines: Section3.3; 65 Fed. Reg. 41281)*				
a) Grantee has written policies that clearly state that none of the funds will be used in programs where abortion is a method of family planning	**M**			
b) Grantee's monitoring process assures that sub-recipients are in compliance with Title X Statute, Section 1008	**M**			
G. Structure of the Grantee/Sub-recipient				
1. Grantee maintains responsibility for quality, cost, accessibility, acceptability, reporting and performance of grant-funded activities of sub-recipient/contract agency				*Write/Type Comments in the space below*
a) Grantee has negotiated, written signed agreements with sub-recipients to provide services consistent with Title X *(45 CFR 74 Subpart C: 74.40-48, as applicable; 45 CFR Subpart C: 92.37; 42 CFR 59.5 (b) (9); Title X Guidelines: Section 6.1)*	**M**			
(1) Where sub-recipient agencies wish to subcontract responsibilities or services, a written agreement consistent with Title X and approved by Grantee is maintained by the sub-recipient *(Title X Guidelines: Section 6.1)*	**M**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
b) Grantee provides an opportunity for maximum participation by existing or potential sub-recipients in the ongoing policy decision making of the project, including input into establishing standards and guidelines *(42 CFR 59.5 (a) (10); Title X Guidelines: Section 6.1)*	**M**			
c) Grantee has established written standards and guidelines for all delegated project activities consistent with Title X and Grants Management programmatic and fiscal requirements *(Title X Guidelines: Sections 6.1 and 7.1)*	**M**			
d) Grantee must have a system to monitor and ensure sub-recipient performance conforms to the terms, conditions and specifications of the sub-recipient agreement, Title X regulations and other Federal regulations *(45 CFR Part 74.41 & 74.47; 45 CFR Part 92.37)*	**M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
H. Governance – Private Not-For-Profit Organizations Only				
1. The Grantee/sub-recipient meets requirements for a legal entity with not-for profit status *(Appropriate State Not for Profit Corporations Act; Organization's Articles of Incorporation and By-Laws)*				
a) Documentation of IRS 501 (c) (3) or other IRS not-for-profit status on file	**M**			
b) Governing Board is appropriately constituted:				
(1) The Agency has a formally constituted Board	**S**			
(2) An orientation process for new Board members is in place	**S**			
(3) The Governing Board has a set of By-Laws.	**S**			
(4) By-Laws are reviewed and revised (if necessary) by the Governing Board, annually or in accordance with the Articles of Incorporation	**S**			
(5) Board meeting minutes demonstrate the Agency operates as per By-Laws and in accordance with Title X regulations	**S**			
(6) The By-Laws address the following functions of the Governing Board: • Terms of Membership • Appointment of committees • Frequency of meetings designated • Number of members specified • Definition of a quorum outlined • Procedures for the appointment/election of officers	**S**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance	C	NC	Comments/Documentation/Explanation
I. Planning and Evaluation			
1. Grantee assesses that the project is competently and efficiently administered *(42 CFR 59.5 (b) (6) & (7); 59.7; Title X Guidelines: Section 6.2)*			*Write/Type Comments in the space below*
a) Grantee has developed goals and objectives for the project period. The goals must: (1) Be clearly stated in writing **M** (2) Be based on needs assessment **M** (3) Have specific objectives that are measurable **M** (4) Be consistent with Title X regulations **M** b) The project includes an evaluation component that identifies indicators by which the program measures achievement of objectives **M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
J. Facilities and Accessibility of Services				
1. Facilities are appropriate for Title X clients				*Write/Type Comments in the space below*
a) Facilities are geographically accessible for population served *(e.g., close to mass transit, etc.)* *(Title X Guidelines: Section 6.4)*	**S**			
Hours of operation are convenient for those seeking services (e.g., evening and or weekend hours). *(Title X Guidelines: Section 6.4)*	**S**			
Facilities are adequate to provide necessary services, are comfortable, ensure provide privacy for clients, and are designed to enhance workflow *(Title X Guidelines: Section 6.4)*	**S**			
b) Grantee has written policies regarding access to timely quality language assistance services to limited English proficient persons that are consistent with the Office of Civil Rights Policy Guidance on Prohibitions Against National Origin Discrimination As It Affects Persons With Limited English Proficiency *(Title VI, Civil Rights Act, 1964; LEP Guidance; Grants Policy Statement 2007)*	**M**			
c) Project does not discriminate on the basis of handicap and, when viewed in its entirety, the facility is readily accessible to people with disabilities *(45 CFR Part 84.4)*	**M**			
d) All Grantees, sub-recipients and Title X clinics are required to have a written plan for management of emergencies *(29 CFR 1910 Subpart E)*	**M**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
e) The clinic facilities meet applicable standards established by Federal, state, and local governments (e.g., local fire, building, and licensing codes)	M			
f) Health and safety issues within the facility fall under the authority of OSHA. Disaster plans and emergency exits are addressed under 29 CFR 1910 Subpart E *(Exit routes, Emergency Action Plan and Fire Plans)* and Subpart H (Hazardous Waste Operations and Emergency Response). The basic requirements of these regulations include:				
(a) Disaster plans (e.g., fire, bomb/terrorism, earthquake, etc.) have been developed and are available to staff	M			
(b) Staff can identify emergency escape routes	M			
(c) Staff has completed training and understands their role in an emergency or natural disaster	M			
(d) Exits are recognizable and free from barriers	M			
Note: Requirements for medical emergencies are addressed under the Clinical Services Section (Guidelines: Section 7.3)				

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
K. Personnel				
1. Grantee/sub-recipient complies with Title X requirements related to personnel				*Write/Type Comments in the space below*
a) Written personnel policies regarding nondiscrimination in recruitment, selection, performance evaluation, discipline, promotion, and termination have been established *(Title VI Civil Rights Act; Rehabilitation Act, Section 504; Title I Americans with Disabilities Act; Title X Guidelines: Section 6.5)*	**M**			
b) A formal grievance mechanism is available for all staff *(Title X Guidelines: Section 6.5)*	**M**			
c) Project staff is broadly representative of the population served *(42 CFR 59.5 (b) (10); Title X Guidelines: Section 6.5)*	**S**			
d) Project staff is sensitive to and able to deal effectively with the cultural characteristics of the client population *(42 CFR 59.5 (b) (10); Title X Guidelines: Section 6.5)*	**S**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
2. Personnel management is consistent with Title X guidance.				*Write/Type Comments in the space below*
a) An organizational chart shows clear lines of authority *(HHS OASH Grant Application; OPA/OFP Guidelines for Title X Grant Application Preparation)*	**S**			
b) Written job descriptions exist for key personnel (*HHS OASH Grant Application; OPA/OFP Guidelines for Title X Grant Application Preparation)*	**S**			
c) Project is administered by qualified program director *(42 CFR 59.5 (b) (7); Title X Guidelines: Section 6.5)*	**M**			
d) Personnel records are kept confidential *(Title X Guidelines: Section 6.5)*	**M**			
e) Grantee has protocols for client care provided under the project *(Title X Guidelines: Section 6.5)*	**M**			
f) Professional licenses are verified prior to employment and documentation of current licensure maintained *(Title X Guidelines: Section 6.5)*	**M**			
Note: Requirements for Medical Director are addressed under the Clinical Services Section (Title X Guidelines: Section 7.0.)				

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
L. Training and Technical Assistance				
1. Project meets training requirements as outlined by Title X *(42 CFR 59.5 (b) (4); OPA Program Instructions 11-01; Title X Guidelines: Section 6.6)*				*Write/Type Comments in the space below*
a) Project provides for orientation and in-service training for all project personnel (includes staffs of sub-recipients agencies and service sites)	**M**			
b) Project personnel participate in continuing education	**S**			
c) Documentation of continuing education is maintained in staff personnel records	**S**			
d) A plan and a process is in place that evaluates the scope and effectiveness of staff training program	**S**			
e) Project training plan provides for routine training of staff on Federal/State requirements for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest , as well as human trafficking *(OPA Program Instructions 11-01;06-01& 99-1)*	**M**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
M. Reporting Requirements				
1. Grantee complies with Title X reporting requirements *(45 CFR 74.51; 45 CFR 92.40; Grants Policy Statement 2007, II-86-II-89; OPA Program Instructions 11-01;Title X Guidelines: Section 6.7)*				*Write/Type Comments in the space below*
a) Grantee complies with DHHS reporting requirements:				
(1) FPAR Reporting Requirements:				
(a) There is a mechanism in place to collect all required data elements	**M**			
(b) There is a system in place for validating the data reported in the FPAR	**M**			
(c) Grantee FPAR reports and revisions are submitted by the required due dates *(Family Planning Annual Report -Forms and Instructions)*	**M**			
(2) Grantee required progress reports detail project accomplishments to date and/or describe changes and the reasons needed for the changes *(45 CFR 74.51; 45 CFR 92.40; OPHS-1; OPA/OFP Guidelines for Title X Grant Application Preparation)*	**M**			
(3) Grantee has written policies for reporting or notification of child abuse, child molestation, sexual abuse, rape or incest, as well as human trafficking *(OPA Program Instructions 11-01; 06-01& 99-1)*	**M**			
b) Organization has written Information System policies and procedures to maintain and secure electronic and hard copy records	**M**			
c) Grantee has appropriate analysis and reporting functionality	**S**			
Note: Compliance with the financial reporting is addressed in the Financial Section of this tool.				

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
N. Publications				
1. The Grantee/sub-recipient meets Title X requirements as they relate to copyright and publication material *(45 CFR 74.36; 45 CFR 92.34; Title X Guidelines: Section 6.10)*				*Write/Type Comments in the space below*
Any publications or other media developed by Grantee/sub-recipient using Federal funds acknowledge Federal grant support	**M**			
a) The Government has unrestricted use of Grantee publications funded by Title X	**M**			
b) Grantee ensures that publications developed under Title X do not contain information contrary to program requirements or accepted clinical practice	**S**			

Title X Family Planning Services
Program Review Tool: ADMINISTRATION Section

U.S. Department of Health & Human Services
Office of Population Affairs

Criteria for Title X Compliance	C	NC	Comments/Documentation/Explanation
O. Federal Assurances			
1. As a recipient of the Title X award, no evidence was found to indicate the Grantee was not in compliance with the following Federal Assurances/Certifications:			*Write/Type Comments in the space below*
a) Assurances-Non-Construction Programs *(Standard Form 424B)*, including, but not limited to: **M**			
(1) Prohibiting discrimination based on race, color, national origin *(Title VI of Civil Rights Act of 1964)* **M**			
(2) Prohibiting discrimination based on handicap *(Rehabilitation Act of 1973, Section 504)* **M**			
(3) Prohibiting discrimination based on age *(Age Discrimination Act of 1975)* **M**			
(4) Prohibiting discrimination on the basis of sex *(Title IX of the Education Amendments of 1972)* **M**			
(5) Assurance that the Grantee has:			
(a) Institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project as described in the award *(42 CFR 59.7 (4), (5) & (7); SF424 A & B)* **M**			
(b) Granted the awarding agency free access to examine all records, books, papers, and documents related to the award *(45 CFR 74.53; 45 CFR 92.42)* **M**			

Reimbursement Analysis – HB228

Legislative Presentation
April 5, 2012

geneia
Bringing new ideas to healthcare

Overview

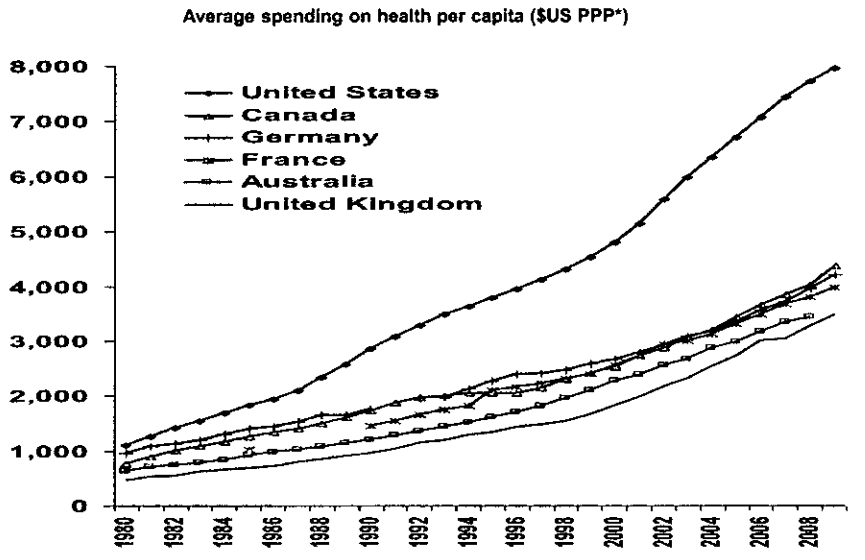
- Introduction
- Goals for Healthcare Delivery Generally and for NH Medicaid Program
- Review of Classification for Primary and Preventive Services
- Overview of Primary and Preventive Services Rendered by Planned Parenthood of Northern New England
- Overview of Cost Differentials for Services by Site of Care
- Impact of Care Shift
- Summation

Introduction

- Heather Staples Lavoie, MBA
- Chief Operating Officer for Geneia, a Health Care Consulting and Product Innovation Firm
- Business entrepreneur and 25-year veteran in health care
- Career spanning independent primary and specialty care, health plan operations, technology start-up, and reimbursement, product innovation and policy consulting
- Career focus on reimbursement design and health care value
- Presenting on behalf of Planned Parenthood of Northern New England, in conjunction with reimbursement analysis work that I am conducting on their behalf

geneia

International Comparison of Spending on Health, 1980–2009

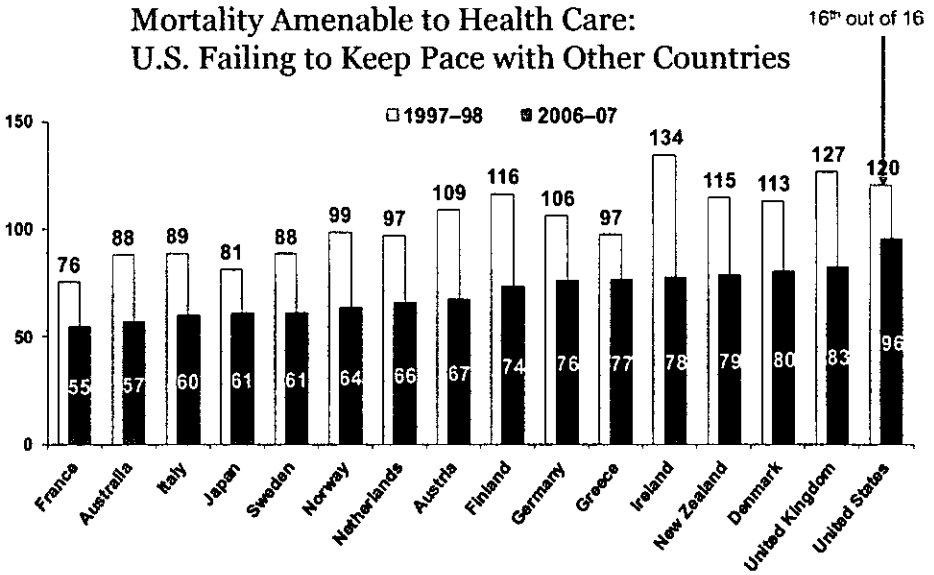


* PPP=Purchasing Power Parity. Data: OECD Health Data 2011 (database), Version 6/2011.

geneia

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011.

Mortality Amenable to Health Care: U.S. Failing to Keep Pace with Other Countries



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

geneia

Shared Health Care Goals

geneia

Medicaid Managed Care Goals

- Design and Intent of Medicaid Program is to Provide Requisite Health Care *within* a Budget to Achieve Savings
- To Achieve Value Goals, Program Design Includes:
  - Quality goals and defined measurement against those goals
  - Fixed per member per month for each payer with freedom for each payer to manage and direct care to best cost providers
  - Outcomes and access measures to ensure quality, outcomes, and access are not at the expense of cost management
  - Very strong focus on primary and preventive care as high value centers of care

geneia

Planned Parenthood of Northern NE Goals

- Program and Operational Design to Achieve Goals
  - Focus on Primary and Preventive Women's Health and Maternal Care
  - Track Rates of Preventive Services and Screenings
  - Implement Standards-Based Electronic Medical Record (NextGen) for Enhanced Tracking and Better Ability to Serve as a Medical Home
  - Provide Necessary and Immediate Access for Women's Health and Maternal Care
  - Provide Services as a Low Cost Provider

geneia

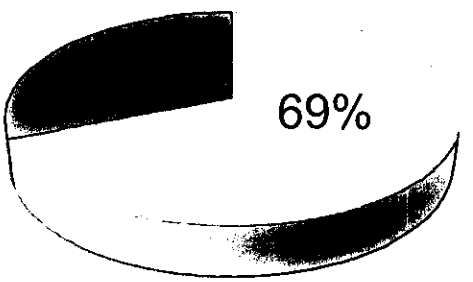
Primary and Preventive Services

- Range of CPT Codes for Primary Care Services and Preventive Screenings
- CMS and Industry-Defined Ranges of Services
- Evaluation and Management (E&M) Range of Codes Billing Requirements Include Review of Systems with Specificity:
  - Number of Systems Reviewed to Justify Visit Level
  - History (Past, Social and Family)
  - Number of Co-Morbidities
  - Amount of Data Reviewed

geneia

PPNNE Primary and Preventive Services

- For the Year 2011, Planned Parenthood of Northern New England's Total Service Mix Was As Follows:



- All Other Medical Services include a full spectrum of care including 135 different CPT Codes ranging from ultrasounds, urinalyses, laboratory tests, IUD placements, blood tests, etc.

geneia

PPNNE Primary and Preventive Services

- Total Number of Preventive and Primary Care Services Across All Payers in 2011 was 147,049
- Total Number of Services Rendered for NH Medicaid Patients in 2011 was 6,105
- Total Number of Preventive and Primary Care Services for NH Medicaid Members in 2011 was 2,855
- 47% of All NH Medicaid Visits in 2011 Were for Primary Care Services

geneia

PPNNE Primary and Preventive Services

- Sample of Top Procedure Codes - All Payers

CPT Code	CPT Code Description	Billed Units
87491	Chlamydia Screening	23,115
99213	Office Visit; Medium to Low Complexity; 15 Minutes	14,860
81025	Pregnancy Test	12,967
99202	Office Visit; Medium Complexity; 20 Minutes	9,341
99395	Periodic comprehensive preventive medicine reevaluation and management; age 18-39	8,261
88142	Cervical Cancer Screening	7,085
99214	Office Visit; Medium to High Complexity; 25 Minutes	6,057
86703	HIV Testing	5,149
99212	Office Visit; Low Complexity; 10Minutes	4,575

geneia

Potential Cost Shift for Services > 10 Units

Code	Procedure	2011 Billed Medicaid Units	High Commercial Rate	Commercial Reimbursement Amount	Medicaid Rate	Medicaid Reimbursement Amount
87591	Gonorrhea Screening	56	$94.63	$5,299.28	$34.70	$1,943.20
87491	Chlamydia Screening	56	$94.63	$5,299.28	$36.16	$2,024.96
99213	Office Visit; Medium to Low Complexity; 15 Minutes	501	$335.47	$168,070.47	$65.28	$32,705.28
81025	Pregnancy Test	717	$22.91	$16,426.47	$7.76	$5,563.92
99202	Office Visit; Medium Complexity; 20 Minutes	260	$163.04	$42,390.40	$68.33	$17,765.80
99395	Periodic comprehensive preventive medicine reevaluation and management; age 18-39	160	$227.31	$36,369.60	$40.32	$6,451.20
99214	Office Visit; Medium to High Complexity; 25 Minutes	365	$478.86	$174,783.90	$99.06	$36,156.90
86703	HIV Testing	135	$19.65	$2,652.75	$9.07	$1,224.45
99212	Office Visit; Low Complexity; 10Minutes	237	$203.11	$48,137.07	$41.18	$9,759.66
85018	Anemia Test	55	$5.50	$302.50	$2.03	$111.65
86901	Rh incompatbility Screening	14	$25.20	$352.80	$2.56	$35.84
99385	Preventative Medicine; New Patient	44	$260.68	$11,469.92	$40.32	$1,774.08
99201	New Patient Visit Level 1	32	$94.84	$3,034.88	$39.88	$1,276.16
99211	Established Patient Visit Level 1	82	$102.02	$8,365.64	$22.01	$1,804.82
99396	Periodic Exam; Established Patient	33	$248.00	$8,184.00	$40.32	$1,330.56
99203	New Patient Visit Level 3	23	$486.35	$11,186.05	$99.89	$2,297.47
99384	Preventive Medicine, New Patient-Adolescent	32	$231.32	$7,402.24	$47.04	$1,505.28
90471	Immunizations/Vaccine	27	$37.55	$1,013.85	$3.05	$82.35
			Totals	$550,741.10		$123,813.58

geneia

In Summation

- PPNNE Provides Primary and Preventive Services Consistent with Industry Standard and CMS Definitions
- PPNNE Serves as a Low Cost Provider for Services
- PPNNE Provides Essential Access to Medicaid and the Future Medicaid Expansion Population
- Shifting Reimbursement for Services to Higher Cost Providers Is Inconsistent with the Goals for Managed Medicaid and Inconsistent with the Common Goals for Health Care

geneia

Contact Information:
Heather Staples Lavoie, MBA
Chief Operating Officer for Geneia
Heather.staples@geneia.com

geneia

TRIM HDZ

224:307 Family Planning Accounting Unit; Funding Abortions Prohibited. Notwithstanding any provision of law to the contrary, the appropriation in accounting unit 05-95-90-902010-5530, family planning program, and any other funds shall not be used for evaluation, assessment, consultation about, preparation for, or provision of an abortion.

05 HEALTH AND SOCIAL SERVICES
95 DEPT OF HEALTH AND HUMAN SVCS
90 HHS: DIVISION OF PUBLIC HEALTH
902010 BUREAU OF POPULATION HEALTH & COMMUNITY SERVICES
9062 OBESITY GRANT

010 Personal Services-Perm. Classi	196,929	190,938
020 Current Expenses	16,567	16,532
026 Organizational Dues	450	450
030 Equipment New/Replacement	2,400	0
041 Audit Fund Set Aside	569	561
042 Additional Fringe Benefits	20,341	19,862
060 Benefits	88,600	92,503
070 In-State Travel Reimbursement	3,000	3,000
080 Out-Of State Travel	9,000	8,500
102 Contracts for program services	132,350	130,000
TOTAL	470,206	462,346

ESTIMATED SOURCE OF FUNDS FOR
OBESITY GRANT

FEDERAL FUNDS	426,062	417,365
GENERAL FUND	44,144	44,981
TOTAL SOURCE OF FUNDS	470,206	462,346

05 HEALTH AND SOCIAL SERVICES
95 DEPT OF HEALTH AND HUMAN SVCS
90 HHS: DIVISION OF PUBLIC HEALTH
902010 BUREAU OF POPULATION HEALTH & COMMUNITY SERVICES
5530 FAMILY PLANNING PROGRAM

010 Personal Services-Perm. Classi	97,270	94,001
020 Current Expenses	15,437	15,437
026 Organizational Dues	556	556
030 Equipment New/Replacement	1,667	1,222
041 Audit Fund Set Aside	1,453	1,450
042 Additional Fringe Benefits	4,415	4,266
060 Benefits	52,556	55,270
070 In-State Travel Reimbursement	1,500	1,500
080 Out-Of State Travel	4,900	4,900
102 Contracts for program services	1,680,844	1,614,715
TOTAL	1,860,598	1,793,317

05 HEALTH AND SOCIAL SERVICES	(CONT.)	
95 DEPT OF HEALTH AND HUMAN SVCS	(CONT.)	
90 HHS: DIVISION OF PUBLIC HEALTH	(CONT.)	
902010 BUREAU OF POPULATION HEALTH & COMMUNITY SERVICES	(CONT.)	
5530 FAMILY PLANNING PROGRAM	(CONT.)	
ESTIMATED SOURCE OF FUNDS FOR FAMILY PLANNING PROGRAM		
FEDERAL FUNDS	1,450,519	1,448,577
GENERAL FUND	410,079	344,740
TOTAL SOURCE OF FUNDS	1,860,598	1,793,317
05 HEALTH AND SOCIAL SERVICES		
95 DEPT OF HEALTH AND HUMAN SVCS		
90 HHS: DIVISION OF PUBLIC HEALTH		
902010 BUREAU OF POPULATION HEALTH & COMMUNITY SERVICES		
5896 ACA HOME VISITING		
010 Personal Services-Perm. Classi	44,084	44,385
020 Current Expenses	12,337	12,337
022 Rents-Leases Other Than State	350	350
026 Organizational Dues	500	500
041 Audit Fund Set Aside	477	479
042 Additional Fringe Benefits	3,721	3,746
060 Benefits	24,466	26,126
066 Employee Training	2,000	2,000
070 In-State Travel Reimbursement	750	750
080 Out-Of State Travel	8,600	8,600
102 Contracts for program services	375,000	375,000
TOTAL	472,285	474,273
ESTIMATED SOURCE OF FUNDS FOR ACA HOME VISITING		
FEDERAL FUNDS	472,285	474,273
TOTAL SOURCE OF FUNDS	472,285	474,273

OFFICE OF LEGISLATIVE BUDGET ASSISTANT

State House, Room 102
Concord, NH 03301
271-3161

DATE April 2, 2012

FROM **Mike Hoffman,**
Senior Budget Officer

SUBJECT **Family Planning Funds**

TO **Senator Jeb Bradley**

During the biennial budget process for fiscal years 2012 and 2013, language was added to the trailer bill to prohibit the use of public funds for abortions or abortion related services. The accounting unit referenced in Chapter 224:307, Laws of 2011 was identified by the Department of Health and Human Services as the only account in the budget that funds contracts for family planning services. The federal funds included in the account are federal Title X Family Planning Funds. In the fiscal note worksheet for HB228, the Department indicates federal Title X guidelines require that pregnant women be offered the opportunity to receive information and counseling on prenatal care and delivery, infant care, foster care or adoption, and pregnancy termination. I have attached the federal guidelines concerning abortion related services in family planning projects. The language from the trailer bill and the budget for the family planning account are included below.

HB2:

224:307 Family Planning Accounting Unit; Funding Abortions Prohibited. Notwithstanding any provision of law to the contrary, the appropriation in accounting unit 05-95-90-902010-5530, family planning program, and any other funds shall not be used for evaluation, assessment, consultation about, preparation for, or provision of an abortion.

FY 2012-13 Operating Budget:

5530 FAMILY PLANNING PROGRAM	FY 2012	FY 2013
010 Personal Services-Perm. Classified	97,270	94,001
020 Current Expenses	15,437	15,437
026 Organizational Dues	556	556
030 Equipment New/Replacement	1,667	1,222
041 Audit Fund Set Aside	1,453	1,450
042 Additional Fringe Benefits	4,415	4,266
060 Benefits	52,556	55,270
070 In-State Travel Reimbursement	1,500	1,500
080 Out-Of State Travel	4,900	4,900
102 Contracts for program services	1,680,844	1,614,715
TOTAL	1,860,598	1,793,317
ESTIMATED SOURCE OF FUNDS FOR FAMILY PLANNING PROGRAM		
FEDERAL FUNDS	1,450,519	1,448,577
GENERAL FUND	410,079	344,740
TOTAL	1,860,598	1,793,317

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Public Health and Science

Provision of Abortion-Related Services in Family Planning Services Projects

AGENCY: Office of Population Affairs, OPHS, DHHS.

ACTION: Notice.

SUMMARY: This notice informs the public of the interpretations relating to the statutory requirement that no funds appropriated under Title X of the Public Health Service Act be used in programs in which abortion is a method of family planning.

FOR FURTHER INFORMATION CONTACT: Samuel S. Taylor, Office of Population Affairs, (301) 594–4001.

SUPPLEMENTARY INFORMATION: On February 5, 1993, the Department of Health and Human Services published in the **Federal Register** a notice of proposed rulemaking that proposed to revise the regulations at 42 CFR Part 59, Subpart A. Subpart A of Part 59 sets forth the program requirements applicable to grantees under section 1001 of the Public Health Service (PHS) Act, 42 U.S.C. 300, *et seq.* The notice of proposed rulemaking proposed to revise that subpart by readopting the program regulations as they existed prior to February 2, 1988. This action would have the effect of revoking the regulations published on February 2, 1988, commonly known as the "Gag Rule," which set forth standards for the compliance by such grantees with section 1008 of that Act, 42 U.S.C. 300a–6.

The February 5, 1993 notice of proposed rulemaking also proposed to reinstitute the pre-1988 policies and interpretations regarding compliance with section 1008. 58 FR 7464. As explained in the notice of proposed rulemaking, those policies and interpretations derived from previous opinions of the Department concerning section 1008. To promote more useful public comment in the rulemaking process, the Department subsequently made available a more detailed summary of the policies and interpretations and reopened the public comment period. 58 FR 34042 (June 23, 1993).

A number of public comments on the prior policies and interpretations were obtained during the reopened comment period, and the public comments received during both comment periods were generally focused on the prior policies and interpretations rather than on the proposed regulatory language. The Department has changed one paragraph of the regulations and has modified its prior interpretations in several particulars based in part on the public comment received. These modifications, and the grounds therefor, are described in the preamble to the final rules published on this date in the rules section of the **Federal Register.** The interpretations, as so modified, are set out in the summary statement below. The summary below is also reorganized from the summary statement made available for public comment, for purposes of clarification.

Accordingly, to provide guidance to grantees in order to promote uniform administration of the program and facilitate grantee compliance with the interpretations that are being reinstituted in conjunction with the final regulations adopted on this date, provided below is a summary of the program regulatory requirements and interpretations that relate to section 1008 of the PHS Act.

Program Policies Regarding the Title X National Family Planning Program and the Section 1008 Abortion Prohibition

Section 1008 of the Title X statute, 42 U.S.C. 300a–6, states: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." This prohibition applies not only to the performance of abortion by a Title X project, but also to the conduct of certain abortion-related activities by the project. However, the prohibition does not apply to all the activities of a Title X grantee, but only to those within the Title X project. This statement summarizes the Department requirements and interpretations in existence prior to the imposition of the 1988 "Gag Rule" with regard to implementation of section 1008, as modified following the rulemaking of 1993.

1. General Principles

In general, section 1008 prohibits Title X programs from engaging in activities which promote or encourage abortion as a method of family planning. However, section 1008 does not prohibit the funding under Title X of activities which have only a possibility of encouraging or promoting abortion; rather, a more direct nexus is required. The general test is whether the immediate effect of the activity in question is to promote or encourage the use of abortion as a method of family planning. If the immediate effect of the activity in question is essentially neutral, then it is not prohibited by the statute. Thus, a Title X project may not provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating abortion within Title X program activities, or failing to preserve sufficient separation between Title X program activities and abortion-related activities.

2. Abortion Counseling and Referral

Under 42 CFR 59.5(a)(5), a Title X project must:

Not provide abortion as a method of family planning. A project must:

(i) Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral on request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

However, there are limitations on what abortion counseling and referral is permissable under the statute. A Title X project may not provide pregnancy options counseling which promotes abortion or encourages persons to obtain abortion, although the project may provide patients with complete factual information about all medical options and the accompanying risks and benefits. While a Title X project may provide a referral for abortion, which may include providing a patient with the name, address, telephone number, and other relevant factual information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider, the project may not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient. Where a referral to another provider who might perform an abortion is medically indicated because of the patient's condition or the condition of the fetus (such as where the woman's life would be endangered), such a referral by a Title X project is not prohibited by section 1008 and is required by 42 CFR 59.5(b)(1). The limitations on referrals do not apply in cases in which a referral is made for medical indications.

c. Advocacy Activities

A Title X project may not promote or encourage the use of abortion as a method of family planning through advocacy activities such as providing speakers to debate in opposition to anti-abortion speakers, bringing legal action to liberalize statutes relating to abortion, or producing and/or showing films that encourage or promote a favorable attitude toward abortion as a method of family planning. Films that present only neutral, factual information about abortion are permissible. A Title X project may be a dues paying participant in a national abortion advocacy organization, so long as there are other legitimate program-related reasons for the affiliation (such as access to certain information or data useful to the Title X project). A Title X project may also discuss abortion as an available alternative when a family planning method fails in a discussion of relative risks of various methods of contraception.

d. Separation

Non-Title X abortion activities must be separate and distinct from Title X project activities. Where a grantee conducts abortion activities that are not part of the Title X project and would not be permissible if they were, the grantee must ensure that the Title X-supported project is separate and distinguishable from those other activities. What must be looked at is whether the abortion element in a program of family planning services is so large and so intimately related to all aspects of the program as to make it difficult or impossible to separate the eligible and non-eligible items of cost.

The Title X project is the set of activities the grantee agreed to perform in the relevant grant documents as a condition of receiving Title X funds. A grant applicant may include both project and nonproject activities in its grant application, and, so long as these are properly distinguished from each other and prohibited activities are not reflected in the amount of the total approved budget, no problem is created. Separation of Title X from abortion activities does not require separate grantees or even a separate health facility, but separate bookkeeping entries alone will not satisfy the spirit of the law. Mere technical allocation of funds, attributing federal dollars to non-abortion activities, is not a legally supportable avoidance of section 1008.

Certain kinds of shared facilities are permissible, so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities: (a) A common waiting room is permissible, as long as the costs properly pro-rated; (b) common staff is permissible, so long as salaries are properly allocated and all abortion related activities of the staff members are performed in a program which is entirely separate from the Title X project; (c) a hospital offering abortions for family planning purposes and also housing a Title X project is permissible, as long as the abortion activities are sufficiently separate from the Title X project; and (d) maintenance of a single file system for abortion and family planning patients is permissible, so long as costs are properly allocated.

Whether a violation of section 1008 has occurred is determined by whether the prohibited activity is part of the funded project, not by whether it has been paid for by federal or non-federal funds. A grantee may demonstrate that prohibited abortion-related activities are not part of the Title X project by various means, including counseling and service protocols, intake and referral procedures, material review procedures, and other administrative procedures.

Dated: June 28, 2000.

Samuel S. Taylor,

Acting Director, Office of Population Affairs.

[FR Doc. 00–16759 Filed 6–30–00; 8:45 am]

BILLING CODE 4160–17–M

Melby

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

DATE: June 1, 2011

FROM: Cindy Mann, JD
Director
Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: **Update on Medicaid/CHIP**

This Informational Bulletin covers three topics of interest to States:

- Federal requirements relating to choice of providers,
- The release of Exchange/Medicaid IT Guidance 2.0 regarding the development of information technology in support of Exchanges, Medicaid and Children's Health Insurance Programs for coverage under the Affordable Care Act, and
- New support available to States relating to the CHIPRA quality measures.

Medicaid Requirement of Freedom of Choice

We have received some inquiries as to whether States may exclude certain providers from participating in Medicaid based on their scope of practice, as well as a proposed state plan amendment presenting the same question, and we thought a review of longstanding federal law would be helpful to States.

States have authority to exclude providers from participating in Medicaid under certain circumstances, and indeed in some situations federal law requires exclusion. States are required, for example, to exclude providers that commit fraud or certain criminal acts. States are not, however, permitted to exclude providers from the program solely on the basis of the range of medical services they provide. Under federal law Medicaid beneficiaries may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." (Section 1902(a)(23) of Title XIX of the Social Security Act (the Act)) This provision is often referred to as the "any willing provider" or "free choice of provider" provision.

Federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (in cases of rape, incest, or when the life of the woman would be in danger). At the same time, Medicaid programs may not exclude qualified health care providers—whether an individual provider, a physician group, an outpatient clinic, or a hospital—from providing services under the program because they separately provide abortion

services (not funded by federal Medicaid dollars, consistent with the federal prohibition) as part of their scope of practice.

If you have any questions about this provision of the law, please contact Dr. Gerald Zelinger at gerald.zelinger@cms.hhs.gov.

Exchange/Medicaid IT Guidance 2.0

On May 31, 2011, CMS released Exchange/Medicaid IT Guidance 2.0, which expands on the prior version of IT Guidance issued in November 2010 guiding development of information technology in support of Exchanges, Medicaid and Children's Health Insurance Programs for coverage under the Affordable Care Act.

This IT Guidance contains additional discussion and details on systems requirements and funding that will assist States in moving forward on their information systems design and development. In particular, it expands the discussion of the business context, particularly for eligibility and enrollment into state health coverage programs; explains further the need and method for cost allocation among the programs; and describes the data services hub supporting State systems. IT Guidance 2.0 also contains additional details on upcoming guidance that States will receive for systems architecture and technical specifications.

IT Guidance 2.0 is available at:
http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/exchangemedicaiditguidance.pdf.

CHIPRA Quality Measures Technical Assistance and Analytic Support

We are pleased to announce the launch of the *"CHIPRA Technical Assistance and Analytic Support Program"* with an award of a contract to Mathematica Policy Research, LLC. This contract will enable CMCS to provide support to States in implementing the Children's Health Insurance Program Reauthorization Act (CHIPRA) quality measurement and improvement initiatives for children enrolled in Medicaid and CHIP (see http://www.cms.gov/smdl/downloads/SHO11001.pdf).

Mathematica – teamed with the National Committee for Quality Assurance (NCQA), the Center for Health Care Strategies (CHCS) and the National Initiative for Child Health Quality (NICHQ) – will support States' child health care quality measurement, reporting, and improvement efforts. The team brings broad and long-standing expertise in Medicaid and CHIP policy and research, child health, quality measurement and improvement, and data analysis. The Mathematica team, led by Margo Rosenbach, PhD, will partner with CMS and States to (1) provide information and support to States in their effort to uniformly collect, calculate, and report the core measures; (2) ensure that program managers and health care providers use the data collected to inform decisions about policies, programs, and practices to improve quality of care; and (3) share emerging best practices and lessons learned. We are confident that the

expertise of Mathematica and its partner organizations will advance States' efforts to use measurement tools to improve care for children in the Medicaid and CHIP programs.

The resources of the Mathematica contract will be available to all States. They will focus the next several months gathering information to better understand State capacity to collect and report data on quality measures. CMS will convene a Quality Conference in August (more details to follow) to help States build capacity, improve completeness and accuracy of collection and reporting on the core measures, and learn about quality improvement strategies. If you have specific questions about the CHIPRA Technical Assistance and Analytic Support program, please contact CHIPRAQualityTA@cms.hhs.gov .

I hope you will find this information helpful. Thank you for your continued commitment to Medicaid and CHIP.

Planned Parenthood®
of Northern New England

Planned Parenthood®
of Northern New England

Jennifer Frizzell
Senior Policy Advisor

18 Low Avenue
Concord, NH 03301
Phone 603-225-2925
Cell 603-340-1593
Fax 603-225-4195
jennifer.frizzell@ppnne.org

WE ARE YOUR SEXUAL HEALTH EXPERTS.
NOTHING WILL FREAK US OUT.

www.ppnne.org

SUMMARY OF HB 228-FN

HB 228-FN creates a new statute, the Whole Woman's Health Funding Priorities Act, for the purpose of defunding any health care entities that provide access to abortion or abortion-related services.

The proposal attempts to reorganize the delivery of women's health care services and redistribute all state and federal public funding for these services so that any medical provider or health care institution that provides abortion care, or offers counseling or referrals for abortion-related care will no longer be eligible to receive funding or reimbursement for health care provided under the following programs:

Title V – The Maternal and Child Health Program
Title X – The Family Planning / Women's Preventive Health Program
Title IX – The Medicaid Program
Title XX – The Social Services Block Grant (health education)

While the original language of the House bill was aimed specifically at defunding Planned Parenthood (by name), the current version impacts any hospital, community health clinic or private physician office where abortion services or abortion counseling and/or referrals are provided.

The legislation plainly discriminates against health care providers and institutions that offer a constitutionally protected medical service or offer patients comprehensive and non-biased information and counseling.

There are two key provisions of the new statute:

1) RSA 126-V:3, II prohibits the New Hampshire Department of Health and Human Services (DHHS) from entering into a contract with, or making a grant to, any entity that performs abortions or maintains or operates a facility where abortions are performed. This language would also prohibit Medicaid provider agreements with such entities. The statute exempts providers who offer only "federally-qualified" abortions which are limited to those necessary to save the life of the mother or those pregnancies resulting from rape or incest per the Hyde Amendment.

2) RSA 126-V:3, I mandates that any state expenditures or grants of public funds for the four designated programs (including Medicaid) be made in the following order of priority:

(a) Public entities;
(Note that NH does not have any public hospitals or publicly-operated health facilities)
(b) Non-public hospitals and Federally Qualified Health Centers;
(c) Rural health clinics ("RHCs");
(d) Non-public health providers whose primary purpose is the provision of primary health services.

Impact of HB 228 – FN

Impact on All Medical Providers

- All providers (including hospitals and physician offices) who provide abortions or abortion information will no longer be eligible to participate in the Medicaid program or to qualify for DHHS grants for maternal & child health, family planning, women's preventive health or health education programs. This will significantly weaken the Medicaid provider network and

undermine the state infrastructure to deliver preventive health services to vulnerable populations.

- No provider or health care institution will be able to lease facilities to or affiliate with other providers who perform abortions without losing their eligibility for the above-listed grants and contracts (including Medicaid provider agreements) with DHHS. Opportunities for collaboration and achieving health care efficiencies and savings will be thwarted by these unworkable restrictions.

- Any public funds made available through the designated health programs must be first made available to hospitals, Federally Qualified Health Centers, Rural Health Centers, then private primary care offices. *Women's health providers and family planning centers are intentionally excluded from statutory list of possible providers even though in many instances they are the most cost-effective and accessible provider for low-income and uninsured women.*

Impact on Planned Parenthood

- Planned Parenthood of Northern New England offers first trimester abortion at 2 of its 6 New Hampshire locations. Even though abortion constitutes less than 5% of PPNNE patient care in New Hampshire, under the proposed bill, all funding for PPNNE preventive care for women...gynecological exams, cancer screenings, clinical breast exams, access to birth control, testing and treatment for sexually transmitted infections and other primary care services will be discontinued.

- HB 228 effectively cuts off Planned Parenthood as a Medicaid provider and a safety net provider for uninsured and underinsured women, men and teens, jeopardizing our ability to provide comprehensive reproductive care to the women and men of New Hampshire.

Impact on Women

- Women for whom Planned Parenthood is the only source of primary care will lose access to needed preventive services, resulting in delayed diagnosis of conditions such as breast and cervical cancer, less reliable use of contraception, more unintended pregnancy and more abortions, and greater use of the emergency room for acute and chronic medical conditions.

- As many as 16,000 patients who receive Planned Parenthood services in Claremont, Derry, Exeter, Keene, Manchester and West Lebanon will be at risk for losing their primary health care provider. Tens of thousands of other Medicaid patients will lose access to hospital care and private physicians who can no longer serve the program under the restrictions of HB 228.

Impact on Health Care Costs / Outcomes

- Cost-effective primary care providers will be eliminated and replaced with more expensive delivery of health care services in more acute settings such as urgent care centers or emergency rooms.

- Current Medicaid care management and budget reduction goals will be unattainable without a statewide infrastructure for meeting women's primary and reproductive health care needs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUN 01 2011

Patricia Casanova, Director
Office of Medicaid Policy and Planning
MS 07, 402 W. Washington Street, Room W382
Indianapolis, IN 46204-2739

Dear Ms. Casanova:

I am responding to your request to approve the State of Indiana's Medicaid State plan amendment (SPA) 11-011, received by the Centers for Medicare & Medicaid Services (CMS) on May 15, 2011. In this amendment, Indiana proposes to prohibit the State Medicaid agency from entering into a contract or grant with providers that perform abortions or maintain or operate facilities where abortions are performed, except for hospitals or ambulatory surgical centers. For the reason set forth below, I am unable to approve SPA 11-011 as submitted, because it does not comply with the requirements of section 1902(a)(23) of the Social Security Act (the Act).

Section 1902(a)(23)(A) of the Act provides that beneficiaries may obtain covered services from any qualified provider that undertakes to provide such services. This SPA would eliminate the ability of Medicaid beneficiaries to receive services from specific providers for reasons not related to their qualifications to provide such services. As you know, federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (such as in cases of rape or incest). At the same time, Medicaid programs may not exclude qualified health care providers from providing services that are funded under the program because of a provider's scope of practice. Such a restriction would have a particular effect on beneficiaries' ability to access family planning providers, who are subject to additional protections under section 1902(a)(23)(B) of the Act. These protections also apply in managed care delivery systems. Therefore, we cannot determine that the proposed amendment complies with section 1902(a)(23) of the Act.

For this reason, and after consulting with the Secretary as required by Federal regulations at 42 CFR 430.15(c), I am unable to approve this SPA. If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of receipt of this letter in accordance with the procedures set forth at 42 CFR 430.18. Your request for reconsideration may be sent to Ms. Cynthia Hentz, Centers for Medicare & Medicaid Services, Center for Medicaid, CHIP and Survey & Certification, 7500 Security Boulevard, Mail Stop S2-01-01, Baltimore, MD 21244-1850.

We assume this decision is not unexpected. As the Indiana Legislative Services Agency indicated in its April 19, 2011 fiscal impact statement, "While States are permitted to waive a recipient's freedom of choice of a provider to implement managed care, restricting freedom of choice with respect to providers of family planning services is prohibited."

If you have any questions or wish to discuss this determination further, please contact Ms. Verlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Centers for Medicare & Medicaid Services, 233 N. Michigan Avenue, Suite 600, Chicago, Illinois, 60601.

Sincerely,

Donald M. Berwick, M.D.
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

DATE: June 1, 2011

FROM: Cindy Mann, JD
Director
Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: Update on Medicaid/CHIP

This Informational Bulletin covers three topics of interest to States:

- Federal requirements relating to choice of providers,
- The release of Exchange/Medicaid IT Guidance 2.0 regarding the development of information technology in support of Exchanges, Medicaid and Children's Health Insurance Programs for coverage under the Affordable Care Act, and
- New support available to States relating to the CHIPRA quality measures.

Medicaid Requirement of Freedom of Choice

We have received some inquiries as to whether States may exclude certain providers from participating in Medicaid based on their scope of practice, as well as a proposed state plan amendment presenting the same question, and we thought a review of longstanding federal law would be helpful to States.

States have authority to exclude providers from participating in Medicaid under certain circumstances, and indeed in some situations federal law requires exclusion. States are required, for example, to exclude providers that commit fraud or certain criminal acts. States are not, however, permitted to exclude providers from the program solely on the basis of the range of medical services they provide. Under federal law Medicaid beneficiaries may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." (Section 1902(a)(23) of Title XIX of the Social Security Act (the Act)) This provision is often referred to as the "any willing provider" or "free choice of provider" provision.

Federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (in cases of rape, incest, or when the life of the woman would be in danger). At the same time, Medicaid programs may not exclude qualified health care providers—whether an individual provider, a physician group, an outpatient clinic, or a hospital—from providing services under the program because they separately provide abortion

services (not funded by federal Medicaid dollars, consistent with the federal prohibition) as part of their scope of practice.

If you have any questions about this provision of the law, please contact Dr. Gerald Zelinger at gerald.zelinger@cms.hhs.gov.

Exchange/Medicaid IT Guidance 2.0

On May 31, 2011, CMS released Exchange/Medicaid IT Guidance 2.0, which expands on the prior version of IT Guidance issued in November 2010 guiding development of information technology in support of Exchanges, Medicaid and Children's Health Insurance Programs for coverage under the Affordable Care Act.

This IT Guidance contains additional discussion and details on systems requirements and funding that will assist States in moving forward on their information systems design and development. In particular, it expands the discussion of the business context, particularly for eligibility and enrollment into state health coverage programs; explains further the need and method for cost allocation among the programs; and describes the data services hub supporting State systems. IT Guidance 2.0 also contains additional details on upcoming guidance that States will receive for systems architecture and technical specifications.

IT Guidance 2.0 is available at:
http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/exchangemedicaiditguidance.pdf.

CHIPRA Quality Measures Technical Assistance and Analytic Support

We are pleased to announce the launch of the *"CHIPRA Technical Assistance and Analytic Support Program"* with an award of a contract to Mathematica Policy Research, LLC. This contract will enable CMCS to provide support to States in implementing the Children's Health Insurance Program Reauthorization Act (CHIPRA) quality measurement and improvement initiatives for children enrolled in Medicaid and CHIP (see http://www.cms.gov/smdl/downloads/SHO11001.pdf).

Mathematica – teamed with the National Committee for Quality Assurance (NCQA), the Center for Health Care Strategies (CHCS) and the National Initiative for Child Health Quality (NICHQ) – will support States' child health care quality measurement, reporting, and improvement efforts. The team brings broad and long-standing expertise in Medicaid and CHIP policy and research, child health, quality measurement and improvement, and data analysis. The Mathematica team, led by Margo Rosenbach, PhD, will partner with CMS and States to (1) provide information and support to States in their effort to uniformly collect, calculate, and report the core measures; (2) ensure that program managers and health care providers use the data collected to inform decisions about policies, programs, and practices to improve quality of care; and (3) share emerging best practices and lessons learned. We are confident that the

expertise of Mathematica and its partner organizations will advance States' efforts to use measurement tools to improve care for children in the Medicaid and CHIP programs.

The resources of the Mathematica contract will be available to all States. They will focus the next several months gathering information to better understand State capacity to collect and report data on quality measures. CMS will convene a Quality Conference in August (more details to follow) to help States build capacity, improve completeness and accuracy of collection and reporting on the core measures, and learn about quality improvement strategies. If you have specific questions about the CHIPRA Technical Assistance and Analytic Support program, please contact CHIPRAQualityTA@cms.hhs.gov .

I hope you will find this information helpful. Thank you for your continued commitment to Medicaid and CHIP.

June 24, 2011

Indiana Law to Cut Planned Parenthood Funding Is Blocked

By ROBERT PEAR

WASHINGTON — A federal judge ruled Friday that the State of Indiana could not cut off money for Planned Parenthood clinics providing health care to low-income women on Medicaid.

The judge, Tanya Walton Pratt of the Federal District Court in Indianapolis, blocked provisions of a new state law that penalized Planned Parenthood because some of its clinics performed abortions. The law, she said, conflicts with the federal Medicaid statute, which generally allows Medicaid beneficiaries to choose their health care providers.

Planned Parenthood provides services other than abortion, including family planning and screenings for cancer and sexually transmitted diseases.

In issuing a preliminary injunction late Friday, Judge Pratt said the state law "will exact a devastating financial toll on Planned Parenthood of Indiana and hinder its ability to continue serving patients' general health needs."

The law took effect immediately when it was signed on May 10 by Gov. Mitch Daniels, a Republican.

As of June 20, the judge said, Planned Parenthood of Indiana stopped treating its Medicaid patients and laid off two of its three specialists in sexually transmitted diseases. The judge said that "only a small percentage" of Planned Parenthood's services involved abortion.

"States do not have carte blanche to expel otherwise competent Medicaid providers," Judge

Pratt said. And "there are no allegations that Planned Parenthood of Indiana is incompetent or that it provides inappropriate or inadequate care."

The ruling has national significance. At least a half-dozen states have taken aim at Planned Parenthood because its clinics perform abortions, about one-fourth of all those performed in the United States.

Judge Pratt gave "some measure of deference" to a ruling by the Obama administration, which on June 1 denied approval for the changes that Indiana wanted to make in its Medicaid program.

The federal government could terminate some or all of Indiana's Medicaid money if the state persisted in violating federal Medicaid law.

"The public interest tilts in favor of granting an injunction," Judge Pratt declared. "The federal government has threatened partial or total withholding of federal Medicaid dollars to the State of Indiana, which could total well over $5 billion annually and affect nearly one million Hoosiers."

Moreover, she said: "Denying the injunction could pit the federal government against the State of Indiana in a high-stakes political impasse. And if dogma trumps pragmatism and neither side budges, Indiana's most vulnerable citizens could end up paying the price as the collateral damage of a partisan battle."

Marcus J. Barlow, a spokesman for the Indiana Family and Social Services Administration, said the state would comply with the preliminary injunction, but could also appeal.

Bryan Corbin, a spokesman for the Indiana attorney general, Greg Zoeller, said the state was likely to seek review by the United States Court of Appeals for the Seventh Circuit, in Chicago.

Since the law was signed, Judge Pratt said, Planned Parenthood of Indiana has seen a surge in donations from supporters. But, she said, "these donations were something of an aberration."

"Common sense suggests that as headlines fade, passions will cool and donations will level off," the judge said. "Thus, with the passage of time, Planned Parenthood of Indiana will be forced to confront the dire financial effects" of the new state law.

State officials argued that Indiana could exclude Planned Parenthood from its Medicaid program because states have the authority to determine who is a "qualified" provider. But, the judge said, that determination cannot be based on factors unrelated to a provider's Medicaid services.

For years, federal law has banned the use of Medicaid money to pay for abortion except in certain cases of rape or incest or danger to the life of a pregnant woman.

The Indiana law goes much further. It prohibits state agencies from entering contracts with or making grants to "any entity that performs abortions or maintains or operates a facility where abortions are performed." It also terminates existing state contracts with such entities. The law does not apply to hospitals.

Planned Parenthood of Indiana and two of its patients filed the suit, challenging the new restrictions as "a blatant violation" of federal law. Judge Pratt agreed, finding the Indiana measure "unlawfully narrows Medicaid recipients' choice of qualified providers."

Printed from the Charlotte Observer - www.CharlotteObserver.com
Posted: Saturday, Aug. 20, 2011

Judge restores N.C. funds for Planned Parenthood

By Craig Jarvis
PUBLISHED IN: TOP STORIES

Related Stories

Related Images

WINSTON-SALEM A federal judge on Friday ordered North Carolina to honor its contract with a Planned Parenthood affiliate, pending the outcome of a lawsuit the organization filed after the General Assembly cut off its funding.

U.S. District Judge James A. Beaty Jr. issued a preliminary injunction that found merit with Planned Parenthood of Central North Carolina's arguments that the ban on funding was unconstitutional on several grounds.

At issue is $212,000 that would have gone to the group's clinics in Durham, Chapel Hill and Fayetteville to pay for contraceptives, teen pregnancy prevention programs and health services such as cancer screenings, pap smears, breast exams and diabetes tests for low-income women. The organization said staff would be laid off and many of those services would cease.

The Republican-controlled General Assembly included a provision in the state budget this summer prohibiting any state funding of Planned Parenthood. Gov. Bev Perdue vetoed the budget but the General Assembly overrode the veto.

"Our first concern is to our patients, so we are deeply grateful that the court has stopped the state from enforcing the ban prohibiting Planned Parenthood from providing much-needed preventative health care to thousands of North Carolinians," the group's CEO, Janet Colm, said in statement released Friday night.

Neither members of the GOP leadership in the General Assembly, nor the Attorney General's Office, which is defending the state Department of Health and Human Services in the lawsuit, could be reached for comment Friday.

Funding must be restarted

Beaty, in his ruling, made it clear Secretary Lanier Cansler must immediately unfreeze the Planned Parenthood funding.

"The court expects defendant Cansler to follow all applicable state and federal laws and regulations," the judge wrote, and cautioned that if the state agency does not release the funds, "further proceedings would be appropriate."

Beaty's ruling notes that Planned Parenthood and the state had a contract in place for the 2011-12 fiscal year before the legislature banned it.

The ruling follows similar rulings in federal courts in Kansas and Illinois, where legislatures tried to ban funding for all organizations that provide abortions. North Carolina's case was different because it singled out a specific group. Beaty makes several references to the recent rulings in Kansas and Illinois.

He found that Planned Parenthood would be likely to succeed at trial on several grounds:

Under the supremacy clause of the U.S. Constitution, the state's ban on funding would be pre-empted by federal law that makes funding available for the organization.

Beaty noted the Kansas court found the ban was an unconstitutional "attempt to punish the plaintiff for its support of abortion rights," a violation of the First and 14th Amendments.

He found the budget provision singled out a specific organization for punishment, which violates the bill of attainder clause that guards against "trial by legislature." Comments Rep. Paul "Skip" Stam, an Apex Republican, and Sen. Warren Daniel made in session support the contention the group was targeted for its abortion services.

Beaty rejected the state's contention that the budget provision serves a legitimate governmental purpose, which is upholding the elected legislature's policy of "favoring childbirth over abortion."

Judge: Abortion not the issue

The judge pointed out that it was unnecessary to impose a contractual ban on abortion funding because none of the money at issue is used for that purpose. In fact, it is illegal to use federal funds for abortions.

"Judge Beaty's ruling confirmed what we already knew, and what our arguments and evidence made clear: This special provision is contrary to federal law, violates the constitutional rights of PPCNC and our patients, unconstitutionally penalizes Planned Parenthood, and has the effect of restricting access to health care for some of North Carolina's most vulnerable populations," said senior staff attorney Helene Krasnoff with the organization's national office.

August 1, 2011

Kansas: Judge Rules for Planned Parenthood

By THE ASSOCIATED PRESS

A federal judge ruled Monday that Planned Parenthood would most likely succeed in overturning a new Kansas law that denies the group access to federal family planning money, saying he believes that the law is unconstitutional and was intended to punish the group for advocating for abortion rights. The judge, J. Thomas Marten, granted Planned Parenthood of Kansas' request for a temporary injunction blocking the law, which would require the state to allocate federal family planning dollars first to public health departments and hospitals, and leave no money for Planned Parenthood or similar groups. The judge's order was to remain in effect until the case is resolved. Kansas says the law is a matter of state sovereignty, arguing that an injunction would unconstitutionally replace the state's discretion with the court's judgment.

Appendix – E_ 3 Virginia Department of Health – Title X Financial Audit Tool	**Title X Program Review Tool: FINANCIAL SECTION**	U.S. Department of Health & Human Services Office of Public Health and Science Office of Population Affairs

FINANCIAL MANAGEMENT: The Grantee/sub-recipient[1] maintains a financial management system consistent with Title X and Federal grant requirements.

An appropriate financial management system includes compliance with the criteria listed in this section. Fiscal Program Review consultants may want to review the documents listed below to aid in assessing compliance:

Budgetary Control Procedures	▫ Notice of Grant Awards for the current and previous years ▫ SF424A, Title X program budgets (including Program Income) , and Budget expenditure reports for the last two years ▫ Budget revisions ▫ Indirect Cost Rate Agreement or Allocation Plan for Administrative Costs ▫ Staff Time and Effort documentation and payroll records ▫ Federal PMS Cash Transaction Reports ▪ Board finance committee meeting minutes ▫ Sub-recipient agency expenditure reports
Accounting Systems and Reports	▪ Accounting/Internal Control policies and procedures and accounting system documentation (Fiscal Policy Manual) ▪ Independent Audit Reports for grantee and sub-recipients ▪ Financial Status Reports ▪ General ledger reports and financial statements ▪ Payment Management System records ▪ Internal control documents

[1] Flow-down of Requirements under Sub-awards and Contracts under HHS Grants: The terms and conditions in the HHS Grants Policy Statement apply directly to the recipient of HHS funds. The recipient is accountable for the performance of the project, program or activity; the appropriate expenditure of funds under the award; and all other obligations of the recipient, as cited in the Notice of Grant Award. In general, the requirements that apply to the recipient, including public policy requirements, also apply to sub-recipients and contractors under grants, unless an exception is specified. *(HHS Grant Policy Statement, January 1, 2007)*

Title X Program Review Tool: FINANCIAL SECTION

Charges, Billing and Collection Policies and Procedures	▪ Grantee/sub-recipient policies and procedures for Charges, Income Verification, Billing & Collection ▪ Client Visit Records ▪ Grantee and sub-recipient: Cost Analyses; Schedule of Discounts; Charges for Services and Supplies; Client Billing/Receipt Statements; Bills to Third Parties ▪ Grantee Fiscal Management Auditing/Review tool
Procurement/Purchasing Procedures and Property Management	▪ Grantee and sub-recipient polices and procedures for procurement of services, equipment and supplies ▪ Sub-recipient agency contracts, sub-recipient allocation formula, sub-recipient funding allocation or schedule and performance data (FPAR) ▪ Sub-recipient agency fiscal monitoring instruments and reports ▪ Inventory system records related to supplies, medications and equipment purchased with Title X funds ▪ Grantee and sub-recipient records of physical inventory for equipment and supplies
Fiscal Monitoring Information	▪ Grantee policies/procedures/schedules/reports and/or tools for fiscal monitoring of sub-recipient agencies.

The Financial Section of the Program Review is based on the following Title X and other Federal grant requirements:

- Title X Legislation and Title X Implementing Regulations, 42 CFR Part 59
- Program Guidelines for Family Planning Project Grants for Family Planning Services, 2001
- OPA Program Instructions: 08-01; 05-03; 05-02; 97-1
- HHS Grant Policy Statement 2007
- Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education., Hospitals, Other Nonprofit Organizations, and Commercial Organizations, 45 CFR Part 74
- Uniform Administrative Requirements for Grants and Cooperative Agreement to State, Local and Tribal Governments, 45 CFR Part 92
- Uniform Administrative Requirements for Grants and Agreements With Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations, OMB Circular A-110
- Cost Principles for State, Local and Indian Tribal Governments, 2 CFR Part 225, OMB Circular A-87
- Cost Principles for Non-Profit Organizations, 2 CFR Part 230, OMB Circular A-122
- Federal Register Notices related to Veterans Health Care Act of 1992, Title VI – Drug Pricing Agreements SEC. 601, 602 Treatment of Prescription Drugs Procured by Department of Veterans Affairs or Purchased by Certain Clinics and Hospitals, 340B
- Generally Accepted Government Audit Standards (GASAS)
- Audits of States, Local Governments, and Non-Profit Organizations, OMB Circular A-133
- Appropriate State Not for Profit Corporations Act
- Organization's Articles of Incorporation and By-Laws
- Generally accepted Internal Control Procedures

Title X Program Review Tool:
FINANCIAL SECTION

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
1. Budgetary control procedures meet Title X and Federal grant requirements				*Write/Type Comments in the space below*
a) Grantee uses a budget to control its fiscal operations *(45 CFR 74.21; 45 CFR 92.20)*	M			Copies of monthly cost code reconciliations. Copies of small purchase charge card reconciliations. Copies of last inventory forms completed. Copy of patient bill of rights Is signage posted to make it clear that services will not be denied due to an imability to pay? Physically look at where pharmaceuticals are stored. How do you determine which funding source to attribute the inventory to? Where are deposit records kept? Copy of travel reimbursement vouchers and supporting documentation. Copy of written guidelines for person conducting inventory. Copies of at least 2 batches (vouchers). Copies of T&E reports and comparison to CARS expenditures. What are your hours of operation? How do you track training for FP staff? How are FP clients coded in WebVision? Copies of patient bills. Do patient bills reflect the full cost of services, discount, and balance due?
b) There is a separate budget applicable to Title X project *(45 CFR 74.21; 45 CFR 92.20)*	M			
c) The governing authority approves the grantee budgets *(Appropriate State Not for Profit Corporations Act; Organization's Articles of Incorporation and By-Laws)*	S			
d) The Grantee operating budget for the Title X project is consistent with the approved budget *(45 CFR 74.21; 45 CFR 92.20)*	M			
e) The Chief Financial Officer or designee monitors the approved Title X budget expenditures *(45 CFR 74.21; 45 CFR 92.20)*	M			
f) The Grantee requests a budget revision when required, including: (1) Change in Project scope or objective (2) Change in key personnel, and (3) When sub-awarding or contracting work not approved in NGA *(45 CFR 74.25; 45 CFR 92.30)*	M			
g) The grantee has appropriate cost centers to track and validate costs applicable to any NGA special conditions and/or special projects (i.e., HIV, project service expansion, etc.) *(45 CFR 74.21; 45 CFR 92.20)*	M			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
h) The allocation of Administrative expense is direct or indirect *(2 CFR 225 Apps. C & E; 2 CFR 230 App. A).* (1) If the Grantee claims indirect costs: (a) Grantee has a Federally approved negotiated indirect rate (IDC) agreement for Administrative expenses (i) Is the IDC rate applied to salaries? (ii) Is the IDC rate applied to total direct costs? (iii) Is there another application of the IDC rate? Specify **OR**	O			Copy of expenditure report. Does liquidation of expenditures occur within the required timeframe? Compate budget spreadsheet to budget submitted. Are expenditures monitored on both state and federal fiscal years?
(b) Grantee has an accepted Administrative cost allocation plan with HHS or other cognizant Federal agency in order to claim indirect costs *(2 CFR 225 Apps. C & E; 2 CFR 230 App. A)*	O			
Note: If grantee does not use an IDC rate, inquire, review and document the allocation method used for charging administrative costs, if applicable *(2 CFR 225 Apps. C & E; 2 CFR 230 App. A)*	M			
i) Proper documentation of all income and expenditures is maintained *(45 CFR 74.21; 45 CFR 92.20)*	M			
j) Program income earned during the project period is used in accordance with the awarding agency NGA *(45 CFR74.21; 45 CFR 92.20)*	M			
k) Charges of salaries/wages to the award are reflective of Title X activities. Time and effort documentation assures proper validation *(2 CFR 225 App. B.8 h.; 2 CFR 230 App. B.8 m.)*	M			
l) Charges to the award, including staff time and effort documentation, reconcile to PMS Transaction Reports and/or to the reconciliation of Federal draw-down actions *(45 CFR 74. 21; 45 CFR 92.20)*	S			

Criteria for Title X Compliance	C	NC	Comments/Documentation/Explanation
2. Accounting Systems and Reports are consistent with Title X and Federal grant requirements			*Write/Type Comments in the space below*

Title X Program Review Tool:
FINANCIAL SECTION

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
a) **Grantee fiscal oversight and audits**				How and when are T&E reconciled?
(1) Grantee and sub-recipient agencies have written accounting policies and procedures for determining reasonableness, allocability and allowablility of costs in accordance with Federal cost principles *(45 CFR 74.21; 45 CFR 92.20)*	M			Are those employees who approve expenditures aware of allowable/unallowable costs?
(2) Grantee monitors sub-recipient agencies as necessary to ensure Federal compliance with laws and regulations, and grant provisions *(45 CFR 74.51; 45 CFR 92.40; OMB A-133-400(d))*	M			Does your district subcontract for any services?
(3) Audits of Grantees/sub-recipients are conducted in accordance with provisions of OMB Circular A-133 *(OMB A-133;45 CFR 74.26; 45 CFR 92.26)*	M			When was the district last audited by APA? Internal Audit?
(a) Grantee secures independent audits from its sub-recipients, including management letter annually *(OMB A-133, 320(e) and 400(d))*	M			
(b) Auditors meet established criteria for qualifications and independent audits *(GAGAS standards and OMB A-133, 305)*	M			
(c) Financial records must be available for review or audit by appropriate officials of the Federal agency *(OMB A-133; 45 CFR 74.53; 45 CFR 92.42)*	M			
b) **Maintenance of internal controls** Internal controls over Federal programs are maintained that provide reasonable assurance that the Grantee is managing the Federal award in compliance with applicable laws and regulations *(OMB A-133, 300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	M			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(1) Separation of duties No one person has complete control over more than one key function or activity *(e.g., authorizing, approving, certifying, disbursing, receiving, or reconciling)* *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	M			
(2) Authorization and approval Transactions are properly authorized and consistent with Federal requirements *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	M			
(3) Custodial and security arrangements Responsibility for physical security/custody of assets is separated from record keeping/accounting for those assets *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	M			
(a) Unauthorized access to assets and accounting records is prevented				
c) **Review and reconciliation** Systems are in place that allow for proper review and reconciliation of grant funds				
(1) Accounting records and documents are examined by employees who have sufficient understanding of the accounting and financial system to verify that recorded transactions actually took place and were made in accordance with policy and procedures *(OMB A-133,300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	S			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(2) Grantee accounting records and documentation are compared with accounting system reports and financial statements to verify their reasonableness, accuracy, and completeness *(OMB A-133,300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**S**			
(3) Control principles are applied to all departmental operations (i.e., payroll; purchasing approval, receiving, and disbursement approval; equipment and supplies inventories; cash receipts; petty cash and change funds; billing; and accounts receivable) *(OMB A-133,300; 45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**S**			
(4) Methods of drawing funds from the Federal Payment Management System and reconciliation of actual Title X expenditures comply with Federal requirements *(45 CFR 74.21; 45 CFR 92.20)*	**M**			
(5) Grantee reconciles Title X cash receipts/collections to accounting system on either a daily or monthly basis *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	**S**			
d) **Fiscal reports**				
(1) Grantee submitted the Financial Status Report (SF-269) for the last budget period on time (90 days after budget period ended) *(45 CFR 74.52; 45 CFR 92.41)*	**M**			
(2) The Financial Status Report (SF-269) was completed in accordance with OGM guidelines and requirements *(45 CFR 74.52; 45 CFR 92.41)*	**M**			

Title X Program Review Tool:
FINANCIAL SECTION

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
3. Charges, billing, and collection procedures meet Title X and Federal grant requirements *(42 CFR 59.2,59.5 (6)-(9); Title X Guidelines: Section 6.3; OPA Program Instructions 08-01 and 97-1)*				*Write/Type Comments in the space below*
a) Grantee is responsible for implementation of policies and procedures for charging, income verification, billing, and collecting funds for services provided by the project *(Title X Guidelines: Section 6.3)*	**M**			
(1) Policies and procedures are approved by the Grantee's governing authority/board and Regional Office *(Title X Guidelines: Section 6.3)*	**S**			
(2) The manner in which the above policies/procedures are implemented ensures that priority for services is to persons from low-income families and ensures that the inability to pay is not a barrier to the receipt of services *(45 CFR 59.5 (a)(6-8); OPA 08-01; OPA 97-1)*	**M**			
b) Charges, billing and collection system has the following characteristics:				
Charges				Charges based on Virginia Medicaid Fee Scale
(1) Charges are based on a cost analysis *(42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3)*	**M**			
(2) A schedule of discounts *(SOD)* has been developed and properly implemented *(42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3).* This includes:	**M**			
(a) Eligibility for discounts is documented in client's financial record *(Title X Guidelines: Section 6.3)*	**M**			
(b) SOD has sufficient proportional increments to ensure income is not a barrier to service *(Title X Guidelines: Section 6.3)*	**M**			
(c) SOD is used for family incomes between 101–250% of FPL *(42 CFR 59.5(a)(8))*	**M**			

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(d) Eligibility for discounts for minors who receive confidential services is based on the income of the minor *(42 CFR 59.2 – Definitions; OPA 97-1)*	M			
(3) Grantee ensures that there is a mechanism is in place throughout the Title X project for waiving fees of individuals who, for good cause, are unable to pay but do not qualify for the SOD *(42 CFR 59.2 – Definitions; Guidelines: Section 6.3)*	M			
(4) Clients at or below 100% of FPL are not charged for Title X services *(Title X Statute, Section 1006; 42 CFR 59.5(a)(7))*	M			
(5) Client income is re-evaluated annually *(Title X Guidelines: Section 6.3)*	S			
(6) There is no evidence clients are denied services or are subjected to variation in quality of services because of the inability to pay *(Guidelines: Section 6.3)*	M			
Billing *(42 CFR 59.5 (a) (9) Title X Guidelines: Section 6.3)*				
(1) At the time of services, clients responsible for paying are given bills directly	M			
(a) Bills to clients show the total charges, as well as any allowable discounts	M			Web Vision does not print an actual "bill" but charges And discounts must be reviewed with the patient at the Time of exit. Sliding scale clients only.
(b) Where a third party is responsible, bills are be submitted to that party	M			
(c) Third parties authorized or legally obligated to pay for clients at or below 100% FPL are properly billed	M			
(d) Third party bills show total charges without any discounts	M			
(e) Bills to third parties show total charges without applying any discount unless there is a contracted reimbursement rate that must be billed per the third party agreement	M			

Title X Program Review Tool:
FINANCIAL SECTION

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
(2) When reimbursement from Title XIX or Title XX of Social Security Act is available, a written agreement at either the Grantee level or sub-recipient level is required *(42 CFR 59.5 (a) (9))*	M			What is the process for collecting delinquent accounts?
Collections *(Title X Guidelines: Section 6.3)*				
(1) Reasonable efforts to collect charges without jeopardizing client confidentiality are made	M			
(2) A method for "aging" outstanding accounts has been established	M			
(3) There is no evidence that clients are pressured to make donations	M			
(a) Donations are not a prerequisite for provision of any service or supply	M			
(b) Billing requirements set out above are not waived because of client donations	M			
(4) Projects offering services not required by Title X should seek other funding for such services before applying Title X funds to those activities	S			

Title X Program Review Tool:
FINANCIAL SECTION

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
4. Procurement /Inventory Control/Property Management meet Title X and Federal grant requirements.				*Write/Type Comments in the space below*
a) Grantee and sub-recipient agencies have written procurement policies and procedures for procurement of supplies, equipment and other services *(45 CFR 74.44; 45 CFR 92.36)*	M			Are requisions/Pos completed for all purchases?
b) All procurement transactions conducted (including those for sub-recipient services) provide for practical, open and free competition (Competitive process is used for purchasing) *(45 CFR 74.43; 45 CFR 92.36 (12) (C); 42 CFR 59.5)*	M			
c) Grantee and sub-recipient agencies maintain records that detail the history of a procurement *(45 CFR 74.21 & 74.41; 45 CFR 92.20 & 92.36 (b) (9); Accepted Internal Control Procedures)*	S			
d) Grantee has proper segregation between requisition, procuring, receiving and payment functions *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	S			
e) Grantee/sub-recipient have inventory system to control purchase, use, reordering of medications and supplies *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures; State Pharmacy Regulations)*	M			
f) Grantee has adequate safeguards for assuring that supplies purchased through the Federal Drug Pricing Program (340B) are provided only to clients served in the Title X project *(Veterans Health Care Act of 1992)*	M			
g) Grantee has established controls over access to medications and supplies *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	M			

Title X Program Review Tool:
FINANCIAL SECTION

U.S. Department of Health & Human Services
Office of Public Health and Science
Office of Population Affairs

Criteria for Title X Compliance		C	NC	Comments/Documentation/Explanation
4. Procurement /Inventory Control/Property Management meet Title X and Federal grant requirements.				*Write/Type Comments in the space below*
h) Grantee periodically confirms inventory with actual inventory counts and provides credit debit adjustment to Title X charges to reflect actual costs *(45 CFR 74.21; 45 CFR 92.20; Accepted Internal Control Procedures)*	M			
i) Grantee evaluates contractor performance and documents if contractors have met the terms, conditions and specifications of the contract *(45 CFR 74.47; 45 CFR 92.36)*	M			
j) Grantee maintains a property management system (Fixed Assets) *(45 CFR 74.34; 45 CFR 92.32)*	M			
k) Property management system includes: asset description, ID number, acquisition date, current location and Federal share of the asset *(45 CFR 74.34; 45 CFR 92.32)*	M			
(1) Grantee performs a physical inventory of equipment at least once every 2 years (Records shall be investigated to determine the cause of any differences). *(45 CFR 74.34; 45 CFR 92.32)*	M			

Planned Parenthood®
of Northern New England

Profile of Services at New Hampshire Health Centers

- 16,067 patients came to our New Hampshire Health Centers for care in 2011. Patients were seen in 23,675 visits.
- 20% of the patients in New Hampshire were teenagers; and 73% were under 30 years old.
- PPNNE provides its services on a sliding fee scale; **no one is turned away because of an inability to pay.**
    - 70% of patients in New Hampshire had incomes of $16,335 or less for a single person.
    - In 2011, PPNNE's New Hampshire Health Centers provided **$5,068,105** in Free or Reduced Cost Care.
- Services Provided by PPNNE Health Centers in New Hampshire include:
    - Annual gynecological exams;
    - Clinical screenings for 5 types of cancer: cervical, breast, uterine, colorectal and ovarian;
    - Birth control education, supplies, and prescriptions including EC (emergency contraception);
    - Sexually transmitted infection testing and treatment for women and men;
    - Confidential HIV testing and counseling for women and men;
    - Vaginal and urinary tract infection screening and treatment;
    - Colposcopy, cryotherapy and LEEP (Loop Electrosurgical Excision Procedure)—follow up treatments for abnormal cervical conditions;
    - Routine immunizations & employment/sports physical for women and men;
    - HPV and Hepatitis vaccines;
    - Abortion care (Surgical and Medical).
- PPNNE's New Hampshire Health Centers provided;
    - 2,746 **Pap tests** in 2011 to screen for pre-cancerous cervical cells.
    - 4001 **clinical breast exams** to screen for breast cancer.
    - 20,525 tests to screen for **sexually transmitted infections** (HIV, Herpes, Gonorrhea, Chlamydia and Syphilis.)
    - 4,630 **pregnancy tests**. (Testing is free for teens under age 18.)

Claremont Health Center
136 Pleasant St.
Claremont, NH 03743
603-542-4568

Exeter Health Center
108 High St.
Exeter, NH 03833
603-772-9315

Manchester Health Center
24 Pennacook St.
Manchester, NH 03104
603-669-7321

Derry Health Center
4 Birch St.
Derry, NH 03038
603-434-4290

Keene Health Center
8 Middle St.
Keene, NH 03431
603-352-6898

West Lebanon Health Center
89 S. Maine St.
West Lebanon, NH 03784
603-298-7766

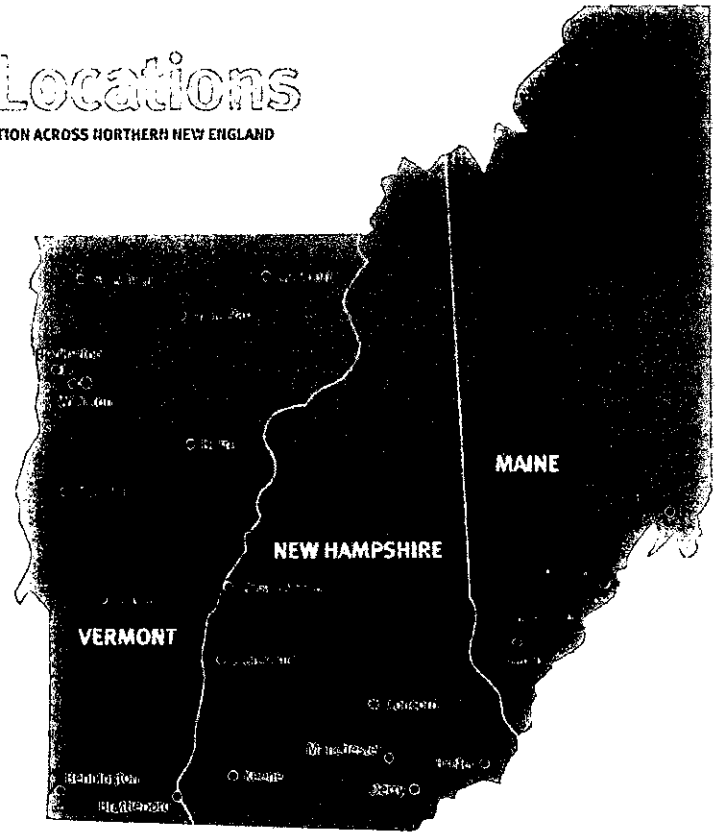
Patients & Patient Visits

MAINE		
VERMONT		
NEW HAMPSHIRE		
PPNNE TOTALS	48,614	71,308

PPNNE Locations

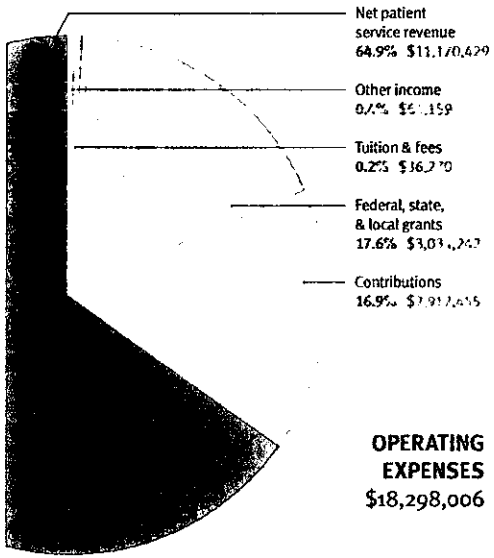
HEALTH CARE, ADVOCACY, & EDUCATION ACROSS NORTHERN NEW ENGLAND

- PPNNE Health Center
- Vermont Women's Choice
- Administration/External Affairs
- Central Administration



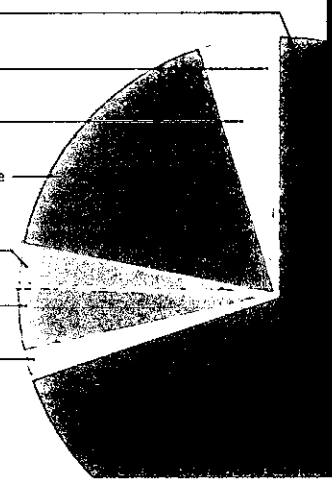
Operating Revenue & Expenses

OPERATING REVENUE
$17,217,555



- Net patient service revenue — 64.9% $11,170,629
- Other income — 0.4% $[illegible]
- Tuition & fees — 0.2% $36,270
- Federal, state, & local grants — 17.6% $3,03[illegible]
- Contributions — 16.9% $[illegible]

OPERATING EXPENSES
$18,298,006



- Direct patient services — 69.8% $12,771,076
- PPFA program support — 1.4% $[illegible]
- Fundraising — 3.3% $[illegible]
- General & administrative — 17.9% $[illegible]
- Marketing & communications — 2.4% $445,014
- Public policy — 4.5% $822,431
- Education & training — 1.6% $293,876

Leadership

Planned Parenthood®
of Northern New England

serving
Maine,
New Hampsh
& Vermont

MEMORANDUM

To: New Hampshire Senate and interested parties
From: Planned Parenthood of Northern New England
By Jennifer Frizzell, Senior Policy Advisor
Date: April 5th, 2012
RE: ISSUES RELATED TO CORPORATE SEPARATION OF ABORTION SERVICES

As a part of the current debate over federal and state funding for women's health care services, the suggestion has been made by outside pressure groups and proponents of House Bill 228 that PPNNE, hospitals and other physician offices should be required to segregate the provision of abortion services into a separate corporation in order to continue to qualify for participation in public health programs such as Medicaid and Title X.

This demand is problematic and unworkable for PPNNE for a number of reasons:

1. It is unclear what a structure that would satisfy this corporate separation requirement would look like. At present, PPNNE provides services in three states. In order to satisfy a requirement that the entity receiving state/federal funding in New Hampshire not provide abortion care we would need to form separate corporations for each state or maintain two separate corporations that operated co-extensively in all three states. PPNNE operates as a 501(c)(3) tax-exempt organization and it would be extremely difficult – if not impossible – to form new corporate entities, develop new Boards of Directors, obtain tax-exempt status from the IRS and then meet all of the charitable registration and reporting requirements that non-profits must adhere to at the state level for operations in a 3-state region. This proposed activity runs directly afoul of the administrative and corporate streamlining that PPNNE has achieved over the past 20 years by consolidating community-based providers into a tri-state organization with regional governance and corresponding operational efficiencies. It would be impossible to accomplish this "separation" in a manner that would preserve the delivery of services in an efficient and cost-effective manner.

2. Furthermore, the ongoing operation of two (or more) separate corporations would place an enormous regulatory burden on PPNNE. PPNNE would need to replicate numerous auditing and licensing functions throughout the organization. These would include, but not be limited to, CLIA and OSHA audits, billing and coding audits, internal risk and quality management functions and would likely require separate payroll and accounting systems. This would involve duplicative licensing fees and duplicative staff compliance functions diverting more dollars away from direct patient care.

3. In order to receive reimbursement for insured patients receiving abortion services at a new entity, PPNNE would need to negotiate new contracts with all third-party insurers in all three states. PPNNE would need to have all physicians and practitioners who work in the new entity re-credentialed with each third-party payer. PPNNE would also need to obtain new professional and facility liability insurance coverage for the new entities that would be more difficult and expensive to acquire for an abortion care entity.

4. Abortion services currently constitute only 3 – 5% of the overall patient care at PPNNE. A requirement that PPNNE form a separate entity and incur substantial new operating costs for such a small volume of services would greatly impact the cost basis for abortion care for patients and payors. It would also disrupt established health care practices where patients routinely seek other primary and contraceptive care in conjunction with an abortion visit. Instead they would need to be sent for a separate appointment at a separate facility.

5. Currently PPNNE has restricted (endowment) funds that have been donated to the organization for the purpose of providing financially eligible clients with subsidized access to abortion care. Because these funds are restricted by donor intent it is unclear whether, or how, we could transfer the funds to be used by one or more separate corporate entities.

6. Finally, assuming corporate separation requires separate facilities at which only abortion care will be provided, PPNNE patients and staff will be subjected to additional harassment, safety risks and privacy intrusions because protestors will know exactly where and when abortion services are provided and who specifically is visiting our facility to access those services. The reality is that facilities focused more on specialized abortion-services will be more vulnerable to physical attacks and constant surveillance by opponents who target abortion providers; this presents a very real public safety concern for PPNNE.

Lessons learned from separation in Texas

The example of Planned Parenthood's corporate separation in Texas has been offered by proponents of HB 228 to demonstrate how 'easy' and 'reasonable' this request is. However, a better understanding of what has happened and is still ongoing in Texas reveals just what a perilous road this is.

Five years ago the Planned Parenthood affiliates in Texas reached a court settlement in which they voluntarily agreed to corporate separation in order to continue to receive state/federal funding. First, it is significant that this came about as a settlement to litigation so that the terms and conditions were expressly outlined and supervised. One significant hurdle with the proposed separation requirement would be achieving agreement on what constitutes separation: Separate corporate entities? Separate facilities? Separate staff? Separate names? Can the remaining organizations have any affiliation whatsoever? Questions like these have been disputed and contentious throughout the Texas experience and are not appropriate for legislative micromanagement.

Originally, our Planned Parenthood colleagues in Texas believed that through the settlement process they could negotiate agreement on these on these structural issues and then return to work of providing services for our clients. However, the ink had barely dried on the settlement before opponents of Planned Parenthood began to attack the separation requirements as insufficient and demand further restrictions. In fact, our Texas affiliates have faced numerous legislative proposals to expand regulation over the separate abortion entity and in 2011 legislation was passed barring funding from organizations that have any affiliation with or shared governance structures with organizations providing abortion care. *An article documenting the devastating impact on health care access for Texas women as a result is attached.*

In addition to all of the operating issues outlined above, our Texas affiliates had to spend hundreds of thousands of dollars to achieve separation and then incurred $500k in audit/legal fees in the first year alone to meet the new requirements imposed by the separation agreement. Tragically, the financial and regulatory burdens imposed by separation have resulted in increased expenditures on lawyers and accountants and thus reduced the funding available for delivering health care in a corresponding amount.

None of this should come as a surprise. The interest groups pushing the separation requirement are the same interest groups that want to outlaw abortion and cripple Planned Parenthood's ability to provide comprehensive reproductive health care. Because they know their ultimate goals are unreasonable in the eyes of the public, our opponents have chosen instead to repackage their agenda and publicly pursue the 'more reasonable' goal of demanding separation - knowing that it will require an operational structure that makes abortion services easier to attack and nearly impossible to sustain. We will not be a party to this deception nor will we willingly enter into corporate structural changes intended to eliminate Planned Parenthood or our provision of abortion services.

New York Times March 7, 2012

Women in Texas Losing Options for Health Care in Abortion Fight
By PAM BELLUCK and EMILY RAMSHAW

Leticia Parra, a mother of five scraping by on income from her husband's sporadic construction jobs, relied on the Planned Parenthoodclinic in San Carlos, an impoverished town in South Texas, for breast cancer screenings, free birth control pills and pap smears forcervical cancer.

But the clinic closed in October, along with more than a dozen others in the state, after financing for women's health was slashed by two-thirds by the Republican-controlled Legislature.

The cuts, which left many low-income women with inconvenient or costly options, grew out of the effort to eliminate state support for Planned Parenthood. Although the cuts also forced clinics that were not affiliated with the agency to close — and none of them, even the ones run by Planned Parenthood, performed abortions — supporters of the cutbacks said they were motivated by the fight againstabortion.

Now, the same sentiment is likely to lead to a shutdown next week of another significant source of reproductive health care: the Medicaid Women's Health Program, which serves 130,000 women with grants to many clinics, including those run by Planned Parenthood. Gov. Rick Perry and Republican lawmakers have said they would forgo the $35 million in federal money that finances the women's health program in order to keep Planned Parenthood from getting any of it.

Although Texas already bars clinics that take such money from performing abortions, the new law is intended to prevent any state money from benefiting Planned Parenthood. "Planned Parenthoods across the country provide abortions, are affiliated with abortion providers, or refer women to abortion providers," said Lucy Nashed, a spokeswoman for Mr. Perry.

Wayne Christian, a Republican state representative said, "I don't think anybody is against providing health care for women. What we're opposed to are abortions." He added, "Planned Parenthood is the main organization that does abortions. So we kind of blend being anti-abortion with being anti-Planned Parenthood."

The situation in Texas is mirrored in several other states that have tried to eliminate various methods of financing Planned Parenthood.

Abortion also undergirds the Republican presidential candidates' opposition to federal financing for Planned Parenthood, a private nonprofit group that offers a variety of reproductive health services and is the nation's largest provider of abortions. And critics ofcontraception coverage under the new federal health care law say that some birth control methods are essentially abortion drugs, an assertion scientists largely dispute.

As the case in Texas illustrates, such battles are affecting broader women's health services. Some women have lost the only nearby clinic providing routine care.

Nationally, the newest target is Title X, the main federal family planning program. All four Republican presidential candidates support eliminating Title X, which was created in 1970 with Republican support from President Nixon and the elder George Bush, then a congressman.

Like other federal financing, Title X does not pay for abortions. Only some of it covers birth control. Title X also provides money for cervical and breast cancer screening, testing for H.I.V. and other sexually transmitted diseases, adolescent abstinence counseling, infertility counseling and other services.

Planned Parenthood receives about a quarter of Title X's $300 million budget and sees about a third of Title X patients. The remaining money goes to clinics, community health centers, hospitals and state agencies.

Mitt Romney's fiscal plan proposes eliminating Title X because it "subsidizes family planning programs that benefit abortion groups like Planned Parenthood."

Rick Santorum, in a recent debate, acknowledged, to boos, that in Congress he voted for appropriations bills that included Title X money. He pledged to rectify that if elected, saying, "I've always opposed Title X funding."

President Obama supports Title X, which serves five million low-income people. "People think Planned Parenthood equals family planning the way Kleenex equals tissue, and it's not true," said Clare Coleman, president of the National Family Planning and Reproductive Health Association, a nonprofit, nonpartisan organization of family planning providers. Title X supports many other providers, she said: "In a lot of states there is no state money for family planning. So Title X is the ballgame."

A 2009 Congressional Research Service report cited federal estimates that Title X helps prevent nearly a million unintended pregnancies annually. Reproductive health experts say that saves money, that every dollar spent on family planning saves about $4 in maternity and infant care.

Some experts also say the financing helps prevent about 400,000 abortions annually. Opponents of Title X and government financing of family planning say these effects are exaggerated.

"Eliminating Title X would not outlaw contraception," said a spokesman for Ron Paul. "People would simply have to pay for contraceptives with their own money or money donated by private sources."

The battle intensified in February when the House of Representatives voted to eliminate Title X and eliminate federal financing for Planned Parenthood. The Senate defeated the bill, but the issue remains alive.

Several state legislatures recently voted to stop some Planned Parenthood financing: Title X money in Kansas and North Carolina, Medicaid in Indiana, other family planning and breast cancer screening funds in Wisconsin. In three of the states, judges blocked the laws, at least temporarily, ruling that Planned Parenthood had been illegally excluded even if it was not named. (Wisconsin's cuts have not been challenged in court.)

New Hampshire canceled a state contract with Planned Parenthood last year, but the federal government awarded the organization a similar contract. Recently, the New Hampshire House of Representatives voted to essentially strip Planned Parenthood of family planning money by creating a tiered system in which Planned Parenthood and other women's clinics could receive financing only in the unlikely possibility that the state could not give it to government-run clinics or to hospitals. The Senate has not voted on the bill.

Texas enacted a similar tiered system and also sliced its two-year family planning budget from $111 million to $38 million, cuts that the nonpartisan state Legislative Budget Board estimated would eliminate services for nearly 284,000 women, lead to 20,500 additional births and cost Medicaid about $230 million. The board had recommended expanding family planning as a way of saving money.

Now, the Medicaid-financed Women's Health Program is in jeopardy. Texas signed regulations prohibiting clinics affiliated with groups that provide abortions from receiving funds, even though the clinics do not perform abortions themselves. The federal government says excluding qualified providers in this way is illegal, requiring it to withhold $35 million — about 90 percent of the program's financing — if the regulations, which take effect on Wednesday, are not rescinded. That would effectively end the program, increasing the number of women without services to about 400,000. Already, Planned Parenthood of Hidalgo County, which is on the Texas-Mexico border, has closed four of eight clinics, including the one in San Carlos, and trimmed services.

The closest clinic to San Carlos is 16 miles away in Edinburg. There, a receptionist informs callers not to expect appointments soon. Wait times have grown to up to four weeks. Many San Carlos patients struggle to reach Edinburg from their homes in impoverished neighborhoods called colonias. Maria Romero, a housecleaner with four children, who had a lump in her breast discovered at the San Carlos clinic, has no way to get there.

Ms. Parra, 33, the mother of five, managed to borrow a car to get to Edinburg after a pap smear at the San Carlos clinic indicated she might have cervical cancer. Further tests showed she was cancer-free. Both women worry about getting birth control pills; the clinic may now have to charge them up to $20 for a month's supply.

"I will have to go without," Ms. Parra said as she left an English class at a community center and was walking to pick up her two youngest children from a Head Start program. "If I get pregnant again, God forbid."

millham

New Hampshire General Court - Bill Status System

Docket of HB228

Docket Abbreviations

Bill Title: (New Title) prohibiting the use of public funds for abortion services.

Official Docket of **HB228**:

Date	Body	Description
1/20/2011	H	**Introduced** 1/6/2011 and Referred to Health, Human Services and Elderly Affairs; **HJ 11**, PG. 178
1/25/2011	H	Public Hearing: 2/8/2011 1:30 PM LOB 205
2/9/2011	H	Subcommittee Work Session: 2/17/2011 2:30 PM LOB 205
2/17/2011	H	Subcommittee Work Session: 2/24/2011 1:00 PM LOB 205
2/25/2011	H	Subcommittee Work Session: 3/3/2011 2:00 PM LOB 205
3/1/2011	H	Executive Session: 3/9/2011 10:00 AM LOB 205
3/9/2011	H	Retained in Committee; **HC 27**, PG.824
10/4/2011	H	Retained Bill - Subcommittee Work Session: 10/10/2011 1:00 PM LOB 205
10/5/2011	H	==CANCELLED== Retained Bill - Executive Session: 10/12/2011 LOB 205 1:00 PM or Immediately Following House Session
10/12/2011	H	Executive Session: 10/20/2011 2:00 PM LOB 205
10/27/2011	H	Committee Report: Inexpedient to Legislate for Jan 4 (Vote 12-5; RC); **HC 70**, PG.2220
1/5/2012	H	Special Order, Postpone to a Time Certain being January 18 (Rep Bettencourt): MA **RC** 298-18; **HJ 8**, PG.518-520
1/18/2012	H	Inexpedient to Legislate: MF **RC** 150-195; **HJ 10**, PG.591-593
1/18/2012	H	Ought to Pass (Rep Tucker); **HJ 10**, PG.593
1/18/2012	H	Floor Amendment **#2012-0237h**(NT) (Rep Groen): AA **RC** 206-147; **HJ 10**, PG.593-596
1/18/2012	H	Ought to Pass with Amendment #0237h(New Title): MA **RC** 207-147; **HJ 10**, PG.597-598
2/15/2012	S	Introduced and Referred to Health and Human Services; **SJ 6**, Pg.144
3/14/2012	S	Hearing: 4/5/12, Room 100, SH, 1:00 p.m.; **SC11**

NH House	NH Senate

Zorkner

April 5, 2012

Dear Chairman Bradley and Health and Human Services Committee Members,

I am in favor of HB 228. Abortion has caused more health care problems than meets the eye because facts are continuously hidden from public view due to the motives of those who make huge amounts of money preying on women and young girls. First, there is the use of abortifacients, which were never medically tested on young women's bodies before they were given out regularly to them through agencies like Planned Parenthood. No one really knows how these hormonally laden drugs impact the body, which is transitioning from girlhood to adult womanhood. Many feel that young women that start on these drugs in their teens and use them for years have problems with fertility later on, costing them pain, hardship and often resulting in childless marriages. Of course that ties into other industries such as fertility treatments for women, how much of that is uncalled for and a result of abortifacient contraceptive use, we will never know for sure.

The other health issues, which impact women and cost us millions of dollars in health care cost result from side issues such as blood clots, some of this can be life threatening even. Recently there have been ads on TV advertising about possible birth defects linked to the use of some birth control methods such as YAZ. All of this is secondarily linked to the abortion industry.

Abortion directly has been linked to breast cancer because the woman's body has a normal way of dealing with pregnancy and the sudden and unnatural removal of the child from the woman's body causes a chain of events and sudden unnatural hormonal changes often resulting in breast cancer, not immediately but often about 10 years after an abortion.

Other health problems shown in studies to be linked to abortion include the emotional side effects and trauma of the realization that a child has been lost. Untold sorrow, often hidden in a woman's heart and soul for years before it is fully realized, is often the story hidden from public view. Women often deal with this sense of loss and guilt through drinking and drugs and have a great loss of respect for themselves, finding it hard to forgive themselves for having done something they now understand as being linked to the death of a child. This can have other results, which are felt even in future childrearing behaviors, child abuse or even at times resulting in deep depression and suicide. No one can predict how an abortion will emotionally affect someone.

I can not be with this group today because of a job but I stand united with them in saying abortion is not health care at all. We need to stop this social experiment, which has gone so wrong.

Sincerely,
Mary Zore
Brookline, NH

Primary Care Internist in the state of NH since 1999. The numbers of people struggling to afford medical care have increased dramatically. The care that is provided by Planned parenthood and other low income clinics is often the only care that men and women can access. The care that is provided during women and men's reproductive years often sets the stage for future healthy lives by helping them avoid serious, life threatening problems that ~~arise without~~ are avoided by preventive care services. Without clinics that are affordable and accessible to those ~~noble~~ notable to afford the increasingly expensive health insurance policies, low income and struggling families will be far more likely to suffer chronic and sometimes life threatening illness. In particular, disrupting women's access o to preventive care such as gynecologic exams, breast exams and access to reproductive services will result in a greater burden of of illness, more expensive medical care and more unintended pregnancy.

I should point out that this legislation is not strictly about reproductive health issues. It is fundamentally limits participation of citizens in making their own private decisions in a free and democratic society. This legislation would deny low income women and families from full participation in civil society by denying them access to fully informed private medical counseling that is both legal and safe. Safe, compassionate affordable full spectrum access to reproductive care is vital to our society. The

men and women who can no longer control the number of children they can care for are destined for a life of hardship and a cycle of poverty. While abortion is rarely desirable, it is a legal and important choice that must be discussed openly and without restriction or censorship. It must be provided by a compassionate and skilled medical team free from bias and available to all.

There is already experience with this sort of censorship in the form of the Global Gag Rule passed in 2002. Dr Eunice Brookman-Amissah from Ethiopia summarized it's impact:

Contrary to it's stated intentions, the global gag rule results in more unwanted pregnancies, more unsafe abortions, and more deaths of women and girls. We who have seen those effects first hand can no longer tolerate silence about the gag rule's tragic effects.

If we want a society that values life, equality, and the opportunity to make informed personal decisions without government imposed censorship then this bill and any other similar legislation should not be passed

Testimony, Senate version of HB 228, an act prohibiting the use of public funds for abortion services, given by Rabbi Robin Nafshi

Good afternoon. My name is Robin Nafshi. I serve as the Rabbi of Temple Beth Jacob here in Concord. Thank you for taking my testimony.

From a religious, moral, and ethical perspective, deciding whether or not to have an abortion – to terminate a pregnancy – is a difficult one. Any woman faced with the decision wrestles with a myriad of issues; highest among them are her own physical and mental health and the physical and mental health of any child she would bring into the world. She often consults her partner, others in her family, her medical care provider, and her clergy. She does not take the decision lightly.

The religious movement to which I belong, Reform Judaism, is a member of the Religious Coalition for Reproductive Choice. This is a non-profit, non-partisan education and advocacy organization of religious groups working together to preserve a woman's right to reproductive choice, including safe and legal abortions, free from government interference or coercion.

While theologically diverse, Religious Coalition members are unified in their commitment to safeguarding reproductive choice as an element of religious liberty. The Religious Coalition is made up of: the Episcopal Church, the Presbyterian Church (USA), the United Church of Christ, the United Methodist Church, the Unitarian Universalist Church, and the Conservative, Reconstructionist, and Reform Jewish movements. Organizations such as Catholics for Choice are also a part of the Coalition. The Conservative, Reconstructionist, and Reform Jewish movements have a long record of support for women's reproductive rights. All life is sacred in Judaism. Although an unborn fetus is precious and to be protected, Judaism views the life and well-being of the mother as paramount, placing a higher value on existing life than on potential life. Women are commanded to care for their own health and well-being above all else. It is due to the fundamental Jewish belief in the sanctity of life that abortion is viewed as both a moral and correct decision under some circumstances.

One Jewish law, for example, forbids a woman from sacrificing her own life for that of the fetus, and if her life is threatened, the law permits her no option but abortion.[1] In addition, if the mental health, sanity, or self-esteem of the woman (for example, in the case of rape or incest) is at risk due to the pregnancy itself, Jewish law permits the woman to terminate the pregnancy. Thus, any law that restricts a woman's access to safe and legal abortion

[1] *Mishnah Ohaloth* 7:6

services is a law that restricts the religious freedom of those whose religious beliefs would dictate that under the circumstances, she terminate her pregnancy. Such a law would also impede my ability to properly and fully provide counseling to pregnant women who come to me for guidance.

This bill, however, is not only about religious freedom. It would also have a disparate impact on the poor. ~~Jewish~~ religious tradition is emphatic about the importance of the community providing health care for its most vulnerable residents. If this bill were to become law, wealthy women would still find access to abortion services. But poor women would not. This bill simply would penalize poor women who are seeking basic, essential, and legal health care. This is immoral. Every person in this state should have access to the health care that is right for him or her, whether that person is rich or poor.

Hebrew scripture details for us one of the world's earliest social welfare systems. We are taught to leave the corners of our fields and the gleanings of our harvest to the poor,[2] and to open our hands and lend to people whatever it is they need.[3] The Hebrew word that means helping fellow human beings in need, *tzedakah*, does not mean charity; rather, it comes from the word that means righteousness and justice. We are *obligated* to help the poor; we do not have the choice not to. And help is not just in the form of giving; it also encompasses advocacy. As we read in the Bible, "champion the [rights of the] poor and the needy."[4]

I know that many people object to abortion as a violation of their religious beliefs. And, some religions teach that abortion is the correct decision under certain circumstances. The state of New Hampshire does not have the right to ~~choose~~ prefer one religious tradition over another.

But the State of New Hampshire does have the right to favor one moral position over another. And an individual's access to basic, essential and legal health care that is right for her has a greater moral standing than another person's objection to abortion.

Please reject HB 228. Do not change the law. As Daniel Webster once said, "A strong conviction that something must be done is the parent of many bad measures."

---

[2]Leviticus 19:9

[3]Deuteronomy 7-11

[4]Proverbs 31:9

4/4/2012

TESTIMONY Senate Health and Human Services Committee

Mr. Chairman and members of the committee, my name is Barry Smith. I am an Obstetrician/ Gynecologist who has worked in NH at DHMC since 1970. I was the Chair of the Department of Obstetrics and Gynecology until I retired from that position six years ago.

During the last six years I worked half time at DHMC doing patient safety and quality improvement work. I retired from that position in June 2011. I continue to serve on the NH Medical Society Executive Council; NH PRAMS(Pregnancy Risk Assessment) advisory committee, as a Hitchcock Foundation Trustees Council; on the Community Advisory Committee to the Superfund Project at DHMC(Arsenic, mercury medical issues); and as President of the New England OB/GYN Society. I am a member of the MOMS (Making Obstetrics Safe) committee of American College of OB/GYN; and a Member of ACOGs Government Affairs Committee. I say this only to show that I continue to be involved in efforts to improve the quality and safety of women's health care.

I am here to speak against House bill 228. As I read this bill it would result in setting back much of the progress made in woman's health care over the past forty years because it would result in loss of access to preventative and basic health care for a large group of women in NH who are already in the poor, underinsured and uninsured group. The opening portions of this bill clearly state what ideal health care might be with every man, woman and child having a primary care provider they could afford. The reality is that the primary care health care provider for many women in NH is Planned Parenthood and other state or Medicaid supported services. I repeat, Planned Parenthood IS the primary care provider for many NH women. As a medical provider who has also volunteered at a PPH clinic I am familiar with the high quality and compassionate care that Planned Parenthood provides to this vulnerable population.

The bottom line of this bill is to restrict funding to any organization that provides as part of comprehensive health care any pregnancy termination services or even counseling. In the case of Planned Parenthood, termination services are a very small portion of their effort which is paid for by no governmental funds.

I should clarify that as a father of two adopted children and the grandfather of two additional adopted children I take pregnancy termination very seriously. I also believe that this legal service, when done should be done safely and only by people well trained in this area to protect the life and fertility of the woman.

In addition, the fiscal outcomes of the passage of this legislation would result in a severe loss of funds to NH which would result in further stress on a health care system that is already at a financial breaking point. This legislation could cripple health care delivery at many hospitals and NH physician offices. This would result in more NH citizens receiving less of the needed health care already detailed in the first part of the bill. I am asking that this committee reject this radical bill which would endanger the health of a large number of NH residents.

Barry D Smith

Barry D. Smith, MD
Professor of Obstetrics and Gynecology, Emeritus
Chairman Emeritus
Dartmouth Hitchcock Medical Center

April 5, 2012 HB 228

Good Afternoon

My name is Maribeth Quinn. I live in Portsmouth, New Hampshire. I am a certified nurse midwife and a nurse practitioner of gynecology since 1997 here is the seacoast. I have delivered over 1600 babies and have provided gynecology care to thousands of women. Currently I am adjunct faculty for the nursing department at UNH and a graduate student at Philadelphia University. I am in opposition of this bill that will defund Planned Parenthood. I believe it is not in our interest to eliminate access of affordable birth control to thousands of women in this state. Typically, Planned Parenthood serves women with limited resources; this is the same population who has disproportionately more unintended pregnancies when contraception is unavailable. I have had a collegial relationship with Planned Parenthood. Women were referred to our practice for prenatal care, once they became pregnant. I saw many teens referred after a birth control failure. Planned Parenthood staff had started them on prenatal vitamins and many received the initial counseling on the negative effects of cigarettes, alcohol and drugs for their growing babies. Once the baby was born, women who were losing their Medicaid or their insurance from a previous job, were referred back to Planned Parenthood for their primary care and contraception. They told me that it was much more affordable there. They felt very comfortable with the care that they received and described the staff as compassionate and nonjudgmental.

I have spoken about this legislation with my Senator, Nancy Stiles as well as with one of the bill sponsors, Representative Cebrowski. I understand that abortion is a moral issue fraught with heartache. I don't believe that anyone would disagree. These conversations prompted me to look deeper into the research. Unlike Representative Pence, Dr. Trussell and his group of data analysts found that abortion rates do not decrease by eliminating contraception, but in fact, the provision of contraception is the keystone in the prevention of unintended pregnancy. Planned Parenthood's promotion of contraception is the vehicle to prevent unintended pregnancies and abortions in this state. Also in my research, I found that providing contraception to a population is cost effective, beyond debate. Many studies have been published that repeatedly show substantial savings to the public in pregnancy related medical expenses from the provision of contraceptive services to low income women. All methods are found to be cost effective, that is, save more money in public expenditures than they cost to provide. ~~From this analysis, I disagree~~

~~with the Fiscal Note attached to this bill. I believe that "indeterminable impact" on state revenues can be estimated and would be astonishing.~~ (Fiscal Note has been updated)

This bill insinuates that primary care providers should be the recipients of federal and state monies, however, the unemployed and impoverished citizens, historically don't have access to primary care providers. When a woman comes to our office for a physical exam, if she has no insurance to bill, she is asked to pay $240.00 before the visit. Many people can't afford that and instead will go to Planned Parenthood for their primary care. There they will be billed on a sliding scale for their exams and prescriptions. We don't have sliding scales at our office. We don't give free antibiotics and birth control to women with no money or job or health insurance. I don't know of any private practice in our city or surrounding city that does provide this. If Planned Parenthood is removed from the health care delivery in our state there will be NO free birth control and there WILL be more unintended pregnancies and there WILL be more abortions.

Mulroy

New Hampshire Public Health ASSOCIATION

Improving Health, Preventing Disease, Reducing Costs for All

April 5, 2012

Subject: **HB 228 – An Act prohibiting the use of public funds for abortion services, FORMERLY ENTITLED, prohibiting NH DHHS from entering into a contract with Planned Parenthood Federation of America, Inc. or any organization that provides abortion services.**

Chairman Bradley and Members of the Health and Human Services Committee:

The New Hampshire Public Health Association (NHPHA) asks that you *OPPOSE* HB 228.

Major public health achievements made in the last century reflected advances in maternal and child health, a critical component of which was family planning - the ability to achieve safe and effective methods of spacing births and planning family size.

Planned Parenthood of Northern New England and other New Hampshire health care agencies have for years played a critical role in ensuring access to a broad range of family planning and related preventive health services for thousands of low-income and uninsured residents, These include: comprehensive reproductive health care including routine exams, screening sexually transmitted infections and a wide range of contraceptive methods; pregnancy testing and counseling; and community education on reproductive health and sexuality.

Timely, affordable access to high quality, comprehensive reproductive services is an essential contributor to healthy pregnancies, and reduces the demand for abortions.

This bill enables discrimination against New Hampshire residents with low incomes who are uninsured or under-insured by denying them access to high quality, comprehensive reproductive health information and services that ensure optimal health for themselves and their families.

The New Hampshire Public Health Association (NHPHA) asks that you *OPPOSE* HB 228.

Thank you,

The Public Policy Committee
New Hampshire Public Health Association

4 Park Street, Suite 403 . Concord, NH 03301 . 603-228-2983 . www.nhpha.org

525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464

BI-STATE PRIMARY CARE ASSOCIATION

SERVING VERMONT & NEW HAMPSHIRE

61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

www.bistatepca.org

Testimony in Opposition

HB 228-FN: "An Act Prohibiting the Use of Public Funds for Abortion Services"

April 5, 2012

Senator Bradley, and distinguished members of the Senate Health and Human Services Committee, my name is Vanessa Santarelli and I serve as the Director of New Hampshire Public Policy for Bi-State Primary Care Association. Bi-State is a 501c3 non-profit organization whose members include: Federally Qualified Health Centers (FQHCs), FQHC Look Alikes (LAL), Rural Health Centers (RHCs), hospital-based primary care practices and non-FQHC Community Health Centers (CHCs). I am testifying today on behalf of our members and the approximately 125,000 patients they serve throughout the state in opposition to HB 228-FN: "*An Act Prohibiting the Use of Public Funds for Abortion Services.*"

The bill summary says the intent is to *"clarify public funding of abortions"*, however, the House amended version that you have before you has far broader implications for the primary and preventive care services our members provide to their patients. Passage of this bill would also adversely impact the state's Medicaid Program. The original bill was deliberated at length in the House Health and Services Committee, and received a bi-partisan vote of 12-5 to ITL. Yet, when it reached the floor of the House, an amendment was brought forward and passed that broadened the scope of "prohibited" services that, if provided, would result in the potential loss of any and all state funds for critical services such as breast and cervical cancer screenings, STD testing, chronic disease management, well-child visits, prenatal care, and other comprehensive primary and preventive care services. This is deeply concerning to the Community Health Centers, considering that they provide a Medical Home to approximately 1 in 10 New Hampshire residents, many of whom are uninsured or on Medicaid.

The Community Health Centers operate on tight margins because they serve a high percentage of medically underserved individuals. As such, the patchwork of federal and state funding they receive through programs such as: 330 federal grants (FQHCs), Title V, Title X (family planning services), WIC, and the state's Maternal and Child Health Program (primary care contracts), are critical resources that allow them to keep their doors open to everyone. The loss of any of these essential funds would deal a tremendous blow to the state's primary care infrastructure because the FQHCs, on average, have fewer than 30 days cash on hand.

The FQHCs are heavily regulated and audited by the federal government and the state to ensure that they are being proper stewards of the funding they receive. They comply with all state and federal laws. However, the provision in this bill that would restrict any entity receiving public funds from providing services that include among others, abortion counseling and referral, would put them out of compliance. This would not only jeopardize their ability to access vital resources which are used to provide high quality patient care; but would also deny their patients' access to services that they are legally entitled to.

Bi-State and the Community Health Centers have been working with members of the Legislature, the Department of Health and Human Services, and the Managed Care Organizations to prepare for the Medicaid Care Management transition. We anticipate and are eager to care for more patients under the new program if and when it is approved by Governor and Council; however, the fiscal note on the bill raises a number of questions and concerns about the future of Medicaid funding and the sustainability of the Medicaid Program. For the preservation of the Medicaid Program, and sustainability of Community Health Centers and primary care services, we respectfully urge the Committee to unanimously oppose HB 228-FN.

I would be pleased to respond to any questions. **Thank you.**

April 5, 2012

Thank you, Chairman Bradley and Members of the Committee. I serve as Senior Counsel and Vice President for Human Life Issues in the Washington office of the Alliance Defense Fund, a non-profit legal alliance that seeks to preserve the sanctity of human life. I'm speaking today on behalf of New Hampshire Right to Life, addressing the constitutionality of HB228, the "Woman's Health Funding Priorities Act."

In our opinion, Mr. Chairman, this bill neither contravenes federal supremacy nor targets particular abortion providers for exclusion from the Medicaid program. Accordingly, it is both constitutional and consonant with applicable federal law.

The findings and purpose section make it clear that the bill is designed to accomplish two legitimate and important fiscal and health care goals: first, to prioritize public funding for family planning and preventive health services for women to providers of primary care; and second, to ensure that no public funds are used to subsidize abortion, either directly or indirectly.

Section 126-V:3(I) of the bill prioritizes public funding for family planning and maternal/fetal services to primary care providers. Public health departments and clinics, and non-public hospitals and Federally-Qualified Health Centers ("FQHCs") and Rural Health Clinics ("RHCs"), provide low-income families with access to not only family planning services, but also vital preventive services, including prenatal and perinatal services, well-child services, immunizations against vaccine-preventable diseases, primary care services, diagnostic laboratory and radiologic services, emergency medical services, and pharmaceutical services as appropriate to a particular health center.

Insofar as its provisions govern the administration of family planning funds, it will primarily impact Title X, the federal family planning program, and Medicaid family planning services under Title XIX.

There is no conflict between the bill's provisions and Title X law and regulations, and the bill therefore raises no federal preemption issues. Preemption requires that the bill erect an obstacle to the execution of Congressional objectives or render it impossible to comply with both state and federal requirements, circumstances not presented by the bill's provisions.

The bill does not reduce funding for family planning services, but simply alters the delivery of such services by prioritizing funding to public and private agencies that provide comprehensive "whole woman" primary and preventative care. Federal HHS guidance states that a Title X program grantee has the discretion to either discharge the duties itself or through select delegate agencies. Where a grantee, such as the New Hampshire State Department of Human Services, decides to utilize delegate agencies, HHS mandates that the grantee nonetheless remains solely responsible for the legal and financial aspects of the delegate agencies' progress towards the project's goals.

The prioritization of public funds to public health care agencies, then to private agencies that are able to provide the primary and preventative care afforded by public providers, is essentially the "consolidated grant system" that has been upheld in federal case law. The D.C. Circuit Court of Appeals in *Planned Parenthood of Utah v. Schweiker* affirmed the State of Utah's authority to act as sole grantee for the Title X program through a consolidated grant award from HHS. The Title X regional administrator awarded the state Department of Health the grant based on its assurances that it could and would provide family planning services to all eligible women that had previously been served by the State and two other providers, including

Planned Parenthood. Planned Parenthood sued, arguing that HHS' actions violated their right to apply directly for grants and that its policy of favoring consolidated grants was unlawful under Title X. The district court dismissed the lawsuit, holding that "not only did Congress not enact legislation prohibiting consolidated grants, but the pertinent legislative history evidences Congress' approval of consolidated grants where appropriate." The award to Utah as the sole source, said the court, was not "arbitrary, capricious, an abuse or discretion, or otherwise not in accordance with law," and was consistent with 'HHS' valid policy of grant consolidation" to "lower administrative costs and assure better delivery of services." The court of appeals affirmed, concluding that Title X protected only the right to apply for a grant, not to receive one, and that the consolidation process was consistent with Congressional directions to encourage "better coordination of existing services" and to "determine the degree of duplication and philosophical consistency existing in current Federal programs including family planning." In fact, the court noted, federal law required HHS to favor consolidated grant applications where appropriate – a mandate HHS remains under to this day.

The bill's provisions also implement the letter and intent of federal law prohibiting subsidization of abortion through the Title X program. *Rust v. Sullivan* upheld the constitutionality of federal Health and Human Services regulations prohibiting Title X family planning recipients from including abortion services, referrals or counseling in program activities. "[T]he Government is not denying a benefit to anyone, but is instead simply insisting that public funds be spent for the purposes for which they were authorized," the Supreme Court held. The government "can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way." Although

the bill allows counseling and referral for abortion by delegate state fund recipients in compliance with Title X rules, delegates that still intend to engage in abortion-related services must "conduct those activities through programs that are separate and independent" from Medicaid-funded facilities, a rule the Court in *Rust* found constitutionally permissible for Title X grantees.

Sec. II of subpart V:3 of the bill, which prohibits State health authorities from contracting with, or making grants to, an entity that performs abortions or maintains or operates a facility where abortions are performed (other than Hyde-Amendment-eligible "federally qualified abortions"), likewise does not offend federal supremacy under the Medicaid law.

The State through this legislation would merely be applying its own congruent conditions to eligibility for qualified provider status under Medicaid, and not imposing conditions inconsistent with federal guidelines. The Medicaid Act expressly embraces State authority to establish provider qualifications such as those contained in the bill. The Medicaid Act provides that "[i]n addition to any other authority, a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the Secretary [of the Department of Health and Human Services] could exclude the individual or entity from participation in [Medicaid]." Thus, according to the U.S. Supreme Court, "[t]he fact that a State's decision to curtail Medicaid benefits may have been motivated by a state policy unrelated to the Medicaid Act does not limit the scope of its broad discretion to define the package of benefits it will finance." A federal appeals court has ruled that the qualifications authority provided to States under Medicaid "was intended to permit a state to exclude an entity from its Medicaid program *for any reason established by state law*."

The bill does not impermissibly condition government benefits on the forfeiture of constitutional rights. The Supreme Court has never held that providers or physicians have a constitutional right to perform abortions—or any medical procedure for that matter—independent from the rights of the patient. To the contrary, it is clear that the State may regulate the ability of physicians to practice medicine, including performing abortions.

Nor does the bill render any particular abortion provider ineligible for Medicaid family planning reimbursements. If a provider desires to continue receiving Medicaid funds after passage of this bill, it can maintain affiliation with abortion clinics and continue eligibility, provided there is no cross-subsidy. Two federal appeals courts have upheld this funding structure as constitutional. In *Planned Parenthood of Mid-Missouri and Eastern Kansas v. Dempsey*, the Eighth Circuit held that a Missouri law employing similar provisions did not impose an unconstitutional condition on abortion providers' receipt of Title X family-planning funds because recipients could continue "to exercise their constitutionally protected rights through independent affiliates." The Fifth Circuit held likewise in reviewing a Texas abortion exclusion provision, including Title X and Medicaid funds, to entities that did not perform elective abortion procedures and did not contract with or provide funds to individuals or entities for the performance of elective abortion procedures.

In conclusion, the Supreme Court has observed that state governments have "a legitimate and substantial interest in preserving and promoting fetal life." To further that end, States have authority to enact laws and policies that encourage childbirth over abortion, including withholding taxpayer subsidies for abortion. As the Court has stated numerous times, "[T]he State need not commit *any* resources to facilitating abortions....", and "[A] woman's freedom of choice [does not] carr[y] with it a constitutional entitlement to the financial resources to avail

herself of the full range of protected choices." The "Women's Health Funding Priorities Act" offends neither federal constitutional law nor federal statutes governing Title X and Medicaid family planning. Thank you for the privilege of testifying today.

Cornerstone
RESEARCH - ACTION - COMPASSION

To: Senate Health and Human Services Committee, 4 April 2012
Re: HB 228, prohibiting the use of public funds for abortion services
Contact: Ellen Kolb, Legislative Affairs Director 603-321-2703

A year ago, House Bill 228 was introduced with the goal of preventing taxpayer money from subsidizing abortion providers, even indirectly. Cornerstone supported the bill as a way to respect the legitimate concerns of New Hampshire residents with objections to abortion, the legality of which is unaffected by the bill. Months of debate and study have taken place since then, and Cornerstone now supports the amended version of the bill to be heard by the Senate Health and Human Services Committee today.

Now called the Woman's Health Funding Priorities Act, the bill balances the needs of women who depend on publicly-funded family planning services with the conscience rights of New Hampshire residents who choose not to subsidize abortion providers. It introduces a set of priorities for determining which entities may receive public funds for family planning services, and in our opinion the time is ripe for this idea. The sponsors, knowing that some other states are enacting or considering similar legislation, sought expert advice that eventually led to the amended bill being considered today.

We recognize that Title X and similar programs cover family planning and not abortion. However, any family planning money that goes to a provider or agency that also performs abortions indirectly subsidizes those abortions by freeing up other money within the provider's budget. HB 228 points the way to preventing such indirect subsidies.

Past and current recipients of public health care money who fear a loss of funds if their current business model is incompatible with this bill would have the option of dividing their operations to keep abortion activities physically, financially, and legally separate from the provision of other services. This arrangement has survived court challenges in Texas. Providers could also choose to allocate their own resources to family planning services for low-income clients, possibly by shifting funds away from expenditures such as marketing or public-policy work. Either way, the amount of family planning funds in the state would be unaffected. HB 228 only affects how the funds are to be allocated.

HB 228 is not an attempt to make some quixotic point before a federal court. We defer to the legal analysis to be presented to the committee today by Steven H. Aden, Esq., Senior Counsel with Alliance Defense Fund. We note that Attorney Aden's analysis concludes with a statement that ADF would be willing to assist the state in a defense of this bill if enacted in substantially the form before you today.

We're not afraid of continued robust discussion of the use of public health-care funds, and we know debate will continue regardless of the outcome of this bill. Any effort to change a piece of the health-care puzzle has effects, sometimes dramatic, on all parties. We encourage you to move forward nonetheless, recognizing the need for provision of health care under Title X and related programs. We encourage you as well to recognize that abortion is not part of that care and that you have New Hampshire neighbors – some of whom are here today – who want no part of subsidizing abortion. HB 228 offers a model for meeting both challenges.

###

ALLIANCE DEFENSE FUND
Defending Our First Liberty

Steven H. Aden, Senior Counsel
801 G St., N.W., Suite 509
Washington, DC 20001
Tel.: 202.393.8690
Email: saden@telladf.org

April 5, 2012

Chair and Members
Health and Human Services Committee
New Hampshire State Senate
107 North Main Street
Concord, NH 03301

Re: Legal Analysis of HB228, "Whole Woman's Health Funding Priorities Act" Written Testimony Submitted on Behalf of New Hampshire Right to Life

Ladies and Gentlemen:

The Alliance Defense Fund is privileged to testify with regard to the constitutionality of HB228, the "Whole Woman's Health Funding Priorities Act," on behalf of New Hampshire Right to Life. In our opinion, the bill neither contravenes federal supremacy nor targets particular abortion providers for exclusion from the Medicaid program. Accordingly, it is both constitutional and consonant with applicable federal law.

Purpose and Effect of the Bill.

Section 126-V:1 of the bill contains legislative findings related to the bill's provisions, and sets out the bill's purpose. The findings and purpose section make it clear that the bill is designed to accomplish two legitimate and important fiscal and health care goals: first, to prioritize public funding for family planning and preventive health services for women to providers of primary care; and second, to ensure that no public funds are used to subsidize abortion, either directly or indirectly.

126-V:3(I) of the bill prioritizes public funding for family planning and maternal/fetal services to primary care providers. Public health departments and clinics, and non-public hospitals and Federally-Qualified Health Centers ("FQHCs") and Rural Health Clinics ("RHCs"), provide low-income families with access to not only family planning services, but also vital preventive services, including prenatal and perinatal services, well-child services, immunizations against vaccine-preventable diseases, primary care services, diagnostic laboratory and radiologic services, emergency medical services, and pharmaceutical services as appropriate to a particular health center.[1] "Federally Qualified Health Center" means a health care provider

[1] *See generally* Health Center Program Expectations, PIN 98-23, dated August 17, 1998. http://www.fachc.org/pdf/cd_programexpectations.pdf; and 42 U.S.C. §§ 254b(b)(1)(A)(i)-(v).

that is eligible for federal funding under 42 U.S.C. § 1396d(1)(2)(B).[2] "Rural Health Clinic" means a health care provider that is eligible for federal funding under 42 U.S.C. § 1395x(aa)(2), which includes provisions for preventative services and patient case management.[3]

Although the bill applies to funding from multiple federal sources, insofar as its provisions govern the administration of family planning funds, it will primarily impact Title X of the Public Health Services Act, the federal family planning program, and Medicaid family planning services under Title XIX. These two programs are administered by the federal and state governments in very different ways, and compensate providers by different mechanisms (Title X is a grant program and Medicaid is a fee-for-service reimbursement program). Accordingly, each will be assessed separately.

Title X of the Public Health Services Act (Federal Family Planning Program).

There is no conflict between the bill's provisions and Title X law and regulations, and the bill therefore raises no federal preemption issues. Implied preemption due to a conflict with

---

[2] The Administration regards federally-qualified health centers as "a critical component of our country's health care safety net" that will "continue to be essential for the foreseeable future." Health Center Program Expectations, supra, at 2. Health centers must have a system of care that ensures access to primary and preventive services, and facilitates access to comprehensive health and social services. *Id.* at 14. In addition to providing the primary and preventative health services noted above, health centers must also ensure that they serve culturally and linguistically diverse populations (*id.* at 3); provide: case management services (*id.* at 14); services to assist the health center's patients gain financial support for health and social services (id. at 14-15); referrals to other providers of medical and health-related services including substance abuse and mental health services; services that enable patients to access health center services such as outreach, transportation and interpretive services; and education of patients and the community regarding the availability and appropriate use of health services. *Id.* at 15. Health center programs that receive funding to serve homeless individuals and families also must provide substance abuse services. *Id.* "All health centers are expected to assess the full health care needs of their target populations, form a comprehensive system of care incorporating appropriate health and social services, and manage the care of their patients throughout the system." *Id.* at 16. Moreover, health centers "must have ongoing referral arrangements with one or more hospitals, and health center clinicians should obtain admitting privileges and hospital staff membership at their referral hospital(s) so health center patients can be followed by health center clinicians." *Id.* Health centers must also provide for comprehensive and continuous after-hours care. *Id.*

[3] Rural Health Clinics (RHCs) must be located in a rural area designated as a medically underserved "shortage area" for health care services. *Interpretive Guidelines - Rural Health Clinics: Conditions for Certification,* Sec. II.A and B (citing 42 C.F.R. 491.5), available at http://www.narhc.org/uploads/pdf/interpretive_guidelines.pdf. RHCs must be staffed by a physician, physician assistant, certified nurse-midwife or nurse practitioner at all times. *Id.*, Sec. V.B (citing 42 C.F.R. 491.8(a)). RHCs must be "primarily engaged" in "primary medical care (treatment of acute or chronic medical problems which usually bring a patient to a physician's office)." *Id.*, Sec. VI.A.2 (citing 42 C.F.R. 491.9). Services provided include "diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system," including "medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions;" "basic laboratory services essential to the immediate diagnosis and treatment of the patient;" and "medical emergency procedures as a first response to common life-threatening injuries and acute illness." *Id.*; *see* 42 U.S.C. 491.9(c).

federal law has been held to arise in only two circumstances: when state law stands as an obstacle to the execution of Congressional objectives,[4] and when it is physically impossible to comply with both state and federal requirements.[5] The bill's provisions present neither circumstance.

The Secretary of the Department of Health and Human Services ("HHS") administers Title X. Under Title X, the Secretary "make[s] grants to and enter[s] into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services."[6] "Any public or nonprofit private entity may apply for a grant" to provide family planning services."[7] In making such grants and contracts under this section, the Secretary is to take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance.[8]

HHS guidance states that a Title X program grantee has the discretion to either discharge the duties itself or to select delegate agencies to perform the Title X services.[9] Where a grantee, such as the New Hampshire State Department of HeaHuman Services, decides to utilize delegate agencies, HHS mandates that the grantee remains solely responsible for the legal and financial aspects of the delegate agencies' progress towards the project's goals.[10]

The prioritization of public funds to public health care agencies, then to private agencies that are able to provide the primary and preventative care afforded by public providers, is consistent with federal case law. *Planned Parenthood Association of Utah, et al. v. Schweiker*[11] affirmed the State of Utah's authority to act as sole grantee (pursuant to a state statutory mandate) for the Title X program within the state through a consolidated grant award from HHS Region VIII. The federal agency's actions were pursuant to a policy of consolidating grants in the interests of efficiency and in view of limited funds availability; in 1982, the court noted, consolidated grants had been awarded in 28 states, with 23 consolidated in state agencies and 5 in non-state agencies.[12] The Title X regional administrator awarded the state Department of Health the grant based on its assurances that it could and would provide family planning services to all eligible women that had previously been served by the State and two other providers.[13]

---

4 *See, e.g., International Paper v. Ouellette*, 479 U.S. 481, 491-92 (1987).

5 *See, e.g., PLIVA, Inc. v. Mensing*, 131 S. Ct. 2567, 2577 (2011).

6 42 U.S.C. § 300(a).

7 42 C.F.R. § 59.3, ref. 42 U.S.C. § 300(b).

8 42 U.S.C. § 300(b).

9 *Program Guidelines for Project Grants for Family Planning Services,* ¶ 6.1 (January 2001) ("Program Guidelines"), U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning. http://www.hhs.gov/opa/familyplanning/toolsdocs/2001_ofp_guidelines_complete.pdf ("Family planning services under Title X grant authority may be offered by grantees directly and/or by delegate/contract agencies operating under the umbrella of the grantee.")

10 *See id.*

11 700 F.2d 710, 723-24 (D.C. Cir. 1983).

12 700 F.2d at 714.

13 *Id.* at 715.

Planned Parenthood and the other non-state provider sued, contending that HHS' actions violated their right to apply directly for grants and that its policy of favoring consolidated grants was unlawful.[14] The district court dismissed the lawsuit, holding that "not only did Congress not enact legislation prohibiting consolidated grants, but the pertinent legislative history evidences Congress' approval of consolidated grants where appropriate."[15] The award decision, said the court, was not "arbitrary, capricious, an abuse or discretion, or otherwise not in accordance with law,"[16] and was consistent with 'HHS' valid policy of grant consolidation" to "lower administrative costs and assure better delivery of services."[17] The court of appeals affirmed, concluding that Title X protected only the right to apply for a grant, not to receive one,[18] and that the consolidation process was consistent with Congressional directions to encourage "better coordination of existing services"[19] and to "determine the degree of duplication and philosophical consistency existing in current Federal programs including family planning."[20] In fact, the court noted, federal law required HHS to favor consolidated grant applications where appropriate.[21] HHS remains under that mandate today.

The bill's provisions implement the letter and intent of federal law prohibiting subsidization of abortion through the Title X program.[22] *Rust v. Sullivan*[23] upheld the constitutionality of federal Health and Human Services regulations prohibiting Title X family planning recipients from including abortion services, referrals or counseling in program activities. "[T]he Government is not denying a benefit to anyone, but is instead simply insisting that public funds be spent for the purposes for which they were authorized," the Supreme Court held.[24] The government "can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way."[25] Delegates that still intend to engage in abortion-related services must "conduct those activities through programs that are separate and independent" from Medicaid-funded facilities, a rule the Court in *Rust* found constitutionally permissible for Title X grantees.[26]

Medicaid Family Planning Funding.

Sec. 4(b) of the bill, prohibiting State health authorities from contracting with, or making grants to, an entity that performs abortions or maintains or operates a facility where abortions are performed (other than Hyde-eligible "federally qualified abortions"), likewise passes muster under federal law.

---

14 *Id.* at 717.
15 *Id.* at 718.
16 *Id.*, quoting 5 U.S.C. § 706(2)(A).
17 *Id.*
18 *Id.* at 723.
19 *Id.* at 724, quoting 42 U.S.C. § 300z(a)(10)(B).
20 *Id.*, quoting S.Rep. No. 161, 97th Cong., 1st Sess. 16 (1981).
21 *Id.* at 726, citing 42 U.S.C § 300z-6(a)(4).
22 *See* 42 U.S.C. § 300a-6.
23 500 U.S. 173, 196-99 (1991).
24 *Id.* at 196.
25 *Rust*, 500 U.S. at 193.
26 *Id.*

The Medicaid Act is a voluntary and cooperative federal-state program that enables States to seek federal matching grants for qualifying State healthcare benefits programs.[27] Medicaid "was designed to provide the states with a degree of flexibility in designing plans that meet their individual needs. As such, states are given considerable latitude in formulating the terms of their own medical assistance plans."[28] A State is free to opt out of eligibility for federal Medicaid funds and is in no way obligated to structure its Medicaid program in accordance with the conditions required for federal funding, although the Secretary has authority to deny or restrict federal Medicaid funding to non-compliant programs.[29]

Federal supremacy does not countermand the provisions of this bill, as the State through this legislation would merely be applying its own congruent conditions to eligibility for qualified provider status under Medicaid, and not imposing conditions inconsistent with federal guidelines. The Medicaid Act expressly embraces State authority to establish provider qualifications such as those contained in the bill. The Medicaid Act provides that "[i]n addition to any other authority, a State may exclude any individual or entity [from participating in its Medicaid program] for any reason for which the Secretary [of the Department of Health and Human Services] could exclude the individual or entity from participation in [Medicaid]."[30] Thus, according to the Supreme Court, "[t]he fact that a State's decision to curtail Medicaid benefits may have been motivated by a state policy unrelated to the Medicaid Act does not limit

---

27 *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003) ("A state's participation in the Medicaid program is completely voluntary.").

28 *Addis v. Whitburn*, 153 F.3d 836, 840 (7th Cir. 1998); *see also See also Pharm. Researchers & Mfrs. of Am. v. Walsh (PhRMA)*, 538 U.S. 644, 675, 686 (2003) (O'Connor, J., concurring in part and dissenting in part) ("Congress has afforded States broad flexibility in tailoring the scope and coverage of their Medicaid programs[.]").

29 *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.12(c). *See also PhRMA*, 538 U.S. at 675 (Scalia, J., concurring):

> [T]he remedy for the State's failure to comply with the obligations it has agreed to undertake under the Medicaid Act, is set forth in the Act itself: termination of funding by the Secretary of the Department of Health and Human Services. Petitioner must seek enforcement of the Medicaid conditions by that authority—and may seek and obtain relief in the courts only when the denial of enforcement is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

The process begins with a State's proposal of a plan or plan amendment. 42 C.F.R. § 430.12(c)(1). CMS then either approves or disapproves the plan. 42 C.F.R. § 430.15. In the event of disapproval, the State may file a request for reconsideration. 42 C.F.R. § 430.18(a). A final determination by CMS is then reviewable by the circuit court of appeals. 42 C.F.R. §§ 430.38, 430.102(c). Affected individuals and groups may participate in the administrative appeal process "if the issues to be considered at the hearing have caused them injury and their interest is within the zone of interests to be protected by the governing Federal statute." 42 C.F.R. § 430.76(b).

30 42 U.S.C. § 1396a(p)(1). *See also* 42 C.F.R. § 1002.2 ("[n]othing contained in this part should be construed to limit a State's own authority to exclude an individual or entity from Medicaid for any reason or period authorized by State law"); S. Rep. No. 100-109, at 20 (1987) (section 1396a(p)(1) "is not intended to preclude a State from establishing, under State law, any other bases for excluding individuals or entities from its Medicaid program").

the scope of its broad discretion to define the package of benefits it will finance."[31] In *First Medical Health Plan v. Vega-Ramos*,[32] the First Circuit interpreted the qualifications authority provided by 1396a(p)(1) as a specific delegation of power to the State to regulate its Medicaid program. The court, citing the legislative history of Section 1396a(p)(1), held that the provision "was intended to permit a state to exclude an entity from its Medicaid program *for any reason established by state law.*"[33]

The Supreme Court has observed that state governments have "a legitimate and substantial interest in preserving and promoting fetal life."[34] To further that end, States have authority to enact laws and policies that encourage childbirth over abortion,[35] including withholding taxpayer subsidies for abortion. As the Court has stated numerous times, "[T]he State need not commit *any* resources to facilitating abortions....",[36] and "[A] woman's freedom of choice [does not] carr[y] with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices."[37] Federal law reflects this policy choice through the Hyde Amendment, which prohibits funding for abortion except under certain extreme circumstances.[38] Funding for these circumstances is retained through this bill via the exception for "federally qualified abortions" set out in Sec. 3(a).[39] Like the Hyde Amendment upheld by

---

31 *PhRMA*, 538 U.S. at 666.

32 479 F.3d 46 (1st Cir. 2007).

33 *Id.* at 53 (emphasis supplied). The Texas Attorney General has issued an opinion that is congruent with this analysis, affirming the constitutional authority of the State to foreclose Medicaid family planning waiver funds to abortion providers or affiliates of abortion providers. *See* OP. ATTY. GEN., Feb. 17, 2011, available at https://www.oag.state.tx.us/opinions/opinions/50abbott/op/2011/pdf/ga0844.pdf; request for this opinion available at https://www.oag.state.tx.us/opinions/opinions/50abbott/rq/2010/pdf/rq0902GA.pdf

34 *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007).

35 *Id.* at 146.

36 *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 511 (1989) (emphasis supplied).

37 *Harris v. McRae*, 448 U.S. 297, 316 (1980).

38 *See* Omnibus Appropriations Act of 2009, Pub. L. No. 118, §§ 507-08, 123 Stat. 524, 802-03 (2009) (enacting H.R. 1105).

39 It is the uniform view in the federal courts that State participation in the Medicaid program obligates State officials to implement public funding of Hyde-qualified abortions. In *Edwards v. Hope Medical Group for Women*, 512 U.S. 1301 (1994), the Supreme Court denied a request for emergency relief from an injunction restraining the State from funding Hyde-qualified abortions, with Justice Antonin Scalia, sitting as Circuit Justice, writing:

> The only issue potentially worthy of certiorari is the premise underlying the District Court's decision: that Title XIX requires States participating in the Medicaid program to fund abortions (at least "medically necessary" ones) unless federal funding for those procedures is proscribed by the Hyde Amendment. *The Courts of Appeals to address this question have uniformly supported that premise.* We have already denied certiorari in two of those cases, and it is in my view a certainty that four Justices will not be found to vote for certiorari on the Title XIX question unless and until a conflict in the Circuits appears.

512 U.S. at 1312-13 (citations omitted; emphasis supplied). No such conflict has appeared in the ensuing years since *Hope Clinic*; in fact, the Circuits have remained unanimous on this point. *See, e.g., Planned Parenthood Affiliates of Michigan v. Engler*, 73 F.3d 634 (6th Cir. 1996); *Hern v. Beye*, 57 F.3d 906 (10th

the Supreme Court, this bill "places no obstacles absolute or otherwise in the pregnant woman's path to an abortion" because she "continues as before to be dependent on private sources for the service she desires."[40] Nor does the bill prevent women from procuring abortions from other privately funded facilities, as with the regulation against using public hospitals for abortions upheld in *Webster v. Reproductive Health Services.*[41] In *Webster*, the Court reasoned that Missouri's law prohibiting use of public facilities for abortions "leaves a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals at all."[42] Here, likewise, the bill leaves pregnant women seeking abortions with the same choices as if the State had chosen not to participate in Medicaid at all.

Nor does the bill impermissibly condition government benefits on the forfeiture of constitutional rights.[43] The Supreme Court has never held that providers or physicians have a constitutional right to perform abortions—or any medical procedure for that matter—independent from the rights of the patient.[44] In fact, the Court has even declined to determine whether a physician has a "constitutional right[] to practice medicine."[45] To the contrary, it is clear that the State may regulate the ability of physicians to practice medicine, including performing abortions.[46]

Moreover, the bill does not by its terms render any particular abortion provider ineligible for Medicaid family planning reimbursements. If a provider desires to continue receiving Medicaid funds after passage of this bill, it can maintain affiliation with abortion clinics and continue eligibility, provided there is no cross-subsidy. In *Planned Parenthood of Mid-Missouri and Eastern Kansas v. Dempsey*,[47] the Eighth Circuit held that a Missouri law employing similar provisions did not impose an unconstitutional condition on abortion providers' receipt of Title X family-planning funds because recipients could continue "to exercise their constitutionally protected rights through independent affiliates."[48] "[N]othing [in the law] expressly prohibits grantees from maintaining an affiliation with an abortion service provider, so long as the affiliated abortion service provider does not directly or indirectly receive State family-planning

---

Cir. 1995), *cert. den.*, 516 U.S. 1011 (1995); *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170 (3rd Cir. 1995), *reh. en banc den., cert. den.*, 516 U.S. 1093 (1995).

40 *Maher v. Roe*, 432 U.S. 464, 474 (1977) (upholding prohibitions on the use of Medicaid to pay for non-therapeutic abortions).

41 492 U.S. 490, 509, 522 (1989).

42 *Id.* at 509.

43 *See Perry v. Sindermann*, 408 U.S. 593, 597 (1972).

44 Notably, state Medicaid agreements are generally considered terminable at will under state law (although the law of the subject jurisdiction where the bill is under consideration should be consulted on this point).

45 *Singleton v. Wulff*, 428 U.S. 106, 113 (1976) (plurality opinion) (citation and internal quotations omitted).

46 *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (plurality opinion); *see also Lambert v. Yellowley*, 272 U.S. 581, 596 (1926) ("[T]here is no right to practice medicine which is not subordinate to the police power of the states[.]"); *A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 685-86, 693 (7th Cir. 2002).

47 167 F.3d 458, 463 (8th Cir. 1999).

48 *Id.* at 463.

funds."[49] Rejecting the assertion that the burden on abortion providers to bifurcate their abortion services from their family planning services rendered the law unconstitutional, the court stated, "The Constitution does not guarantee that recipients of State funds will not be required to 'expend effort' to comply with funding restrictions."[50]

The Fifth Circuit Court of Appeals held likewise in reviewing an abortion exclusion provision similar to the one set out in the bill.[51] Texas' amendment, "Rider 8," passed in 2003, restricted distribution of federal family planning funds, including Title X and Title XIX funds, to individuals or entities that did not perform elective abortion procedures and did not contract with or provide funds to individuals or entities for the performance of elective abortion procedures. Planned Parenthood filed suit, claiming among other grounds that Rider 8 violated the Supremacy Clause by imposing additional eligibility requirements on its receipt of federal funds that were inconsistent with federal funding law.[52] The Fifth Circuit Court of Appeals rejected this argument, holding that Rider 8 did not impose conflicting requirements on providers.[53] Because Rider 8's language could be read to permit family planning agencies to continue to receive funds by creating separate affiliates, in the court's words by "dividing into 'Family Planning' entities and 'Abortion Services' entities," it did not run afoul of federal law. [54] It is well established that "The mere fact that a state program imposes an additional 'modest impediment' to eligibility for federal funds does not provide a sufficient basis for preemption," the court concluded.[55]

CONCLUSION

The "Whole Woman's Health Funding Priorities Act" offends neither federal constitutional law nor federal statutes governing Title X and Medicaid family planning. Thank

---

49 *Id.*

50 *Id.* at 464.

51 *Planned Parenthood v. Sanchez*, 403 F.3d 324 (5th Cir. 2005).

52 *Id.*, at 328.

53 *Id.*, at 337-338.

54 The Texas lawsuit was subsequently dismissed after Planned Parenthood unilaterally complied with the requirements of Rider 8 by incorporating six separate, independent affiliates for the provision of abortion services, transferring the abortion licenses to those facilities and agreeing to maintain accounting, timekeeping and boards of directors separate from the family planning services providers. See *Planned Parenthood of Houston and Southeast Texas v. Sanchez*, 480 F.3d 734, 737 (5th Cir. 2007) ("Plaintiffs took the necessary steps to establish legally separate affiliates to provide abortion services. Plaintiffs thereby maintained their eligibility for receiving TDH family planning funds.").

55 *Planned Parenthood v. Sanchez*, 403 F.3d at 337, citing *PhARMA v. Walsh*, 538 U.S. at 661-62 (rejecting Medicaid Act preemption challenge to state statute imposing prior authorization requirement on access to prescription drugs financed by federal funds); *Vega-Ramos*, 479 F.3d at 52 (territory's modifications to Medicare Advantage plan held not a prohibited "standard" for operation under Medicare Part C, but rather a permissible eligibility requirement for an entity wishing to participate in a Puerto Rico Medicaid program).

you for the privilege of offering this opinion.

Respectfully submitted,

__/s/__Steven H. Aden___
Steven H. Aden
Senior Counsel/
Vice-President for Human Life Issues

cc: New Hampshire Right to Life
Interested Members of the Public

Testimony by Kurt Wuelper
President of New Hampshire Right to Life
Senate Health and Human Services Committee
April 5, 2012

Planned Parenthood Abortion Business Settles Medicaid Fraud Case 10/30/10
The state of Washington ...Initial audits from Washington state officials showed Planned Parenthood wrongly **overbilled the state $629,143 over a three-year period,** according to the Associated Press. ...a settlement whereby it would not admit any incorrect billing, documentation or payment and Planned Parenthood will only repay $345,000 of the money it obtained. http://www.lifenews.com/2010/10/30/state-5633/

Massive Fraud Case Against Planned Parenthood Moving Forward
A lawsuit filed by P. Victor Gonzalez, a former vice president of a Planned Parenthood, abortion business affiliate in California. The complaint charges PP with bilking the state and federal governments of some $100 million. A 2003 state audit found at least $5.2 million in overbilling in 2003 alone from just one of the nine California Planned Parenthood affiliates. Medi-Cal officials first noticed the problems in 1997 and Planned Parenthood received two separate letters at that time pointing out the problems.

Planned Parenthood Accused of Massive Medicaid Fraud in Texas 11/3/11

Karen Reynolds, who worked as a "health care assistant" from 1999 to 2009 at the Lufkin, Texas, branch of the affiliate formerly known as Planned Parenthood of Houston and Southeast Texas, has submitted company memos and emails to support her charge that PPGC has engaged in a systemwide scheme to bilk Medicaid, Title XX, and the Women's Health Program of tens of millions of dollars over the course of at least a decade.
Reynolds alleges bosses trained employees to bill government agencies for medical and family planning services not rendered, for services no reasonable medical personnel would provide, and – the biggest bombshell – for abortion-related services fudged to appear as if they were not.
Planned Parenthood has been found to have engaged in fraudulent billing or faces accusations of such improper billing in multiple states:

- California – A 2004 audit found that Planned Parenthood of San Diego and Riverside Counties overcharged the government $5,213,645.92 for oral contraceptives. The problem was that Planned Parenthood was supposed to charge the government the cost of the pills. Instead, it charged a much higher price.
- New York – A 2008 federal audit of state family planning claims resulted in a finding that the state of New York **had overbilled the federal government $17,151,156** by claiming procedures as "family planning" services when they were not. The federal audit report noted that, "Officials at Planned Parenthood providers stated that they believed that nearly all the services they provide are related to family planning. However, the medical review determined that the providers improperly claimed, for example, services to pregnant women, treatment for sexually transmitted diseases, and counseling visits unrelated to family planning services."
- New Jersey – In 2008, the federal government conducted an audit of New Jersey and published a report, *Review of Outpatient Medicaid Claims Billed as Family*

Planning by New Jersey, which showed the state had **overcharged the federal government $597,496.00**. In a section entitled "Causes of Overpayment," the report states: "... many providers (especially Planned Parenthood providers) stated that they billed all claims to Medicaid as "family planning. Therefore, officials at these clinics often populated the family planning indicator field on Medicaid claims even though the service provided did not meet the criteria for 90-percent Federal funding.."

- Washington – A 2009 audit found Planned Parenthood of the Inland Northwest **overcharged the government $629,142.88**. The audit found Planned Parenthood was charging excessive amounts for contraceptives and distributed and charged for prescription medication without having a valid prescription.
- New York City – A 2009 Medicaid audit determined that Planned Parenthood's Margaret Sanger Center in New York City was found to have **overcharged Medicaid $1,254,603.00** which included double billing—billing Medicaid for services provided to patients who were enrolled in the provider's HMO network

http://www.lifenews.com/2011/11/03/planned-parenthood-accused-of-massive-medicaid-fraud-in-texas /

Planned Parenthood Continues Falsifying Medicaid Documents
by Phill Kline | Washington, DC | LifeNews.com | 11/7/11
So far, the only criminal case ever filed against a Planned Parenthood facility is the case I filed on October 17, 2007 in Olathe, Kansas. The case was only filed after an independent judge reviewed the evidence and concluded that probable cause exists to believe that Planned Parenthood committed 107 criminal acts, including 23 felonies for falsifying records.
It is also now public that my investigators uncovered evidence that during a time when **166 abortions were performed on child in Kansas** in 2002 and 2003 that **Planned Parenthood only reported to the state one case of child sexual abuse despite state law requiring reports.**[ix]
This information, sealed for years by the actions of the Sebelius appointed Kansas Supreme Court, has only recently come to light.
This documentary evidence combined with direct statements by a Planned Parenthood security guard that he was instructed to "accept all patients" and was told to disregard false identifications provided by children and ignore signs that laws were not being followed provides compelling evidence that the abortion provider failed to follow Kansas law. The evidence from around the nation indicates similar behavior.

Ohio Planned Parenthood Won't Be Charged in Raped Teen's Secret Abortion
Cincinnati, OH (LifeNews.com)— *June 30, 2005* ...an Ohio Planned Parenthood abortion business will not be charged in connection with a secret abortion it performed on a 14-year old girl who was a victim of rape. The girls' parents filed a lawsuit against the abortion facility for violating the state's parental notification law by not telling them of her abortion, which may have been coerced.
The parents of the 14 year old girl are also wondering why Planned Parenthood of the Southwest Ohio Region failed to contact police about the possible statutory rape.

Testimony by Kurt Wuelper
President of New Hampshire Right to Life
Senate Health and Human Services Committee
April 5, 2012

Any sexual relations with a young teenager are considered rape under Ohio law if the perpetrator is 18 or older. Statutes in Ohio also require reporting any suspected cases of statutory rape to law enforcement.
The boyfriend was eventually prosecuted for statutory rape after officials received a tip from a friend of the girl. He is now serving three years in prison for the crime.
http://www.lifenews.com/2005/06/30/state-1106 /

http://www.liveaction.org/monalisa
The Mona Lisa Project videos document Planned Parenthood's willingness to repeatedly violate mandatory reporting laws for statutory rape that protect children in half a dozen states.

7 former employees offer to testify against Planned Parenthood in congressional probe by John Jalsevac **Wed Dec 07, 2011**
December 7, 2011 (LifeSiteNews.com) – Seven former Planned Parenthood employees [from Boston, MA , Sioux Falls, SD, Bryan, TX, San Jose, CA, Storm Lake, IA, and Sacramento, CA] have expressed their support for Congress' current investigation of the abortion giant to determine whether the group mishandles criminal conduct, or uses federal funding to pay for abortions, and offered to testify against the organization, in a letter released this week.

In a letter addressed to leaders of the House Subcommittee on Oversight and Investigations, the former Planned Parenthood workers say they "have personally witnessed and can testify [that] Planned Parenthood has failed to notify parents when an underage girl is seeking an abortion, to detect or report cases of coerced abortion or sex trafficking, and to properly segregate government funds away from abortion costs, among other violations.

Planned Parenthood profits

Fiscal Year	$ "Excess Revenue"	Sources: PPFA Annual Reports 2004/05-2008/09 and PPFA Services Fact Sheet s 2008 and 2009 © 2011 American Life League www.stopp.org
2008/2009	$63.4 Million	
2007/2008	$85 Million	
2006/2007	$114.8 Million	
2005/2006	$55.8 Million	
2004/2005	$$63.0 Million	

Planned Parenthood is a non-profit with over $305 million profit in just those five years. PP continues to make 'excess revenue' year after yearJust how Planne parenthood maintains its tax exempt status is dubious.

Testimony by Kurt Wuelper
President of New Hampshire Right to Life
Senate Health and Human Services Committee
April 5, 2012

http://www.liveaction.org/traffick/

2/1/2011	Caught on Tape: Planned Parenthood Aids Pimp's Underage Sex Ring
2/2/2011	Planned Parenthood Fails to Discredit Live Action Video: Fires Manager
2/3/2011	Richmond Virginia Planned Parenthood Clinic Shows Willingness to Aid and Abet Sexual Exploitation of Minors
2/4/2011	Pattern Emerges: Three More Virginia Planned Parenthood Clinics Caught On Tape Willing to Aid and Abet Sexual Exploitation of Minors
2/8/2011	Bronx, NY Planned Parenthood Staffer Tells "Pimp" He Can Pose As Guardian To Get Tax Payer Funded Services For Underage Sex Workers
2/10/2011	DC Planned Parenthood Staffer Counsels Sex-Trafficker How Underage Girls Can Get Abortions And Testing, No Questions Asked

The "Rosa Acuna Project" http://www.liveaction.org/rosaacuna is a multi-state undercover investigation documenting Planned Parenthood's use of unscientific and fabricated medical information to convince women to have abortions. A series of hidden camera videos shot in clinics across the United States reveals the exploitative tactics abortion doctors and clinicians employ to conceal the truth about abortion from women who most need honest and accurate information. Leading embryologists have denounced Planned Parenthood's conduct caught on tape as "erroneous and scientifically absurd.

- Indiana Planned Parenthood Caught On Tape Giving Fabricated Medical Information
- Appleton, December 11 — New undercover footage from an Appleton, WI Planned Parenthood abortion clinic shows clinic staff, including the abortion doctor, lying to two young women about fetal development and encouraging the one who is pregnant to obtain an abortion
- MILWAUKEE, April 12th–A new undercover video reveals medically inaccurate abortion counseling at a tax-funded Milwaukee Planned Parenthood clinic. The video records Planned Parenthood staff [telling] a 6 to 8 weeks pregnant woman that at this stage her baby has "no arms, no legs, no heart no head, no brain." The staffer emphasizes the difficulties of adoption, urges the woman to obtain an abortion as soon as possible, says that images of abortion are fabricated, and states that the unborn child at 6 to 8 weeks has no "identifiable parts" and is just "fetal matter."

Testimony by the Hon. Marilyn Musgrave
Vice President of Government Affairs
Susan B. Anthony List

Senate Health and Human Services Committee
Concord, New Hampshire
April 5, 2012

Chairman Bradley, Vice Chairman De Blois, Ranking Member Kelly, and members of the Health and Human Services Committee, thank you for allowing me this opportunity to testify today in support of H.B. 228.

My name is Marilyn Musgrave. I am vice president of government affairs at the Susan B. Anthony List, a Washington, D.C.-based organization dedicated to advancing women in public office at the federal and state level. Our organization has a membership base of 365,000. We are proud of the record number of po-life women who hold elective office in Congress and the state houses as a result of our work since 1992.

Today I address you not only in my current role but from my history of three terms as a state legislator in Colorado, where I served in both the house and senate, and three terms as a member of the U.S. Congress representing the 4th District of Colorado. Throughout my public service, I have seen firsthand the need for legislation like H.B. 228-FN, because it simultaneously serves goals important to the women of this nation and to taxpayers. This bill, similar to measures gaining favor across the country, ensures that family planning projects are integrated holistically with women's health care, that family planning funds are spent frugally, and that these funds are never, consistent with Congressional intent, used to cross-subsidize or promote abortion, which is the antithesis of sound and ethical family planning.

The legislation before you today is reasonable, moderate, and focused on improving both the quality and coherence of health care for women in New Hampshire. It follows the requirements of existing federal and state law while ensuring that federal-state matching funds are prioritized to providers capable of providing women with a range of coordinated care that serves their needs.

H.B. 228-FN does not take away a single dollar of family planning funds, contrary to the implications of some defenders of the status quo. Nor does it affect the eligibility of a single resident of New Hampshire for the assistance prioritized under the bill. The bill does, however, ensure that those funds are provided on a priority basis to health care entities that offer the full

range of primary health care services for women. If enacted, the bill will make it easier for women to receive their medical care from providers who are equipped to serve all their health care needs, including such services as mental health counseling, dental care, cancer screenings, including mammograms as appropriate, and prenatal care by the most experienced providers.

Because HB 228-FN does not represent a single new dollar in cost, it represents the equivalent of a free upgrade to first-class from coach in women's health care. As legislators you can be proud to provide this upgrade to women who are too often assisted by a patchwork of providers, some of whom focus narrowly on their own mission rather than the real needs of women and children.

The Whole Woman Approach

As HB 228-FN notes, "Limited federal and state public funding exists for family planning and preventive health services for women generally, and for maternal and fetal patients in particular." This fact will not change anytime soon. Federal deficits continue to exceed $1 trillion annually and the White House projection for Fiscal Year 2013 is just below that level. The nonpartisan Congressional Budget Office projects that the FY 2013 deficit will be $977 billion. Daunting fiscal constraints like these mandate that the states allocate available funding efficiently.

This bill is not just about saving money, however. It is sound health care policy, too. Again, as the proposed legislation says, "Individuals who have a primary care clinician are more likely to access health care services, leading to more favorable long-term outcomes. Health care costs are lowered when primary and preventive care is provided by such primary care clinicians in a setting that addresses the whole person by emphasizing counseling, screening and early detection of leading causes of morbidity and mortality - including diabetes, hypertension, obesity, cardiovascular and renal diseases, and asthma. Indirect costs such as lost worker productivity and employer health care costs are also reduced. Most importantly, individual citizens will lead longer, healthier and happier lives as a result of having less fragmented health care."

By passing this legislation, therefore, the New Hampshire legislature will be easing the burden on lower-income women in the Granite State by reducing the number of providers and clinic locations they must visit in order to obtain primary care. A woman is more than a womb. Reproductive health care providers that have this singular focus fail to meet many needs of their female patients, including needs that affect their reproductive systems by virtue of the close biochemical, behavioral and physiological connections among all of our major organ systems.

Insights like this have prompted the U.S. Centers for Disease Control to state, "Comprehensive preconception and prenatal care includes encouraging women to stop smoking, refrain from using alcohol and other drugs, eat a healthy diet, take folic acid supplements, maintain a healthy weight, control high blood pressure and diabetes, and reduce exposure to workplace and environmental hazards. In addition, screening and providing services to prevent intimate partner violence and infections (*e.g.*, HIV, STI and viral hepatitis) help to improve the health of the mother and the baby."

Again, delivery of these critical services is best accomplished through a single point-of-service provider such as a primary care provider, and directed by a primary care clinician who has knowledge of the patient's medical history and personal, familial, and environmental health factors. The utilization of public funding to maximize effective delivery of holistic health care is

a proper objective of health care policy for New Hampshire, and it most closely resembles the kind of health care relied upon by women who are not required by force of circumstance to seek public assistance in financing their care.

Funding Priorities

H.B. 228-FN directs funds in a four-tiered order of priority. It begins with "public entities." These are the institutions most accountable to the taxpayer. Second are "non-public hospitals and federally qualified health centers." Federally qualified health centers (FQHCs), which are located in both urban and rural areas, are required under federal law to provide a wide range of services to the public.[1] These centers are receiving an infusion of federal funds as a result of efforts by a bipartisan group of legislators in Washington working in a rare area of agreement. As Senator Mike Enzi (R-Wyo.), the ranking Republican on the Senate health committee, has said, these centers "ensure that people can get the primary health care services they need and cut down on costs for everyone by reducing the need for expensive emergency room care."[2] In New Hampshire the number of federally qualified health centers has grown due to this increased funding, reaching 12 centers with 52 clinic sites across the state.[3]

Third in funding priority under the bill are rural health clinics in New Hampshire. According to the Rural Assistance Center web site, citing Kaiser (2012)[4], there are 12 such clinics in the state, operating at a minimum of 15 sites.[5]

Finally, HB 228-FN priotizes funds to "non-public health providers that have as their primary purpose the provision of the primary health care services enumerated in 42 U.S.C. Section 254b(a)(1)." While this tier of providers is fourth in order of priority, it represents a potentially very long list of alternatives that can meet the objectives of this legislation in the event that the first three tiers cannot in a particular instance. Again, according to the Kaiser Family Foundation's Statehealthfacts.org, New Hampshire has 1,701 primary care physicians, including 530 engaged in family practice/general medicine and 280 who are obstetrician-gynecologists.

New Hampshire can be proud of the array of health care providers the state has produced and offers, and it is well situated to strengthen that array by ensuring that women's care is integrated and the entanglement of public money in controversial practices is avoided. Today New Hampshire has more than one-third fewer uninsured (10%) than the national average (16%), and the rate of uninsured children (5%) is half the national average (10%). Nonetheless, this success has come with per capita health care expenses that are significantly higher than the national

---

[1] Federally Qualified Health Centers (FQHCs) are community-based and community-directed non-profits that serve people facing financial, geographic, language, cultural or other barriers to health care. *See* 42 U.S.C. § 1396d(1)(2)(B).

[2] "Insurance and Uninsured," California Healthline, July 23, 2008, at http://www.californiahealthline.org/articles/2008/7/23/US-Senate-Approves-Funding-for-Community-Health-Centers.aspx?topicID=39#ixzz1guFbA0nC; citing Congress Daily, July 22, 2008 (viewed April 2, 2012).

[3] Rural Assistance Center: Health and Human Services Information for Rural America, at http://www.raconline.org/states/newhampshire.php (viewed April 2, 2012).

[4] Kaiser Family Foundatio at Statehealthfacts.org (viewed April 2, 2012).

[5] http://www.wheretofindcare.com/RuralHealthClinics/NewHampshire-NH/Center-Ossipee/303813/Family-Health-First-P-C.aspx (viewed April 2, 2012).

average and with average premium costs for employer-sponsored health insurance that are also well above the norm. This lends added urgency to the desirability of providing holistic health care that does not replicate overhead. Increasing the number and percentage of New Hampshire women who have a medical home and receive coordinated care will ultimately provide the greatest savings to taxpayers in these stringent budgetary condtions.

Harmony of H.B. 228-FN with Federal Law Distinguishing Family Planning and Abortion

Sec. 1008 of the federal Family Planning and Reproductive Health Services Act of 1970 (Title X of the Public Health Service Act) stipulated that "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."[6] While the meaning of the word "program" was not explicitly stated in the law, its intent was made clear by Rep. John Dingell (D-Mich.,) a prominent member of the committee of jurisdiction, in his statement on the floor of the U.S. House of Representatives on November 16, 1970:

> "[T]he committee members clearly intend that abortion is not to be encouraged or promoted in any way through this legislation. Programs which include abortion as a method of family planning are not eligible for funds allocated through this act."

Rep. Dingell, who later chaired this committee, continued:

> "There is a fundamental difference between the prevention of conception and the destruction of developing human life. Responsible parenthood requires different attitudes toward human life once conceived than toward the employment of preventive contraceptive devices or methods. What is unplanned contraceptively does not necessarily become unwanted humanly."

Rep. Dingell concluded that the failure to achieve program separation, that is, to ensure that "abortion is not to be encouraged or promoted in any way," would be unwise because "there is evidence that the prevalence of abortion as a substitute or a back-up for contraceptive methods can reduce the effectiveness of family planning services."[7]

At the time of enactment of Title X, it should be noted, the most dedicated family planning agencies in the country essentially shunned the clinical practice of abortion. They sensed the distinction Congress was determined to reinforce between family planning and abortion and asserted their confidence that Title X and other federal family planning programs would reduce abortion rates.

A quarter century later that confidence was sharply diminshed to the point where an internal effort at the nation's largest abortion provider, Planned Parenthood, to change its focus away from abortion rights to primary care led to the forced resignation of its president. As reported in the *New York Times* on July 22, 1995, Pamela Maraldo had generated opposition within the

---

[6] 42 U.S.C. § 300a.

[7] *Congressional Record*, November 16, 1970, p. 37375.

organization because "some of the group's affiliates felt [the change to primary care] would inevitably diminish their role as advocates for abortion rights."[8]

Planned Parenthood has certainly emerged as America's largest abortion enterprise. Over the past three years for which data is available, Planned Parenthood clinics nationwide performed nearly 986,000 abortions, roughly 27 percent of all abortions carried out in the United States over that time period. A total of nearly 1,000,000 abortions over the past three years in one institution is not "rare" by any defintion. The potential to confuse these destructive acts with "family planning" and with "health care" is real, and it is exactly what the authors of Title X were most anxious to avoid.

For New Hampshire, published information about abortions performed at facilities in the state is difficult to obtain. I understand that this topic is being addressed in separate proposed legislation and I encourage the legislature to deal with it forthrightly. If we truly desire and intend to make abortion rare, then the bare minimum we must do as public officials is to measure it accurately and report it through public agencies directly accountable to the taxpayer. The vast majority of the states do this routinely, inexpensively, and uneventfully. In any event, the last publicly available report I was able to find shows that in 2005 Planned Parenthood of Northern New England, a three-state affiliate covering New Hampshire, carried out 3,185 abortions for that reporting year.[9] At least 91 percent of the pregnant women who go to Planned Parenthood nationally obtain abortions. A small number obtain prenatal care or place for adoption. These abortion numbers are substantial and a proper object of the legislature's concern.

In short, it is not the law or appropriate women's health care priorities that have changed since 1970, it is Planned Parenthood that has changed by becoming the nation's largest abortion enterprise and by putting that enterprise ahead of better alternatives – the very approaches the bill before you today will reinforce and expand.

---

[8] Maraldo, then-president of the Planned Parenthood Federation of America, proposed to expand the organization's mission in 1995 because of fears, according to a Planned Parenthood board member, that it could not survive in an era of health care reform as a "niche provider, a reproductive-health provider." According to a contemporary report in the *Seattle Times*, a confidential memo signed by Planned Parenthood clinic executives in New York City, Chicago, and Los Angeles rebuked Maraldo's proposal, saying "Never has a document seemed so out of touch with our mission." The memo complained, "The word 'abortion' is mentioned only eight times" in Maraldo's blueprint, "and never in the discussion of our future." (Michael Blood, "Planned Parenthood Debates a New Focus: Primary Care," *Seattle Times*, March 2, 1995; at http://community.seattletimes.nwsource.com/archive/?date=19950302&slug=2107745 (February 8, 2012)). Four months later Maraldo resigned and left Planned Parenthood. According to *the New York Times* account of her departure, "Sources both inside Planned Parenthood and outside said that Ms. Maraldo had aroused opposition with her emphasis on reshaping Planned Parenthood into a broad health organization that could compete in an era of managed care – a focus that some of the group's affiliates felt would inevitably diminish their role as advocates for abortion rights and low-income women's access to health care." Tamar Lewin, "Planned Parenthood President Resigns," *The New York Times*, July 22, 1995; at http://www.nytimes.com/1995/07/22/us/planned-president-parenthood-resigns.html (February 8, 2012)).

[9] "Forty Years: Personal Care. Personal Choices," Planned Parenthood of Northern New England 2005 Annual Report," at http://www.plannedparenthood.org/ppnne/files/Northern-New-England/Annual_Report_-_05_%28Low_Resolution%29.pdf (viewed April 2, 2012).

Conclusion

H.B. 228-FN is good and necessary legislation because it focuses existing federal-state funding streams on family planning services so they are provided in the context of holistic health care for women and their families. It does not reduce current family planning spending levels by a single penny, nor does it change a single woman's eligibility for services. It does ensure that these tax dollars are prioritized to agencies that can best serve the needs of Granite State women. It is an upgrade in service at no additional cost. Moreover, H.B. 228-FN harmonizes with the longstanding goals of federal and New Hampshire law with respect to preventing the use of public money to encourage or promote abortion as a method of family planning. It favors childbirth over abortion, consistent with numerous rulings of the U.S. Supreme Court,[10] as the appropriate outcome when unexpected pregnancies do occur.

Thank you for giving me the opportunity to testify today.

[10] "There is no question but that 1008's prohibition is constitutional, since the Government may make a value judgment favoring childbirth over abortion, and implement that judgment by the allocation of public funds." *Maher* v. *Roe,* 432 U.S. 464, 474." (*Rust v. Sullivan*, 500 U.S. 173 (1991). In addition, the question of whether a state may make funding decisions that prioritize family planning funds for providers of primary care and other coordinated services has been answered in the affirmative by federal courts with respect to such laws in Texas and Missouri. *See Planned Parenthood of Houston and Southeast Texas v. Sanchez* 403 F.3d 324, 337 (5th Cir. 2005) and *Planned Parenthood of Mid-Missouri and Eastern Kansas v. Dempsey* 167 F.3d 458 (8th Cir. 1999).

WADLEIGH, STARR & PETERS, P.L.L.C.

WILLIAM C. TUCKER
EUGENE M. VAN LOAN III
JOHN E. FRIBERG, Sr.
JAMES C. WHEAT
RONALD J. LAJOIE
KATHLEEN N. SULLIVAN
JEFFREY H. KARLIN
DONALD J. PERRAULT
MARC R. SCHEER
GREGORY G. PETERS
ROBERT E. MURPHY, Jr.
DEAN B. EGGERT

Attorneys At Law
95 Market Street
Manchester, New Hampshire 03101
Telephone (603) 669-4140
Facsimile (603) 669-6018

WWW.WADLEIGHLAW.COM

Serving New Hampshire since 1899

MICHAEL R. MORTIMER
KATHLEEN C. PEAHL
RICHARD THORNER
CHARLES F. CLEARY
CHRISTINE GORDON
JENNIFER L. ST. HILAIRE
TODD J. HATHAWAY
STEPHEN J. JUDGE
STEPHEN L. BOYD
ALISON M. MINUTELLI
MICHAEL J. TIERNEY
PIERRE A. CHABOT
JOSEPH G. MATTSON

Direct Dial: (603) 206-7239
mtierney@wadleighlaw.com

April 5, 2012

Tierney

Senator Jeb Bradley, Chairman
Senate Committee on Health and Human Services
New Hampshire State House
107 North State Street
Concord, N.H. 03301

Re: HB 228 – Prioritizing Assistance to Full Service Health Providers Instead of Abortion Clinics

Dear Chairman Bradley and Senators of the Health and Human Services Committee:

My name is Michael Tierney, I am resident of Contoocook and an attorney in Manchester.

I am writing on behalf of myself, as well as my client, New Hampshire Right to Life, to voice my support and urge the Senate to adopt HB 228.

For the past year, I have been closely following the issues relating to the funding of family planning clinics in New Hampshire. For the past 35 years the state of New Hampshire has administered the federal Title X program. Basically, the federal government provides a grant to the state of New Hampshire and the state then provides subgrants, combining both federal and state funds, to different providers to cover the entire state. Federal HHS requirements require that there be a provider within one hour's drive of any place in the State.

On June 22, 2011, the Executive Council approved funding to several providers but declined to approve funding to Planned Parenthood as PP was unable to give adequate assurances that tax dollars were not being used to subsidize Planned Parenthood's abortion business. Other providers, such as Manchester Community Health Clinic, expressed an interest in obtaining these grants but were not given the opportunity to bid on these grants. Instead, the federal HHS awarded a non-competitive grant directly to Planned Parenthood. On behalf of my client, NHRTL, I requested copies of documents relating to the decision to fund without any competitive bidding. What these documents revealed may be astounding:

The rationale for funding Planned Parenthood without any competitive bidding was that there would be no provision of services if the grant was not immediately issued. Nevertheless, HHS had received a call from Meegan Gallagher on July 5, 2011 letting HHS that Planned Parenthood was open and would continue seeing patients whether or not they were tax payer funded. See attached as Exhibit A, p. 2.

1) The real rationale for getting the money to Planned Parenthood was so that PP could dispense pharmaceuticals without a pharmaceutical license. Pursuant to RSA 318:42(VII), there is an exception to the pharmaceutical law that allows prescription drugs to be dispensed by grantees of the DHHS. PP said that without the grant it was being forced to write prescriptions and having its clients go to pharmacies to have their prescriptions filled. See attached as Exhibit A, p. 2.

2) To give the committee an idea of the how far some clients of Planned Parenthood needed to walk to get their prescriptions filled, I have attached an aerial picture of Planned Parenthood's busiest clinic on Pennacook Street in Manchester. As you can see, Planned Parenthood's parking lot is adjacent to the parking lot for a Rite Aid pharmacy. See attached as Exhibit B.

3) In addition, HHS's documents reveal that people could get their birth control cheaper at Walmart than going to Planned Parenthood. So the government is spending over a million dollars in taxpayers' money to have people go to Planned Parenthood to get their birth control at greater cost than if they had gone to Walmart. See Ex. A, p. 1.

4) Governor Lynch contacted PPNNE and was concerned that because PPNNE was unable to lawfully dispense pharmaceuticals, Planned Parenthood was losing approximately $4,000 a day in lost sales. See attached as Exhibit C.

5) Furthermore, our FOIA request discovered that the government has minimal to no oversight over whether Planned Parenthood is using tax dollars to subsidize and support their abortion business. Although Planned Parenthood claims to have a policy of keeping abortion funds separate than activities funded by the government, this is not a very bright line. (See attached at Exhibit D) I have attached to this letter Planned Parenthood's own grant application where they claim that their various employees spend 80 to 90% of their time eligible for tax payer funding while spending 10% to 20% on abortions. (See attached as Exhibit E) Nevertheless, certain employees may in any given year spend a much higher percentage of their time

supporting the abortion business than what is predicted on Planned Parenthood's grant application.

6) Finally, Planned Parenthood objected to public disclosure of its grant application on the basis that if disclosed Planned Parenthood's competitors, and in particular "health care clinics, private practices and hospitals" knew how much Planned Parenthood charged the government, Planned Parenthood's competitors would be able to competitively underbid Planned Parenthood and obtain lucrative government grants. See attached as Exhibit F.

By funding Planned Parenthood instead of full service health providers, the state has given PP an unhealthy sense of entitlement to feed at the public trough. In their tax returns, Planned Parenthood Federation of America reports surpluses (i.e., profits) of $21,773,569.00 in 2009 and $5,626,756.00 in 2010.[1] PPNNE reported on its 2010 tax return that they grew their endowment from $5.6 million to $6.6 million and spent $678,000 on "public affairs" efforts, including efforts to "successfully . . . [fight] to keep a majority of our [Planned Parenthood of Northern New England's] state funding [in New Hampshire] despite massive cuts in the governor's budget."[2] Planned Parenthood spends a substantial amount of money lobbying to protect its government grants. For example, Senator Shaheen has received more than $391,000 in political campaign contributions from pro-abortion political action committees controlled by Planned Parenthood Federation of American, Inc., NARAL, and Emily's List during the 2008 election cycle.[3]

New Hampshire has better things to spend its tax dollars on that subsidizing the state's largest abortion provider. PPNNE does not operate in the rural parts of the state, but only in the population centers. In all of the places where PPNNE operates a clinic, there is a full service hospital or full service health clinic such as Manchester Community Health Clinic, Derry's Parkland Medical Center, West Lebanon's Dartmouth Hitchcock, Keene's Cheshire Medical Center, Claremont's Valley Regional Hospital, and Exeter's Exeter Hospital. If New Hampshire's department of health and human services want to direct tax dollars to support health care in NH, HB 228 directs that the tax dollars should be going to where they can provide the most good – full service health providers and not to the state's largest and most profitable abortion business.

I urge the committee to vote in favor of HB 228.

---

[1] See http://www.plannedparenthood.org/files/PPFA_FY_11_990_-_public_disclosure.pdf; www.plannedparenthood.org/files/PPFA/PPFA_FY_2010_990_Public_Disclosure_Copy.PDF

[2] See http://www.plannedparenthood.org/ppnne/files/Northern-New-England/2010_PPNNE_Public_Disclosure_Copy.pdf

[3] See http://www.opensecrets.org/politicians/contrib.php?cid=N00024790&cycle=2012&type=I&newMem=N&recs=100

Very truly yours,

Michael J. Tierney

MJT/pad
Enclosures

G:\D50500\50974\corr\SenateTestimony.docx

EXHIBIT A

Desilets, Kathleen (HHS/OPHS)

From: Desilets, Kathleen (HHS/OPHS)
Sent: Tuesday, July 05, 2011 1:11 PM
To: 'Michelle.R.Ricco@dhhs.state.nh.us'
Subject: RE: NH Status (7/6/11 at 12:31pm)

I guess that PP might find that Walmart is cheaper than they are for a lot of clients. I hadn't fully thought through how they could help clients - but I was wondering if they could as a pharmacy or another clinic to dispense for them. Clearly this would take some work... and might not even be practical. K

-----Original Message-----
From: Michelle.R.Ricco@dhhs.state.nh.us [mailto:Michelle.R.Ricco@dhhs.state.nh.us]
Sent: Tuesday, July 05, 2011 1:09 PM
To: Desilets, Kathleen (HHS/OPHS)
Subject: RE: NH Status (7/6/11 at 12:31pm)

Hi Kathy
I'm not sure of any collaborative agreements....I know that Walmart sells "pill" pretty inexpensively.

M

"Desilets, Kathleen (HHS/OPHS)" <Kathleen.Desilets@hhs.gov>

07/05/2011 12:46 PM

To "Michelle.R.Ricco@dhhs.state.nh.us" <Michelle.R.Ricco@dhhs.state.nh.us>

cc

Subject RE: NH Status (7/6/11 at 12:31pm)

Thanks, Michelle - this makes sense. I am wondering if there are any collaborative agreements, either with pharmacies or with other providers that might help clients get their medications at lower prices? k

-----Original Message-----
From: Michelle.R.Ricco@dhhs.state.nh.us
[mailto:Michelle.R.Ricco@dhhs.state.nh.us]
Sent: Tuesday, July 05, 2011 12:35 PM
To: Desilets, Kathleen (HHS/OPHS)

Subject: NH Status (7/6/11 at 12:31pm)

Hi Kathy
I put the date and time - as you know this stuff can change in the minute :)

I received a message from Meegan Gallager (SR. VP) of PPNNE. She said that PPNNE is currently seeing patients, but with no contract they have lost their dispensing privileges, so they are not handing out contraceptives but rather Rx and directing their clients to cost effective pharmacies. She noted that the clients responses have been "allot of tears".

That is what I know right now - will keep you updated even atleast daily even if there is not an update.

Michelle

Michelle R. Ricco, BS, CPM
Family Planning Program Manager
Maternal & Child Health Section
NH DHHS DPHS
29 Hazen Drive
Concord, NH 03301

Tel: 603-271-4527
mrricco@dhhs.state.nh.us

EXHIBIT B

Print

bing Maps

Manchester, NH

Planned Parenthood and
Rite Aid

On the go? Use **m.bing.com** to find maps, directions, businesses, and more

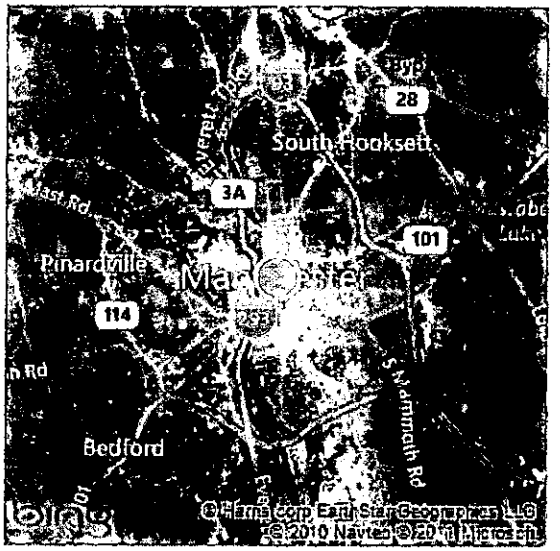


EXHIBIT C

EXHIBIT C

Desilets, Kathleen (HHS/OPHS)

From: Desilets, Kathleen (HHS/OPHS)
Sent: Friday, July 15, 2011 5:33 AM
To: Rosenfeld, Betsy F (HHS/OASH); Milner, Michael R (HHS/OASH)
Cc: 'Michelle.R.Ricco@dhhs.state.nh.us'
Subject: RE: NH Update

HI Betsy - Michelle says that NH hopes to bring the PPNNE Contract up (if support appears to be available to pass it) on the 8/24 EC meeting. In the meantime, Sununu and the Commissioner are working to feel out the cusnelors. I think they are trying to get an answer as quickly as possible, but thus far, this process has been characterized by additional requests for informaiton. K Michelle???

Mike and Betsy - I would like to talk as early as is feasible so that we/I can talk with Sue on this as well. K

From: Rosenfeld, Betsy F (HHS/OASH)
Sent: Thursday, July 14, 2011 6:31 PM
To: Desilets, Kathleen (HHS/OPHS); Milner, Michael R (HHS/OASH)
Cc: 'Michelle.R.Ricco@dhhs.state.nh.us'
Subject: Re: NH Update

Hi Kath and Michelle - glad to have this update, and let's plan to talk tomorrow with Mike about the small contract to PPNNE re notice to patients.

I am pretty sure we can all gather by phone and/or in person to review that.

One question re the longer-term options outlined below: When might NH find out if option #1 is a true possibility, or is a non-starter? I know the next EC meeting is not for a while, but I'm guessing a read on #1 might be available sooner?

Thx again to both of you, and we'll talk as soon as we can tomorrow re PPNNE contract. - Betsy

---

From: Desilets, Kathleen (HHS/OPHS)
Sent: Thursday, July 14, 2011 06:23 PM
To: Rosenfeld, Betsy F (HHS/OASH); Milner, Michael R (HHS/OASH)
Cc: (Michelle.R.Ricco@dhhs.state.nh.us) <Michelle.R.Ricco@dhhs.state.nh.us>
Subject: NH Update

Hello - Just got the following on the high level NH meeting held to day on the PPNNE/FP funding situation.

The meeting involved Michelle, Gov. Lyntch, reps from the AG's office, Commissioner Toumpas, and EC member Sununu and the purpose was to look at options and strategies to fill the gap in family planning services created by the rejection of the PPNNE Contract.

The governor's office has been in touch with PPNNE and they say they have kept their clinics open thus far, althoughn they are not providing medications, and the board will decide toaay what to do next. Currently, under NH law and regulations PPNNEhave no ability to dispense contraception and as a result they estimate that they are losing $4,000/day.

The state is trying to come to a best case way to fill the gap in services. Here are the opitons/

1. They have some hope that they may be able to move the counselors to adopt a new contract with PPNNE - the new contract would have revised dates and numbers and also would include language to spell out the restriction on using these funds for abortion and reqyure audited reprots that support it. NH officials will test whether this option might allow any movememtn in the counsel.

If this doesn;t work ---

2. NH could execute sole source extentions to current contracts (even those that are not for FP) to enable those providerst to offere family planning services. These providers would either provide services directly - or subcontract - in some cases they could liek to subcontract with PPNNE. This wouyld be a least a short term solution - until rebidding could occur...or it could be a ltonger term solution and depending on how subcontracting went would fill part of the gap..

3. NH could rebid the area now served by PPNNE - this would mean that it would be unlikely that servcies could be restored in this way before late fall at the best.

4. They could tell us that they cannot deliver services and we sould need to rebid.

In the meantime NH is interested in issuing a minor contract to pPNNE to enable them to meet the requirement we are putting on them to notify patients fo the options. We would have approval of this letter which would outline optons for clients including letting them know what other services are available, where to get low cost RX drugs, etc. They feel that this would held them avoid litighation, keep PP sites open, although not in full Title X status NH would ask that PP keep reporting theri service numbers. I think I suppor this action which is a placeholder becasue it is providng funds for PP to do the notification of clients that we are telling NH to do. BH really can't do it because they don;t have access to client information.

So - Hopefully, we can discuss this early tomorrow to see what we think. THen we need to push it on to Sue.

Thanks for all your support through this... and I have to say that we should send a letter or somethign to Michelle or to Jose about Michelle saying how much we appreciate her work on this, and her extra efforts to keep us fully informed.

Hopefully we can talk tomorrow. I will be in the office by 8 AM. K

Michelle - I have cced you so that you can be sure my notes and report on this are accuratte. K

EXHIBIT D

EXHIBIT D

1. Reproductive Health Services
   - Minors must be encouraged to consult with their parents with respect to such services.
   - Services must not be denied when consultation with parents is not feasible (unless prohibited by state law/regulations).
   - Any person who signs the request for services form must sign the CIIC(s) for the corresponding procedure. For example, if the affiliate uses the PPNNE Request for Surgery or Special Procedure to document compliance with a state's parental consent for abortion law, the parent(s) or guardian who signs the request should sign the CIICs relating to the minor's abortion procedure.
   - Affiliates should consult local counsel on compliance with state laws on parental consent and notification.
   - The parent or guardian who consents for a minor must be given the affiliate's notice of health information privacy practices
2. Non-Contraceptive or Non-STI Services (e.g., some limited or periodic health screening services and family practice services)

- Consent of a parent or guardian must be obtained when required by PPNNE standards (Family Practice/Non-Reproductive Health Care) or by state law.
- Each affiliate must consult with local legal counsel to clarify state requirements.
- Any circumstances in which parental consent are not required (e.g., "mature" or "emancipated" minors) must be clearly defined in the affiliate's protocols.

5. Fee Schedule: See Attached Excel Spreadsheet

6. Policy Regarding the Separation of Title X and Abortion Services

Policy Name	Separation of Title X and Abortion Services
Author	(b) (6)
Scope	All PPNNE Administrative and Health Centers
Effective Date	August 23, 2011
Revision Date(s)	August 30, 2011 (b) (6) /Medical Services

I. POLICY

Planned Parenthood of Northern New England (PPNNE) complies with all federal regulations with regard to separation of Title X and abortion services. Rigorous accounting processes are in place to ensure that federal Title X dollars do not contribute to any of the costs of providing abortion services at PPNNE. In addition, Title X-designated PPNNE health centers comply with all Title X guidelines for the provision of family planning services.

II. PROCEDURE

a. PPNNE's abortion services consist of:
   i. Surgical Abortion or Medication Abortion
   ii. Pre-operative Education
   iii. Options Education and documentation of patients choice
   iv. Informed consent procedure
   v. Testing for Rh blood type and Rhogam, if indicated
   vi. Pre-operative physical exam as indicated
   vii. Pre-operative vital signs
   viii. Pre-operative ultrasound
   ix. Abortion procedure
   x. Post-abortion visit

b. Allowable education at Title-X sites
   i. Pregnant women must be offered the opportunity to be provided information and education regarding each of the following options:
      - Prenatal care and delivery;
      - Infant care, foster care, or adoption; and
      - Pregnancy termination.
   ii. If this information and education is requested, it must be provided in a manner that is neutral, factual, and nondirective with regard to each of the options. Referral may also be given on request, except with respect to any options about which the pregnant woman indicates she does not wish to receive such information and counseling.
   iii. A referral may be provided for abortion, which may include providing the patient with the name, address, telephone number, and other factual information (charges, insurance coverage) about an abortion provider.

c. Restricted education at Title X sites
   i. A Title X site "may not take further affirmative action, such as negotiating a fee reduction, making an appointment, providing transportation, to secure abortion servicesto the patient".
   ii. However, these limitations do not apply in cases in which a referral is made for medical indications (such as where the women's life would be in danger).

d. Provision of Family Planning Services at Abortion Visits

When patients wish to receive a birth control method at an abortion visit, separate visit must be documented and charged out to the contraceptive program on the day of the procedure and (2), abortion program staff must allocate the time they spent providing contraceptive counseling to their site's contraceptive cost center via their timesheets. For more detailed information, please refer to the Provision of Contraceptive Services at Abortion Visit Policy

e. Allocation of Time

Abortion services are provided at set times each week with specific staff designated to provide those services. For health centers that receive Title X funds, other staff may make appointments or answer questions related to the abortion program. However, that time must also be charged to the abortion program. All abortion program activities take place in seven sites where PPNNE provides abortion. No abortion program activities take place in any other sites and no time or expenses are charged to any abortion program site by staff in other sites. On days when abortion procedures are not being provided and an abortion patient has a problem, question, or concern, they are handled as follows:

i. Emergency Calls: 24-hour a day on-call phone service is available; a practitioner will handle after hours calls and mark the time spent on these calls on her time sheet. This cost is budgeted between all the abortion programs. If calls occur during business hours, the person handling the call will mark the time spent on those calls on her timesheet and charge that time to the abortion program cost center.

ii. Appointment setting/questions: Time spent on extensive questions concerning the abortion program will be charged by those staff personnel to the abortion program.

iii. When a patient returns to the abortion site for a follow-up post-op visit, charges are not a accrued. The follow-up visit is covered in the initial procedure charge. PPNNE also does not bill for complications following affiliate-performed procedures.

f. Program Clarifications At times patient visits or patient problems may not clearly be related to either the contraceptive or abortion programs- that is, some judgment is called for. When in doubt, time and expenses are always charged to the abortion program.

g. Financial Reporting

i. Abortion program financial reporting is done separately from other medical services programs. In PPNNE's monthly financial statement, two pages of data refer to each abortion program. The first page is called the Revenue & Expense Report and outlines revenues &expenditures by line-item plus net income for the:

1. Current Month's Actual Figures
2. Current Month's Budgeted Figures
3. Year-to-Date Actual Figures
4. Year-to-Date Budgeted Figures
5. Year-to-Date Variance Figures
6. Last Year's Actual Year-to-Date Figures
7. The Current Annual Budget
8. The Current Remaining Budget

ii. The second page is called the Clinic Visit & Financial Indicators Report and includes the following information broken down by the current month and year-to-date's actual, budgeted & prior year figures. It also provides a percentage change comparison for the current and prior year's year-to-date figures along with a year-end projection.

1. The number of follow-up visits
2. Number of procedures
3. Total Visits
4. Total Patients
5. Number of Medicaid procedures
6. Number of insurance procedures
7. Number of Private Pay procedures
8. Private patient, Medicaid and insurance fees per procedure
9. Uncollectibles per procedure
10. Net fee per procedure
11. 11. Payroll cost per procedure
12. 12. Operating costs per procedure
13. 13. Total costs per procedure
14. 14. Net per procedure (excess or deficit of revenue relative to expenses)
15. 15. Net Revenue without subsidy
16. 16. Bottom Line
17. 17. Bottom Line per procedure

III. ADMINISTRATIVE GUIDELINES

a. Forms

i. 1. Time Sheets: All staff are required to list the time spent in each cost center; the format of the

ii. time sheet is based upon assignment of time by cost center. All staff must record the time spent in the abortion program using the appropriate cost center number. Combined Time Off (CTO) is allocated based on the time budgeted in the abortion program as a percentage of each employee's total budgeted work hours. For time recorded on days other than those when abortions are provided, record in half hour time increments.

b. Check Requests and Invoices: Expenses for the abortion program must be coded directly to the abortion program. When shared costs exist that are not directly attributable to the abortion program, they will be allocated on the basis of pre-determined formulas.

c. Lab Expense: All lab tests for the abortion program are coded 100% to that program. PPNNE AB programs have separate identification numbers set up with Converge Laboratory.
d. Licensed Professionals: All costs for abortion providers are coded 100% to the abortion program.
e. Medical Supplies: All medical supply purchases used exclusively by the abortion program (curettes etc.) are coded 100% to that program. Medical supplies used by all medical programs (contraceptive, teen & abortion) are allocated between those programs based upon their total budgeted visit percentages.
f. External Loan Distribution: This expense is allocated through the central office, based upon actual usage for internal and external loans.
g. Travel Expenses: All expenses for mileage, meals, lodging, and seminars related to providing abortion services are coded 100% to the abortion program
h. Office Supplies: Snacks for patients seen in the abortion program should be coded 100% to the abortion program. Any office supplies purchased for a particular program must be coded to that
i. program. General office supplies purchased for use by all programs within a building are coded using allocation percentages.
j. Advertising: All advertising costs for the abortion program are coded directly to that program. If a joint advertisement is run, then the cost for the advertisement is allocated based upon visit percentages.
k. Forms/Publications: Forms used specifically by the abortion program are coded directly to that program. Allocations for forms used jointly by both the abortion and contraceptive programs are based upon the visit percentages listed above.
l. Dues: National Abortion Federation dues are coded 100% to the abortion program.
m. Malpractice Insurance: Malpractice Insurance cost is allocated to the abortion sites based upon the product of the procedures provided and the current rate per procedure.
n. Telephone: Long distance phone service is provided by One Communications with all cost allocations based upon actual usage. This is tracked using a three-digit code that must be
o. entered before placing long-distance calls. AB Pager expense is split evenly among the seven Abortion programs.
p. Non-Capital Equipment: Includes service contracts for machine maintenance, copier rental, etc. Also includes furniture, equipment, medical instruments costing between $301 and $1000, and NEMED contract costs. Any non-capital equipment purchased for a particular program must be coded to that program. Non-capital equipment purchased for use by all programs within a building is coded using assigned allocation percentages. The cost of non-capital equipment

purchased for medical programs only (contraceptive, teen & abortion) is allocated using the allocation percentages for medical programs.

q. Mortgage Interest: Based upon the remaining mortgage values by location and total amount of area and the total time that area is used by each program.
r. Space Repair & Maintenance: Includes painting, fix-up, plowing, lawn mowing, office space cleaning, trash removal and renovations to space costing less than $1000. Based upon the total amount of area and the total time that area is used by each program.
s. Utilities: Includes heat, electricity, water and cable TV costs. Based upon the total amount of area
t. and the total time that area is used by each program
u. Property Insurance: Includes insurance costs on property we own. Based upon the total amount of area and the total time that area is used by each program
v. Miscellaneous Expenses: Any costs related to the abortion program that does not fit into an expense account above.
w. Revenue: All information regarding patient services provided in the abortion programs is entered into the practice management system using the appropriate office code, which allows for all revenue and statistical information to be recorded separately.

IV. ORIGINS/RATIONALE

Compliance with Title X regulations. All PPNNE abortion sites (except those in Vermont) are recipients of Title X funding. Title X expressly prohibits the use of Title X funding for abortion services.

7. Charging Costs to Federal Grant Program Policy

POLICY DOCUMENT	
EFFECTIVE DATE: 01/01/2011	TITLE: Charging Costs to Federal Grant Programs
NEXT REVIEW DATES: 6/1/2012	AUTHOR: Heather Bushey, Chief Financial Officer
RENEWAL AND/OR REVISION DATES:	OWNER: Chief Financial Officer

PURPOSE

To establish guidelines that ensure that costs charged to Federal grant programs are reasonable, allowable and allocable under the grant/award.

EXHIBIT E

Staff List Form

New Hampshire Department of Health and Human Services
Division of Public Health Services
COMPLETE ONE STAFF LIST FORM FOR EACH BUDGET PERIOD

Bidder/Program Name: Planned Parenthood of Northern New England

Name of RFP: Family Planning

Budget Period: July 1, 2011 - June 30, 2012

A	B	C	D	E	F	G	H
Position Title	Current Individual in Position	Proposed Hrly Rate for Budget Period	Hours per Week	Proj. Amt Funded by this Contract for Budget Period	Proj. Amount from Other Sources for Budget Period	Annual Salary All Sources	Site*
Example:							
Prenatal Coordinator	Sandra Little	$21.00	40	$21,840	$21,840	$43,680	
Health Care Associate	Libby Chehale Alexand	$13.20	27.375	$18,790.20		$18,790.20	Keene
Practitioner	Deborah Bowler	$40.21	35.625	$74,490.88		$74,490.88	Manchester/Exeter
Health Care Associate	Norma Carter	$12.50	27.25	$17,712.50		$17,712.50	Manchester
HCA Site Manager	Sharon Chase	$21.12	31.75	$34,869.12		$34,869.12	Claremont
Health Care Associate	Molly Crowley	$13.88	20.375	$14,705.86		$14,705.86	Exeter
HCA Admin Coord	Kathleen Curit	$16.68	31.75	$27,538.68		$27,538.68	Manchester
Health Care Associate	Erin Dunbar	$13.12	32.625	$22,258.08		$22,258.08	W. Lebanon
Health Care Associate	Jacqueline Fleming	$16.23	26.25	$22,153.95		$22,153.95	Manchester
Health Care Associate	Hannah Forman	$13.52	35.375	$24,870.04		$24,870.04	Keene
Practitioner	Maribeth Fries	$39.58	20.125	$41,423.61		$41,423.61	Keene
Regional Site Manager	Kristin Gagnon	$23.18	34	$40,982.24		$40,982.24	Keene/Derry
Health Care Associate	Jessica Gogolen	$12.88	22.625	$15,153.32		$15,153.32	Derry
Health Care Associate	Barbara Hawes	$17.13	24.875	$22,157.66		$22,157.66	Exeter
Practitioner	Anne Hildreth	$39.58	26.875	$55,317.24		$55,317.24	W. Lebanon
Health Care Associate	Erin Hooley	$13.61	23.875	$16,896.82		$16,896.82	Derry
HCA Site Mgr	Kerryn Hyde	$25.60	30.5	$40,601.60		$40,601.60	Manchester
Practitioner	Carolyn Jones	$39.44	26.875	$55,117.40		$55,117.40	Claremont/Keene
Practitioner	Caren Kachoris	$40.12	8	$16,689.92		$16,689.92	Manchester
Practitioner	Roxanne Karter	$42.72	33.25	$73,869.80		$73,869.80	Claremont/Manchester
Health Care Associate	Lottie Kelley	$14.46	14.875	$11,184.81		$11,184.81	Exeter
Marketing Coordinator/Organizer	Amy Lafayette	$18.93	3	$2,953.08		$2,953.08	Central Office
RN	Jessica Lambert	$29.48	16	$24,527.36		$24,527.36	Manchester
Health Care Associate	Amy Landers	$15.13	24.875	$19,570.66		$19,570.66	Derry

*Please list which site(s) each staff member works at, if bidder has multiple sites. Not applicable to WIC.

Staff List Form

New Hampshire Department of Health and Human Services
Division of Public Health Services

COMPLETE ONE STAFF LIST FORM FOR EACH BUDGET PERIOD

Bidder/Program Name: Planned Parenthood of Northern New England

Name of RFP: Family Planning

Budget Period: July 1, 2011 - June 30, 2012

A	B	C	D	E	F	G	H
Position Title	Current Individual in Position	Projected Hourly Rate as of 1st Day of Budget Period	Hours per Week	Prof. Amount Funded by this Contract for Budget Period	Prof. Amount from Other Sources for Budget Period	Total Salary/ All Sources	Site*
Example:							
Prenatal Coordinator	Sandra Little	$21.00	40	$21,840	$21,840	$43,680	
Health Care Associate	Jill Lowell	$13.27	27.25	$18,802		$18,802	Manchester
Practitioner	Patricia Magaw	$37.40	22.75	$44,244		$44,244	Manchester
Health Care Associate	Amy Mash	$12.88	29.5	$19,758		$19,758	Manchester/Derry
HCA Site Manager	Amanda Mehegan	$17.36	29.375	$26,517		$26,517	W. Lebanon
Health Care Associate	Angela Morand	$12.62	28.625	$18,785		$18,785	W. Lebanon
HCA Admin Assoc	Jennie Newcombe	$15.80	31.125	$25,572		$25,572	Keene
Practitioner	Bonnie O'Connell	$40.21	24.875	$52,013		$52,013	Derry
Health Care Associate	Rosemery Rodriguez	$14.07	31.75	$473	$22,757	$23,230	Manchester
Health Care Associate	Debra Sabalewski	$17.13	28.75		$25,609	$25,609	Claremont
HCA Site Manager	Holly Schiavoni	$18.14	34.5		$32,543	$32,543	Exeter
Health Care Associate	Shannie Sturk	$14.68	19.875		$15,172	$15,172	Exeter
Prac Flex Float	Prac Flex Float	$47.91	2.78		$6,926	$6,926	Claremont
Prac Flex Float	Prac Flex Float	$47.91	3.04		$7,574	$7,574	Derry
Prac Flex Float	Prac Flex Float	$47.91	4.2		$10,464	$10,464	Keene
Prac Flex Float	Prac Flex Float	$47.91	7.05		$17,564	$17,564	Manchester
Prac Flex Float	Prac Flex Float	$47.91	3.7		$9,218	$9,218	W. Lebanon
Prac Flex Float	Prac Flex Float	$47.91	4.13		$10,289	$10,289	Exeter
HCA Flex Float	HCA Flex Float	$21.16	4.28		$4,709	$4,709	Claremont
HCA Flex Float	HCA Flex Float	$21.16	7.11		$7,823	$7,823	Derry
HCA Flex Float	HCA Flex Float	$21.16	6.21		$6,833	$6,833	Exeter
HCA Flex Float	HCA Flex Float	$21.16	6.75		$7,427	$7,427	Keene
HCA Flex Float	HCA Flex Float	$21.16	19.01		$20,917	$20,917	Manchester
HCA Flex Float	HCA Flex Float	$21.16	5.07		$5,579	$5,579	W. Lebanon
Health Care Associate	VACANT	$14.00	11.375		$8,281	$8,281	W. Lebanon/Manchester
Director Comm. Engagement	Valerie Vass	$31.69	3		$4,944	$4,944	Central Office
Total Salaries by Source				$900,000	$224,628	$1,124,627	

*Please list which site(s) each staff member works at, if bidder has multiple sites. Not applicable to WIC.

Staff List Form

New Hampshire Department of Health and Human Services
Division of Public Health Services
COMPLETE ONE STAFF LIST FORM FOR EACH BUDGET PERIOD

Bidder/Program Name: Planned Parenthood of Northern New England

Name of RFP: Family Planning

Budget Period: July 1, 2012 - June 30, 2013

A	B	C	D	E	F	G	H
Position Title	Current Individual in Position	Projected Hrly Rate as of 1st Day of Budget Period	Hours per Week	Prop. Amnt Funded by this Contract for Budget Period	Prop. Amount from Other Sources for Budget Period	Total Salaries All Sources	Site*
Example:							
Prenatal Coordinator	Sandra Little	$21.00	40	$21,840	$21,840	$43,680	
Health Care Associate	Libby Chehale Alexander	$13.60	27.375	$19,354		$19,354	Keene
Practitioner	Deborah Bowler	$41.42	35.625	$76,726		$76,726	Manchester/Exeter
Health Care Associate	Norma Carter	$12.88	27.25	$18,244		$18,244	Manchester
HCA Site Manager	Sharon Chase	$21.75	31.75	$35,915		$35,915	Claremont
Health Care Associate	Molly Crowley	$14.30	20.375	$15,147		$15,147	Exeter
HCA Admin Coord	Kathleen Curit	$17.18	31.75	$28,365		$28,365	Manchester
Health Care Associate	Erin Dunbar	$13.51	32.625	$22,926		$22,926	W. Lebanon
Health Care Associate	Jacqueline Fleming	$16.72	26.25	$22,819		$22,819	Manchester
Health Care Associate	Hannah Forman	$13.93	35.375	$25,616		$25,616	Keene
Practitioner	Maribeth Fries	$40.77	20.125	$42,666		$42,666	Keene
Regional Site Manager	Kristin Gagnon	$23.88	34	$42,212		$42,212	Keene/Derry
Health Care Associate	Jessica Gogolen	$13.27	22.625	$15,608		$15,608	Derry
Health Care Associate	Barbara Hawes	$17.64	24.875	$22,822		$22,822	Exeter
Health Care Associate	HCA, New	$14.42	11.375	$8,529		$8,529	W. Lebanon/Manchester
Practitioner	Anne Hildreth	$40.77	26.875	$56,977		$56,977	W. Lebanon
Health Care Associate	Erin Hooley	$14.02	23.875	$17,404		$17,404	Derry
HCA Site Mgr	Kerryn Hyde	$26.37	30.5	$41,820		$41,820	Manchester
Practitioner	Carolyn Jones	$40.62	26.875	$56,771		$56,771	Claremont/Keene
Practitioner	Caren Kachoris	$41.32	8	$17,191		$17,191	Manchester
Practitioner	Roxanne Karter	$44.01	33.25	$76,086		$76,086	Claremont/Manchester
Health Care Associate	Lottie Kelley	$14.89	14.875	$11,520		$11,520	Exeter
Marketing/Organizer	Amy Lafayette	$19.50	3	$3,042		$3,042	Central Office
RN	Jessica Lambert	$30.36	16	$25,263		$25,263	Manchester
Health Care Associate	Amy Landers	$15.58	24.875	$20,158		$20,158	Derry

*Please list which site(s) each staff member works at, if bidder has multiple sites. Not applicable to WIC.

Staff List Form

New Hampshire Department of Health and Human Services
Division of Public Health Services

COMPLETE ONE STAFF LIST FORM FOR EACH BUDGET PERIOD

Bidder/Program Name: Planned Parenthood of Northern New England

Name of RFP: Family Planning

Budget Period: July 1, 2012 - June 30, 2013

A	B	C	D	E	F	G	H
Position Title	Current Individual and Position	Projected Hrly Rate as of 1st Day of Budget Period	Hours per Week	Proj. Amount Funded by This Contract for the Budget Period	Proj. Amount from Other Sources for Budget Period	Total Salaries (All Sources)	Site*
Example:							
Prenatal Coordinator	Sandra Little	$21.00	40	$21,840	$21,840	$43,680	
Health Care Associate	Jill Lowell	$13.67	27.25	$19,366		$19,366	Manchester
Practitioner	Patricia Magaw	$38.52	22.75	$45,572		$45,572	Manchester
Health Care Associate	Amy Mash	$13.27	29.5	$20,351		$20,351	Manchester/Derry
HCA Site Manager	Amanda Mehegan	$17.88	29.375	$27,313		$27,313	W. Lebanon
Health Care Associate	Angela Morand	$13.00	28.625	$19,348		$19,348	W. Lebanon
HCA Admin Assoc	Jennie Newcombe	$16.27	31.125	$26,339		$26,339	Keene
Practitioner	Bonnie O'Connell	$41.42	24.875	$18,531	$35,042	$53,573	Derry
Health Care Associate	Rosemery Rodriguez	$14.49	31.75		$23,926	$23,926	Manchester
Health Care Associate	Debra Sabalewski	$17.64	28.75		$26,378	$26,378	Claremont
HCA Site Manager	Holly Schiavoni	$18.68	34.5		$33,519	$33,519	Exeter
Health Care Associate	Shannie Sturk	$15.12	19.875		$15,627	$15,627	Exeter
Prac Flex Float	Prac Flex Float	$49.35	2.78		$7,134	$7,134	Claremont
Prac Flex Float	Prac Flex Float	$49.35	3.04		$7,801	$7,801	Derry
Prac Flex Float	Prac Flex Float	$49.35	4.2		$10,777	$10,777	Keene
Prac Flex Float	Prac Flex Float	$49.35	7.05		$18,091	$18,091	Manchester
Prac Flex Float	Prac Flex Float	$49.35	3.7		$9,494	$9,494	W. Lebanon
Prac Flex Float	Prac Flex Float	$49.35	4.13		$10,598	$10,598	Exeter
HCA Flex Float	HCA Flex Float	$21.79	4.28		$4,851	$4,851	Claremont
HCA Flex Float	HCA Flex Float	$21.79	7.11		$8,058	$8,058	Derry
HCA Flex Float	HCA Flex Float	$21.79	6.21		$7,038	$7,038	Exeter
HCA Flex Float	HCA Flex Float	$21.79	6.75		$7,650	$7,650	Keene
HCA Flex Float	HCA Flex Float	$21.79	19.01		$21,545	$21,545	Manchester
HCA Flex Float	HCA Flex Float	$21.79	5.07		$5,746	$5,746	W. Lebanon
Director Comm. Engagement	Valerie Vass	$32.64	3		$5,092	$5,092	Central Office
Total Salaries by Source				$900,000	$258,366	$1,158,366	

*Please list which site(s) each staff member works at, if bidder has multiple sites. Not applicable to WIC.

EXHIBIT F

EXHIBIT F

RATH YOUNG PIGNATELLI

Lucy C. Hodder
Attorney-At-Law
lch@rathlaw.com
Please reply to: Concord Office

January 23, 2012

Sent by Email and Federal Express

Department of Health and Human Services
Attn: Latrice Gilliard
Division of FOIA Services
770 Wisconsin Avenue, Suite 920
Bethesda, MD 20814

Re: FOIA Case No. 12-0063

Dear Ms. Gilliard:

We represent Planned Parenthood of Northern New England (PPNNE). PPNNE appreciates your letter of January 13, 2012 regarding pre-disclosure notification procedures for confidential information. In accordance with Executive Order 12600, PPNNE has examined the documents you sent PPNNE, and identified information determined to be exempt from disclosure under the Freedom of Information Act (FOIA). 5 U.S.C. § 552(b).

Enclosed please find PPNNE's response and copies of the actual pages containing the exempt information. All the redactions have been highlighted for ease of reference.

Please call with any questions.

Very truly yours,

Lucy C. Hodder

Enclosures

Planned Parenthood®
of Northern New England

January 23, 2012

Sent by Email and Federal Express

Department of Health and Human Services
Attn: Latrice Gilliard
Division of FOIA Services
770 Wisconsin Avenue, Suite 920
Bethesda, MD 20814

Re: FOIA Case No. 12-0063

Dear Ms. Gilliard:

Thank you for your letter of January 13, 2012 regarding pre-disclosure notification procedures for confidential information. In accordance with Executive Order 12600, PPNNE has examined the documents you sent us and it is our position that the information identified in this letter by page number is exempt from disclosure under the Freedom of Information Act (FOIA) exemption 4 because it is "commercial or financial information obtained from a person and privileged or confidential." 5 U.S.C. § 552(b) (4)

We have also attached copies of the actual pages containing the exempt information. All the redactions have been highlighted for ease of reference. Where whole pages contain confidential information and should be redacted, we have used a highlighter to mark an "X" through the entire page.

The information we seek to have redacted as exempt is commercial information PPNNE keeps confidential because disclosure would cause it substantial competitive harm. This proprietary information is not part of PPNNE's public IRS 990 filings, on its website, in its annual reports and legislative testimony, or disclosed by it in any public forum because disclosure would harm its competitive position nationally, regionally, and in New Hampshire. Disclosure of funding amounts, budget requests, cost allocation formulas, and expenses will permit PPNNE's competitors to undercut it and compete unfairly for grants, contracts, patients, employees, vendors and other business ventures.

In addition to confidential financial information, PPNNE's business plans, practices, goals, strategies, and internal policies and procedures are confidential and, if disclosed, would benefit its competitors (health care clinics, private practices and hospitals) to its substantial detriment. PPNNE has

spent a great deal of time, money and staff effort over the years developing and refining its strategies, plans, protocols and internal procedures. It would put PPNNE at a substantial competitive disadvantage if other health care providers were to obtain, adopt or use this confidential information in any way.

Additionally, the information from PPNNE's personnel files about its staff is not only proprietary under FOIA Exemption 4, but private personnel information exempted under 5 U.S.C. § (b)(6) because the disclosure of such information "would constitute a clearly unwarranted invasion of personal privacy." The personal information we redacted identifies PPNNE staff by name and position, reveals salary information, and provides private biographical information. But for the 990 information, how PPNNE is staffed, its employees' identities, and how much they earn is proprietary information. Disclosure of PPNNE's staffing levels, names, salaries, and biographical information would permit competitors to out-bid it, hire staff away, publish personal and personnel details publicly, or harass staff to the point where they may leave PPNNE's employ.

PPNNE has reason to be concerned about its confidential and private information being disclosed to the public because the requester of this information has publicly pledged to release the information to every newspaper in New Hampshire. Also, the requester makes it clear in the FOIA request that entities like the Manchester Community Health Clinic and New Hampshire hospitals are interested in providing family planning services and would compete against PPNNE for Title X funding. Consequently, the information requested would be used as a road map to PPNNE's competitors seeking funding and to otherwise commercially harm PPNNE.

All of the confidential proprietary information listed below, and highlighted on the attached pages at your request, was provided as part of the Replacement Grant application required by the Department of Health and Human Services (HHS). The proprietary business and personnel information provided to HHS in support of the grant is not publicly available.

For the above reasons, we have redacted the information listed below. Please see the attached pages for the actual redactions:

- Notice of Grant Award: pages 1 and 2. The monetary amounts of the grant award and the approved budget have been redacted.
- Grant Solutions.gov: The project director's name, phone number and the funded amount have been redacted.
- Application for Federal Assistance SF-424:
    - Page 2 of 71: The contact person's name, email address and phone number have been redacted.
    - Page 11 of 71: The contact person's name, email address and phone number have been redacted.
    - Page 13 of 71: The estimated funding amounts and the email address for PPNNE's president have been redacted.

- Pages 19-20 of 71: The budget numbers in the "Budget Information" request form have been redacted.
- Page 21 of 71: The Family Planning Personnel Listing of the names, positions, total annual salary, and federal and non-federal components have been redacted.
- Pages 22-24 of 71: The information populating the "Budget Justification Narrative" form has been redacted.
- Pages 26-27 of 71: Section 6, the "Biographical Sketches for Project Director and other key personnel" has been redacted.
- Page 28 of 71: The names of four employees in the Project Narrative regarding clinical capability have been redacted.
- Page 30-31 of 71: The information about PPNNE's upgrades to its practice management system has been redacted, as have the names of two employees.
- Page 32-35 of 71: Specific strategic, administrative and management information has been redacted. Also, on page 35, PPNNE's proposed number of patients to be served by the Grant has been redacted.
- Page 37-38 of 71: The Statement of Goals for FY2012 and the Project Strategies have been redacted.
- Pages 39-40 of 71: The names of two PPNNE employees have been redacted.
- Page 42 of 71: The name of a PPNNE employee has been redacted.
- Pages 48-53 of 71: PPNNE's *Mandatory Reporting Policy and Procedure* has been redacted.
- Pages 53-56 of 71: PPNNE's *Human Trafficking Policy* has been redacted.
- Page 56 of 71: **Although it was not attached to the documents sent to PPNNE for review under Executive Order No. 12600, the Fee Schedule contained in an Excel Spreadsheet that was provided by PPNNE to HHS, which contains proprietary fee information for PPNNE's services, is confidential and should be redacted because of the substantial competitive harm to PPNNE that would result.**
- Pages 56-61 of 71: PPNNE's *Policy Regarding the Separation of Title X and Abortion Services* has been redacted.
- Pages 61-63 of 71: PPNNE's *Charging Costs to Federal Grant Program Policy* has been redacted.
- Pages 65 to 71 of 71: A PPNNE employee's CV has been redacted.

PPNNE certifies that the information it is requesting to be redacted, as set forth above and on the attached pages, has not been disclosed to the public by PPNNE and is non-public because it is not routinely available to the public from other sources.

Helen S. Reid, MPH
Director of Health Center Operations
PPNNE
Helen.Reid@ppnne.org

Testimony for HB228 Chapter 126-V Whole Women's Health Funding Priorities Act

My name is Darlene Marie Pawlik. I have been a nurse for almost 25 years. Most of that time, I have practiced here in NH. I brought up five children here, three girls and two boys. I have lived in NH for almost my whole life. I thank you for your service to our State.

I am here today to assert that, abortion is not health care. Public funds should promote the health and well being of NH women.

I will speak for just a few minutes. I have enclosed citations for the assertions I will make and I will be open to questions. If you would, please permit me to read through this testimony.

The intentional disruption of a first pregnancy, by surgical or chemical means is deleterious to women. In 1986, government scientists wrote a letter to the British journal Lancet and acknowledged that abortion is a cause of breast cancer. They wrote, "Induced abortion before first term pregnancy increases the risk of breast cancer." (Lancet, 2/22/86, p. 436) The logic behind the finding is actually simple. The hormones that sustain pregnancy increase the ductwork for the production of mother's milk, but the cells of this increased ductwork are immature and vulnerable to mutate abnormally and these lobules do not mature until the hormonal changes that occur with the culmination of the first pregnancy. The hormones that induce childbirth cause the maturation of the cells that make up the expanded ductwork. Thus, the disruption of the natural process by abortion leaves the tissue vulnerable to cancer. If a pregnancy is 'miscarried', it is often due, at least in part, to hormonal insufficiency and generally doesn't carry the same risks. (Please see numerous citations on page two.)

Many women are at risk for injurious psychosocial effects of abortion. Some 18.8% of women who had undergone induced abortion 3-5 years previously reported all Post Traumatic Stress Syndrome criteria (DSM-III R). Some 39-45% of women still had sleep disorders, hyper-vigilance and flashbacks of the abortion experience. Some 16.9% had high intrusion scores on the Millon Clinical Multiaxial Inventory-III, or theMCMI, this tests the areas of histrionic, anti-social narcissism, paranoid personality disorder and elevated anxiety compared with the sample on which the test had been normed. This is from the *Long-Term Psycho-social Effects of Abortion,* Catherine A. Barnard (Portsmouth, NH.: Institute For Pregnancy Loss, 1990)

This statement exemplifies the most deleterious of the effects of abortion for women in NH. This is an old study, more than 20 years old. Abortion in New Hampshire is shrouded in secrecy. Anecdotal evidences are available, but few follow-up studies exist for NH women. I have enclosed a sheet of Traumatic effects of abortion, compiled nationally, with the citations for each on the reverse. In short, suicide risks are higher, incidences of clinical depression is increased, PTSD, generalized anxiety disorder, sleep disorders and eating disorders have been found to be increased following abortion, when compared to women who delivered live births. Please see the enclosure.

Women are at risk for preterm births in subsequent pregnancies following abortion. After studying data on 1,943 very preterm births, 276 moderately preterm babies and 618 full-term controls, Dr. Caroline Moreau of Hospital de Bicetre and colleagues concluded that women with a history of abortion were 1.5 times more likely to give birth very prematurely (under 33 weeks gestation), and 1.7 times more likely to have a baby born extremely (under 28 weeks gestation) preterm. Their findings were reported in the April, 2005 issue of the British Journal of Obstetrics and Gynecology, a peer-reviewed medical journal.

Preterm births are usually associated with increased care and costs, not to mention additional stress on women.

Abortion isn't healthcare, even in the event of breast cancer. A new collection of studies and medical data from The Lancet, a prominent British medical journal, shows pregnant women do not need to have an abortion in order to get treatment for cancer. "Importantly, the new insights we gained during our research facilitate cancer treatment and provide hope for mother and child in most cases" say researchers, Philippe Morice, Catherine Uzan, and Serge Uzan. They go on to say. "Most mothers feel stronger and are even more motivated to undergo the cancer treatment and its side effects, since she is fighting for her child as well. Whether the patient already has children, her desire to continue the present pregnancy, the opinion of the partner and the predicted outcome determine her choices and reactions when breast cancer is diagnosed during pregnancy. The patient and her partner should be informed about the different treatment options and the physician should explain that termination of pregnancy does not seem to improve maternal outcome."

NH Taxpayers do not want to pay for abortion. Abortion is not healthcare and it is deleterious to the health of NH women. As a woman, as a healthcare provider and as a mother I ask you to pass HB228.

Honorable Senators of the Health and Human Services Committee, in as much as it is within your authority and power to do so, please protect the health of the women of NH.

Citations:

[1]Harris Jr. *Diseases of the Breast,* 2nd ed. Lippincott Williams &Wilkins 2000 (Ch1. Breast anatomy and development; Ch. 2. Biochemical control of breast development).

[2] Blackwell RE, Grotting JC. *Diagnosis and management of breast disease.* Blackwell Science 1996 (Ch 2. *Breast dysfunction; galactorrhea and mastagia)*

[3]Daling Jr et al. Risk of breast cancer among young women: relationship to induced abortion. *J Natl Cancer Institute* 1994;86:1584-1592

[4] *Te Long-Term Psycho-social Effects of Abortion,* Catherine A. Barnard (Portsmouth, NH: Institute For Pregnancy Loss, 1990)

[5]4/05 Issue, British Journal of Obstetrics and Gynecology, Reuters Health; Dr. Caroline Moreau et al. Epidemiology Research Unit, Perinatal/Women's Health, Hospital DeBicetre, France]

[6] Russo J, et al. Cancer risk related to mammary gland structure and development. *Microscopy Research and technique* 2001;52:204-233

[7] Rooney B, et al. Induced abortion and risk of later premature births. *J Am Phys Surgs* 2003;8:46-49

[8] Berman R, et al. Preterm Birth: Causes, Consequences and Prevention. Institute of Medicine 2006 page 519 Appendix B, Table 5

[9] *The Lancet Oncology*, vol. 13 No.3 pp218-220 by Philippe Morice, Catherine Uzan, and Serge Uzan of the Department of Gynecologic Surgery, at the Institute Gustave Roussy, in France

Psychological Risks
Traumatic Aftereffects of Abortion

Suicide

- **6 times higher suicide rate.** Aborting women were 6 times more likely to commit suicide in the following year than were delivering women.[1] A study of women for up to eight years after the pregnancy ended found a 2.5 times higher suicide rate after abortion than after giving birth.[2]
- **Up to 60% have suicidal thoughts.** In a study in a major scientific journal, 31% of women had thoughts of suicide after undergoing an abortion.[3] In another survey, approximately 60% of women with post-abortion problems reported suicidal thoughts, with 28% attempting suicide and half of those attempting suicide two or more times.[4]

Depression

- **65% higher risk of clinical depression.** Women who aborted were 65% more likely than delivering women to be at risk of long-term clinical depression after controlling for age, race, education, marital status, income, and prior psychiatric state.[5]
- **Depression risk remained high, even when pregnancies were unplanned.** Among women with unintended first pregnancies, aborting women were at significantly higher risk of long-term clinical depression compared to delivering women.[6]

Trauma

- **65% report symptoms of post-traumatic stress disorder.** 65% of U.S. women who had abortions experienced multiple symptoms of PTSD, which they attributed to their abortions. Slightly over 14% reported all the symptoms necessary for a clinical diagnosis of abortion-induced PTSD.[3]
- **60% said they felt "part of me died."** In the above study, 60% reported that they felt "part of me died" after their abortions.[3]
- **More psychiatric treatment.** Compared to women who deliver, women who abort are more than twice as likely to be subsequently hospitalized for psychiatric illness within six months.[7] Analysis of California Medicaid records shows that women who have abortions subsequently require significantly more treatments for psychiatric illness through outpatient care.[8]
- **Multiple disorders and regrets.** In a study eight weeks after abortion, 36% of women experienced sleep disturbances, 31% had regrets about the abortion, and 11% had been prescribed psychotropic medicine by their family doctor.[9]
- **Generalized anxiety disorder.** Among women with no previous history of anxiety, women who aborted a first, unplanned pregnancy were 30% more likely to subsequently report all the symptoms associated with a diagnosis for generalized anxiety disorder, compared to women who carried to term.[10]
- **Sleep disorders.** In a study of women with no known history of sleep disorders, women were more likely to be treated for sleep disorders after having an abortion compared to giving birth (nearly twice as likely in the first 180 days afterwards). Numerous studies have shown that trauma victims often experience sleep difficulties.[11]
- **Disorders not pre-existing.** A New Zealand study found that women had higher rates of suicidal behavior, depression, anxiety, substance abuse, and other disorders after abortion. The study found that these were not pre-existing problems.[12]

Eating disorders & substance abuse

- **39% had eating disorders.** In a survey of women with post-abortion problems, 39% reported subsequent eating disorders.[13]
- **Five-fold higher risk of drug and alcohol abuse.** Excluding women with a prior history of substance abuse, those who abort their first pregnancy are 5 times more likely to report subsequent drug and alcohol abuse vs. those who give birth.[14]

continued ▸

Divorce and chronic relationship problems

- **Women with a history of abortion are significantly more likely to subsequently have shorter relationships and more divorces.**[15]
- **More poverty and single parenthood after repeat abortions.** Women who have more than one abortion (nearly half of those seeking abortions each year[16]) are more likely to become single parents and to require public assistance.[17]
- **30-50% of post-abortive women report experiencing sexual dysfunctions** such as promiscuity, loss of pleasure from intercourse, increased pain, and aversion to sex and/or men.[18]
- **Studies have identified factors that put women at risk for negative reactions to abortion,** including feeling pressured to abort, lack of support, being more religious, prior emotional or psychological problems, adolescence, being unsure of her decision, and receiving little or no counseling prior to abortion.[19]

To find out more, including pregnancy help and post-abortion resources, visit TheUnChoice.com

Citations

1. Gissler, Hemminki & Lonnqvist, "Suicides after pregnancy in Finland, 1987-94: register linkage study," *British Journal of Medicine* 313:1431-4, 1996; and M. Gissler, "Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000," *European J. Public Health* 15(5):459-63,2005.

2. DC Reardon et. al., "Deaths Associated With Pregnancy Outcome: A Record Linkage Study of Low Income Women," *Southern Medical Journal* 95(8):834-41, Aug. 2002.

3. VM Rue et. al., "Induced abortion and traumatic stress: A preliminary comparison of American and Russian women," *Medical Science Monitor* 10(10): SR5-16, 2004.

4. D. Reardon, *Aborted Women, Silent No More* (Springfield, IL: Acorn Books, 2002).

5. JR Cougle, DC Reardon & PK Coleman, "Depression Associated With Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort," *Medical Science Monitor* 9(4):CR105-112, 2003.

6. DC Reardon, JR Cougle, "Depression and unintended pregnancy in the National Longitudinal Study of Youth: a cohort study," *British Medical Journal* 324:151-2, 2002.

7. DC Reardon et. al., "Psychiatric admissions of low-income women following abortions and childbirth," *Canadian Medical Association Journal* 168(10): May 13, 2003.

8. PK Coleman et. al., "State-Funded Abortions Versus Deliveries: A Comparison of Outpatient Mental Health Claims Over Four Years," *American Journal of Orthopsychiatry* 72(1):141-152, 2002.

9. Ashton,"The Psychosocial Outcome of Induced Abortion", *British Journal of Ob & Gyn.* 87:1115-1122, 1980.

10. JR Cougle, DC Reardon, PK Coleman, "Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth and Abortion: A Cohort Study of the 1995 National Survey of Family Growth," *Journal of Anxiety Disorders* 19:137-142 (2005).

11. DC Reardon and PK Coleman, "Relative Treatment Rates for Sleep Disorders and Sleep Disturbances Following Abortion and Childbirth: A Prospective Record Based-Study," *Sleep* 29(1):105-106, 2006.

12. DM Fergusson et. al., "Abortion in young women and subsequent mental health," *Journal of Child Psychology and Psychiatry* 47(1): 16-24, 2006.

13. T. Burke with D. Reardon, *Forbidden Grief: The Unspoken Pain of Abortion* (Springfield, IL: Acorn Books, 2002) 189, 293

14. DC Reardon, PG Ney, "Abortion and Subsequent Substance Abuse," *American Journal of Drug and Alcohol Abuse* 26(1):61-75, 2000.

15. Shepard, et al., "Contraceptive Practice and Repeat Induced Abortion: An Epidemiological Investigation," *J. Biosocial Science* 11:289-302, 1979; M. Bracken, "First and Repeated Abortions: A Study of Decision-Making and Delay," *J. Biosocial Science* 7:473-491, 1975; S. Henshaw, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," *Family Planning Perspectives*, 20(4):158-168, 1988; D. Sherman, et al., "The Abortion Experience in Private Practice," *Women and Loss: Psychobiological Perspectives*, ed. W.F. Finn, et al., (New York: Praeger Publishers, 1985) 98-107; E.M. Belsey, et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Social Science and Medicine* 11:71-82, 1977; E. Freeman, et al., "Emotional Distress Patterns Among Women Having First or Repeat Abortions," *Obstetrics and Gynecology* 55(5):630-636, 1980; C. Berger, et al., "Repeat Abortion: Is it a Problem?" *Family Planning Perspectives* 16(2):70-75 (1984).

16. "Facts in Brief: Induced Abortion," The Alan Guttmacher Institute (www.agi-usa.org), 2002.

17. Speckhard, *Psycho-social Stress Following Abortion*, (Kansas City, MO: Sheed & Ward, 1987); and Belsey, et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Social Science & Medicine* 11:71-82, 1977.

18. Speckhard, *Psycho-social Stress Following Abortion*, (Kansas City, MO: Sheed & Ward, 1987); and Belsey, et al., "Predictive Factors in Emotional Response to Abortion: King's Termination Study - IV," *Social Science & Medicine* 11:71-82, 1977. See also P.K. Coleman, V.M. Rue, C.T. Coyle, "Induced abortion and intimate relationship quality in the Chicago Health and Social Life Survey," *Public Health* (2009), doi:10,1016/j.puhe.2009.01.005.

19. David C. Reardon, "The Duty to Screen: Clinical, Legal, and Ethical Implications of Predictive Risk Factors of Post-Abortion Maladjustment," *The Journal of Contemporary Health Law and Policy* 20(2):33-114, Spring 2004.

April 5, 2012, Senate Health and Human Services Committee

Testimony of Joan Espinola on HB228, prohibiting the use of public funds for abortion services.

I respectfully ask the Senate Health and Human Services Committee to vote for HB228, prohibiting the use of public funds for abortion services.

In 1973 the Supreme Court of the United States found a right to kill unborn babies in their Roe V. Wade decision, and the same day they found the right to kill unborn babies at any stage of development and for any reason, in their Doe V. Bolton decision. This I thought was bad enough, but for the taxpayer to have to fund abortion for any reason, is shameful and disgraceful.

Money is fungible. Giving an abortion clinic money, is like adding water to water. You don't know which is the water that was there or which is the water that was added. It all goes together. Any organization that will kill the unborn, the most innocent among us, will do anything, and taking money from one column to another, is nothing in the scheme of things. They can very easily take the money the government gave and put it in the column for STD testing, and then take the money in the STD testing column and use it for abortions. As I said money is fungible, meaning, it's of a nature or kind as to be FREELY exchangeable or replaceable, in whole or in part for another of like nature or kind. Money is money.

I ask you to please vote HB228, ought to pass

Respectfully submitted

Joan Espinola
170 No. Policy Street
Salem, NH 03079

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: 4/20/12

THE COMMITTEE ON Health and Human Services

to which was referred House Bill 228-FN

AN ACT (New Title) prohibiting the use of public funds for abortion services.

Having considered the same, the committee recommends that the Bill:

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 3-2

AMENDMENT # 1768s

Senator Gary E. Lambert
For the Committee

Robyn Dangora 271-4154

New Hampshire General Court - Bill Status System

Docket of HB228

Docket Abbreviations

Bill Title: (New Title) prohibiting the use of public funds for abortion services.

Official Docket of **HB228**:

Date	Body	Description
1/20/2011	H	**Introduced** 1/6/2011 and Referred to Health, Human Services and Elderly Affairs; **HJ 11**, PG. 178
1/25/2011	H	Public Hearing: 2/8/2011 1:30 PM LOB 205
2/9/2011	H	Subcommittee Work Session: 2/17/2011 2:30 PM LOB 205
2/17/2011	H	Subcommittee Work Session: 2/24/2011 1:00 PM LOB 205
2/25/2011	H	Subcommittee Work Session: 3/3/2011 2:00 PM LOB 205
3/1/2011	H	Executive Session: 3/9/2011 10:00 AM LOB 205
3/9/2011	H	Retained in Committee; **HC 27**, PG.824
10/4/2011	H	Retained Bill - Subcommittee Work Session: 10/10/2011 1:00 PM LOB 205
10/5/2011	H	==CANCELLED== Retained Bill - Executive Session: 10/12/2011 LOB 205 1:00 PM or Immediately Following House Session
10/12/2011	H	Executive Session: 10/20/2011 2:00 PM LOB 205
10/27/2011	H	Committee Report: Inexpedient to Legislate for Jan 4 (Vote 12-5; RC); **HC 70**, PG.2220
1/5/2012	H	Special Order, Postpone to a Time Certain being January 18 (Rep Bettencourt): MA **RC** 298-18; **HJ 8**, PG.518-520
1/18/2012	H	Inexpedient to Legislate: MF **RC** 150-195; **HJ 10**, PG.591-593
1/18/2012	H	Ought to Pass (Rep Tucker); **HJ 10**, PG.593
1/18/2012	H	Floor Amendment **#2012-0237h**(NT) (Rep Groen): AA **RC** 206-147; **HJ 10**, PG.593-596
1/18/2012	H	Ought to Pass with Amendment #0237h(New Title): MA **RC** 207-147; **HJ 10**, PG.597-598
2/15/2012	S	Introduced and Referred to Health and Human Services; **SJ 6**, Pg.144
3/14/2012	S	Hearing: 4/5/12, Room 100, SH, 1:00 p.m.; **SC11**
4/20/2012	S	Committee Report: Ought to Pass with Amendment **#2012-1768s**, 4/25/12; **SC16A**
4/25/2012	S	Committee Amendment 1768s, Not Voted On
4/25/2012	S	Sen. Bradley Moved Laid On Table, **RC** 17Y-6N, MA

NH House	NH Senate

Other Referrals

COMMITTEE REPORT FILE INVENTORY

HB 2228-FN ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

✓ DOCKET (Submit only the latest docket found in Bill Status)

✓ COMMITTEE REPORT

___ CALENDAR NOTICE

✓ HEARING REPORT

✓ HANDOUTS FROM THE PUBLIC HEARING

✓ PREPARED TESTIMONY AND OTHER SUBMISSIONS

✓ SIGN-UP SHEET(S)

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

✓ - AMENDMENT # ~~2011~~ 1727s ___ - AMENDMENT # _____

___ - AMENDMENT # _____ ___ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

✓ AS INTRODUCED ✓ AS AMENDED BY THE HOUSE

N/A FINAL VERSION N/A AS AMENDED BY THE SENATE

___ OTHER (Anything else deemed important but not listed above, such as amended fiscal notes): _____

DATE DELIVERED TO SENATE CLERK 5/31/12 _____

BY COMMITTEE AIDE

Revised 2011