

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

PLANNED PARENTHOOD
FEDERATION OF AMERICA, INC.

Plaintiff,

v.

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES et al.,

Defendants.

Case No. 1:26-cv-02656-CRC

**BRIEF OF *AMICI CURIAE* IN SUPPORT OF
PLAINTIFF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.'S
MOTION FOR SUMMARY JUDGMENT**

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CORPORATE DISCLOSURE STATEMENT

Amici curiae are non-profit organizations. They have no parent corporations and do not issue stock.

INTEREST OF *AMICI CURIAE*¹

The American College of Obstetricians and Gynecologists (“ACOG”), alongside fourteen other national medical organizations (with ACOG, “*amici*”), submits this brief in support of Plaintiff. *Amici*, identified in the attached Appendix, are medical organizations representing physicians, surgeons, nurse practitioners, nurses, as well as scientists, researchers, and a broad spectrum of other medical professionals. *Amici* share the common goal of ensuring access to high-quality reproductive health care that is comprehensive, high-quality, ethical, and evidence-based. *Amici* can attest that if the recent Notice of Funding issued by the Office of Population Affairs is not enjoined, it will cause tangible harm to patients, particularly those of vulnerable populations, jeopardizing the public health gains that Title X has achieved over more than fifty years.

¹ All parties consented to the filing of this *amicus* brief. No party’s counsel in this case authored this brief in whole or in part. No party or party’s counsel contributed any money intended to fund preparing or submitting this brief. No person, other than *amici*, their members, or their counsel, contributed money that was intended to fund preparing or submitting this brief.

INTRODUCTION

For more than fifty years, Title X of the Public Health Service Act (“Title X”) has been the nation’s only federal program devoted to providing low-income patients with essential family planning and preventive health care at low or no cost, including Food and Drug Administration (“FDA”)-approved contraceptive methods and counseling, well-woman exams, cancer screenings, sexually transmitted infection (“STI”) and HIV testing and treatment, pregnancy testing and counseling, and related referrals. For millions of patients, Title X-funded clinics are the primary or only source of health care.

The Office of Population Affairs (“OPA”), an office within the Department of Health and Human Services (“HHS”), administers the Title X program. OPA issues periodic Notices of Funding Opportunities, including the one at issue here (“the NOFO”), which describe applicant eligibility requirements and the criteria used to determine funding status in connection with Title X grants. Congress built the Title X program around two foundational premises: that family planning decisions belong to the patient, and that the care funded by Title X must be consistent with evidence-based standards of medical practice, not the government’s own preferences.² However, the NOFO abandons these principles. Rather than funding projects based on their compliance with Title X’s statutory mandate, the NOFO conditions funding chiefly on applicants’ “alignment” with a set of political priorities that have no medical or statutory basis.

For example, the NOFO’s priorities favor “fertility-awareness based methods” (“FABMs”) over FDA-approved contraception, direct providers to counsel patients toward marriage and

² See *About Title X Service Grants*, Off. Of Population Affs., U.S. Dep’t of Health & Hum. Servs., <https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants> (last visited Oct. 14, 2026) (“Title X projects must ensure that services are provided in a manner that is client-centered ... protects the dignity of the individual; and ensures quality service delivery consistent with nationally recognized standards of care.”).

parenthood, require providers to treat a patient’s sex as fixed and unchangeable, and impose a vague “life-affirming” standard that fails to specify whether providers may still offer nondirective pregnancy counseling and abortion referrals. The NOFO’s practical effect is that Title X applicants who are faithful to the law, to their medical and ethical guidelines, and to offering evidence-based care will score lowest, risking their funding.

This is not the first time an administration has sought to influence Title X funding, and the effects of prior political interference are instructive. In 2019, a revision to Title X regulations required that pregnant patients be referred to prenatal care, and mandated complete physical and financial separation between Title X-funded activities and abortion-related services, including referrals (collectively, the “2019 Rule Change”).³ The consequences were measurable and devastating to public health—between 2018 and 2020, the number of patients served by Title X clinics fell from 3.9 million to 1.5 million, family-planning visits declined from 6.5 million to 2.7 million, and the number of participating clinic sites dropped nearly 25%.⁴ Data also show that the decline in access to these services disproportionately impacted low-income, uninsured, and racial and ethnic minority populations.⁵

The NOFO threatens to have similar, if not greater, negative impacts, most acutely impacting the patients who depend on Title X the most: minor patients, patients of color, economically disadvantaged patients, patients in rural areas, and transgender patients. If the Court

³ See Compliance with Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) (to be codified at 42 C.F.R. pt. 59).

⁴ See Brittni Frederiksen et al., *Rebuilding Title X: New Regulations for the Federal Family Planning Program*, KFF (Nov. 3, 2021), <https://www.kff.org/womens-health-policy/rebuilding-title-x-new-regulations-for-the-federal-family-planning-program/>; Polina Krass et al., *Adolescent Access to Federally Funded Clinics Providing Confidential Family Planning Following Changes to Title X Funding Regulations*, 5 JAMA Network Open e2217488 (2022).

⁵ *Id.*

does not enjoin the NOFO, practitioners may be forced to choose between the funding that enables them to serve patients and their professional, ethical, and medical obligations to those patients, jeopardizing the public health gains that Title X has achieved over more than fifty years.

ARGUMENT

I. TITLE X PROVIDES ESSENTIAL HEALTH CARE TO UNDERSERVED PATIENTS

Title X is the only domestic federal program devoted solely to providing low-income patients with essential family planning and preventive health services and information, including cervical and breast cancer screenings, STI testing and treatment, basic infertility services, pregnancy testing, well-woman preventive care visits, contraceptive and pregnancy counseling, and risk assessment and referral services for pregnant patients.⁶ This care is not a peripheral or discretionary service, but “a key aspect of people’s overall health and quality of life.”⁷ Title X funds help ensure that safe, timely, and evidence-based care is available to all patients seeking such care regardless of financial circumstances.⁸

In 2023, Title X grantees provided services to 2.8 million patients in 4.3 million family planning encounters at 3,853 service sites.⁹ Of those patients, 83% were low income and received

⁶ Off. of Population Affs., *supra* note 2; Sarah E. Romer et al., *Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs* (Revised 2024), 67 Am. J. Prev. Med. S41 (2024) [hereinafter “2024 QFP”], <https://perma.cc/KF7M-7PGC>.

⁷ 2024 QFP, *supra* note 6, at S42; *see also* *Contraceptive Need, Use and Preferences in the United States*, Guttmacher Inst. (June 2026), <https://www.guttmacher.org/fact-sheet/contraceptive-need-use-and-preferences-united-states>.

⁸ *See, e.g., Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services*, 86 Fed. Reg. 56,144, 56,149 (Oct. 7, 2021) (“Advancing equity for all, including people from low-income families, people of color, and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality, is a priority ... for the Title X program.”).

⁹ Phil Killewald et al., Off. of Population Affs., U.S. Dep’t of Health & Hum. Servs., *Family Planning Annual Report: 2023 National Summary* 10 (2024) [hereinafter “2023 FPAR”], <https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf>.

services fully or partially paid for through Title X grants.¹⁰ Those patients also had low rates of health insurance: 27% were uninsured (more than three times the national average for adults) and 67% relied on public insurance.¹¹ Title X-funded providers are often patients' only source of health care and referrals: 60% of Title X patients reported having no other source of health care in the previous year.¹²

The benefits of medical care provided through Title X are significant. In 2023, Title X care contributed to a 16% drop in the U.S. unintended pregnancy rate¹³ and Title X-funded clinics provided 1.3 million chlamydia tests, over 1.5 million gonorrhea tests, 734,879 syphilis tests, 984,000 HIV tests,¹⁴ and conducted 461,000 cervical cancer screenings (Pap smears).¹⁵ Contraception provided through Title X funding has been linked to an almost 16% reduction in unintended pregnancy and a 12% reduction in abortions.¹⁶ These outcomes are the product of evidence-based, patient-centered care—the very model the NOFO undermines.

II. UNDER THE NOFO, MEDICAL PROVIDERS RISK LOSING TITLE X FUNDING BY COMPLYING WITH STATUTORY, REGULATORY, AND CLINICAL GUIDELINES

For decades, Title X's statute and regulations have required grantees to “[p]rovide a broad

¹⁰ *Id.* at 12-13.

¹¹ *Id.* at 13.

¹² Megan L. Kavanaugh, Mia R. Zolna & Kristen L. Burke, *Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X-Funded Facilities in 2016*, 50 Persps. on Sexual & Reprod. Health 101, 105 (2018); *see also* Off. of Population Affs., *Features of a Title X Family Planning Clinic*, U.S. Dep't of Health & Hum. Servs., <https://opa.hhs.gov/node/4174> (last visited Oct. 14, 2026).

¹³ *See* Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 NEJM 843, 850 (2016); *see also* Citlalli Chávez-Nava, *Reducing Financial Barriers to Contraception Lowers Rate of Unintended Pregnancies and Abortions*, UCLA Newsroom (Dec. 2, 2025), <https://socialsciences.ucla.edu/reducing-financial-barriers-to-contraception-lowers-rate-of-unintended-pregnancies-and-abortions/>.

¹⁴ 2023 FPAR, *supra* note 9, at Appendix B, Exs. B.10a-B.11a (2024).

¹⁵ *Id.* at Ex. B.9a.

¹⁶ Chávez-Nava, *supra* note 13.

range of acceptable and effective medically approved family planning methods ... and services”¹⁷ in a manner that is patient-centered and “responsive to[] individual client preferences, needs, and values,” such that “client values guide all clinical decisions.”¹⁸ Additionally, Title X requires providers to deliver services without coercing patients to accept or decline particular family planning methods, to refrain from discriminatory practices, and to offer comprehensive pregnancy counseling at the patient’s discretion.¹⁹ Appropriations riders and regulations are consistent with these standards, requiring Title X grantees to provide “nondirective”²⁰ pregnancy counseling and, on request, “neutral, factual information” on all pregnancy options.²¹ Care must also be “consistent with nationally recognized standards of care,” a standard articulated in the Quality Family Planning (“QFP”) guidelines issued by the OPA.²² These requirements mirror ACOG’s clinical guidance, which calls for offering patients a full range of contraceptive methods, with the choice of method left to the patient, nondirective pregnancy counseling, and provision of inclusive and equitable care for all patients.²³

¹⁷ 42 C.F.R. §§ 59.5(a)(1), 59.2.

¹⁸ 42 C.F.R. §§ 59.5(a)(3), 59.2.

¹⁹ 42 C.F.R. §§ 59.5(a)(2)–(5).

²⁰ Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3070–3071 (2018); Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321, 1321–221 (1996).

²¹ 42 C.F.R. § 59.5(a)(5).

²² 42 C.F.R. § 59.5(a)(3); *see* 2024 QFP, *supra* note 6, at S41.

²³ *See, e.g.,* ACOG, *Comm. Statement No. 1: Access to Contraception*, 146 *Obstetrics & Gynecology* 350, 350-352 (Feb. 2022) [hereinafter “ACOG Comm. Statement No. 1”], <https://www.ovid.com/10.1097/AOG.0000000000004659>; ACOG, *Comm. Statement No. 21: Access to Contraception*, 146 *Obstetrics & Gynecology* e88, e91–e95 (Nov. 2025) [hereinafter “ACOG Comm. Statement No. 21”], <https://www.ovid.com/10.1097/AOG.0000000000006075>; ACOG, *Comm. Statement No. 29: Person-Centered Pregnancy Options Counseling*, 148 *Obstetrics & Gynecology* e68, e69–70 (July 2026) [hereinafter “ACOG Comm. Statement No. 29”], <https://www.ovid.com/10.1097/AOG.0000000000006302>; *see also* Loretta Gavin et al., *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of*

This statutory, regulatory, and clinical framework cannot be squared with several of the NOFO’s priorities.²⁴ These priorities include “[r]educing overmedicalization in health care” by promoting natural family-planning methods²⁵ (the “Overmedicalization Priority”), contributing to agency efforts to “safeguard life-affirming ... program delivery”²⁶ (the “Life Affirming Program Delivery Priority”), counseling patients about “marriage prior to childbearing”²⁷ (the “Marriage & Parenthood Counseling Priority”), “[p]romoting body and health literacy”²⁸ (the “Body & Health Literacy Priority”), “respecting biological reality”²⁹ (the “Biological Reality” Priority), “[a]ddressing the chronic disease epidemic”³⁰ (the “Chronic Disease Epidemic Priority”), and “[e]nsuring adolescent program materials are age-appropriate”³¹ (the “Age-Appropriate Priority”) (collectively, the “NOFO Priorities”). The NOFO’s scoring rubric allocates 35 of the 100 available points to “alignment” with the NOFO Priorities—more than double the 15 points for compliance with the Title X statute and its implementing regulations—without explaining what such “alignment” requires of a grantee’s clinical practice.³² As such, the NOFO forces providers to choose between statutory, regulatory, and clinical compliance and funding.

For example, the Marriage & Parenthood Counseling Priority specifies that patient counseling “should affirm marriage and parenthood as meaningful and valued components of adult

Population Affairs, 66 Morbidity & Mortality Weekly Report 1383 (2017), <https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6650a4-H.pdf>.

²⁴ Notice of Funding Opportunity No. PA-FPH-27-001 at 7-8 (July 9, 2026) [hereinafter “NOFO”].

²⁵ *Id.* at 11.

²⁶ *Id.* at 14.

²⁷ *Id.* at 13.

²⁸ *Id.* at 12.

²⁹ *Id.* at 13.

³⁰ See Off. of the Assistant Sec’y for Health, *Priorities of Office of the Assistant Secretary for Health* [hereinafter “OASH Priorities Statement”], <https://perma.cc/3UZS-FUNY> (last accessed Oct. 14, 2026).

³¹ *Id.*

³² NOFO at 39-40.

life,” and requires Title X clinics to “provide services that support individuals and families seeking to have children.”³³ This directive counseling, untethered from patients’ desires and decisions, threatens to displace the *nondirective* patient-centered counseling—including “complete, medically accurate, and unbiased information and resources for all pregnancy options”—that physicians are otherwise required to provide.³⁴ Directive counseling prioritizing marriage and parenthood is fundamentally at odds with the client-centered standard regulatory and clinical guidelines require.³⁵

III. THE NOFO IS INCONSISTENT WITH CORE PRINCIPLES OF MEDICAL ETHICS

The NOFO also conflicts with core principles of medical ethics and intrudes upon the physician-patient relationship. ACOG’s Committee on Ethics has explained that “[a]bsent a substantial public health justification, government should not interfere with individual patient-physician encounters,”³⁶ and the American Medical Association (the “AMA”) emphasizes that “[c]onduct that is legally permissible may be ethically unacceptable.”³⁷

³³ *Id.* at 13.

³⁴ Kinsey Hasstedt, *Unbiased Information on and Referral for All Pregnancy Options Are Essential to Informed Consent in Reproductive Health Care*, 21 Guttmacher Pol’y Rev. 1 (2018).

³⁵ See Adam Bonnington et al., *Society of Family Planning Clinical Recommendations: Contraceptive Counseling for Transgender and Gender Diverse People Who Were Female Sex Assigned at Birth*, 102 Contraception 70, 71 (2020) (“[s]ome contraceptive counseling tools and quality assessment strategies have moved away from a ‘Reproductive Life Planning’ framework that may alienate people who do not conform to normative expectations of pregnancy planning in favor of a patient-centered counseling framework that focuses on interpersonal communication.”); see also Kathryn M. Curtis et al., *U.S. Selected Practice Recommendations for Contraceptive Use, 2024*, 73 Morbidity & Mortality Wkly. Rep. 1, 2 (2024), <https://www.cdc.gov/mmwr/volumes/73/rr/pdfs/rr7303a1-H.pdf> (providing “evidence-based clinical guidance” to “support the provision of person-centered contraceptive counseling and services in a noncoercive manner”).

³⁶ ACOG Comm. on Ethics, *Comm. Op. No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e34, e38 (Feb. 2021) [hereinafter “ACOG Comm. Op. No. 819”], <https://www.ovid.com/10.1097/AOG.0000000000004247>.

³⁷ AMA Code of Med. Ethics, Preface & Preamble, <https://code-medical-ethics.ama-assn.org/preface-preamble> (last visited Oct. 14, 2026).

Providers' obligations to conform with certain core principles—including by providing the information necessary for informed consent, respecting patient autonomy, and providing evidence-based care—exist apart from the law because “[t]he relationship between a patient and a physician is based on trust.”³⁸ Because that relationship is “the cornerstone of health care,” a law that requires “physicians to mislead and misinform their patients with messages that contradict reality and science” undermines the physician-patient relationship and puts medical providers in an untenable ethical bind.³⁹

A. **Informed Consent Requires Nondirective, Patient-Centered, and Comprehensive Counseling at Odds with the NOFO Priorities.**

Informed consent is “a practical application of the bioethics principle of respect for patient autonomy and self-determination as well as the legal right of a patient to bodily integrity.”⁴⁰ It includes providing patients with “adequate, accurate, and understandable information” and that the patient be free “to make an intentional and voluntary choice, which may include refusal of care or treatment.”⁴¹ The NOFO Priorities jeopardize physicians’ ability to provide complete and accurate information and threaten patients’ ability to give informed consent.

Central to informed consent is “shared decision making,” which is “a patient-centered, individualized approach . . . that involves discussion of the benefits and risks of available treatment

³⁸ AMA Code of Med. Ethics, Opinion 1.1.1, *Patient-Physician Relationships*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships> (last visited Oct. 14, 2026); AMA, Code of Med. Ethics, Opinion 1.1.3, *Patient Rights*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights> (last visited Oct. 14, 2026).

³⁹ AMA, *Judicial Advocacy Update*, AMA Health Care Advocacy (July 12, 2019), <https://www.ama-assn.org/health-care-advocacy/advocacy-update/july-12-2019-judicial-advocacy-update>.

⁴⁰ ACOG Comm. Op. No. 819, *supra* note 36, at e35.

⁴¹ *Id.* at e34; *see also* Jessica De Bord, *Ethics in Medicine, Informed Consent*, Univ. of Wash. Dep’t of Bioethics & Humanities, <https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/articles/informed-consent> (last visited Oct. 14, 2026).

options in the context of a patient’s values and priorities.”⁴² This approach “facilitates meeting the highest ethical standard for the informed consent process,” “allows patients to obtain personalized information about their treatment options with the goal of improving their ability to make an autonomous decision,”⁴³ and requires that information be “tailored to the desires of the individual patient and to the patient’s ability to understand this information.”⁴⁴

In addition, ACOG’s Committee on Ethics instructs that patients have the “right to be counseled by a physician according to the best currently available medical evidence and the physician’s professional medical judgment” and that physicians’ ethical obligations include providing “information that is evidence-based, tailored to that patient, and comprehensive enough to allow [a] patient to make an informed decision about care and treatment.”⁴⁵

The NOFO Priorities impair grantees’ ability to provide patients with the complete and accurate information that informed consent requires. For example, the Overmedicalization Priority and the Body & Health Literacy Priority (together, the “Anti-Contraception Priorities”), reward providers who focus on “natural family planning” over contraceptives, who speak favorably of “noninvasive” practices that “promote health literacy, fertility awareness, and reproductive health without unnecessary medicalization,” and who counsel patients to reactively seek medical intervention (*i.e.*, in response to “pain, irregular cycles, hormonal disruption, or changes in sexual health”) rather than proactively seek “symptom suppression.”⁴⁶ Providing information that categorically emphasizes “natural family planning” and denigrates “symptom suppression,”

⁴² ACOG Comm. Op. No. 819, *supra* note 36, at e34; *see also* ACOG Comm. Statement No. 1, *supra* note 23, at 350 (“Ob-gyns should adhere to the recommended ethical approach of shared decision making through patient-centered contraceptive counseling.”).

⁴³ ACOG Comm. Op. No. 819, *supra* note 36, at e36.

⁴⁴ *Id.* at e35.

⁴⁵ *Id.* at e38.

⁴⁶ NOFO at 12.

however, is inconsistent with medical evidence, *see infra* at Section IV.⁴⁷ It also conflicts with the ethical requirement that counseling be “tailored to the desires of the individual patient,” because it disfavors symptom relief and precautionary medical intervention rather than presenting them as available options to patients who may want them.⁴⁸

Similarly, the Life Affirming Program Delivery Priority expects program participants to demonstrably “uphold” the Hyde Amendment’s prohibition on elective abortion and advance related efforts to “safeguard life-affirming” care.⁴⁹ This approach conflicts with medical guidance stating that providers who treat pregnant patients must be able to counsel and, where medically indicated, treat and refer for abortion care and miscarriage management. Because a referral is often necessary to give a patient complete information about all relevant options, a provider’s duty to refer is often inseparable from the duty to counsel, and the two cannot be isolated without compromising informed consent.⁵⁰

B. The NOFO Undermines Patient Autonomy.

Patient autonomy is also a fundamental principle of medical ethics. The AMA cites patient autonomy as “a cornerstone of medical ethics,” noting that “[r]estrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.”⁵¹ Furthermore, “[t]he right to bodily autonomy centers on an individual’s ability to make informed, uncoerced decisions about their body and pregnancy” and “requires not only the legal

⁴⁷ *Id.*

⁴⁸ ACOG Comm. Op. No. 819, *supra* note 36, at e34–e35.

⁴⁹ NOFO at 14.

⁵⁰ AMA, Code of Med. Ethics, Opinion 1.1.7, *Physician Exercise of Conscience*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience> (last visited Oct. 14, 2026); AMA, Code of Med. Ethics, Opinion 2.1.3, *Withholding Information from Patients*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-information-patients> (last visited Oct. 14, 2026).

⁵¹ AMA, Code of Med. Ethics, Opinion 11.2.4, *Transparency in Healthcare*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/transparency-health-care> (last visited Oct. 6, 2026).

right to make decisions, but the material ability to act on them without delay, coercion, or punishment.”⁵² Any counseling framework that respects patient autonomy as a central principle must “[r]ecognize[] that moral authority for decision making lies with the patients[.]”⁵³

The NOFO Priorities are incompatible with that principle.⁵⁴ For instance, the Marriage & Parenthood Counseling Priority awards grantees who steer patients toward marriage and prioritize parenthood, an approach at odds with nondirective and patient-centered counseling.⁵⁵ Similarly, the Life Affirming Program Delivery Priority cannot be reconciled with ethical requirements to provide patients with nondirective counseling and abortion referral upon request.⁵⁶ The Biological Reality Priority likewise rewards providers who forgo the individualized counseling and treatment planning that patient autonomy requires,⁵⁷ treating transgender patients according to a biologically-reductive, government-imposed conception of sex that remains inconsistent with expert guidance.⁵⁸

These harms are not theoretical. Directive mandates chill the candid exchange of

⁵² Abigail B. Wilpers et al., *Navigating Fetal Conditions Through a Reproductive Justice Lens: Lessons From Composite Cases in the United States*, 23 *Reprod. Health* 1, 2-4 (2026).

⁵³ Isa Ryan, Ashish Premkumar & Katie Watson, *Why the Post-Roe Era Requires Protecting Conscientious Provision as We Protect Conscientious Refusal in Health Care*, 24 *AMA J. Ethics* 906, 908 (2022).

⁵⁴ See, e.g., ACOG Comm. Statement No. 29, *supra* note 23, at e69 (“When providing pregnancy options counseling, clinicians should seek to preserve a patient’s reproductive autonomy.... To support reproductive autonomy for a pregnant patient considering pregnancy continuation or abortion, clinicians should involve patients in an unbiased discussion.”).

⁵⁵ NOFO at 13; 42 C.F.R. §§ 59.5(a)(2) and (a)(4); see also *supra* Section II.

⁵⁶ 42 C.F.R. § 59.5(a)(5)(i)–(ii); see 2024 QFP, *supra* note 6, at S68.

⁵⁷ NOFO at 13.

⁵⁸ See generally Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 *Pediatrics* e20182162, tbl.1 (2018) (reaffirmed Aug. 2023) (differentiating “sex,” “gender identity,” “gender expression” and related terminology); ACOG, *ACOG Comm. Op. No. 823: Health Care for Transgender and Gender Diverse Individuals*, 137 *Obstetrics & Gynecology* e75 (Mar. 2021) [hereinafter “ACOG Comm. Op. No. 823”], <https://www.ovid.com/10.1097/AOG.0000000000004294>.

information between patients and providers.⁵⁹ Patients who fear that their choices will be met with judgment are less likely to be forthcoming, undermining the trust effective health care requires.⁶⁰

C. **The NOFO Restricts Practitioners’ Ability to Provide Evidence-Based Care.**

Medical organizations advocate for reproductive health services that are evidence-based and patient-centered, a clinical framework that tracks the 2024 QFP’s clinical recommendations.⁶¹ This approach requires obstetrician-gynecologists to provide patients with full information about the appropriate courses of care relevant to the patient’s particular situation and expressed need.⁶² In several instances, the NOFO conditions funding on alignment with vague or undefined priorities that conflict with clear and clinically-established care options.

First, the Anti-Contraception Priorities conflict with the ethical standard and Congressional mandate that underpins Title X that providers must deliver “patient-centered counseling” and not prioritize one contraceptive method over another.⁶³

⁵⁹ See ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (Feb. 2025), <https://perma.cc/DN2W-WHDD> (last visited Oct. 14, 2026); Josh Serchen, Shari Erickson, David Hilden, et al. *Reproductive Health Policy in the United States: An American College of Physicians Policy Brief*, 176 *Annals Internal Med.* 364-366 (2023).

⁶⁰ Judy Margo et al., *Women’s Pathways to Abortion Care in South Carolina: A Qualitative Study of Obstacles and Supports*, 48 *Persps. on Sexual & Reprod. Health* 199, 199–207 (2016) (patients’ concerns about judgment, dissuasion, and disruption of the patient-provider relationship contributed to reluctance to discuss abortion with their regular providers); see also Annik Mahalia Sorhaindo & Antonella Francheska Lavelanet, *Why Does Abortion Stigma Matter? A Scoping Review and Hybrid Analysis of Qualitative Evidence Illustrating the Role of Stigma in the Quality of Abortion Care*, 311 *Soc. Sci. & Med.* 115271, at 13 (2022) (“[O]verlooking the implications of abortion stigma . . . may result in deleterious outcomes for the health and wellbeing of people seeking abortion.”).

⁶¹ See ACOG Comm. Statement No. 1, *supra* note 23 at 350-352; ACOG Comm. Statement No. 29, *supra* note 23, at e70; ACOG, Comm. Statement No. 21, *supra* note 23, at e89-e95.

⁶² See, e.g., Hasstedt, *supra* note 34, at 1; see ACOG Comm. Statement No. 21, *supra* note 23 at e91 (“Patient-centered counseling ensures that patients’ needs are paramount when choosing a method”).

⁶³ ACOG Comm. Statement No. 21, *supra* note 23, at e91.

Second, the Marriage & Parenthood Counseling Priority’s mandate is inconsistent with the ethical and medical requirements that providers offer “nondirective counseling” and “factual, neutral, nonjudgmental information about each option.”⁶⁴

Third, the Life Affirming Program Delivery Priority does not address or explain how to reconcile the “life-affirming” mandate with nondirective counseling and referral.⁶⁵

IV. THE NOFO WILL REDUCE ACCESS TO CARE AND RISK PATIENT HEALTH

The NOFO Priorities are not only inconsistent with Title X’s statutory and regulatory requirements and with medical ethics; they are also inconsistent with evidence-based medicine.

A. The NOFO Awards Grantees Who Deprioritize Access to Contraception.

Citing an “overreliance on pharmaceutical and surgical treatments,” the Anti-Contraception Priorities direct applicants to emphasize FABMs, which the NOFO refers to as “natural family planning.”⁶⁶ FABMs lack the rigorous scientific support of FDA-approved alternatives, and artificially subordinating access to contraception in its favor will have devastating impacts.

The NOFO portrays FABMs as part of an approach that is “effective in improving optimal health,” but its own citations do not support that conclusion.⁶⁷ For example, the NOFO cites a survey for the proposition that “the most common reason women reported discontinuing use related to dissatisfaction was side effects,”⁶⁸ but the survey included women who switched from

⁶⁴ *Supra* Section II and Section III.B; see 2024 QFP, *supra* note 6 at S68-69.

⁶⁵ 2024 QFP, *supra* note 6, at S68.

⁶⁶ NOFO at 11-12.

⁶⁷ *Id.*

⁶⁸ *Id.* at 11.

one method to another as having “discontinued” use,⁶⁹ emphasizing that some patients discontinue particular contraceptive methods because of dissatisfaction with a particular method, not that side effects warrant deprioritizing contraception in favor of FABMs or that ceasing contraceptive use improves health.⁷⁰ Indeed, the cited study shows that most pill or IUD users did *not* discontinue those methods because of side effects, undermining the NOFO’s purported connection between “overreliance on pharmaceutical and surgical treatments” and a “decrease in females’ current use of any contraception” due to side effects.⁷¹ This premise is further undermined by the wealth of scientific research concluding that “the associations between hormonal contraceptive use and adverse health outcomes are not supported by high-quality evidence.”⁷²

Similarly, the NOFO lists “expanding access to [FABMs]” as a “key strateg[y] for advancing optimal health,” implying that fertility-awareness is a broadly reliable, one-size-fits-all approach to advancing reproductive health.⁷³ That implication directly contradicts clinical guidance, which cautions that the effectiveness and suitability of such methods vary significantly across patient populations.⁷⁴ Promoting FABMs results in meaningfully higher unintended

⁶⁹ Kimberly Daniels & Joyce C. Abma, *Contraceptive Methods Women Have Ever Used: United States, 2015–2019*, U.S. Dep’t Health & Hum. Servs., Nat’l Health Stat. Reps., No. 195, at 3 (2023), <https://doi.org/10.15620/cdc:134502>.

⁷⁰ *Id.*

⁷¹ NOFO at 11–12; *see also* Daniels & Abma, *supra* note 69, at 7 (approximately 22% of pill users and 21% of IUD users discontinued due to side effects, calculated as the share who discontinued due to dissatisfaction (approximately 34% and 33%, respectively) multiplied by the share of those discontinuations attributed to side effects (approximately 64% for both)).

⁷² Sharmila Brabaharan et al., *Association of Hormonal Contraceptive Use With Adverse Health Outcomes: An Umbrella Review of Meta-analyses of Randomized Clinical Trials and Cohort Studies*, 5 JAMA Network Open e2143730, at 1 (2022) (reviewing 58 meta-analyses of randomized clinical trials and cohort studies).

⁷³ NOFO at 12–13.

⁷⁴ *See* ACOG, *Frequently Asked Questions, Fertility Awareness-Based Methods of Family Planning*, <https://www.acog.org/womens-health/faqs/fertility-awareness-based-methods-of-family-planning> (last visited Oct. 6, 2026) (cautioning against this approach for, e.g., patients with

pregnancy rates than using FDA-approved contraceptive methods such as IUDs, implants, and hormonal contraception, making it a significantly less effective alternative.⁷⁵ FABMs may be particularly ineffective for adolescents, who often lack the predictable ovulation and attentive adherence the method's success requires.⁷⁶ Accordingly, the NOFO will jeopardize patients' health and lead to higher rates of unintended pregnancy and abortion.⁷⁷

B. The NOFO Will Reduce Adolescents' Access to Contraception and STI Testing.

The NOFO also threatens adolescents' access to essential care, including contraception and STI testing.⁷⁸ The American Academy of Pediatrics ("AAP") emphasizes that "[f]or many adolescents seeking contraception, pregnancy prevention is a key priority, and counseling should proceed from most effective to least effective method," explains that "[g]ender-inclusive language ensures that adolescents maintain trust and confidence with their care team," and recommends that pediatricians obtain "a developmentally tailored sexual history from the adolescent ... assess STI and pregnancy risk ... provide appropriate screening, counseling, and, when needed, contraception."⁷⁹ Many of the priorities targeting adolescents are inconsistent with these

certain medical risks and patients who cannot supplement it with a barrier method or avoid sexual intercourse during their fertile period).

⁷⁵ See, e.g., Scott L. Paradise, Corinne A. Landis & David A. Klein, *Evidence-Based Contraception: Common Questions and Answers*, 106 Am. Fam. Physician 251, 251–59 (2022); Stephanie Teal & Alison Edelman, *Contraception Selection, Effectiveness, and Adverse Effects: A Review*, 326 JAMA 2507 (2021); Duane et al., *Fertility Awareness-Based Methods for Women's Health and Family Planning*, 9 Frontiers in Medicine 858977 (2022); Christina I. Fowler et al., *Patterns and Trends in Contraceptive Use Among Women Attending Title X Clinics and a National Sample of Low-Income Women*, 1 Contraception: X 100004, at 8-9 (2019), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7286153/pdf/main.pdf>.

⁷⁶ Mary A. Ott et al., *Contraceptive Counseling and Methods for Adolescents: Clinical Report*, 156 Pediatrics e2025072218, at 9 (2025).

⁷⁷ Finer & Zolna, *supra* note 13, at 850.

⁷⁸ Title X's authorizing statute identifies "services to minors" among the required services it provides at low or no cost. 42 C.F.R. § 59.10(b).

⁷⁹ Ott et al., *supra* note 76, at 3-4.

recommendations and with scientific evidence. For example, the Anti-Contraception Priorities risk steering adolescents away from effective and well-researched contraceptive methods, requiring providers to deprioritize long-acting reversible contraceptives (“LARCs”) despite research demonstrating that “adolescents have adult-type capacity to understand health information, weigh risks and benefits, and make rational, voluntary choices,” including about contraceptives.⁸⁰ The Age-Appropriate Priority compounds this by directing funding only to “programs that do not promote material that depicts, describes, exposes or presents . . . sexually explicit content, including content that encourages, normalizes or promotes sexual activity for minors,” without defining or explaining how a grantee might counsel adolescents about safer sex, contraceptive options, and STI prevention and testing without addressing sexual activity.⁸¹ By discouraging the “evidence-informed, developmentally tailored, equity-focused counseling” that pediatric experts recommend,⁸² the Anti-Contraception Priorities will leave adolescents with incomplete counseling and less information, with no demonstrated clinical benefit.⁸³

C. **The NOFO Could Limit Access to Fertility Treatments.**

The Anti-Contraception Priorities and the Chronic Disease Epidemic Priority also threaten Title X’s mandate to provide “basic infertility services.”⁸⁴ The Chronic Disease Epidemic Priority directs Title X programs to incorporate HHS’s broader chronic-disease agenda into reproductive health care, emphasizing “root causes” of fertility-related conditions and directing programs toward “solutions” involving “nutrition, physical activity, sleep, and exposure to harmful chemical and environmental toxins.”⁸⁵ This approach can delay effective infertility treatment and prove

⁸⁰ *Id.*

⁸¹ OASH Priorities Statement, *supra* note 30.

⁸² Ott et al., *supra* note 76, at 2.

⁸³ *Id.*

⁸⁴ 42 C.F.R. §§ 59.1-59.2, 59.5(a)(1), 59.5(b)(1).

⁸⁵ NOFO at 11.

ineffective and redundant. The NOFO also ignores how fertility issues impact transgender men and nonbinary patients, despite guidance from the American Society of Reproductive Medicine that these “patients require the same targeted evaluation tailored to the desired treatment if they wish to pursue fertility treatments.”⁸⁶ By framing infertility and conditions affecting fertility principally as chronic-disease problems susceptible to lifestyle-based interventions, the NOFO disregards the diverse medical causes of infertility and risks displacing the evidence-based evaluation and treatment that Title X’s mandate requires, potentially “mak[ing] patients less likely to have a baby by delaying the identification and treatment process until patients are much deeper into—or even past—their fertility window.”⁸⁷

Medical guidance makes clear that “[p]atients with infertility have a medical disease (not a ‘social condition’), and health care professionals should provide medically and ethically sound care specific to the etiology of a patient’s diagnosis.”⁸⁸ Data show that 85% of infertility among couples has an identifiable cause, commonly including ovulatory dysfunction, male factor infertility, and tubal disease.⁸⁹ Evidence does not establish lifestyle interventions as an effective

⁸⁶ Prac. Comm. of the Am. Soc’y for Reprod. Med., *Fertility Evaluation of Infertile Women: A Committee Opinion*, 116 Fertility & Sterility 1255, 1255 (2021), <https://doi.org/10.1016/j.fertnstert.2021.08.038>; see also Prac. Comm. of the Am. Soc’y for Reprod. Med., *Definition of infertility: A Committee Opinion* (2023), https://www.asrm.org/globalassets/_asrm/practice-guidance/practice-guidelines/pdf/definition-of-infertility.pdf.

⁸⁷ ACOG, *Issue Brief: Restorative Reproductive Medicine*, at pdf p. 1 (June 2025), <https://dam.acog.org/download/assets/restorative-reproductive-medicine.pdf/e46bb8bc64d311f1bc727a06434288fd> (last visited Oct. 10, 2026); see also ACOG, *Comm. Statement No. 14: Infertility: Disparities and Access to Services*, 145 Infertility Disparities & Access e53–e55 (Jan. 2025) [hereinafter “ACOG Comm. Statement No. 14”], <https://www.ovid.com/10.1097/AOG.00000000000005769>.

⁸⁸ *Id.* at e51.

⁸⁹ Sandra A. Carson & Amanda N. Kallen, *Diagnosis and Management of Infertility: A Review*, 326 JAMA 65, at 1 (2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9302705/pdf/nihms-1804691.pdf>.

replacement for infertility treatment. For example, a randomized controlled study of over 300 women with obesity and unexplained infertility found that preconception weight loss intervention did not improve fertility or birth outcomes, a result also reflected in other studies.⁹⁰

Moreover, the NOFO's encouraged emphasis on lifestyle and behavior may compound the psychological burden of infertility in a context where patients already "experience shame, grief, a perceived lack of femininity, and self-blame."⁹¹ Whatever role certain behaviors may play in reproductive health, directing Title X providers toward "lifestyle and behavioral factors"⁹² as "solutions"⁹³ for conditions affecting fertility substitutes an unproven lifestyle-focused framework for the individualized evaluation, referral, and treatment that infertility requires. Infertility concerns warrant clinical evaluation and, where an underlying medical condition is suspected, referrals to specialized providers.⁹⁴ By rewarding applicants that center infertility care on lifestyle and behavioral factors, the NOFO incentivizes providers to emphasize lifestyle modification before or instead of clinically indicated diagnostic evaluation and referral, potentially delaying identification and treatment of underlying medical conditions.

D. The NOFO Jeopardizes Patient Health by Focusing on "Life Affirming" Programs

The NOFO's Life Affirming Program Delivery Priority, which requires grantees and applicants to "safeguard life-affirming" care, attempts to expand application of the Hyde Amendment in the Title X context beyond funding for abortions to prohibit sharing of information

⁹⁰ Richard S. Legro et al., *Effects of Preconception Lifestyle Intervention in Infertile Women with Obesity: The FIT-PLESE Randomized Controlled Trial*, 19 PLOS Medicine e1003883, at 2 (2022), <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003883>.

⁹¹ See ACOG, *Comm. Statement No. 14*, *supra* note 87, at e54.

⁹² NOFO at 10.

⁹³ *Id.* at 10-11.

⁹⁴ *Id.* at 11.

about abortion care.⁹⁵ This is inconsistent with evidence-based medicine, since abortion care and miscarriage management are basic, integral components of reproductive health care, not services collateral to it.⁹⁶ Medical guidance requires providers to care for patients effectively and ethically by counseling, treating, and referring for abortion care and miscarriage management.⁹⁷ Limiting pregnant patients' access to such care risks increased and severe harm to patient health and compounds dangerous structural barriers to overall health care access. Studies have found that in states with abortion bans, maternal mortality and morbidity increased, particularly affecting Black communities,⁹⁸ and barriers to abortion care and miscarriage management exacerbate existing social disparities.⁹⁹ The Life Affirming Program Delivery Priority therefore does not advance patient health or safety, and may lead to poor health outcomes.

⁹⁵ *Id.* at 13-14.

⁹⁶ See, e.g., ACOG, *Understanding ACOG's Policy on Abortion* (Sept. 22, 2023), <https://www.acog.org/news/news-releases/2023/09/understanding-acog-policy-on-abortion> 43CX (last visited Oct. 14, 2026); World Health Org., WHO Guideline on Self-Care Interventions for Health and Well-Being, 2022 Revision 74–75 (June 2022), <https://www.who.int/publications/i/item/9789240052192>.

⁹⁷ See, e.g., ACOG, *Comm. Statement No. 29*, *supra* note 23, at e70; Mary Alice Yeskey, *Study Suggests Increase in Deaths During or Within One Year of Pregnancy in States That Imposed Abortion Bans*, Johns Hopkins Bloomberg Sch. of Pub. Health (Apr. 27, 2026), <https://publichealth.jhu.edu/2026/study-higher-maternal-death-rate-in-states-with-abortion-bans>.

⁹⁸ See ACOG, *Comm. Statement No. 16, Increasing Access to Abortion*, 145 *Obstetrics & Gynecology* e86, e90, e92 (Feb. 2025), <https://doi.org/10.1097/AOG.0000000000005804> (“Some estimates suggest that a complete abortion ban could result in a 21% increase in overall maternal mortality in the general population, with a 33% increase in Black pregnant people.” Not only that, “maternal morbidity in the periviable period doubled compared with the time period before the enactment of the law.”); Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, Commonwealth Fund (Dec. 14, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes> (“death rates were 62 percent higher in 2020 in abortion-restriction states than in abortion-access states (28.8 vs. 17.8 per 100,000 births)”); Yeskey, *supra* note 97 (Possible 9.2% increase in pregnancy-associated deaths in states with abortion bans).

⁹⁹ See ACOG, *Abortion Access Fact Sheet*, <https://perma.cc/K48E-43CX> (last visited Oct. 14, 2026).

V. THE NOFO WILL MOST AFFECT VULNERABLE PATIENT POPULATIONS

If the NOFO remains in place, current grantees will face an impossible choice: (1) keep their current level and quality of services, but lose funding, or (2) keep their funding by aligning with the NOFO's priorities, which will likely come at the cost of limiting services or lowering the quality of care. Either outcome will be devastating for patients, particularly vulnerable populations, as clinics are an already-strained resource. History bears this out. Following the 2019 Rule Change, there was a nationwide drop of 945 health care centers from the Title X network and an estimated 1.5 million fewer patients served in 2020 than in 2018.¹⁰⁰ Approximately 1.3 million Black, 4.6 million Hispanic, and over 100,000 Native American residents (including 4 million people living below the poverty line) in ten states who previously had access to a Title X-funded clinic lost that access.¹⁰¹ When essential care is no longer funded, many patients simply forgo care altogether,¹⁰² and the consequences fall most heavily on the most vulnerable patient populations.¹⁰³ The NOFO's funding rubric "promot[es] the inaccurate stereotype that those who seek

¹⁰⁰ Megan L. Kavanaugh, Ellie Leong & Madeleine Haas, *Measuring the Relationship Between the 2019 Title X Final Rule and Patients' Sexual and Reproductive Health Care Access and Behavior in Iowa Using a Difference-in-Difference Approach*, 21 *Sexuality Rsch. & Soc. Pol'y* 598, 598-99 (2024).

¹⁰¹ See, e.g., Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half*, Guttmacher Inst. (April 15, 2021 update), <https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half>; Alicia VandeVusse et al., *The Impact of Policy Changes from the Perspective of Providers of Family Planning Care in the US: Results from a Qualitative Study*, 30 *Sexual & Reprod. Health Matters* 2089322 (July 2022); Candis Watts Smith, Rebecca J. Kreitzer, Kellen A. Kane & Tracee M. Saunders, *Contraception Deserts: The Effects of Title X Rule Changes on Access to Reproductive Health Care Resources*, 18 *Pol. & Gender* 672, 699 (2022).

¹⁰² For example, the most effective forms of contraception, such as LARCs, are frequently unaffordable without Title X subsidization. See Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 *NEJM* 853, 853 (2016) (After the 2019 Rule Change, the number of women using LARC contraception in Texas decreased by 35% and the number of births covered by Medicaid increased by 27%).

¹⁰³ Watts Smith, Kreitzer, Kane & Saunders, *supra* note 101, at 699.

[disfavored] services are morally deviant,” and the resulting stigma “increases the risk of poor psychological and physical health outcomes,”¹⁰⁴ and limits access to vulnerable patient populations.

Minor Patients. Title X clinics are critical for providing adolescents with confidential contraceptive counseling alongside STI testing and treatment.¹⁰⁵ By conditioning funding on mandates against program materials that could “normalize” or “promote” sexual activity for minors, the NOFO leaves providers less able to continue offering adolescents confidential and medically accurate family planning counseling, STI education, and contraceptive access.¹⁰⁶

Transgender Patients. The NOFO’s Biological Reality Priority¹⁰⁷ directly conflicts with expert guidance recognizing that transgender patients face additional barriers to contraceptive care, including limited access to knowledgeable, gender-affirming clinicians, anticipated bias, and past experiences of discrimination,¹⁰⁸ and will increase the inequities this vulnerable patient population faces. Removing Title X grantees’ ability to provide inclusive gender-affirming care or counseling is likely to heighten an already significant risk that transgender patients will delay or avoid reproductive health care altogether.¹⁰⁹

Economically Disadvantaged Patients. Title X plays a critical role in providing affordable

¹⁰⁴ Janet M. Turan & Henna Budhwani, *Restrictive Abortion Laws Exacerbate Stigma, Resulting in Harm to Patients and Providers*, 111 Am. J. Pub. Health 37, 38 (Jan. 2021).

¹⁰⁵ See *supra* Section IV.B.

¹⁰⁶ See *supra* Section IV.B.

¹⁰⁷ NOFO at 14.

¹⁰⁸ See, e.g., ACOG Comm. Op. No. 823, *supra* note 58, at e78; Diana M. Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open e220978 at 2, 10 (2022); AMA, *Advocating for the LGBTQ Community*, <https://www.ama-assn.org/public-health/population-health/advocating-lgbtq-community> (last visited Oct. 14, 2026).

¹⁰⁹ Yasaman Zia et al., *A Qualitative Study on Healthcare Providers’ Biases Towards Transgender and Gender Diverse People Accessing Contraceptive Care*, 33 Sexual & Reprod. Health Matters 2577002, at 2-3 (2025).

family planning and preventive health services to low-income and uninsured patients who make up the large majority of the program's patient base.¹¹⁰ Although Medicaid is the largest source of public funding for family planning services, nearly one in five low-income women of reproductive age still depend on safety-net providers like Title X clinics for low-cost contraceptive and preventive care that often remains inaccessible, even with Medicaid,¹¹¹ particularly given that insurance status, scope of coverage, out-of-pocket costs, and practitioner availability all remain significant barriers to contraceptive access for economically-disadvantaged patients.¹¹² The NOFO threatens to further reduce low-income patients' access because practitioner applicants who refuse to align with the NOFO Priorities will either be forced to withdraw from the program or potentially be denied funding, a risk underscored by data showing that 23% of low-income contraceptive users would use a different method if cost were not a factor, and 39% of low-income

¹¹⁰ 2023 FPAR, *supra* note 9, at 13.

¹¹¹ See Tracee M. Saunders, Kellen A. Kane & Candis Watts Smith, *Implementing Title X: Policy Design, Administration, and Geographic Access to Care*, 4 Health Affs. Scholar 4, at 2 (2026), <https://doi.org/10.1093/haschl/qxag082> (18% of low-income women obtain contraception from Title X clinics); Brittini Frederiksen & Alina Salganicoff, *State Variations in the Role of the Reproductive Health Safety Net for Contraceptive Care Among Medicaid Enrollees*, KFF (Dec. 1, 2025), <https://www.kff.org/womens-health-policy/state-variations-in-the-role-of-the-reproductive-health-safety-net-for-contraceptive-care-among-medicaid-enrollees> (43% of female Medicaid enrollees receiving contraceptive care obtain it from safety-net providers).

¹¹² See, e.g., Kavanaugh, Zolna & Burke, *supra* note 12, at 105–06 (60% of Title X contraceptive patients reported that the facility was their only source of health care in the prior year); Megan L. Kavanaugh, Emma Pliskin & Rachel J. Useche, *Unsatisfied Contraceptive Preferences Due to Cost Among Women in the United States*, 2 Contraception: X 100032, at 2 (2020) (finding cost-related barriers to preferred contraceptive methods were more prevalent among low-income and uninsured women); Corinne D. Sexsmith et al., *Contraceptive Method Uptake at Title X Health Centers in Utah*, 31 Women's Health Issues 1, 7 (2021) (finding removal of “cost barriers” increased uptake of highly effective contraceptive methods among Title X patients); Blair G. Darney et al., *Title X Improved Access to Most Effective and Moderately Effective Contraception in US Safety-Net Clinics, 2016–18*, 41 Health Affs. 497, 500–03 (2022) (identifying provider training and clinic capacity as barriers to provision of effective contraceptive methods).

non-users would start using contraception but for its cost.¹¹³ State-level studies following the 2019 Rule Change confirm this dynamic: Iowa patients whose provider left the Title X program were 11% less likely to receive contraceptive care,¹¹⁴ while Arizona Title X patients had significantly higher odds of using their preferred method.¹¹⁵

Patients in Rural Areas. Rural patients face overlapping barriers to reproductive health care, including isolation, practitioner shortages, and limited transportation,¹¹⁶ leaving them particularly vulnerable to any reduction in Title X-funded services. A 2026 national study found “widespread and substantial gaps in geographic access” to Title X-funded care in rural and low-income populations,¹¹⁷ and that non-Title X clinics “are not structured to deliver comprehensive contraceptive options at scale, and their capacity to absorb additional demand is limited.”¹¹⁸ These threats extend beyond contraceptive access and choice, as illustrated by a major HIV outbreak in rural Indiana after funding changes reduced STI testing services.¹¹⁹ Reductions in services caused by the NOFO matter in rural communities where patients face higher rates of poverty and uninsurance and must travel farther to specialty providers,¹²⁰ or where a Title X-funded clinic may

¹¹³ Megan L. Kavanaugh, Emma Pliskin & Rubina Hussain, *Associations Between Unfulfilled Contraceptive Preferences Due to Cost and Low-Income Patients’ Access to and Experiences of Contraceptive Care in the United States, 2015-2019*, 4 Contraception: X 100076, at 3-7 (2022).

¹¹⁴ Kavanaugh, Leong & Haas, *supra* note 100, at 598.

¹¹⁵ Megan L. Kavanaugh, Ellie Leong & Christina Geddes, *Differential Associations Between Access to Sexual and Reproductive Healthcare and Subsequent Contraceptive and Pregnancy Outcomes by Ethnicity Among Family Planning Patients in Arizona*, 12 Women’s Reprod. Health 199, 210-11 (2025).

¹¹⁶ Alecia Fields et al., *Reshaping Access: Community-Led Action for Contraceptive Access in Rural Appalachian Kentucky*, 155 Contraception 111278, at 1 (2025).

¹¹⁷ Saunders, Kane & Watts Smith, *supra* note 111, at 1.

¹¹⁸ *Id.* at 2.

¹¹⁹ Hal C. Lawrence & Debra L. Ness, *Planned Parenthood Provides Essential Services That Improve Women’s Health*, 166 Annals Internal Med. 443, 444 (2017).

¹²⁰ See Megan L. Kavanaugh et al., *Trump Administration’s Withholding of Funds Could Impact 30% of Title X Patients*, Guttmacher Inst. (Apr. 8, 2025), <https://www.guttmacher.org/2025/04/trump-administrations-withholding-funds-could-impact-30->

be the community’s sole local provider.¹²¹

Patients of Color. Bias in reproductive counseling carries clinical significance because the information and referrals a patient receives shape the care they ultimately obtain. Patients of color, and Black patients in particular, continue to report experiences of bias, coercion, and inconsistent counseling regarding contraceptive options.¹²² These disparities predate the NOFO: “[e]ven before the Title X rule change, Black and Hispanic youth faced inequitable access to evidence-based family planning care,”¹²³ and Black patients at Delaware Title X clinics were less likely than White or Hispanic patients to report “a sense of relief at the idea of having an LARC,” even after controlling for insurance coverage, practitioner trust, and fertility concerns.¹²⁴ This matters given Title X’s patient base: of the 2.8 million family planning users served in 2023, 48% identified as a race other than white, including 23% Black or African American, and 36% Hispanic or Latino; 19% self-reported limited proficiency in English.¹²⁵

CONCLUSION

For the reasons stated herein, *amicus curiae* respectfully requests this Court grant Plaintiff’s motion for summary judgment and enjoin the NOFO.

percent-title-x-patients; Helen Robins, Kate Meyer & Zara Day, *Reducing or Eliminating the Title X Family Planning Program Would Restrict Contraceptive Access Nationwide*, Commonwealth Fund: To the Point Blog (Oct. 22, 2025), <https://www.commonwealthfund.org/blog/2025/reducing-or-eliminating-title-x-family-planning-program-would-restrict-contraceptive>.

¹²¹ See Kavanaugh, Zolna & Burke, *supra* note 12, at 107.

¹²² See Cosette A. Kathawa & Kavita Shah Arora, *Implicit Bias in Counseling for Permanent Contraception: Historical Context and Recommendations for Counseling*, 4 Health Equity 326, 327 (2020); see also Collin W. Mueller, Constanza Hurtado-Acuna & Heide M. Jackson, *Disparities in Perceptions of Long-Acting Reversible Contraceptives Among Patients in Delaware Title X Clinics*, 150 Contraception 111002, 111002 (2025).

¹²³ Polina Krass et al., *supra* note 4, at 9.

¹²⁴ Mueller et al., *supra* note 122, at 3–4, tbl. 3.

¹²⁵ 2023 FPAR, *supra* note 9, at 13.

Dated: October 14, 2026

Respectfully submitted,

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APPENDIX: LIST OF AMICI CURIAE

1. **American College of Obstetricians & Gynecologists (ACOG)** is the nation’s leading group of physicians providing obstetric and gynecologic health care. With more than 60,000 members—representing more than 90% of all OB/GYNs in the United States—ACOG advocates for quality reproductive health care, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women’s health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care for all women and people needing gynecologic or obstetric care. ACOG believes that the full array of clinical services should be available to patients without costly delays or the imposition of ideological, geographic, financial, or legal barriers. ACOG members care for people of all socioeconomic backgrounds, including low-income women and adolescents who rely on Title X-funded projects for their care. ACOG has previously appeared as *amicus curiae* in various courts throughout the country, and ACOG’s briefs and guidelines have been cited by numerous courts as the authoritative voice of science and medicine relating to obstetric and gynecologic health care.¹²⁶
2. **American Academy of Family Physicians (AAFP)**, founded in 1947, is one of the largest national medical organizations, representing nearly 130,000 family physicians and medical

¹²⁶ See, e.g., *Little Sisters of the Poor Saints Peter & Paul Home v. Pa.*, 140 S. Ct. 2367, 2402, 2409 (2020) (Ginsburg, J., joined by Sotomayor, J., dissenting); *June Med. Servs. LLC v. Russo*, 591 U.S. 299, 340 (2020); *Edwards v. Witherspoon*, 2026 WL 2661096, *5, *7 (4th Cir. 2026); *Whole Woman’s Health v. Hellerstedt*, 579 U.S. 582, 613, 618 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 916, 928, 932 (2000); *Whole Woman’s Health v. Paxton*, 978 F.3d 896, 910 (5th Cir. 2020); *Ojimba v. United States*, 824 F.Supp.3d 732, 746-47, 752 (N.D. Ill. 2026); *Planned Parenthood S. Atl. v. State*, 882 S.E.2d 770, 787–88 (S.C. 2023); *Okla. Call for Reprod. Just. v. Drummond*, 526 P.3d 1123, 1158 n.10 (Okla. 2023).

students nationwide. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and by supporting its members in providing continuous comprehensive health care to all.

3. **American College of Medical Genetics and Genomics (ACMG)** is the only nationally recognized medical professional organization solely dedicated to improving health through the practice of medical genetics and genomics, and the only medical specialty society in the United States that represents the full spectrum of medical genetics disciplines in a single organization. The ACMG is dedicated to improving health through the clinical and laboratory practice of medical genetics and to guiding the safe and effective integration of genetics and genomics into all of medicine and healthcare, resulting in improved personal and public health.
4. **American College of Preventive Medicine (ACPM)** is a professional medical society representing approximately 2,000 physicians, dedicated to the practice of preventive medicine and improving the health and quality of life of individuals, families, and communities through disease prevention and health promotion. ACPM supports the peer-reviewed, evidence-based practice of medical care and comprehensive reproductive health services.
5. **American Gynecological and Obstetrical Society (AGOS)** is composed of individuals attaining national prominence in scholarship and leadership in the discipline of Obstetrics, Gynecology and Women's Health. AGOS's mission is to promote excellence in women's health care through advocacy for research and clinical training and the development of academic leaders in obstetrics and gynecology. AGOS is committed to enhancing diversity and inclusion across the organization.

6. **America's Physician Groups (APG)** is a national association representing more than 300 physician groups, whose members collectively work with approximately 260,000 physicians and other clinicians to provide care for approximately 90 million patients nationwide. APG and its members are committed to clinically integrated, coordinated, value-based health care based on nationally recognized, evidence-based standards of care. Preventive care and services that reduce illness, hospitalization, and the costs associated with treating avoidable conditions are essential to this care model, as are family planning and reproductive health services. APG's members include federally qualified health centers (FQHCs) that rely on Title X funding to support the contraceptive counseling, pregnancy testing, STI and HIV testing and treatment, and cancer screenings that they provide. APG therefore has a strong interest in ensuring that Title X-funded providers remain free to deliver care consistent with evidence-based medicine and professional clinical judgment, without being forced to choose between continued funding and compliance with the statutory, regulatory, and ethical obligations that undermine high-quality, patient-centered care. Proposed changes to Title X would reduce patients' access to this important center-provided health care and cause them to delay or forego care, resulting in unplanned pregnancies and other reproductive issues and exposing them to potential harm.
7. **American Society for Reproductive Medicine (ASRM)** is dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately 8,000 professionals.
8. **Council of Chairs of Obstetrics and Gynecology (CUCOG)** is an association promoting excellence in medical education in the fields of obstetrics and gynecology. Its members

represent the departments of obstetrics and gynecology of schools of medicine across the country.

9. **National Association of Nurse Practitioners in Women's Health (NPWH)** is the national professional association for nurse practitioners and advanced practice registered nurses who specialize in women's comprehensive healthcare needs and men's reproductive and sexual healthcare. NPWH sets a standard of excellence by translating and promoting the latest women's healthcare research and evidence-based clinical guidance, providing high quality continuing education, and advocating for patients, providers, and the women's health nurse practitioner profession.
10. **Society for Adolescent Health and Medicine (SAHM)** is a multidisciplinary organization committed to the promotion of optimal health and well-being for all adolescents and young adults by supporting adolescent health and medicine professionals through the advancement of clinical practice, care delivery, research, advocacy, and professional development.
11. **Society of Family Planning (SFP):** The Society of Family Planning's vision is just and equitable abortion and contraception informed by science. SFP represents more than 1,900 clinicians, scholars, and partners united by a shared interest in advancing the science and clinical care of family planning.
12. **Society of General Internal Medicine (SGIM)** is a member-based internal medical association of over 3,300 of the world's leading general internists, who are dedicated to improving access to care for all populations, eliminating health care disparities, and enhancing medical education. SGIM's mission is to cultivate innovative educators, researchers, and clinicians in general internal medicine, leading the way to better health for

everyone. SGIM members advance the practice of medicine through their commitment to providing comprehensive, coordinated, and cost-effective care to adults; educating the next generation of outstanding physicians; and conducting cutting-edge research to improve quality of care and clinical outcomes of all patients.

13. **Society of Gynecologic Oncology (SGO)** is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. As a 501(c)(6) organization, SGO contributes to the advancement of women's cancer care by encouraging research, providing education, raising standards of practice, advocating for patients and members, and collaborating with other domestic and international organizations.
14. **Society of Gynecologic Surgeons (SGS)** is a select member group of over 500 physicians representing both private practice and academic faculty who are all involved in teaching and the practice of advanced gynecologic surgery. SGS promotes excellence in gynecologic surgery through acquisition of knowledge and improvement of skills, advancement of basic and clinical research, and professional and public education.
15. **The Society for Maternal-Fetal Medicine (SMFM)** is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 6,500 members caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals

experiencing high-risk pregnancies. SMFM’s amicus briefs also have been cited by many courts.

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing complies with Local Civil Rule 7(o)(4) and does not exceed twenty-five pages. I further certify that the attached brief complies with the typeface and type style requirements of Local Civil Rule 5.1(d) because it has been prepared in a proportionally spaced typeface using Microsoft Word and 12-point Times New Roman font.

Dated: October 14, 2026

/s/ Melinda K. Johnson
Melinda K. Johnson

CERTIFICATE OF SERVICE

I hereby certify that, on October 14, 2026, I caused to be filed electronically a copy of the foregoing document, which will electronically serve all counsel of record who have entered an appearance in the case.

Dated: October 14, 2026

/s/ Melinda K. Johnson
Melinda K. Johnson