No. 18-35920

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PLANNED PARENTHOOD OF GREATER WASHINGTON AND NORTH IDAHO, ET. AL.,
Plaintiffs-Appellants,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Washington
No. 2:18-cv-0207-TOR

AMICI CURIAE BRIEF OF DR. RON HASKINS AND ANDREA KANE, MPA IN SUPPORT OF PLAINTIFFS-APPELLANTS AND IN SUPPORT OF REVERSAL

KATHLEEN HARTNETT*
BRENT K. NAKAMURA
BOIES SCHILLER FLEXNER LLP
1999 Harrison Street, Suite 900
Oakland, CA 94612
(510) 874-1000
khartnett@bsfllp.com
bnakamura@bsfllp.com
* Counsel of Record

MELISSA SHUBE
BOIES SCHILLER FLEXNER LLP
1401 New York Avenue, Suite 1100
Washington, DC 20005
(202) 237-2727
mshube@bsfllp.com

Counsel for Amici Curiae Dr. Ron Haskins and Andrea Kane, MPA

March 18, 2019

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Rules

INTEREST OF AMICI CURIAE[1]

Amici are experts in and advocates for evidence-based programs and policy. Andrea Kane, MPA, appearing in her personal capacity, is the Vice President for Policy and Strategic Partnerships at Power to Decide.[2] Ron Haskins, Ph.D., appearing in his personal capacity, is the Cabot Family Chair, a Senior Fellow in Economics Studies, and the Co-Director of the Center on Children and Families at the Brookings Institution.

Amici possess experience in evidence-based policymaking and teen pregnancy prevention policy and programs. Kane has extensive experience in policy development, advocacy and program innovation at the national, state and local levels, including nearly two decades working specifically on teen pregnancy prevention policies and evidence-based programs at Power to Decide. She served at the Domestic Policy Council in the Clinton Administration, focusing on welfare reform, teen pregnancy, responsible fatherhood, and other social policy issues. Haskins has extensive public policy and research experience, including

---

[1] Amici submit this brief pursuant to Federal Rule of Appellate Procedure 29(a)(2) and state that all parties have consented to its timely filing. Amici further state, pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), that no counsel for a party authored this brief in whole or in part, and no person other than the amici or their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

[2] Power to Decide (formerly The National Campaign to Prevent Teen and Unplanned Pregnancy) is currently a Teen Pregnancy Prevention Program Tier 2 grantee.

serving in senior roles for the House Ways & Means Committee and as Senior Advisor to President George W. Bush for welfare policy. By appointment of Speaker Paul Ryan, he served as co-chair of the bipartisan Evidence-Based Policymaking Commission, and has authored numerous publications about evidence-based policymaking. In 2016, he served as President of the Association for Public Policy Analysis and Management and received the Moynihan Prize from the American Academy of Political and Social Science for his advocacy for public policy based on social science research.

Amici's expertise can assist this Court in understanding the growing national movement towards evidence-based policymaking and the place of the Teen Pregnancy Prevention Program ("TPPP") within this movement. Amici can further assist the Court in understanding how the United States Department of Health and Human Services' ("HHS") 2018 Funding Opportunity Announcement for the TPPP undermines the approach to evidence-based programming provided for by Congress and implemented by HHS prior to 2017.

INTRODUCTION AND BACKGROUND

Since Congress's first authorization of the Teen Pregnancy Prevention Program in December of 2009, Congress has made yearly, direct, specific, and consistent commitments to evidence-based programs designed to reduce teenage pregnancy and associated sexual risks. The TPPP directs HHS to make "grants to

public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy." Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat. 3034, 3253 (2010) ("2010 CAA").[3] HHS uses Funding Opportunity Announcements ("FOAs") to determine TPPP grantees.

In seeking to ensure the effectiveness of the programs funded through the TPPP and to continue building evidence, Congress designed the program with a tiered structure. Congress assigned the majority of TPPP funding to competitive grants for "replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors." 2010 CAA, 123 Stat. at 3253. These are called "Tier 1" grants. In addition, Congress mandated that a smaller share of TPPP funding, called "Tier 2" grants, would go to "research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy." 2010 CAA, 123 Stat. at 3253. Congress permitted up to ten percent of total TPPP funding to go to "training and technical assistance, evaluation, outreach, and additional program support activities." 2010 CAA, 123 Stat. at 3253; 2018 CAA, 132 Stat. at 733 (2018). Of

[3] Congress has reauthorized the program every year, including 2018. *See infra* Section IID; Consolidated Appropriations Act, Pub. L. No. 115-141, 132 Stat. 348, 733 (2018) ("2018 CAA").

the remainder, Congress allocated 75 percent to Tier 1 and 25 percent to Tier 2. *Id.* This tiered structure allowed the TPPP not only to replicate successful programs but to rigorously evaluate innovative, promising approaches to programming.[4] The TPPP's tiered funding structure is recognized as a hallmark of evidence-based policymaking and is similar to other programs enacted around the same time by Congress.[5]

The TPPP's first round of five-year projects based on FOAs issued in 2010 served nearly 500,000 teens in 39 states and Washington, D.C.[6] It also contributed

---

[4] Julieta Lugo-Gil, et al., *Updated findings from the HHS Teen Pregnancy Prevention Evidence Review: August 2015 through October 2016*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (Apr. 2018), https://tppevidencereview.aspe.hhs.gov/pdfs/Summary_of_findings_2016-2017.pdf; Jon Baron, *A Brief History of Evidence-Based Policy*, 678 The ANNALS of the Am. Academy of Pol. and Soc. Sci., 45–48 (2018); Results for America, *Invest in What Works Fact Sheet: Evidence-Based Innovation Programs* (Oct. 21, 2015), https://results4america.org/tools/invest-works-fact-sheet-federal-evidence-based-innovation-programs.

[5] *See, e.g.*, Personal Responsibility Education Program, Pub. L. No. 111-148, 124 Stat. 347, 922 (2010) (evidence-based sexual education program with a tiered structure, enacted as part of the Affordable Care Act); the Maternal, Infant, and Early Childhood Home Visiting Initiative, Pub. L. No. 111-148, 124 Stat. 119, 337-38 (2010) (evidence-based home visiting program containing a tiered structure, enacted as part of the Affordable Care Act, and requiring, inter alia, delivery models that are "research-based" and "grounded in relevant empirically-based knowledge," and that demonstrate positive outcomes as evaluated by "well-designed and rigorous" testing").

[6] Ron Haskins & Andrea Kane, *The Trump Administration Deals a Blow to Evidence-Based Policy,* Evidence-Based Policymaking Collaborative, 2 (Oct.

significantly to building evidence about effectiveness of teen pregnancy prevention programs.[7] HHS's Office of Adolescent Health ("OAH"), which administers the TPPP, issued a second round of FOAs in 2015, again awarding five-year grants. The second round of projects—to be completed in 2020—was on track to serve 1.2 million youth.[8]

Despite Congress's clear language and intent, and consistent support for the TPP Program, in 2017, HHS began trying to dismantle the TPPP. Compl. ¶ 63. First, it attempted to cut short existing TPPP grants after the third of five years. *Id.*[9] In total, this meant 84 grants would lose approximately $200 million in expected funding for years four and five.[10] The attempted grant shortening was challenged in courts across the country and unanimously found to be unlawful.[11]

2018), https://www.evidencecollaborative.org/policy-briefs/trump-administration-deals-blow-evidence-based-policy.

[7] *Id.*

[8] *Id.*

[9] Nate Raymond, *U.S. groups sue Trump administration over teen pregnancy grant cuts*, Reuters (Feb. 15, 2018), https://www.reuters.com/article/us-usa-teens-pregnancy/u-s-groups-sue-trump-administration-over-teen-pregnancy-grant-cuts-idUSKCN1FZ30L.

[10] *Id.*

[11] *King County v. Azar*, 2018 WL 2411759, at *6-8 (W.D. Wash. May 29, 2018); *Policy & Research, LLC v. HHS*, 2018 WL 2184449, at *2-5 (D.D.C. May 11, 2018), *appeal filed* (D.C. Cir. June 21, 2018); *Healthy Teen Network v. Azar*, 2018 WL 1942171, at *1-4 (D. Md. Apr. 25, 2018), *appeal filed*, No. 18-709 (4th Cir. June 26, 2018); *Planned Parenthood of Greater Wash. & N. Idaho v. HHS*, 2018 WL 1934070, at *1-2 (E.D. Wash. Apr. 24, 2018), *appeal filed*, No. 18-35533 (9th Cir. June 26, 2018); *Healthy Futures of Texas v. Dep't of Health & Human Servs.*,

Then, in April 2018, HHS issued new FOAs for Tier 1 and Tier 2 (referred to as the "2018 FOAs"). These FOAs, which are the subject of this appeal, purport to continue the TPPP but actually replace the existing program with criteria that are wholly inconsistent with congressional intent to fund evidence-based programming. Rather than requiring TPPP-funded programs to meet the rigorous requirements for program effectiveness contemplated by Congress, the 2018 FOAs rely on new requirements that lack scientific rigor and favor an ideological "sexual risk avoidance" approach (a rebranded term for abstinence) over evidence-based programs.

The TPPP must be understood within the context of a movement towards evidence and science-based programs, which includes replicating programs that have previously been tested through rigorous evaluation, as well as expanding the evidence base by testing new and innovative approaches. Contrary to congressional intent, the 2018 FOAs impermissibly shift the TPPP away from a tiered evidence-based approach that focuses on results rather than content, towards a single abstinence approach with weak evidence and evaluation standards. The redirection of the TPPP, as reflected by the 2018 FOAs, impedes the scientific

315 F. Supp. 3d 339 (D.D.C. 2018), *appeal dismissed sub nom. Healthy Futures of Texas v. Dep't of Health & Human Res.*, 2018 WL 6167384 (D.C. Cir. Oct. 26, 2018).

enterprise of learning, testing, and continuously improving, which is central to evidence-based policies and programs.

ARGUMENT

I. The TPPP Is Part of A Congressional Movement Toward Evidence-Based Policy Initiatives.

Over a roughly 2-year period beginning in 2009, Congress enacted six evidence-based initiatives including the TPPP.[12] This marked a deliberate, growing effort to ground federal programs in rigorous research and evidence of what works to address selected social problems.[13] The TPPP, and Congress's decision to rely on evidence-based programming, is part of a broader movement toward an

---

[12] Maternal, Infant, and Early Childhood Home Visiting Initiative, *supra* note 5; the TPPP, 2010 CAA, 123 Stat. at 3253; Innovation Fund, Pub. L. No. 111-5, 123 Stat. 115, 284 (2009); Social Innovation Funds Pilot Program, Pub. L. No. 111-13, 123 Stat, 1460, 1564-66 (2009) (appropriating funds to make competitive grants to entities that "have an evidence-based decisionmaking strategy including" the "use of evidence produced by prior rigorous evaluations of program effectiveness including, where available, well-implemented randomized controlled trials" and to, *inter alia*, "replicate and expand research-proven initiatives shown to produce sizeable, sustained benefits to participants or society"); Workforce Innovation Fund, Pub. L. No. 112-10, 125 Stat. 38, 155-56 (2011) (supporting "projects that demonstrate innovative strategies or replicate effective evidence-based strategies that align and strengthen the workforce investment system"); and Trade Adjustment Assistance Community College and Career Training Initiative, Pub. L. No. 111-5, 123 Stat. 115, 406-409 (2009) ("TAACCCT"). *See* Ron Haskins & Greg Margolis, *Show Me the Evidence: Obama's Fight for Rigor and Results in Social Policy* (2015) (describing each of the six evidence-based initiatives); Baron, *supra* note 4, at 44-48.

[13] Haskins & Margolis, *supra* note 12, at 5-12.

evidence-based approach to policymaking, which has gained a foothold in both the scholarly world and in governmental bodies nationwide.[14] The evidence-based policy movement is focused on finding and developing programs that produce measurable positive impacts on the social problems they address. The movement has been particularly effective in the teen pregnancy prevention field, and has produced high-quality evidence showing that a variety of individual teen pregnancy prevention programs can significantly reduce teen pregnancy and improve associated sexual behavior.[15]

The creation of the TPPP also reflected Congress's intent to support an evidence-based alternative to abstinence-only sex education focused on ideological content and lacking evidence or effectiveness requirements.[16] The TPPP was designed to fund programs or approaches, regardless of ideology, as long as they met the evidence criteria and were "medically accurate" and "age appropriate." 2010 CAA, 123 Stat. at 3253. Both the House and Senate Committees acknowledged that abstinence education programs were eligible for TPPP funding

---

[14] Baron, *supra* note 4, at 45-48; Adrienne L. Fernandes-Alcantara, *Teen Pregnancy: Federal Prevention Programs*, Cong. Research Serv. R45183, 4 (2018) ("*CRS TP Federal Prevention Programs*").

[15] Lugo-Gil et al., *supra* note 4, at 1-2.

[16] *CRS TP Federal Prevention Programs*, *supra* note 14, at 3 n.7, 4, 17, 19. For example, at the time Congress first created and appropriated $110 million for the TPPP, it also stopped appropriating $110 million for an abstinence-only education program that was not considered evidence-based. *Id.* at 3 n.7.

provided they met the evidence-based criteria. H.R. Rep. No. 111-220, at 177 (2009) ("Abstinence education approaches meeting the qualifications laid out in the Teenage Pregnancy Prevention program will be eligible for funding under that program"); S. Rep. No. 111-66, at 150 (2009) ("programs formerly receiving abstinence education funding are eligible for funding under this new initiative provided they meet the evidence-based criteria").

In addition to numerous, evidence-based commitments embodied in programs like the TPPP, Congress developed an institutional commitment to evidence-based policymaking more broadly. In March 2016, Congress passed the Evidence-Based Policymaking Commission Act of 2016, establishing a 15-member commission to study, *inter alia*, how data may be used to "facilitate program evaluation, continuous improvement, policy-relevant research, and cost-benefit analysis by qualified researchers and institutions" and to "make recommendations on how to best incorporate outcomes measurement, institutionalize randomized controlled trials, and rigorous impact analysis into program design." Pub. L. No. 114-140, 130 Stat. 317, 318 (2016). The House Committee Report accompanying the Act stated: "Ensuring policymakers have access to high quality administrative data is essential for evidence-based policymaking" and that "[w]ithout evidence, the federal government is an ineffective fiduciary on behalf of the taxpayer." H.R. Rep. No. 114-211, at 5 (2015).

II. The TPPP, As Established And Continually Funded By Congress, Has The Hallmarks Of Evidence-Based Policy.

According to the Collaborative on Evidence-Based Policymaking, "Evidence-based policymaking has two goals: *to use what we already know* from program evaluation to make policy decisions and *to build more knowledge* to better inform future decisions."[17] In practice, the hallmarks of evidence-based policy and programming can be roughly categorized as: (1) rigorous research and scientific evaluation of the efficacy of programs, with effective programs being catalogued and prioritized; (2) a structure that supports and fosters innovation and the development of new programming; and (3) an emphasis on outcomes over ideology.[18] The TPPP embodies each of these principles.

A. The TPPP, As Enacted By Congress, Requires Rigorous Standards For Program Evaluation And Use Of Effective Programs.

A hallmark of evidence-based policy is a prioritization of programs that have already been proven effective through rigorous evaluation. Rigorous evaluation commonly means Randomized Control Trials ("RCT") or Quasi-Experimental

[17] Evidence-Based Policymaking Collaborative, *Principles of Evidence-Based Policymaking*, 2 (Sept. 2016), https://www.evidencecollaborative.org/principles-evidence-based-policymaking.
[18] *Id.* at 2-4; Judith M. Gueron and Howard Rolston, *Fighting for Reliable Evidence* 1-21 (2013).

Designs ("QED").[19] RCTs are an evaluation method in which individuals or families are assigned at random to one of two groups. One group receives the experimental treatment or programming while the other does not, and thus any differences between the two groups at the end of the experiment can be attributed to the treatment or programming. QEDs also include a comparison group, but subjects are sorted into the research groups through a process other than random assignment.[20] Although RCTs are not the only acceptable means of rigorous evaluation, they are the "gold standard" in evaluating programs designed to reduce unwanted public health outcomes because they are based on foundational scientific practices including randomization.[21]

---

[19] Virginia Knox, et al., *Can Evidence-Based Policy Ameliorate the Nation's Social Problems?* 678 The ANNALS of the Am. Academy of Pol. and Soc. Sci., 166–179 (2018).

[20]Mathematica Policy Research, *Identifying Programs that Impact Teen Pregnancy, Sexually Transmitted Infections, and Associated Sexual Risk Behaviors: Review Protocol Version 5.0*, 5 (describing quasi-experimental designs) https://tppevidencereview.aspe.hhs.gov/pdfs/TPPER_Review%20Protocol_v5.pdf.

[21] For example, the latest version of the TPPP Review Protocol used by Mathematica Policy Research, a well-regarded research organization that HHS uses to review and evaluate teen pregnancy prevention programs, explained that "[t]he highest study quality rating is reserved for randomized control trials and similar studies that randomly assigned subjects to their research groups" because such studies "provide the strongest evidence that differences in the outcomes between the treatment and control groups can be attributed to the program." *Id.* at 4; *see also* Evidence-Based Policymaking Collaborative, *supra* note 17, at 7 (describing RCTs as the "gold standard").

As enacted by Congress, the TPPP incorporates rigorous program evaluation by requiring that Tier 1 funding go to "replicating programs that have been proven effective through rigorous evaluation." 2010 CAA, 123 Stat. at 3253. To retain expert guidance on identifying the programs that can qualify for Tier 1 funding because they have been rigorously evaluated and proven effective, HHS established evidence standards consistent with the congressional framework and contracted with Mathematica Policy Research to conduct an objective, systematic review of the literature and identify qualifying teen pregnancy prevention programs.[22] This process, which was managed by the HHS Assistant Secretary for Planning and Education, resulted in the HHS Teen Pregnancy Prevention Evidence Review ("HHS TPP Evidence Review").[23]

The HHS TPP Evidence Review has been maintained and updated periodically to account for the ever-expanding number of evidence-based programs. When initially published in 2010, the HHS TPP Evidence Review listed 28 teen pregnancy prevention programs that met the Tier 1 criteria.[24] *Id.* The most recent update, published in April 2018, included 48 evidence-based programs, including programs that were added as a result of the research produced by the first

[22] Lugo-Gil et al., *supra* note 4, at 1.
[23] *Id.*
[24] Haskins & Kane, *supra* note 6, at 4.

cohort of TPPP grants that operated from 2010-2015.[25] The HHS TPP Evidence Review is also included in a well-established clearinghouse of evidence-based programs by the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation.[26] Databases or clearinghouses of evidence-based programs like the HHS TPP Evidence Review are recognized as essential resources for evidence-based policymaking.[27]

In 2010 and 2015, OAH issued FOAs that were consistent with the evidence-based approach mandated by Congress. For example, the 2010 Tier 1 FOA described "evidence-based program models" as "models for which systematic empirical research or evaluation has provided evidence of effectiveness." ER 983 (2010 Tier 1 FOA). It required applicants to either replicate a program identified as effective on the HHS TPP Evidence Review or replicate other programs if they met "a set of stringent criteria," including that Mathematica review of such

---

[25] *Id.* at 4.

[26] *Results First Clearinghouse Database*, Pew Charitable Trusts and the John D, and Catherine T. MacArthur Foundation, https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database.

[27] *Id.*; *Policy Analysis in the United States* 126 (John Hird ed., University of Chicago Press, 2018) (describing the Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation as examples of "centralized database[s] that enable[] policy analysts to quickly identify the rating issued by eight clearinghouses that examine social policy interventions" and explaining that the clearinghouses have "develop[ed] lists of 'what works'" including "policy choices that rigorous analyses and evaluations have found to be effective").

applications under the "same evidence review criteria" as its previous independent review. *Id.* at 945-946.

B. The TPPP, As Enacted By Congress, Supports New And Innovative Programing Through A Tiered Funding Structure.

In addition to supporting replication of tested, effective programming—as embodied by Tier 1 of the TPPP—evidence-based policymaking also recognizes the importance of continuing to expand evidence by developing and testing new and innovative programming, including programs that have evidence of success but do not yet meet the higher standards of effectiveness. Accordingly, a hallmark of evidence-based policy is a tiered-evidence approach that dedicates a portion of funding to supporting the further development and testing of promising programs.[28] As one organization noted, "Federal evidence-based innovation programs are commonly anchored by a unique system of grant classification, in which grants are awarded to programs according to their level of evidence of effectiveness."[29]

The use of a tiered approach reflects that one important goal of evidence-based policymaking is continuous learning.[30] The lower tier of an evidence-based policy typically includes developing and rigorously evaluating promising programs

[28] Baron, *supra* note 4, at 47-48; Results for America, *supra* note 4.
[29] Results for America, *supra* note 4.
[30] Knox, et al., *supra* note 19, at 168.

over multiple years to determine if they demonstrate strong evidence of success and in turn qualify for higher tier funding. The TPPP's Tier 2 funding serves this function by developing and testing programs in order to expand the menu of effective programs. This includes programming for underserved populations at high risk for teen pregnancy such as Native American and Latino youth, LGBTQ youth, and youth involved in the foster care and juvenile justice systems.

To ensure that the research from Tier 2 TPPP grants could contribute to the evidence base, and so that Tier 2 programs found to be effective could be added to the menu of evidence-based teen pregnancy prevention programs and become eligible for Tier 1 replication in the future, OAH required nearly all of the 2010 Tier 2 and 2015 Tier 2 grantees to rigorously evaluate their projects.[31] *See, e.g.*, ER 852 (2015 Tier 2B FOA) ("all grantees are expected to conduct a rigorous impact evaluation of their proposed intervention against a counterfactual (control) condition"). In addition, all TPPP grant projects were set up as five-year grants which provided adequate time to design and implement a rigorous evaluation, collect both short-term and long-term follow-up data, and report results on at least one behavioral outcome. This allowed the TPPP funding to make vital investments

[31] A subset of Tier 1 grantees were also required to evaluate their projects. However, evaluations are particularly important in the Tier 2 context because of the role of Tier 2 in testing innovative programs.

in innovation and to contribute to expanding the number of effective programs available.

C. The TPPP, As Enacted By Congress, Requires Results Over Ideology.

Another hallmark of evidence-based policymaking is a focus on results rather than ideology.[32] When Congress first enacted the TPPP, both the House and Senate Committees emphasized that, with respect to both Tier 1 and Tier 2 funding, the TPPP was to prioritize evidence over ideology or content. *See supra* Section I at 8-9. As explained above, the TPPP did not mandate a particular program or approach, and abstinence programs could still qualify for TPPP funding if they met the scientific standards (both evidence requirements and medical accuracy), but they were not entitled to priority based on their content or ideology. *See id.*

Until 2017, HHS implemented the TPPP consistent with this non-ideological mandate. The TPPP grants issued in 2010 and 2015 have supported replication of a wide range of approaches and content (including those that focus on abstinence, those that address both abstinence and contraception, and those that focus on healthy relationships and youth development), with the unifying feature that they meet evidence criteria and comply with the statutory requirements to be medically

[32]Evidence-Based Policymaking Collaborative, *supra* note 17, at 2.

accurate and age appropriate.[33] Moreover, the HHS TPP Evidence Review includes four abstinence programs.[34]

D. Congress's Continued Funding Of The TPPP Reflects An Ongoing Commitment To An Evidence-Based Approach.

Congress's commitment to the TPPP has remained significant and steadfast, with annual appropriations ranging from $98.3 million to $110.0 million between fiscal years 2010 through 2018.[35] Congress has continued to use nearly identical funding allocation language for Tier 1 and Tier 2 grants from the TPPP's inception to the present, reflecting an ongoing commitment to a tiered, evidence-based approach. *Compare* 2010 CAA, 123 Stat. at 3253 *with* 2018 CAA, 132 Stat. at 733.

---

[33] Office of Adolescent Health, *TPP Successful Strategies,* https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/successful-strategies/index.html (last visited March 15, 2019); Evelyn Kappeler, Director at OAH, Presentation at the National Conference of State Legislatures, *Teen Pregnancy Prevention Program: A Case Study in Evidence Based Policymaking*, 9-11 (June 30, 2016), http://www.ncsl.org/portals/1/documents/health/TPPwebinar616.pdf.

[34] *See* U.S. Department of Health and Human Services, Teen Pregnancy Prevention Evidence Review, Abstinence program search filter, https://tppevidencereview.aspe.hhs.gov/FindAProgram.aspx (last visited March 15, 2019).

[35] *CRS TP Federal Prevention Programs*, *supra* note 14, at 6, 21.

III. The 2018 FOAs Redirect The TPPP Away From Its Mandated Evidence-Based Approach And Towards Abstinence-Only Programming.

Rather than continuing to fulfill the will of Congress and build on the success of the TPPP, in 2017, the current administration began an effort to dismantle the program. First, in 2017, HHS attempted to prematurely end existing grants under the 2015 FOAs; courts have subsequently invalidated that action. *See supra* note 11. Second, in April 2018, HHS issued new TPPP FOAs that were contrary to Congress's evidence-based mandate. The 2018 FOAs replace the scientifically valid approach of prior FOAs with new tests that do not meet Congress's "rigorous evaluation" requirement, disregard the body of rigorous evidence that has grown in recent years, and favor ideological, abstinence-only content (rebranded as "sexual risk avoidance"). They also use weaker standards for evaluating the new programs than were used in past FOAs. The 2018 FOAs attempt to cloak ideological preferences in the language of "public health priorities" and a "SMARTool" that cannot provide the required "rigorous" evaluation.

A. The 2018 Tier 1 FOA No Longer Requires The Replication Of Effective Programs.

The 2018 Tier 1 FOA ignores the clear congressional directive that Tier 1 funds are to replicate programs "proven effective through rigorous evaluation." 2010 CAA, 123 Stat. at 3253; 2018 CAA, 132 Stat. at 733. Although this language is widely understood to mean replicating a curriculum that has been rigorously

evaluated through an RCT or QED (to determine if it changes behaviors), the 2018 Tier 1 FOA simply drops the requirement to replicate "programs proven effective." 2018 Tier 1 FOA. The 2018 Tier 1 FOA does not even reference the replication of programs "proven effective" or the HHS TPP Evidence Review, which catalogs effective programs. *Id.* Jon Baron, one of the nation's foremost experts in evidence-based policymaking, described the approach as "starting from ground zero as if nothing has been learned."[36]

Instead of requiring the replication of effective programs, the 2018 Tier 1 FOA requires only that applicants "replicate" one of two checklists that the FOA erroneously refer to as "programs." ER 32-33 (2018 Tier 1 FOA). Specifically, the 2018 Tier 1 FOA requires applicants "to replicate a risk avoidance model[37] or a risk reduction model[38] that incorporates the common characteristics outlined in one

---

[36]Pam Belluck, *Trump Administration Pushes Abstinence in Teen Pregnancy Programs*, The New York Times (Apr. 23, 2018). https://www.nytimes.com/2018/04/23/health/trump-teen-pregnancy-abstinence.html.

[37] The terms "risk avoidance" and "sexual risk avoidance" are synonymous with "abstinence-only." ER 1046 (Kantor Decl. ¶ 29). For instance, sexual risk avoidance is defined "as voluntarily refraining from non-marital sexual activity" in the statute establishing the Sexual Risk Avoidance Education Program, a rebranded abstinence grant program. 42 U.S. Code § 710 (b)(1).

[38] While the 2018 FOAs do not define sexual risk reduction, it is reasonable to assume it means something similar to "comprehensive risk reduction" interventions. Comprehensive risk reduction interventions may include or promote abstinence, but do not exclusively rely on abstinence. For example, the Community Preventive Services Task Force (CPSTF), an independent group whose

of the two programs"—the Systematic Method for Assessing Risk-avoidance tool ("SMARTool") or the Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs (TAC). *Id.* The 2018 Tier 1 FOA states that the "programs" include "protective factors shown to be effective in preventing teen pregnancy and/or sexual risk behaviors with youth." *Id.* at 32. But the SMARTool and TAC, and the characteristics (or "protective factors") they bundle, are *tools* for choosing programs, not themselves programs. The FOA's use of tools designed to identify programs is not equivalent to or a substitute for Congress's directive to support programs through Tier 1 only if such *programs* are proven effective by RCTs or other rigorous evaluation. Actual trial and evaluation of the programs themselves is required to determine effectiveness. As Jon Baron has explained, "Until you have an evaluation of an actual program that people are showing up for and an actual curriculum and actual people teaching it, you really don't have reliable evidence."[39]

---

members are appointed by the Director of the Centers for Disease Control and Prevention, issued a report in 2012 that explained, "As defined by this review, comprehensive risk reduction interventions promote various behaviors to prevent or reduce the risk of pregnancy, HIV, and other STIs. Abstinence education interventions, however, promote only abstinence from sexual activity." The Guide to Community Preventive Services, *Abstinence Education and Comprehensive Risk Reduction for Teens,* https://www.thecommunityguide.org/content/abstinence-education-and-comprehensive-risk-reduction-for-teens.

[39] Belluck, *supra* note 36 (quoting Baron).

Compounding the problems with the 2018 Tier 1 FOA's tool-based approach is that the SMARTool —one of the two options—is out of date, lacks transparency, and does not have a clear link to demonstrated results.[40] First published in 2008,[41] the SMARTool fails to incorporate the substantial body of evidence accumulated in recent years about most effectively serving the targeted population. HHS essentially acknowledged the weakness of relying on the tool when it published a request in the Federal Register, on July 2, 2018, for authorization to "assess the SMARTool's impact" by conducting an evaluation seeking "preliminary evidence" of the effectiveness of curriculum aligned with SMARTool.[42] Accordingly, the SMARTool appears to neither be a "program" nor already "proven effective."

---

[40] The SMARTool's nine "protective factors" or "targets" appear to have been developed from a literature review. There is no indication that the nine curricula had rigorous evaluations—either RCTs or high quality quasi-experimental designs—showing behavior change. A SMARTool summary states that the nine protective factors create an "*evidence-informed* framework that provides practical strategies most likely to achieve positive behaviors and attitudes related to sexual activity." *SMARTool Summary Document*,1, https://www.myrelationshipcenter.org/getmedia/dbed93af-9424-4009-8f1f-8495b4aba8b4/SMARTool-Curricula.pdf.aspx. There is a significant difference between an "evidence-informed" framework and programs that have actually proven effective—as evaluation experts well understand.

[41] *Id.* at 1.

[42] Agency Information Collection Request; 60-Day Public Comment Request, 83 Fed. Reg. 127 (July 2, 2018), https://www.federalregister.gov/documents/2018/07/02/2018-14203/agency-information-collection-request-60-day-public-comment-request.

In sum, the 2018 Tier 1 FOA discards appropriate scientific standards for determining whether programs are eligible for Tier 1 funding and replaces them with a watered-down requirement that does not embody the replication of rigorously evaluated programs required by Congress for Tier 1 funding.

B. The 2018 Tier 1 And Tier 2 FOAs Favor Ideological, Abstinence-Only Content Over An Evidence-Based Approach.

As explained above, Congress directed that the TPPP be evidence-based and ideology-neutral. Yet, in a break from past practice and congressional intent, the 2018 FOAs for both Tier 1 and Tier 2 emphasize content that is clearly synonymous with an abstinence-only approach.

Specifically, both of the 2018 FOAs require "weaving the goal of optimal health into every component." ER 43, 88 (2018 Tier 1 FOA); ER 136 (2018 Tier 2 FOA). While "optimal health" is a broadly used public health term, in this particular context it is a euphemism for teen abstinence. For example, the term appears in the Sexual Risk Avoidance Education program, a rebranded abstinence grant program, which states, "Education on sexual risk avoidance" shall "ensure that the unambiguous and primary emphasis and context for each topic . . . is a message to youth that normalizes the *optimal health behavior* of avoiding nonmarital sexual activity." 42 U.S.C 710(b)(2)(A)(2018) (emphasis added).

The 2018 FOAs also emphasize "public health priorities," which require all programs to "clearly communicate that teen sex is a risk behavior for both the

physical consequences of pregnancy and sexually transmitted infections; as well as sociological, economic and other related risks" and "include skills associated with helping youth delay sex as well as skills to help those youth already engaged in sexual risk to return toward risk-free choices in the future." ER 43-45, 88-89 (2018 Tier 1 FOA); ER 136-137, 177-178 (2018 Tier 2 FOA). The 2018 Tier 1 FOA requires grantees to overlay these priorities *on top of* the "program" they "replicate," ER 32-33, 43, 88 (2018 Tier 1 FOA), contrary to the well-recognized scientific understanding that replication of a program does not permit one to meaningfully change the program.

Further confirming the ideological intent of the 2018 FOAs, and in sharp contrast to past FOAs, the scoring criteria gives the largest allocation of points to applicants that meet these current ideological priorities. ER 87 (2018 Tier 1 FOA); ER 177 (2018 Tier 2 FOA).

Amici respectfully submit that the 2018 FOAs' "optimal health" and "public health priorities" requirements, combined with the scoring criteria favoring abstinence, would prevent a program not primarily focused on abstinence from obtaining funding. Thus, contrary to the district court's ruling on review, the 2018 FOAs would require Plaintiffs "to go against their commitment to implementing evidence-based programs in favor of abstinence-only education." ER 20-21 (Order Granting Defendants' Cross-Motion to Dismiss).

In addition, the 2018 Tier 1 FOA's focus on abstinence is entirely divorced from whether the abstinence content is proven effective or leads to a demonstrated change of behavior—further showing that the Tier 1 2018 FOA favors ideology over efficacy. While many abstinence-only programs have been shown to have no demonstrable effect,[43] there are, as noted earlier, some abstinence programs that have met the standards for the HHS TPP Evidence Review. However, the 2018 Tier 1 FOA neither requires replication of such evidence-based programs nor even references this evidence review.

While there is little disagreement about the value of ensuring youth know the value of delaying sex as one option, the messages favored by the 2018 FOAs make it more difficult to meet the needs of youth who will become or are already sexually active. Indeed, the FOAs contain virtually no recognition of the value of giving youth information about the effective use of condoms and other forms of contraception to protect themselves from pregnancy or STIs. No matter what path TPPP grant applicants choose, the clear implication is that anything other than not having sex is not "optimal health behavior." This anti-scientific, ideological approach ignores the needs, realities, and risks faced by many young people.

[43] Haskins & Kane, *supra* note 6, at 11.

C. The 2018 Tier 2 FOA Hinders Congress's Intent To Develop And Test Innovative Strategies.

As explained above, Congress created Tier 2 grants—a recognized part of evidence-based policymaking—to develop and test innovative strategies for preventing teenage pregnancy. The 2018 Tier 2 FOA makes it more difficult for grantees to be effectively evaluated and for successful programs to be identified. In addition, the requirement that all programs emphasize abstinence-only messages, s*upra* Section IIIB, limits innovation.

First, the 2018 Tier 2 FOA does not permit the same type of rigorous evaluation of effectiveness enabled by the 2010 and 2015 grants, which provided for adequate time and funding to collect and evaluate data. Instead, the 2018 Tier 2 FOA calls for "formative and process/implementation evaluation" during years 1-2, and asks applicants to "propose a summative outcome/impact evaluation plan" in the second year. ER 137-139 (2018 Tier 2 FOA). To begin with, process and implementation evaluations do not assess the impact or efficacy of the program.[44] With respect to the second year evaluations, the FOA indicates grantees "may" be selected to begin this second type of evaluation, *id.* at 139, but

[44] Centers for Disease Control and Prevention, *Types of Evaluation*, 1, https://www.cdc.gov/std/program/pupestd/types%20of%20evaluation.pdf (describing "process/implementation evaluation" as determining "whether program activities have been implemented as intended" and "outcome/effectiveness evaluation" as measuring "program effects in the target population.")

since the 2018 Tier 2 projects last only two years, grantees would then have to compete for a subsequent two-year grant in 2020 to continue the evaluation. In short, while the 2018 Tier 2 FOA requires grantees to propose a plan for rigorous evaluation, the funding awarded could not possibly support a grantee in actually carrying out such an evaluation within the time frame and funds awarded. This makes it exceedingly difficult for Tier 2 programs to be effectively evaluated, which in turn makes it less likely that they could produce rigorous evidence in order to expand options of evidence-based programs eligible for Tier 1 replication in the future.

The shortened time frame of the 2018 FOAs also makes it more difficult for Tier 2 grantees to develop programs that, if effective, can be "implementation ready" for replication by the end of the two year period. Previous FOAs required that Tier 2 grantees "document and package the intervention to be implementation ready and able to be replicated if found to be effective." ER 833, 848-849 (2015 Tier 2B FOA). The 2018 Tier 2 FOA drops the "implementation ready" requirement in this context, and asks recipients only to "document and package key pieces of their project." ER 145 (2018 Tier 2 FOA).

In addition, the abstinence requirements, described in *supra* Section IIIB, limit the kind of innovation that the Tier 2 grants were designed to encourage. Requiring the programs to focus on abstinence constrains the range of innovation

that grantees might pursue to fill gaps in scientific knowledge about how to most effectively serve at-risk youth, many of whom are sexually active or are likely to begin having sex within a few years.

IV. The 2018 FOAs, By Disrupting And Redirecting TPPP Funding, Harm Congress's Goals And The Scientific Enterprise.

The TPPP, as implemented prior to the 2018 FOAs, has significantly advanced both the field of adolescent pregnancy prevention and the broader field of evidence-based policy. Transforming the TPPP as embodied by the 2018 FOAs would severely undercut Congress's goals, including both teen pregnancy prevention and the scientific enterprise of replicating effective programs, learning, testing, and continuously improving that the TPPP embodies.

Until 2017, HHS's administration of the TPPP was viewed as a shining example of how to implement high quality evidence-based policymaking.[45] As the congressionally-created Commission on Evidence Based Policymaking reported in 2017:

> The Commission identified numerous examples of Federal programs developing increasingly rigorous portfolios of evidence . . . One example is

[45] ER 1124 (Commission on Evidence-Based Policymaking, *The Promise of Evidence-Based Policymaking*); Daniel Stid, et al., *What Does It Take to Implement Evidence-Based Practices? A Teen Pregnancy Prevention Program Shows the Way,* The Bridgespan Group, 2 (Nov. 2013), https://www.bridgespan.org/bridgespan/Images/articles/What-Does-It-Take-to-Implement-Evidence-based-Prac/What-Does-It-Take-to-Implement-Evidence-based-Practices.pdf (describing the TPPP as a "model worth emulating").

> the Teen Pregnancy Prevention Program administered by HHS, which was designed to address high teen pregnancy rates in the United States by replicating evidence-based models and testing innovative strategies. Evidence building was woven into the program from the start, including a full range of studies from implementation assessments to impact evaluations, using random assignment when appropriate.[46]

Among other things, in implementing the TPPP through 2017, HHS has supported and published an unprecedented number of high quality evaluations, played a leadership role in convening researchers and grantees to exchange information and learned from results, produced two peer-reviewed journal supplements documenting both the process and results from the program, and provided strong technical assistance and support to communities doing the hard work of replicating and evaluating evidence-based programs and testing new and innovative approaches.[47]

The TPPP also has produced impressive results from its inception through the recent efforts to subvert it, exceeding the expectations of experts. Evaluation experts understand that replicating results under rigorous evaluation is difficult; experts find that only 10 to 20 percent of RCTs across various disciplines

---

[46] ER 1124 (Commission on Evidence-Based Policymaking), *supra* note 45.
[47] *Implementing Evidence-Based Teen Pregnancy Prevention Programs: Legislation to Practice*, 54 J. of Adolescent Health, Issue 3, Supplement (2014) S1-S96, https://www.jahonline.org/issue/S1054-139X(13)X0030-8; 106 Am. J. of Pub. Health, no. S1 (2016), https://ajph.aphapublications.org/toc/ajph/106/S1; *see also* Haskins & Kane, *supra* note 6, at 6-7.

demonstrate positive results.[48] In July 2016, OAH published 41 studies from the first cohort of TPPP grantees.[49] In total, 12 individual programs that were evaluated demonstrated at least one significant positive impact—including 4 of 10 (40 percent) of Tier 1 programs and 8 of 19 (42 percent) of Tier 2 programs.[50] With respect to individual *studies* rather than *programs* (as several programs were evaluated in multiple settings), 4 of 19 (21 percent) of Tier 1 evaluations and 8 of 22 (36 percent) of Tier 2 evaluations produced at least one significant positive impact.[51] Excluding 13 studies that OAH determined to be inconclusive due to implementation or evaluation challenges (such as having too small a sample size), 4 of 12 (33 percent) of Tier 1 evaluations and 8 of 16 (50 percent) of Tier 2 evaluations produced positive impacts.[52] In short, by any measure, the TPPP's results far exceeded the 10-20 percent positive impact that experts typically expect

---

[48] Ron Haskins & Nathan Joo, *Tiered Evidence: What Happens When Evidence-Based Teen Pregnancy Programs are Scaled Up to New Sites?* Evidence-Based Policymaking Collaborative, 6 (May 2017), https://www.evidencecollaborative.org/policy-briefs/tiered-evidence-what-happens-when-evidence-based-teen-pregnancy-programs-are-scaled; Ron Haskins, *Evidence-Based Policy: The Movement, the Goals, the Issues, the Promise*, 678 The ANNALS of the Am. Academy of Pol. and Soc. Sci., 9 (2018).
[49] Haskins & Kane, *supra* note 6, at 7.
[50] *Id.*
[51] *Id.*
[52] *Id.*

for rigorous evaluation.[53]

HHS's efforts to cut short the work of the 2015 TPPP grantees (actions which were subsequently halted by multiple courts), not only interrupted needed services to young people but disrupted critical research and evaluation already underway. The 2018 FOAs further interfered with a key feature of evidence-based policymaking—faithfully replicating and rigorously evaluating proven programs to determine whether results can be reproduced in new settings or with different populations, one of the biggest challenges facing the broader evidence movement.

The disruption caused by HHS's recent actions has also been damaging to the Tier 2 programs, nearly all of which were being rigorously evaluated and had the potential to contribute substantially to expanding knowledge about new programs to serve youth, especially underserved youth and communities. The 2010 Tier 2 grantees had already contributed important new knowledge and expanded the menu of evidence-based programs that communities could choose from, and the 2015 Tier 2 grantees were on track to yield even more evidence-based approaches to meet the diverse and evolving needs of teens. HHS's reckless actions concerning TPPP implementation created enormous uncertainty, likely

[53] *Id.*; Robert Gordon and Ron Haskins, *Trump team doesn't understand evidence-based policies regarding social problems*, The Hill (July 26, 2017), https://thehill.com/blogs/pundits-blog/the-administration/343908-trump-team-doesnt-understand-evidence-based-policies.

affecting the ability of some evaluations to recruit participants and to achieve the sample sizes needed to meet their evaluation targets.[54]

CONCLUSION

HHS's undermining since 2017 of the evidence-based TPPP that Congress intended, including through the 2018 FOAs, not only undermines the effort to effectively prevent teen pregnancy but damages the larger field of evidence-based policymaking and programs. The 2018 FOAs are contrary to recognized standards of evidence-based policymaking and represent a major step backwards—both for the communities served by the TPPP and the broader evidence-based approach to policymaking that the TPPP was intended to advance.

[54] Haskins & Kane, *supra* note 6, at 12.

Respectfully submitted,

/S/*KATHLEEN HARTNETT*

KATHLEEN HARTNETT
BRENT K. NAKAMURA
BOIES SCHILLER FLEXNER LLP
1999 Harrison Street, Suite 900
Oakland, CA 94612
(510) 874-1000
khartnett@bsfllp.com
bnakamura@bsfllp.com

MELISSA SHUBE
BOIES SCHILLER FLEXNER LLP
1401 New York Avenue, Suite 1100
Washington, DC 20005
(202) 237-2727
mshube@bsfllp.com

Counsel for Amici Curiae Dr. Ron Haskins and Andrea Kane, MPA

March 18, 2019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 8. Certificate of Compliance for Briefs

Instructions for this form: http://www.ca9.uscourts.gov/forms/form08instructions.pdf

9th Cir. Case Number(s) 18-35920

I am the attorney or self-represented party.

This brief contains 6,941 **words**, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

I certify that this brief *(select only one)*:

- (•) complies with the word limit of Cir. R. 32-1.
- ( ) is a **cross-appeal** brief and complies with the word limit of Cir. R. 28.1-1.
- ( ) is an **amicus** brief and complies with the word limit of Fed. R. App. P. 29(a)(5), Cir. R. 29-2(c)(2), or Cir. R. 29-2(c)(3).
- ( ) is for a **death penalty** case and complies with the word limit of Cir. R. 32-4.
- ( ) complies with the longer length limit permitted by Cir. R. 32-2(b) because *(select only one):*
  - ( ) it is a joint brief submitted by separately represented parties;
  - ( ) a party or parties are filing a single brief in response to multiple briefs; or
  - ( ) a party or parties are filing a single brief in response to a longer joint brief.
- ( ) complies with the length limit designated by court order dated _____.
- ( ) is accompanied by a motion to file a longer brief pursuant to Cir. R. 32-2(a).

Signature /s/ Kathleen Hartnett **Date** 3/18/2019

(use "s/[typed name]" to sign electronically-filed documents)

Feedback or questions about this form? Email us at forms@ca9.uscourts.gov

CERTIFICATE OF SERVICE

I hereby certify that on March 18, 2019, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the CM/ECF system. I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ *Kathleen Hartnett*
Kathleen Hartnett